Paid Feeding Assistant Training

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The Meaning of Mealtime

Mealtime is more than the simple intake of food. It is also a time for pleasure. The company of friends and family adds social enjoyment, and often mealtime becomes a pleasurable experience associated with home.

Mealtime can be the highlight of the resident's day.

Food choices have been influenced over time by many factors, including:

- Culture
- Emotions
- Surrounding
- The people around us
- Our personal views of ourselves
- Foods that were available at a given time in our lives; and
- What people know about nutrition

Many lifestyle changes which accompany the aging process can take away from a resident's dining pleasure. As a person ages, physical challenges may interfere with the ability to open packages and cartons or to use utensils. Biological changes such as hearing and vision loss may also interfere with the enjoyment of food.

A pleasant mealtime experience may help residents who have been struggling with a poor appetite.

Caregivers' attitudes toward residents directly affect how the residents eat. A respectful and kind approach is encouraging and stimulates the resident's efforts toward independence. During mealtime, the feeding assistant should focus on the resident. It is important to be attentive, listen well, and provide for the resident's needs. Anticipate the resident's needs in an unobtrusive manner.

The feeding assistant's attitude sets the mood at mealtime and is an important factor in meal acceptance. Always treat residents with respect.

Everyone has a lifestyle associated with mealtimes. Some residents prefer to maintain their previous mealtime lifestyle. They may prefer a large lunch and small dinner, or a large breakfast and small lunch and dinner. Previous lifestyle may have a large influence on the residents' mealtime preferences and their intake.

Feeding Assistant Regulation

- CMS Regulation §483.16 allows for the cross training of non-nursing staff to assist with nutritional care
- Almost all states have also passed state-level regulations

History

- Growing care needs in long-term care
- Feeding assistance required by many residents
- Good quality assistance takes a lot of staff time
- Many homes do not have enough CNAs

Feeding Assistant Regulation

Goals of both federal and state regulations:

- Increase number of staff available to help with nutritional care tasks both during and between meals
- Improve the quality of care so that residents receive:
  - Amount of help they need during meals
  - Snacks and supplements between meals
  - Availability of options (resident-centered)

Federal Feeding Assistant Regulation

- 8 - Hour Training Course: **MUST COMPLETE ALL 8 HOURS**
  - Assistance with Feeding & Hydration
  - Diet (types and purpose)
  - Feeding Techniques (not limited to physical help)
  - Communication & Interpersonal Skills (how to keep resident's attention)
  - Appropriate Responses to Resident Behavior (difficult behaviors)
  - Resident Rights (offering choices, dignity)
  - Recognizing Changes in Residents (warning signs and symptoms)
  - Safety & Emergency Procedures (choking risk)
  - Infection Control (proper handling of food when helping)

Complete Written or Performance Evaluation

Feeding Assistant Regulation

- **REQUIREMENTS – Important Things you Need to Know:**
  - Assistants cannot help residents with "complicated feeding issues" (e.g., history of aspiration, high risk of choking) - A licensed nurse or Speech Therapist in your facility should make this decision.
  - Assistants should not provide care for which they have not been trained (e.g., helping residents out of bed, to the bathroom).
  - Training does not have to be repeated unless it's been more than 1 year since you last worked as an Assistant.

Role of Dining Assistant

- Most places have more residents who need help than they have CNAs to provide help.
- The more staff who are trained to help, the better the care will be for all residents.
- Each facility should decide how best to utilize assistants (meals, snacks, weekdays/weekends).

Module 2 – Nutrition, Hydration, and Therapeutic Diets

Objectives

- At the end of this module, you will be able to:
- Describe the importance of adequate nutrition and hydration;
- Describe your facility's special or therapeutic diets;
- Identify your facility's texture modified diets and liquids;
- Explain the importance of fluid intake for older adults; and
- Define the terms dysphagia and aspiration.

This module includes:

- Nutritional and fluid needs
- Dehydration
- Nutrition and weight loss
- Nutrition and pressure ulcers
- Therapeutic diets
- Swallowing, dysphagia, and aspiration

Importance of Good Nutrition
Older adults require extra foods and fluids due to:

- Chronic illness
- Wound healing (e.g., pressure ulcers, skin breakdown)
- Muscle weakness
- Higher risk for acute illness

An acute illness (stomach virus, flu) can quickly lead to weight loss, dehydration and hospitalization. As a general rule, older adults benefit from having some 'extra' weight to protect them against rapid decline.

Nutritional Needs

Food needs change as a person ages. As we get older, most of us use less energy or calories. We do not need as many calories as we did in our younger years. Older adults need the same amount of vitamins, minerals, and protein as they did when they were younger. When they are sick, have a healing wound or a pressure ulcer, they need more vitamins, minerals, and protein to get better and to heal. Good nutrition may have positive effects on the physical and mental health of the elderly. For some elderly people protein-rich foods, such as meat or poultry, may be hard to chew or to digest.

Why is Nutrition Important?

- The energy and nutrients from the foods we eat are necessary to maintain health, to prevent injury and disease, and to manage chronic illness.
- What is necessary for good nutrition?
    - Whole foods
    - Variety
    - Balance
    - Consistency
    - Adequate fluid / water intake
    - Adequate vitamins & minerals

Warning Signs of Malnutrition

What might you notice?

- Poor appetite (change in appetite) eats less than 3/4 of meals and snacks
- Low food intake (less than half of meal, refusal of snacks)
- Increased tiredness, weakness
- Swelling
- Difficulty chewing or swallowing
- Skin breakdown: delayed wound healing, cracked skin, dry skin, hair loss
- Weight loss
- Muscle mass loss
- Fat mass loss
- Fluid accumulation/edema

A person's size is not a good indicator – a larger person can still become malnourished and unplanned weight loss is still a bad sign, regardless of someone's size.

Notify a nurse of any changes or concerns.

Risk Factors for Poor Nutrition

- Older age
- Physical inactivity
- Illness or Injury
- Diarrhea / Fever
- Fatigue
- Poor appetite
- Impaired taste or smell
- Missing teeth / Loose dentures
- Impaired memory or cognition
- Loneliness or depression
- Pain / Discomfort
- Lack of assistance

Outcomes of Poor Nutrition

- Increases risk for infection
- Exacerbates chronic illness
- Loss of muscle mass and physical strength
- Slows wound healing
- Constipation or diarrhea
- Falls and fractures
- Poor quality of life

Fluid Needs

Water is the most abundant substance in the human body as well as the most common substance on earth. Like the oxygen you breathe, you can't live without water. People need approximately six to eight cups of water or other fluids every day. Drinking water and other beverages are the main sources of fluids. People "eat" quite a bit of water in solid foods, too. For example, juicy fruits and vegetables, such as lettuce, watermelon, celery, and tomato, contain more than 90% water. Even dry foods, such as bread, supply some water.

Thirst is like a warning light that's flashing on the dashboard of a car. This physical sensation signals us that our body needs more fluid to perform its many functions. To satisfy thirst, we drink fluids. Thirst signals the need for fluids, but it is not a foolproof mechanism. Body fluids may already be depleted in the older population if they wait until they feel thirst.

Many older adults have a decreased sensation of thirst and do not drink adequate fluids. To prevent inadequate fluid intake requires a team approach. Many older adults cannot drink large amounts of liquids all at once but will drink smaller amounts throughout the day.

Some residents may not drink adequate fluids as a result of a fear of incontinence, their inability to request adequate fluids, or as a medication side effect. It is important for all staff members to offer a variety of beverages throughout the day, as well as at meals.

Dehydration is a condition of a loss of body water. A dehydrated resident may experience thirst, followed by fatigue, weakness, delirium, and ultimately death. While these events may take days or weeks to occur, it is important that everyone involved in the resident's care be alert for signs of dehydration, particularly among those residents who are at risk.

Conditions That Increase Risk of Dehydration

- Fever
- High protein diet
- Infection
- Constipation
- Confusion
- Diarrhea
- Medications
- Decreased appetite
- Draining wounds
- Excessive sweating

Warning Signs of Dehydration

What might you notice?

- Dry or sticky mouth/tongue
- Increased confusion
- Increased tiredness, weakness
- Hollow or sunken look under eyes
- Fast pulse
- Low urine and/or strong smell of urine
- Dry or cracked lips
- Dry, flaky, cracked skin
- Fatigue

- Tongue thick and coated white
- Constipation

Notify a nurse of any changes or concerns.

Suggestions to Ensure Adequate Fluid Intake

- Give residents who may be confused special attention to include placing cup/straw in person's mouth or making frequent offerings of sips of liquid.
    - Offer a variety of liquids
    - Offer liquids that meet the resident's preferences
- Check that adaptive devices to aid the drinking process are available (such as special cups). (Note: These are only to be used if medical personnel, such as the speech therapist, have given the resident an adaptive device.)

Items that Interfere with Adequate Nutrition and Fluid Intake

- Inability to feed oneself
- Poor oral health
- Dementia
- Medications
- Depression
- Medical condition
- Loss of senses (smell, taste, sight)

Risk Factors for Poor Nutrition

Imagine the last great meal you ate. What made it memorable? How does this compare to mealtime in the long-term care setting?

Risk Factors: Physical

- Physiological changes with advancing age
- Reduced hunger/thirst sensations
- Poor dentition (few teeth, ill-fitting dentures, mouth sores)
- Physical impairment
- Inability to feed self (e.g., stroke, dementia)
- Difficulty holding utensils (e.g., tremors, contractures)
- Difficulty chewing, swallowing

Risk Factors: Sensory

- Medications
- Some common medications can reduce appetite or change sense of taste
- Diet orders may make food less appealing in taste, texture and/or appearance
- Sensory impairment
    - Reduced taste
    - Impaired sight
    - Reduced smell
    - Impaired hearing (interfere with assistance)

Risk Factors: Cognitive Impairment

- Memory and perception of time
    - Forget that they have (or haven't) eaten
    - May not remember how to use silverware
- Perception of Food
    - May not recognize certain foods or what is edible v. inedible

Risk Factors: Surroundings

- Noisy dining room – distracting, confusing
- Different staff - interrupted assistance
- Improper positioning – increases choking risk
- Lack of Socialization – mealtime should be enjoyable, a social event

Risk Factors: The Environment

- Lack of familiar food options
- Habit, culture, religion
- Dining routines that work well for staff but don't necessarily reflect resident preferences (timing, location)
- Limited options alternatives to served meal, variety of snacks

Risk Factors: The Psycho-Social

- Loneliness (lack of social interaction)
- Depression (lack of enjoyment)
- Frustration (dependence on staff, limited choices)
- Discomfort (pain, constipation, arthritis)

What can you do as an Assistant?

- Take resident to the dining room for meals.
- Sit with resident throughout the meal and talk to them (socially, reminders to eat).
- Offer choices (during meals and between meals).

Weight Loss

Weight loss is a frequent problem among the elderly. Weight loss may be caused by many factors. It may be due to an infection or a disease, such as cancer. Other contributors to weight loss in the elderly may include the following:

- Increased need for assistance with eating
- Disability
- Ill-fitting dentures
- Teeth in need of repair
- Depression
- Changes in body composition
- Confusion or memory loss
- Increased nutritional needs
- Frequent use of medication or multiple medications
- Immobility
- Lack of socialization

The primary goal of feeding assistants is to help prevent weight loss in residents.

Pressure Ulcers

Pressure Ulcer/Pressure Sore:

- Skin with a reddened area or an open sore that develops as a result of pressure
- Pressure ulcers usually develop over a bony area
- One risk factor for pressure ulcers is poor nutritional intake
- Nutritional needs may be increased due to weight loss, pressure ulcers, or both
- You may assist someone who receives a nutritional supplement, such as a milkshake or cookies. These specialty items usually have added protein to aid with the healing of pressure ulcers.

Some examples of nutritional approaches are:

- Enhanced foods, such as super cereal
- Supplement drinks, such as shakes and Ensure
- Between meal snacks and supplements
- Protein powder added to food and drinks

Diet

- The amount and type of foods and beverages that a person consumes.
- Residents have orders for a specific diet that indicates the amounts and types of foods.
- A resident's diet orders are located in the medical chart and on his/her meal ticket.
- Facilities may also have a diet order list and snack chart posted in the main dining room.

Diet Goal

- The registered dietitian nutritionist (RDN) assesses the resident and determines which diet is most appropriate.
  - The speech therapist (SLP) has a role in assessing type of diet when there are swallowing problems.
- In choosing the most appropriate diet, the RDN considers eating problems, health needs, nutrient needs, and individual preferences.

Importance of Therapeutic Diets

There is a relationship between nutrition and disease. Some residents will have doctor's orders for a special or "therapeutic" diet to meet their needs. This means one or more ingredients are lowered or increased in the diet, or the food texture needs to be changed or modified. Some examples are low cholesterol, low sodium, and pureed diets. Special diets are designed to meet the specific nutrient needs of a resident who has an illness or injury or chronic disease. The regular diet has been altered to meet the specific nutrient needs of the resident's health condition

The type of therapeutic diet prescribed by the doctor depends on:

- the presence of disease or potential disease; and/or
- the presence of chewing or swallowing problems or the potential for chewing or swallowing problems.

It is very important that residents with doctor's orders for therapeutic diets be given those diets.

For frail older adults, their overall health goals may not warrant the use of a therapeutic diet because of its possible negative effect on their quality of life. If the resident finds the diet unpalatable or unacceptable, he or she may refuse all or part of the food and/or fluids offered. Poor food and fluid intake results in weight loss and undernutrition, followed by a spiral of negative health effects. There has been a recent trend in nursing facilities toward reducing dietary restrictions. It is still very important that therapeutic diets are served when there is a doctor's order.

This manual reviews the following types of therapeutic diets:

- High Calorie, High Protein Diets
- Reduced Sodium Diets
- Low-fat and Low-cholesterol Diets
- Calorie- and Carbohydrate-controlled Diets
    - Diabetic -- Also called Carbohydrate Controlled or No Added Sweets
    - No Added Salt (NAS) -- Also called Low Sodium
    - Renal
    - Fluid Restricted
    - Facility Specific Diets
    - Texture-modified Diets

High Calorie, High Protein Diets

A high calorie, high protein diet is used to provide extra energy (or calories) and extra protein to improve nutritional status, promote weight gain, aid in healing wounds, or aid the resident's response to a medical treatment. The diet consists of foods that are higher in calories and protein. Occasionally, small frequent feedings of high calorie, high protein foods are encouraged to increase intake. Nutritional beverages, also called supplements or shakes, may be provided to residents in order to increase protein or calorie intake.

Reduced Sodium Diets

Some diets may be restricted in sodium, commonly found in table salt and naturally occurring in some foods. Sodium-restricted diets are used to limit the amount of sodium provided in order to prevent a buildup of fluid, to promote a loss of excess body water, or both. Diet orders may state low sodium, 4-gram sodium, 2-gram sodium, or no added salt. A "No Added Salt Diet" usually means there should be no salt packet on the resident's tray.

Low-fat and Low- cholesterol Diets

Low-fat diets and low cholesterol diets restrict the type of fats or the amount of fat provided. A diet order may state low fat or low cholesterol, or both restrictions may be included.

Calorie and Carbohydrate controlled Diets

In order to better manage diabetes (a condition which causes the body problems with processing carbohydrates, fat, and protein) or to induce weight loss, diets may restrict calories or total carbohydrates. There may be a diet order, for example, that states "1500-calorie diet" or "no concentrated sweets." The "No Concentrated Sweets" diet is a regular diet with desserts that have been modified. There are also "Controlled Carbohydrate" and "Consistent Carbohydrate Diets," which omit the sugar packet but allow regular foods and desserts.

Diabetic Diet

- Also called Controlled Carbohydrate (CCHO) or No Added Sweets
- For residents diagnosed with diabetes – designed to control blood glucose (blood sugar)
- Portion sizes of high carbohydrate foods (foods high in starch or sugar) are smaller
- Smaller portions of desserts or sweet items
- Uses sugar substitutes

No Added Salt (NAS) Diet

- Also called Low Sodium diet
- For residents with hypertension (high blood pressure) or heart disease.
- A regular diet - except no salt is added to foods during or after preparation.
- No salt packet or saltshaker is allowed with the resident's meals or snacks.

Renal Diet

For residents who have a diagnosis of Chronic Kidney Disease or get Dialysis (when the kidneys do not filter urine and function normally). Nutrients that must be monitored and are usually restricted:

- Potassium, Phosphorus, Sodium, Fluid
- Excess amounts of these nutrients can cause heart problems, fluid retention (edema), and bone loss.
- Foods to avoid: tomatoes, potatoes, bananas, oranges, beans, processed meats, salt packets, and dairy products

Fluid Restricted Diet

- A fluid is anything that is liquid at room temperature, including water
- Broth based soups, ice cream, popsicles, gravy, sauces, and Jell-O are all considered fluids because they have a high-water content.
- For residents with End Stage Renal Disease, Congested Heart Failure, Liver Disease, or Hyponatremia (low blood level of sodium).
- The amount of fluid allowed varies based on the resident's condition
- Check with nursing staff before offering additional fluids to a resident on a fluid restriction

Snacks

- Snacks must be consistent with the type of diet order that the resident has
- Snacks can be foods or beverages
- Snacks often help residents meet their energy and nutrient needs

Texture-modified Diets

Residents may have difficulty chewing. They may wear dentures, or their natural teeth may be in poor condition. Their dentures may be poor fitting as a result of shrinkage of the supporting bone, and mouth sores may develop. They may not salivate as much, which causes a dry mouth and makes it hard to chew.

Changing the texture of food and drinks, commonly called texture modification, may help to relieve some of these conditions.

Food texture may be chopped or blended to different levels. Diet orders may be for mechanical soft, pureed, dysphagia diets or other similar terminology. Liquids may be modified to a thicker consistency than a usual cup of water. Descriptions of different types of texture modification are described below.

Dysphagia Diet

- Diets are likely given different names at different facilities
- The resident's physician orders special diet considerations

Common stages of diets:

- Stage 1. Pureed
- Stage 2. Pureed/Ground
- Stage 3. Ground
- Stage 4. Mechanical Soft
- Stage 5. Regular

Common stages of liquids:

- Thin (regular)
- Nectar thick (like processed syrup)
- Honey thick (like honey or buttermilk)
- Pudding thick (like pudding in a pudding pack, sticks to spoon without running off)

Mechanical Soft or Dysphagia Advanced
Foods served are of nearly regular textures. The diet consists of soft solid foods that require some chewing ability. Foods included are easy-to-cut whole meats, fruits, and vegetables. Foods avoided are hard, crunchy fruits and vegetables; sticky foods; and very dry foods. Meats are chopped or ground Vegetables are cooked soft enough to mash with a fork. Some foods that may not be allowed: fresh fruit or vegetables that have a tough skin, dried fruits, hard rolls, bagels, breadsticks, popcorn, bacon, nuts, deep fried crispy foods, desserts with dried fruit or nuts, potato or snack chips.

Mechanically Altered or Chopped
Foods served are moist, semi-solid foods that require some chewing ability. Foods included are fork-mashable fruits and vegetables. Meats are ground or chopped, usually no larger than ¼-inch pieces. The ground or chopped meat should still be moist. Foods avoided are crackers, most bread products, and other dry foods.

Pureed
Foods served are smooth, pureed, very cohesive, pudding-like foods that require some chewing ability. Food is usually processed in a blender or food processor. Foods have the consistency of mashed potatoes, applesauce, pudding, oatmeal or refried beans. Commercially prepared pureed foods often come as formed puree which provides a pureed food in the shape of the original food.

Liquid Consistency
Liquids may be thickened to aid with swallowing. Liquids or beverages are described as having a specific consistency. Consistency of a liquid is defined as the flow of the liquid.

Beverages and soups may be thickened with a special thickening agent. A thickening powder or liquid may be added to drinks by nursing or dietary staff. Some nursing homes purchase beverages that are already thickened. Diet orders may include an order for thin liquids. Thin liquids include all unthickened beverages and supplements.

Thin liquids:
Water, coffee, tea, soda, ices, lemonade, and juice that does not have pulp or fiber (clear juices)

Three Types of Thickened Liquids

There are three types of thickened liquids:
- Nectar-like
- Honey-like
- Pudding-like

Nectar-like or nectar-thick liquids:
- Fluids that can be sipped from a cup or through a straw and will slowly fall off a spoon that is tipped. Liquids that have been thickened to a consistency that coats and drips off a spoon, similar to unset jello. Examples include buttermilk, cold tomato juice, eggnog, and fruit nectars.

Honey-like or honey-thick liquids:
- Fluids that can be eaten with a spoon but do not hold their shape on a spoon. They may be sipped from a cup but are too thick to be taken through a straw. Liquids that have been thickened to the consistency of honey-like, the liquid flows off a spoon in a ribbon just like actual honey. Examples include thick yogurt, tomato sauce, and honey.

Spoon-thick, pudding-thick or pudding-like liquids:
- Very thick fluids that must be eaten with a spoon. They hold their own shape on a spoon and are too thick to be sipped from a cup. Liquids that have been thickened to a pudding consistency; they remain on the spoon in a soft mass. Examples include thickened applesauce and thick milk pudding.

There are other types of therapeutic diets. The diets described here are some of the more common therapeutic diets, and this list is not all-inclusive.

International Dysphagia Diet Standardization Initiative

The International Dysphagia Diet Standardization Initiative (IDDSI) is a global standard with terminology and definitions to describe texture modified foods and thickened liquids used for individuals with dysphagia of all ages, in all care settings, and for all cultures.

The IDDSI framework consists of a continuum of 8 levels (0-7). Levels are identified by text labels, numbers, and color codes to improve safety and identification. The standardized descriptors and testing methods will allow for consistent production and easy testing of thickened liquids and texture modified foods.

Liquids are tested through a gravity flow test. Remove the plunger from a 10ml slip tip syringe, cover the nozzle with your finger, and fill with 10ml of the liquid. Release the nozzle and start the timer. After ten seconds, the amount of liquid remaining will tell you the classification of your liquid:
- 0 ml for thin (Level 0)
- 1-4 for slightly thick (Level 1)
- 4-8 for mildly thick (Level 2)
- 8-10 for moderately thick (Level 3)
- 10 for extremely thick (Level 4); Level 4 should be tested by the IDDSI fork-drip/spoon-tilt tests.

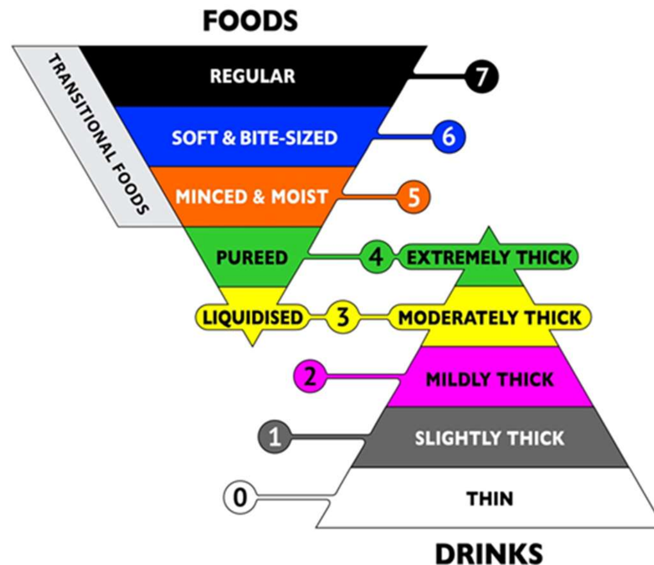
Solids are measured through the fork drip test (Levels 3 and 4 liquids can also be tested through the fork drip test)

- Level 3 (Liquidized or Moderately Thick liquids) should drip slowly or in dollops/strands through the tines/prongs of a fork.
- Level 4 (Puree food or Extremely Thick liquids): a small amount may flow through and form a tail below the fork but it does not dollop, flow or drip continuously through the fork prongs.

Levels 4 and 5, materials should not be sticky. This can be tested with a spoon tilt test- the sample should be cohesive enough to hold its shape on the spoon but must slide or pour off the spoon if the spoon is tilted or turned sideways or shaken lightly.

- Level 5 Minced and Moist foods, particles of food should fit between the tines/prongs of a standard metal fork for adults, or the size of the child's fifth fingernail for children.
- Level 6- Soft and Bite-sized recommends maximum food size of 1.5 cm x 1.5 cm (the entire width of a standard fork.

Softness/hardness of food can be tested with the Fork pressure test. Press the fork into the food sample by placing the thumb onto the bowl of the fork until blanching is observed which pressure is consistent with tongue force used during swallowing.



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Special Diets for Residents with Swallowing Problems

- Verify the correct diet
- Check the card that comes with the food on the tray, the resident's name and the name band
- Check that the card and the food on the tray is the correct diet and consistency

Normal Swallow

A normal swallow is done without thought and occurs within 1-2 seconds. For some older adults, problems such as poor dental health, sore mouth, or muscle weakness due to a stroke can make eating and drinking difficult.

Chewing and swallowing may be frustrating for residents. These adults may be reluctant or refuse to put food in their mouths because the normally simple act of eating has become difficult or dangerous.

Think of a time that you swallowed a food or drink and it felt like it "went down the wrong way." If you remember a time when this has happened to you, then you have an idea of what it might be like to have a swallowing problem.

Dysphagia

Dysphagia is the term used for any change in the normal process of swallowing. Dysphagia is not a disease. Dysphagia is difficulty swallowing, which can occur at any time from the time food enters the mouth to when it reaches the stomach. Some residents may not be able to swallow at all, while others have problems with solids, liquids, saliva, or any combination of these items. Safe swallowing is important for residents to stay healthy, maintain ideal body weight and prevent aspiration pneumonia, dehydration, development of pressure sores, loss of balance and falls. It is very important to preserve these skills.

What is Dysphagia?

- Dysphagia is a swallowing disorder in which an individual demonstrates difficulty moving food from mouth to stomach, including food acceptance and recognition.
- Some individuals may be completely unable to swallow, leading to the need for alternative feeding methods, while others may only have difficulties with lip closure and/or leakage of liquids, foods or saliva from the lips.
- An impairment in any or all stages of swallowing
- Results in reduced ability to obtain adequate nutrition by mouth
- Often requires therapist intervention

What Causes Dysphagia?

Any condition that weakens or damages the muscles and nerves used for swallowing, affects coordination and/or limits sensation may cause dysphagia, such as:

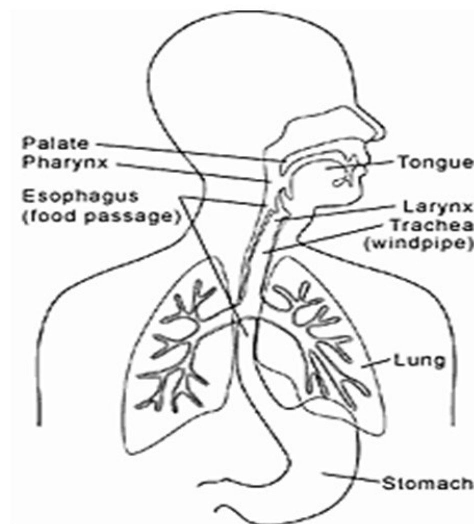
- Multiple Sclerosis
- Dementia or Parkinson's disease
- Stroke/CVA
- Head injury
- An infection or irritation can sometimes cause narrowing of the esophagus
- Cancer of the head, neck or esophagus may cause swallowing problems
- Sometimes specific cancer treatment can cause dysphagia
- Injuries of the head, neck and chest
- Congenital abnormalities of the swallowing mechanism (e.g., cleft palate)

Some adults have problems with the control of their tongue, causing them to have trouble pushing the food to the back of their mouths. These residents may have some problems with their speech. Some residents may have a dry mouth caused by medication. Other residents may have more complex problems during the swallowing process.

Residents with chewing and swallowing problems are provided texture-modified diets in order to:

- Promote safe nutritional intake
- Restore their ability to swallow liquids and solids; and
- Maintain and improve their feeding and swallowing abilities and nutritional status

Important Physical Structures for Swallowing



Note: From National Institutes on Health. “How Do We Swallow?” Bethesda, MD: National Institute on Deafness and Other Communication Disorders. Copyright October, 1998 by National Institutes of Health

Structure	**Description**
Hard Palate	The roof of the mouth
Soft Palate	Soft rear portion of the roof of the mouth
Tongue	Used to form the bolus (ball of chewed food) and to propel the bolus to the back of the mouth
Pharynx	Upper throat space
Larynx	Voice box
Adam's Apple	The prominent lump at the front of the neck, which can be seen/felt approximately 2 inches below the chin. It should move upward each time the resident swallows. It is also called the "larynx" or "voice box". It can be felt by placing fingers on the neck/throat to confirm resident swallowed
Trachea	Pathway for air to the lungs or "windpipe"
Esophagus	Pathway for food to the stomach; when not in use, it is collapsed against itself

Key Terms

Term	Definition
Aspiration	Aspiration occurs when food or liquids go into the lungs instead of the stomach. Aspiration is the most serious health risk from dysphagia or swallowing problems. Residents who aspirate may develop pneumonia, have difficulty breathing, or may choke.
Aspiration Pneumonia	Inflammation and/or infection of the lungs caused by inhaling food, liquid or other substance. A serious condition, it may occur before, during, or after the swallow, require hospitalization or result in death.
Bite Reflex	Automatically biting or clenching the spoon with one's teeth.
Dry Swallows	Swallowing when food is not present in the mouth.
Dysphagia	Difficulty with swallowing. Some residents may have difficulty with swallowing liquids, others may have trouble with textured food, and d some may have difficulty swallowing any type of food or liquid.
NPO	Nothing by mouth
Paralysis	Numbness in a limb, lips, tongue, palate, etc. which may prevent a resident from being able to self-feed or swallowing a regular diet.
PO	By mouth
Pocketing	Keeping food in the cheeks when attempting to swallow. The resident may not be able to sweep away food in the cheeks because of weakness in the tongue or cheeks.
Reflux	Return of food or liquid to the throat from the stomach.
Self-feeding	The ability to feed oneself, with or without adaptive equipment.
Silent Aspiration	Food or liquid entering the airway or lungs without producing any symptoms of disturbance such as coughing or struggling behavior.
Tongue Thrust	Extending the tongue beyond the front teeth and out of the mouth each time a resident takes a bite of food.

Four Stages of Swallowing

- Oral Preparatory Phase

Acceptance of food into the mouth and the chewing, tasting and manipulation of the food into a bolus (ball of chewed food) in the oral cavity

- Oral Phase

Tongue moves bolus back to the pharynx

- Pharyngeal Phase

Swallow reflex is triggered; bolus moves through pharynx to esophagus

- Esophageal Phase

Bolus moves through esophagus to stomach

Swallowing problems are sometimes obvious, while other times they are not evident until other problems begin to occur. It is important that feeding assistants be aware of the signs and symptoms of dysphagia. If you observe any of these signs and symptoms you must report to the nurse in charge so the nurse can report the observations to the physician to obtain further orders.

Signs and Symptoms of Swallowing Problems

Some common signs of swallowing problems include the following:

- Decreased recognition of eating environment/situation/specific foods
- Decreased desire to eat in front of or with others
- Difficulty opening mouth for food acceptance
- Decreased physiological responses to food and/or liquids
- Recent diet changes
- Difficulty in chewing, excessive chewing
- Excessively long mealtime (45-60 minutes)
- Unusual posture during mealtime
- Difficulty managing saliva
- Excessive drooling, especially immediately after eating
- Food or liquid leaking from mouth
- Nasal regurgitation (food or liquid coming out the nose during swallow)
- Food remaining on tongue after swallowing
- Pocketing of food on one side or both sides of the mouth or tongue
- Spitting out food after chewing
- “Holding” food or medications in the mouth
- Refusing to swallow
- “Refusing” foods of different textures
- Difficulty starting a swallow
- Facial grimacing
- Gagging
- Complaining of pain or “something stuck” during or after swallow
- Coughing or choking before, during and/or after eating or drinking
- Watery eyes and/or reddened face while eating or drinking
- Attempts to clear throat during eating or drinking

- Difficulty or inability to breathe while consuming meals, snack or nutritional supplement
- Needing to swallow two or three times “to get all the food down”
- “Wet” voice after eating or drinking
- Excessive mouth movement during chewing and swallowing
- Increased body temperature of unknown cause
- Pneumonia or chronic respiratory distress
- Unexplained weight loss
- Gastro esophageal reflux
- Unable to keep food in mouth
- Unable to drink
- Unable to move food or liquids backward to swallow
- Food is not chewed enough to swallow
- Unable to complete meals

Module 3 – Communication and Interpersonal Skills

Objectives
At the end of this module, you will be able to:
- Explain the importance of appropriate communication skills, both verbal and non-verbal; and
- Describe techniques for effective communication.

This module includes:
- Communication defined
- Changes due to aging that affect communication
- The importance of good communication and techniques for effective communication
- Communication during meals
- Appropriate and inappropriate topics for discussion with residents
- Talking to visitors

Communication Process

Communication is the process we use to exchange messages with others. It is the basis of our interpersonal relations.

What is communication?
A means of exchanging information and connecting to one another
- What images or words come to mind when you think about communication?
- How do you define communication?
- Think of a good and bad example

What is communication?
Communication is a two-way process in which people exchange information (e.g., requests, feelings, socialize)

Why do we communicate?
- To request information
- To find information
- To maintain social contact
- To provide information

We receive information (receptive communication) through:
- Listening/hearing
- Reading
- Watching

We exchange information (expressive communication) through:
- Verbal (spoken words)
- Writing
- Gestures (pointing, head nods, etc.)
- Facial expressions (frowns, smiles, etc.)

What happens if we don't communicate?

- Needs are not known or met
- May become isolated, depressed, frustrated, angry, aggressive or belligerent
  - Imagine you are in pain and no one can understand what you are trying to tell them or where you feel the pain.
  - Imagine you are looking for an important piece of paper but no one understands what you need.
  - Imagine you want to join a game of bingo but the group just ignores you because they can't understand what you are saying.
- Loss of self esteem
- Decreased social interaction

Clear Communication w/ Residents

- Why is it so important?
  - It's essential to provide residents with good, quality care
- What prevents good communication between staff and residents?
  - Talking too fast
  - Changing the subject
  - Clichés and false assurances
  - Insensitivity
  - Sensory impairment

The Communication Process

Sending messages

- Verbal – the spoken message
- Non-verbal/body language – the message we send without words, such as facial expressions, gestures, nods, posture, and personal appearance.

Receiving messages

- Effective listening
- Body language

Feedback

- Acknowledging the message; the use of verbal and non-verbal messages to acknowledge the message that is sent.

Verbal v. Non-verbal Communication
VERBAL

- Spoken word including word choice, tone, and speed
- May be a challenge for some residents

NON-VERBAL
Body language including:

- Posture
- Eye Contact
- Hand movements
- Facial expressions
- Touch

Positive Verbal Communication

- Speak on the resident's "good" side
- Use the resident's proper name
- Utilize a friendly tone
- Be patient
- Speak slowly
- Use short sentences or one step commands
- Allow time for resident to process and respond
- Repeat statements as originally made

Positive Non-Verbal Communication

- Approach slowly and calmly
- Do not approach from behind
- Face the resident while speaking
- Make eye contact
- Smile, nod, move hands

Techniques for Effective Communication

When speaking with residents:

- Pronounce words properly
- Look for non-verbal cues
- Be sensitive to the resident
- Use face-to-face communication
- Use simple language
- Practice repetition
- Listen attentively
- Be aware of symbolic meanings
- Use feedback
- Time communications carefully
- Be honest and sincere

Positive communication may improve residents' response to you. This may result in an improved meal intake.

Methods of staying positive include the following

- Be welcoming
- Listen carefully
- Stand or sit at the same level as the resident
- Use a relaxed pace of communication
- Display a relaxed, friendly facial expression
- Use encouragement and praise
- Smile

Use Caution: Residents are sensitive to:

- Your tone of voice
- Body posture that may be perceived as threatening
- Conversations that leave them out; and
- Expressions that show lack of patience or disrespect

How to Start a Conversation

- Approach the resident in a calm and courteous manner
- Identify yourself by name and title and greet the resident by their preferred name
- Explain why you are there and what you are going to do

Guidelines for Talking and Listening

- Get the resident's attention before speaking
- Speak courteously with the resident, listening and responding appropriately. Avoid slang or words with more than one meaning.
- Use a normal tone of voice and adjust your volume to the resident's needs. Speak slowly and adjust your rate to the resident's needs.
- Speak clearly and avoid mumbling
- Be sure your verbal and non-verbal message match
- Use open posture, leaning slightly toward resident while listening. Pay attention and really listen to what the resident is saying.
- Give, receive, and request feedback as appropriate to ensure understanding
- Use silence to allow the resident to think and continue talking (this shows respect and acceptance).
- Use open-ended questions, such as, "And then what happened?"
- Use responses that indicate you understand the resident's feelings, such as, "It sounds like you really miss your son."

How to Avoid Barriers to Conversation

- Avoid interrupting or changing the subject
- Avoid expressing your opinion if it implies passing judgment
- Avoid pat answers such as "Don't worry," as this can make residents feel their concerns are not important.
- Avoid questions that start with "why" to avoid defensive responses

How to End a Conversation

- Tell the resident that you are finished, that you have to leave, and, if appropriate, when you will be back.
- Tell the resident that you enjoyed the conversation.
- Leave the resident in a position of comfort and safety, with needed items within easy reach.

Being an Active Listener

- Be attentive
- Show interest & ask clarifying questions
- Avoid interruptions and distractions
- Restate what the resident has said to check understanding

Changes Due to Aging

Changes due to aging that affect communication are sensory and memory changes.

Sensory losses include:

- Vision loss
- Hearing loss
- Problems with speaking; and
- Problems with understanding

Memory losses include:

- Short term memory loss; and
- Long term memory loss

It is important that you understand residents' losses that have been identified and how those losses may affect the residents' ability to eat or feed themselves. Also, be aware that some changes or losses may not be obvious or may not have been identified yet.

Communicating with Residents Who Have Vision Loss

- Identify yourself by name and title as you approach the resident to avoid startling him or her.
- Stand (or sit, if assisting with eating) comfortably close to the resident in a good light and face the resident when you speak.
- Speak in a normal tone of voice. Do not speak too loudly.
- Use talk and touch to communicate. Encourage the resident to do the same
- If the resident is feeding him/herself, identify each food on the tray and explain where each item is on the tray.
- Tell the resident when you are finished and when you are leaving

General Guidelines for Successful Communication with Residents with Hearing Loss

- Alert the resident by approaching from the front or side and lightly touching the resident's arm. Avoid startling the resident.
- Speak at a slightly lower pitch and at a normal or only slightly increased volume—avoid shouting.
- If the resident hears better in one ear, sit on the preferred side. Face the resident when you speak.
- Speak slowly, clearly, and distinctly, using your lips to emphasize sounds—do not chew gum or cover your face with your hands while talking.
- Keep conversations short and limited to a single topic
- Do not convey negative messages by your tone of voice or body language
- Be sure resident is wearing hearing aid in correct method and ear, if applicable
- Ensure resident uses assistive listening device if prescribed
- Say the resident’s name or tap gently to get the resident’s attention before you begin talking
- Eliminate background noise such as TV, radios, noisy carts or others talking nearby
- Position yourself in front of the resident so you can be seen before you start talking
- Have light on your face so your mouth can be seen
- Reduce glare from lights and windows
- Don’t talk with anything in your mouth, such as gum, cigarettes or food
- Kneel or bend in order to be at eye level with someone in a wheelchair

- Stay in the same room while talking. Do not move around the room, speak while leaving the room or turn your back while speaking.
- Speak in a normal tone of voice or lower your voice pitch
- Don't shout. Move closer to the resident and speak to the "better" ear or ear with hearing aid
- Speak clearly, using short sentences
- Don't speak either too fast or too slowly
- Use non-verbal communication such as facial expressions, gestures and pointing
- Rephrase or reword. Some words are easier than others to speech read. Find a different way to say something that is not understood.
- Use written words to help clarify your message
- Verify your communication. Ask the resident to repeat the message to be sure of accuracy
- Be patient!

Aphasia

Aphasia is a language disorder resulting from damage to the language centers of the brain. Aphasia usually occurs suddenly, often as the result of a stroke or head injury, but it may also develop slowly, as in the case of a brain tumor, series of TIAs or seizures.

There are 3 types of aphasia:

Receptive Aphasia
If you have this, you may:

- Say many words that don't make sense
- Use the wrong words; for instance, you might call a fork a "gleeble"
- String together a series of meaningless words that sound like a sentence but don't make sense

Receptive Language Suggestions

- Speak in a normal tone
- Use clear, concise communication
    - Limit adjectives, adverbs and prepositions
    - Use consistent phrases
    - Use gestures and motions to describe actions
- Use communication aids
    - Pictures
    - Spelling boards

Communicating with Residents Who Have Problems with Understanding

- Use simple sentences and words and pronounce words clearly and slowly
- Keep conversation short and focused on a single topic. Give simple, one-step instructions as appropriate.
- Allow the resident adequate time to respond
- Monitor your body language to ensure you are not sending negative messages
- Use gestures and expressions to enhance your verbal messages (e.g., as you ask the resident if they want more to drink, pick up the cup).

Expressive Aphasia

This is characterized by:

- Difficulty forming complete sentences
- Leaving out words like “is” or “the”
- Saying something that doesn’t resemble a sentence
- Trouble understanding sentences
- Making mistakes in following directions like “left, right, under and after”
- Using a word that’s close to what you intend, but not the exact word; for example, saying “car” when you mean “truck”

Expressive Language Suggestions

- Respond to all communication efforts
- Give adequate time to respond
- Allow completion of statements and thoughts
- Do not anticipate what the resident is trying to say
- Use techniques and triggers when difficulty is experienced
- Watch resident’s lips for verbal cues

Communicating with Residents Who Have Problems with Speaking

- Keep conversations short, but frequent. Ask direct questions if resident can answer "Yes" or "No"
- Allow the resident adequate time to respond
- Listen carefully. Don't pretend to understand the resident if you don't
- If you can't understand the words, validate what you think the resident is saying or feeling
- Take the time to complete each conversation and avoid showing impatience
- Monitor your body language to assure you are not sending negative messages
- Encourage and assist the resident to point or nod to communicate with you

Global Aphasia

This means you have both types. You may have difficulty:

- Understanding words and sentences
- Forming words and sentences

General Guidelines for Successful Interaction with Residents with Communication Impairments

- Reduce background noise and visual distractions
- Approach and gain the resident’s attention from the front, at eye level
- Use the resident’s name, identify yourself by name and what you plan to do
- Put yourself in a face-to-face position, gaining eye-contact with the resident
- State what you plan to do
- Speak clearly and use short simple sentences
- Treat resident as an adult and involve in decision-making
- Limit use of language (use sparingly) when resident is fatigued
- Speak in a normal tone of voice; do not shout
- Begin a conversation with casual topics
- Avoid changing the topic of a conversation too quickly
- Allow extra time for the resident to understand what was said
- Allow extra time for the resident to respond verbally or express himself in some manner to what was said
- Use gestures to help get the message across

- Use a forced choice question technique, e.g., " Would you like ……… or …………..", so the resident may be able to make personal choices.
- Utilize additional communication methods (as defined by the SLP) and the resident to increase communication effectiveness, such as:
  - Pointing to words or pictures
  - Gestures
  - Alphabet board

Dementia

Dementia is defined as "a structurally caused permanent or progressive decline in several dimensions of intellectual function that interferes substantially with the person's normal social or economic activity".

Dementia can impact the parts of the brain related to:

- Memory
- Language (speech & comprehension)
- Concentration
- Orientation
- Judgment
- Sequencing

Techniques for Communicating Successfully with Residents with Dementia

- Approach resident from the front to avoid startling the resident
- Call resident by name and use gentle touch to get the resident's attention
- Stand directly in front of the resident. Maintain eye and physical contact to hold attention
- Use a calm, soothing tone of voice and pleasant facial expression
- Use simple adult language and speak slowly
- Use resident's name frequently
- Give one message at a time
- Allow time for a response
- Repeat statements or questions as often as necessary
- If it is necessary to repeat, use the same words
- Wait until one step is completed before going on to the next step
- Use body language (gestures) to help explain statements
- Make questions into statements; for example, use "Let's go to the dining room," instead of "Do you want to go to the dining room?".
- Don't ask questions to test the resident's memory, e.g. "What's my name?" Bombardment may cause the resident to become embarrassed, angry or upset.
- Don't offer choices if there are none or if one of the options is not acceptable
- Use direct statements about what you are preparing to do. Be clear about what is taking place
- Don't argue, but instead try to change the subject
- Identify feelings rather than arguing facts
- Use non-confronting statements. Agree first then limit your response
- Ask for cooperation and help
- Make negative statements into positive ones, e.g. "Let's come over here" vs. "Don't go out"
- Run activities without competing noises, e.g. television in background
- Stimulate resident with language about topic/task, not "gossip"
- Allow for reminiscing. It is ok the resident isn't oriented to here and now

Your Conversations with Residents

Conversations with residents should:

- Center on the resident being assisted
- Include the resident
- Focus on topics of interest to the resident; and
- Be informal, social, and non-judgmental

Communication During Meals

One common error of those who help residents at mealtime is to talk to each other over and around the residents they are assisting. As much as possible, talk to the residents or talk about subjects the residents can relate to. This may be a challenge with those who are confused, hearing impaired, or who don't talk very much.

Topics of a general nature that may appeal to residents include:

- Activities going on in the facility
- The weather
- Meals and food preferences (e.g., ask what the resident wants help with, offer substitutes or second helpings, etc.)

Personal Attention

Appropriate conversation with residents is an opportunity to offer one-on-one personal attention and conversation. Everyone enjoys personal attention. Some residents do not talk to other residents, they may have difficulty talking to others and miss the opportunity to get to know each other. By drawing residents into a conversation around the dining table, it is possible to build friendships in the facility.

Inappropriate Conversations

It is inappropriate to have discussions that:

- Center on personal problems (relationships, finances); or
- Are negative discussions of coworkers, work related matters, or management

Communicating with Visitors

When family or friends of the resident ask you about the resident, tell them something about the resident's meal, such as, "She ate a good breakfast." Refer visitors to the charge nurse for problems, complaints, or reports on a resident's condition.

Positive Effects of Communication

- Residents eat better at meals
- Staff time for serving meals and dining room cleanup are reduced
- Residents have a better quality of life

FOCUS Technique

- **F-** Face to Face
- **O-** Orient
- **C-** Continue
- **U-** Unstick
- **S-** Structure

FOCUS: Face to Face

- Face the resident directly
- Smile
- Talk before you touch
- Maintain eye contact
- Speak in soothing tones

FOCUS: Orient

- Guide the conversation
- Redirect
- Allow plenty of time to respond
- Use visual aids

FOCUS: Continue the Same Topic

- Short attention span/ loss of interest in food in front of them
- If they refuse, offer them something else
- Use verbal reminders
- Try to stay with the resident

FOCUS: Unstick

- Residents may have difficulty finding the right words
- Be patient and respectful, not corrective, when they get the words wrong
- Ask them to point to what they want

FOCUS: Structure Your Question

- Sentences: short, simple, direct
- Provide only 2 choices at a time
- Example: “Do you want peas or potatoes

Key points

- Good communication is important
- Communication involves active listening
- Communication is both verbal and nonverbal
- Special techniques help communication for residents with sensory impairment or dementia

Module 4 -- Resident Rights and Resident Dignity

Objectives
At the end of this module, you will be able to:

- Describe resident rights regarding abuse, neglect, exploitation and personal preferences
- Describe how to ensure the privacy of residents within a nursing facility
- Describe how you would act to avoid abuse, neglect, and misappropriation of resident property.

This module includes the following topics:

- Resident rights
- The role of the feeding assistant in respecting and promoting resident rights and independence
- Promoting resident privacy
- Definitions of abuse, neglect, and misappropriation
- Guidelines for avoiding abuse, neglect, and misappropriation of resident property
- Facility procedures

Effect of Institutionalization on Resident Rights

Residents do not give up any rights when they enter a nursing facility. They have all the same rights and protections as ordinary citizens. The facility and its staff must encourage and assist residents to fully exercise their rights.

Residents' Rights
Resident rights are stated in the Long-term Care Nursing Facility Requirements and State Administrative Codes.

Importance of Resident Rights

- Safety
- Respect
- Quality of Life
- Freedom
- Choices
- Dignity

Resident Rights Agreement
Facilities must:

- Provide residents with a copy of rights upon admission
- Post a copy of the rights in a public area of the facility

Resident Rights

We need to take all steps reasonable and necessary to ensure the rights of residents are protected and safeguarded. This includes the rights of the resident to have a dignified existence, freedom of choice, self-determination, reasonable accommodation of individual needs, and freedom from harassment.

The **Nursing Home Reform Act** established the following rights for residents**.** Recognize that some of these will not apply to you as a feeding assistant, but it is still important to review each one.

The Right to Be Fully Informed of:

- Available services and the charges for each service
- Facility rules and regulations, including a written copy of resident rights
- Address and telephone number of the State Ombudsman and state survey agency
- State survey reports and the nursing home's plan of correction
- Advance plans of a change in rooms or roommates
- Assistance if a sensory impairment exists
- Residents have a right to receive information in a language they understand (Spanish, Braille, etc.)

Right to Complain

- Present grievances to staff or any other person, without fear of reprisal and with prompt efforts by the facility to resolve those grievances
- To complain to the ombudsman program
- To file a complaint with the state survey and certification agency

Right to Participate in One's Own Care

- Receive adequate and appropriate care
- Be informed of all changes in medical condition
- Participate in their own assessment, care planning, treatment, and discharge
- Refuse medication and treatment
- Refuse chemical and physical restraints
- Review one's medical record
- Be free from charge for services covered by Medicaid or Medicare

Right to Privacy and Confidentiality

- Private and unrestricted communication with any person of their choice
- During treatment and care of one's personal needs
- Regarding medical, personal, or financial affairs

Rights During Transfers and Discharges

- Remain in the nursing facility unless a transfer or discharge:
  - ✓ is necessary to meet the resident's welfare
  - ✓ is appropriate because the resident's health has improved and nursing home care is no longer required.
  - ✓ is needed to protect the health and safety of other residents or staff
  - ✓ is required because the resident has failed, after reasonable notice, to pay the facility
  - ✓ charge for an item or service provided at the resident's request
- Receive thirty-day notice of transfer or discharge which includes the reason, effective date, location to which the resident is transferred or discharged, the right to appeal, and the name, address, and telephone number of the state long-term care ombudsman.
- Safe transfer or discharge through sufficient preparation by the nursing home

Right to Dignity, Respect, and Freedom

- To be treated with consideration, respect, and dignity
- To be free from mental and physical abuse, corporal punishment, involuntary seclusion, and physical and chemical restraints.
- To self-determination
- Security of possessions

Right to Visits

- By a resident's personal physician and representatives from the state survey agency and ombudsman programs
- By relatives, friends, and others of the residents' choosing
- By organizations or individuals providing health, social, legal, or other services
- Residents have the right to refuse visitors

Right to Make Independent Choices

- Make personal decisions, such as what to wear and how to spend free time
- Reasonable accommodation of one's needs and preferences
- Choose a physician
- Participate in community activities, both inside and outside the nursing home
- Organize and participate in a Resident Council
- Manage one's own financial affairs

Long-term care ombudsmen are advocates for residents of nursing homes, board and care homes and assisted living facilities. Ombudsmen provide information about how to find a facility and what to do to get quality care. They are trained to resolve problems. If you want, the ombudsman can assist the resident or families, or even you, with complaints. However, unless you give the ombudsman permission to share your concerns, these matters are kept confidential. Under the federal Older Americans Act, every state is required to have an Ombudsman Program that addresses complaints and advocates for improvements in the long-term care system.

The ombudsman program is administered by the Administration on Aging (AoA). Whether through individual contact with residents or systemic advocacy, ombudsmen make a difference in the lives of residents in long-term care facilities everyday.

A Long-Term Care Ombudsman:

- Resolves complaints made by or for residents of long-term care facilities
- Educates consumers and long-term care providers about residents' rights and good care practices
- Promotes community involvement through volunteer opportunities
- Provides information to the public on nursing homes and other long-term care facilities and services, residents' rights and legislative and policy issues
- Advocates for residents' rights and quality care in nursing homes, personal care, residential care and other long-term care facilities
- Promotes the development of citizen organizations, family councils and resident councils

As a feeding assistant, what is your role in protecting resident's rights?

Your Role in Respecting and Promoting Resident Rights and Independence

- Maintain confidentiality. Protect resident's dignity and privacy - 24 hours a day, 7 days a week.
- Encourage residents to make personal choices as much as they are able
- Accommodate individual needs and preferences. Allow residents to make choices about their care.
- Encourage residents to participate in feeding themselves as much as possible
- Maintain safety
- Provide care and security of resident's personal possessions
- Do not discriminate based on race, national origin, disability, age, or religion
- Treat residents with dignity and respect
- Do not abuse or neglect residents
- Know the rights of your residents
- Speak to residents respectfully and in a positive manner
- Respect a resident's right to refuse care, diets, activities, etc.
- Listen to residents, and their family members, who have concerns about resident's rights. Refer residents and families with questions or concerns about resident rights to the appropriate facility representative or facility ombudsman program.

Report abuse or neglect of a resident following facility protocol. This may involve reporting to facility administration, the State Department of Aging and Disability Services, or local Long-Term Care Ombudsman. The phone numbers for the required departments should be posted in the nursing home.

Promoting Resident Privacy

Feeding assistants and all facility staff are responsible for protecting resident privacy.
Guidelines for Protecting Resident Privacy

- Do not discuss a resident's medical condition
- Do not discuss residents (current or former residents) with anyone other than those who are providing care to the resident.
- Be sure no one can hear your discussion with the care team or charge nurse regarding the resident.
- Resident records are private and confidential. You should only review those records that the supervisory nurse has directed you to review.
- Before entering a resident's room, you should knock on the door and identify yourself by name and title (even if the door is open).
- Respect the resident's room—it is his/her private space
- Have the charge nurse identify visitors with whom you may discuss the resident's needs for care and treatment.

Protecting Residents from Abuse, Neglect, and Misappropriation of Resident Property
Feeding assistants and all facility staff are responsible for protecting residents from abuse, neglect and misappropriation of resident property.

All residents have the right to be free from verbal, sexual, physical and mental abuse; corporal punishment; and involuntary seclusion.

Elder Abuse and Neglect

Elder Abuse: Definitions

- Elder: any person residing in your State who is 65 years of age or older.
- Elder abuse: acts of omission or commission by a person who stands in a trust relationship that result in harm or threatened harm to the health and/or welfare of an older adult.
- Caregiver: any person who has the care, custody or control of, or stands in a position of trust with, an elder or dependent adult.

Prevalence

- Estimated from 2%-10%, based on the samples, surveys, and definitions utilized
- Victim-perpetrator: No typical victim, but 90% of abusers are known to victim

Elder abuse is considered "Acts of omission or commission by a person who stands in a trust relationship that result in harm or threatened harm to the health and/or welfare of an older adult." "Willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish."

Abuse, as defined by federal agencies a little more closely, means:

- Willful infliction of injury
- Unreasonable confinement/Involuntary seclusion
    - Separation of a resident from other residents or from their room or other area against the resident's will or the will of the resident's legal representative.
- Intimidation with resulting physical harm, or pain, or mental anguish
- Punishment with resulting physical harm, or pain, or mental anguish
- Deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial wellbeing.
- Corporal punishment & any physical or chemical restraint not required to treat the resident's symptoms.
- Instances of abuse of residents, irrespective of any mental or physical condition that causes physical harm, pain or mental anguish to include verbal, sexual, physical, & mental abuse.
- Abuse that includes that which is facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

Forms of abuse include:

- Verbal
- Physical
- Sexual
- Mental/Emotional
- Neglect
- Abandonment
- Financial exploitation
- Self-neglect

In additional to federal requirements, each state may have specific reporting requirements related to abuse. It is important that you familiarize yourself with the requirements for the state in which you work/provide services. If you feel or have reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, you should report this to your

supervisor and communicate with the facility; the facility shall report such concerns as needed and in the manner required under state law.

Residents must not be subject to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, or other individuals.

Definitions:
Verbal abuse

- Oral, written, or gestured language that includes disparaging and derogatory terms to the residents or their families to describe the resident within their hearing distance, regardless of their age and /or ability to comprehend or disability.

Physical abuse

- Includes hitting, slapping, pinching, scratching, spitting, holding roughly, etc. It also includes controlling behavior through corporal punishment.

Sexual abuse

- Includes but is not limited to, humiliation, harassment, coercion, or sexual assault. Sexual abuse is non-consensual sexual contact of any type with a resident.

Medication diversion

- Knowingly, or intentionally, interrupting, obstructing, or altering the delivery, or administration of a prescription drug.

Mental/Emotional abuse

- Includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation.
  - During the delivery of personal care, staff must remove residents from public view & provide clothing or draping to prevent unnecessary exposure of body parts.
  - The taking of unauthorized photographs may constitute mental, physical, and/or sexual abuse. No employee should take, keep, or distribute any photograph that is demeaning or humiliating toward a resident.
  - Whether mental abuse has occurred is determined by a “reasonable person standard” and does not require a specific response from the resident.

Neglect

- Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.

Exploitation/Misappropriation of Resident Property

- Deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident’s belongings or money without the resident’s consent.

Elder Abuse Indicators

Events or “injuries of unknown origin,” such as suspicious bruising occurrences, patterns and trends or other resident injury that may constitute abuse, neglect, or mistreatment should be identified, thoroughly investigated, and reported as appropriate or indicated. Indicators for the various forms of abuse include the following:

Physical abuse

- Sprains, dislocations, fractures, or broken bones. Burns, internal injuries, abrasions, bruising. Injuries are unexplained or explanations are implausible.

Sexual abuse

- Fear of being touched/inappropriate modesty on evaluation. Inner thigh/breast bruising, tenderness.

Emotional abuse

- Depression, sleep and appetite disturbances, decreased social contact, loss of interest in self, apathy and suicidal ideation. Evasiveness, anxiety, hostility.

Neglect and Self-Neglect

- Inadequate, dirty or inappropriate clothing, malnutrition, dehydration, odor and poor hygiene, pressure sores. Misuse/disregard/absence of medicines, medical assistive devices, medical regimens.

Self-Neglect

- Eccentric or idiosyncratic behavior, self-imposed isolation, marked indifference.

Financial abuse

- Fear, vague answer, anxiety when asked about personal finances. Disparity between assets and appearance and general condition. Failure to purchase medicines, medical assistive devices, seek medical care or follow medical regimens.

What are the Risk Factors?

Several studies have investigated what particular factors might make someone more at risk of becoming a victim of elder abuse. Some key findings in this area are as follows.

- Low social support has been found to significantly increase the risk of virtually all forms of mistreatment.
- Dementia is also a risk factor. A 2009 study revealed that close to 50% of people with dementia experience some kind of abuse.
- Experience of previous traumatic events—including interpersonal and domestic violence—has been found to increase the risk for emotional, sexual, and financial mistreatment.
- Functional impairment and poor physical health are associated with greater risk of abuse among older persons.
- Women appear to be more likely to be abused than men.
- Younger age may be associated with greater risk of abuse. A study found that adults in their late 50s and 60s are more likely to report verbal mistreatment or financial mistreatment than older adults. Another study found that young-old respondents (aged < 70 years) were more likely than respondents in the old-old group to fall victim to emotional, physical, and financial mistreatment by strangers. However, this difference may be attributable to the absence of institutionalized older adults or their representatives in their sample.
- Living with a large number of household members other than a spouse is associated with an increased risk of abuse, especially financial abuse.
- Lower income or poverty has been found to be associated with elder abuse. Low economic resources have been conceptualized as a contextual or situational stressor contributing to elder abuse.

- The following factors have been found to be associated with financial exploitation of older adults.
    - Non-use of social services
    - Need for ADL assistance
    - Poor self-rated health
    - No spouse/partner
    - African-American race
    - Lower age

Who are the Perpetrators?

- Perpetrators are most likely to be adult children or spouses, more likely to be male, to have history of past or current substance abuse, to have mental or physical health problems, to have history of trouble with the police, to be socially isolated, to be unemployed or have financial problems, and to be experiencing major stress.
- In a study of 4,156 older adults, family members were the most common perpetrators of financial exploitation of older adults (FEOA) (57.9%), followed by friends and neighbors (16.9%), followed by home care aides (14.9%).
- In a sample of 5,777 older adults 60 or above, when comparing across types of mistreatment, a higher proportion of perpetrators of physical mistreatment (compared to emotional and sexual mistreatment) had problems with police, received psychological treatment, were using substances at the time of the incident, lived with the victim, and were related to the victim.
- A study that reviewed newsfeed articles collected daily by the National Association of Adult Protective Services (NAPSA) through an initiative funded by the National Center on Elder Abuse found that instances of fraud perpetrated by strangers comprised 51% of news articles related to elder financial abuse, followed by family, friends, and neighbors (34%), the business sector (12%), and Medicare and Medicaid fraud (4%). Nearly 60% of perpetrators were men, mostly between the ages of 30 and 59. The newsfeed tracked media reports of all types of elder abuse through Google and Yahoo Alerts over a three-month period.

Avoiding Abuse, Neglect, and Misappropriation of Resident Property

- Remain calm and don't take the resident's behavior personally. Remember that there is no excuse for abusing a resident.
- Abuse often occurs when caregivers are tired, over-worked, experiencing personal problems, stressed, or losing control. If you are feeling overwhelmed with your assigned duties or a certain resident, discuss it with your charge nurse and/or make arrangements to take a break and compose yourself.
- If you see a co-worker who is feeling overwhelmed, offer support and assistance if possible; encourage the coworker to report the situation or report the situation to the charge nurse yourself.
- Do not use residents' personal belongings. Do not take money from residents.
- What is your facility’s policy for reporting of abuse, neglect, and exploitation? This should include who should be notified.

The Elder Justice Act

What is the Elder Justice Act?

- It is a federal law that requires the reporting of a suspicion of a crime against a resident or resident of a long-term care facility.
- The duty to report applies to an owner, operator, employee, manager, agent or contractor of a long-term care facility.
- You have a duty to report any suspected acts involving resident mistreatment, neglect, abuse, crimes, misappropriation of resident property, or injuries of unknown source.

Reporting Requirements under the Elder Justice Act *(Patient Protection and Affordable Care Act of 2010, H.R 3590)*

- You must immediately report any reasonable suspicion of a crime to your supervisor, who will immediately contact the facility.
- The facility must then report any reasonable suspicion of a crime against a resident to:
  - ✓ the Secretary of U.S Health and Human Services; and
  - ✓ the law enforcement authorities in the political subdivision where the facility is located
- If the events that cause suspicion of a crime:
  - ✓ result in "serious bodily injury" or is a suspicion of sexual abuse, the report must be made to Health and Human Services and to local law enforcement authorities immediately, but not later than **two hours** after forming the suspicion.
  - ✓ do not result in "serious bodily injury"; the report must be made to Health and Human Services and to local law enforcement authorities immediately, but not later than **24 hours** after forming the suspicion.
- "Serious bodily injury" is an injury:
  - ✓ involving extreme physical pain
  - ✓ involving substantial risk of death
  - ✓ involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty, or
  - ✓ requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

Penalties under the Elder Justice Act

- Civil monetary penalties: up to $200,000. If the failure to report exacerbates harm to the victim or results in harm to another person, maximum penalty is increased to $300,000.
- Anyone who does not fulfill the duty to report may be classified as an "excluded individual" who becomes ineligible to participate in any federally funded plan or program that provides health benefits, through insurance or otherwise.

This is for your information only … remember you have a responsibility to follow the reporting procedures of your facility!

Best Practice Guidelines for Resident Dignity in Long-Term Care

Maintenance of an individual's dignity is a critical to all persons. This is no different for those residing in skilled nursing facilities. The manner in which staff relates to persons for whom they are caring has the potential for great impact on the individual resident's sense of self and well-being.

The requirements State Survey related to dignity state: "The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." This means staff must carry out activities in a manner which

assists the resident to maintain and enhance his/her self-esteem and self-worth. According to the surveyor guidelines for this requirement, maintaining a resident's dignity should include the following:

- Promoting resident independence and dignity in dining (such as avoidance of day-to-day use of plastic cutlery and paper/plastic dishware, bibs instead of napkins, dining room conducive to pleasant dining, aides not yelling, not standing over the resident when feeding)
- Respecting resident's social status, speaking respectfully, listening carefully, treating residents with respect (e.g., addressing the resident with a name of the resident's choice, not excluding residents from conversations or discussing residents in community setting)
- Focusing on residents as individuals when they talk to them and addressing residents as individuals when providing care and services.

Maintaining Resident Dignity

The focus of the requirements is to ensure caregivers provide services in a manner which enhances/ maintains a dignified existence for residents. If all facility staff keep in mind the basic principle of caring for residents in the manner in which s/he would expect to be treated, or would expect a loved one to be treated, the facility staff will have made great strides towards compliance.

The Dining Experience

Residents gather for meals daily. A large portion of one's day is spent in dining and interactions during mealtime can be meaningful to individual residents. Areas of potential non-compliance related to the dining experience may include:

- Serving trays in an order resulting in residents waiting for their trays while others are the table are eating.
- Use of clothing protectors (bibs) for all residents, regardless of individual preference
- Staff standing over residents as they are assisted with dining

Best practice for maintaining a dignified dining experience may include:

- Design the meal serving tray delivery to ensure all residents seated at the same table are served at the same time, similar to a restaurant with table service. This would reduce the chance of some residents waiting for serving trays while others at the table are eating.
- Develop a policy for use of clothing protectors for residents. Clothing protectors should be used primarily for residents who spill food while eating, which should only apply to a few residents. The practice of putting clothing protectors on all of the residents in a particular dining area, without consideration of the residents' needs and consent is considered an institutional practice.
- For residents who spill food, assess the reasons for this problem, to determine if this can be resolved in other ways, such as providing adaptive equipment or appropriate eating assistance. If residents spill food while eating, even with wearing a clothing protector, the facility may need to provide additional food to ensure adequate intake for the food that is spilled.
- Clothing protectors may be appropriate for eating certain types of foods, like spaghetti sauce. If food is spilled on clothing, staff should promptly assist residents requiring assistance with changing into clean clothing after the meal.
- Develop an environment to ensure that direct care staff can assist with feeding residents comfortably. Ensure there is adequate space and furniture to allow direct care staff to sit comfortably next to residents to enhance proper feeding techniques. Staff should be seated at eye level when possible and in a manner to promote socialization, even for those residents who have limitations with cognition and/or communication.

- Provide training to staff, in which they had to feed each other, demonstrating the emotions and sensations of being fed by a staff person standing, not positioned comfortably and without direct eye contact and/or to be fed by staff without conversation or interaction.
- Develop a system to ensure a pleasant, relaxing dining environment, similar to that in a fine restaurant. Consider the following:
    - Staff activity in the dining room – Is it busy and chaotic; or organized and relaxed?
    - Noise level in the dining room – Is it loud or quiet and soothing? Soft music or music of resident's choice can make the dining experience more enjoyable.
    - Lighting in the dining room – Is there sufficient ambient light for the residents' comfort and the staff to function? Soft lighting can make the mood more relaxing.
    - Serving tray presentation – Do staff place plates and utensils on the table in a manner that looks pleasant? Do staff remove plates from trays? Do staff remove plate lids and paper litter from the resident's tables? Providing glassware for resident's beverages, such as milk and juice look more appealing than consuming the beverage from the carton or package.
- Consider training the direct care staff on techniques for serving meals, similar to that of restaurant servers.
- Monitor the dining of residents with dementia or cognitive impairment. Provide adequate supervision and assistance to ensure residents are not taking food from other residents. Staff should monitor food consistency to determine appropriateness. For residents who do not tolerate consuming solid foods, make sure pureed foods are thinned with appropriate liquids, rather than thinning pureed eggs with orange juice for example. Staff make certain separate foods are offered for residents with this need, rather than blended together.

For Residents with Dementia

The facility staff must always remember the residents have led a full life, rich in experiences. Even late into the disease process, when given appropriate cues, residents may retain a sense of personal history, achievements, and values. Maintaining the respect and dignity of residents include all of the previously mentioned areas of focus.

Areas of potential non-compliance include:

- Inappropriate activities and language, such as having a former judge cut out paper dolls or speaking to the residents in baby language and calling them names such as "Granny", "Sweetie", "Honey", etc.
- Allowing residents to wander, attend activities or dine wearing soiled clothing, knowing the resident has become incontinent.

Best practice may include:

- Address the resident by his/her given name, in an adult manner
- Provide activities that are age appropriate and meaningful, taking into account unique abilities and past interests.
- Clothing is a form of self-expression. Make sure clothing is clean and pieces match.

If staff members consistently treat the residents for whom they care with respect and consideration, great strides will have been made towards compliance with the requirements for state survey. Facility managers should promote and develop an organizational culture of caring and resident empowerment, which is reinforced through ongoing staff education and sensitivity training.

Dignity at End of Life

Throughout our lives, a sense of personal dignity is essential to our well-being. We each need to feel valued and respected. Near the end-of-life, the challenges of serious illness can erode a person's dignity – which can increase pain and despair for both the resident and family. In an effort to address a resident's physical needs, for instance, caregivers may treat the person more like a set of symptoms than a human being. They may unthinkingly deprive the person of basic privacy. And they may overlook the resident's social, emotional and spiritual needs. But this doesn't have to be the case. Both family and professional care providers can take important steps to help maintain the person's dignity.

One of the greatest fears people have about dying is losing their sense of dignity and independence. For us as caregivers, our philosophy of care is built around respecting the resident and their wishes, providing each individual with the highest quality of life for however many days they have remaining. Maintaining resident dignity at end of life is paramount.

The most important thing that you can do to help a resident maintain dignity at end of life is to remember you are caring for an individual with unique needs, experiences, and desires. Everyone wants to be treated with respect.

Dignity is a lifelong, universal need that's vital to a person's welfare. It means feeling a sense of worth or respect. Near the end-of-life, most people have less control over their life due to illness. Therefore, caregivers must act in ways that help preserve the person's sense of dignity. We are caregivers maintain residents' dignity by focusing on their comfort and quality of life. The concept of dignity varies from person to person and across different cultures. Key aspects of dignity in end-of-life care are:

- Respect, which includes self-respect, mutual respect, and respect for privacy.
- Autonomy, which involves having and providing choices, as well as competence and independence.
- Empowerment, which can involve self-esteem, pride, and modesty.
- Communication, such as explaining and understanding information, both verbally and non-verbally.

Remember, a person's concept of dignity is influenced by their culture and values. For example, a Muslim resident may wish to die facing Mecca, the religion's holiest city. A Jewish person may want to be assured that, after death, someone will stay with their body before burial – a religious practice that honors the dead.

How to Maintain Dignity at End of Life

When caring for an individual at end of life, keep the following seven ideas in mind to maintain resident dignity:

- Speak to the resident directly. Caregivers should say hello to the resident when they walk in the room, and introduce themselves the first time they meet. Never speak about a resident in the third person if they are in the room.
- Speak respectfully to and about the resident. Use terms the resident can understand. Speak without jargon and in terms that a resident can understand. At the same time, do not patronize or speak down to a resident. Practice patience and empathy. Do not make jokes about the resident even if you think they are out of earshot. Answer residents honestly to build trust and take time to listen to their concerns. Listen to their concerns, and answer them honestly. Don't joke about or criticize the resident, even if they seem out of hearing range. Involve the resident in decisions as much as possible.
- Ask how the resident would like to be cared for. For example, when helping the person to eat, ask what they want to eat first. Explain what you will be doing before you do it –

especially if you will be touching the resident. Remember that what is routine for you may be a new experience for the resident.

- Protect personal information. Don't share personal information about the resident or family, except what's necessary for other care team members to know.
- Protect the resident's physical privacy. Maintain resident dignity by ensuring they remain covered while providing care and they're not exposed.
- Protect the resident's personal information. Do not gossip or share personal information about the resident or family beyond what is necessary for members of the care team. It is a privilege to be invited into a resident's life.
- Assist the resident with personal grooming. Go beyond the basics to help residents retain pride in their appearance. Maybe this involves helping them to use a napkin while eating, washing their face after the meal, and the like. For individuals who found great satisfaction in their sense of style throughout their lives, pride in appearance is essential to their self-respect.
- Create a respectful atmosphere. Maintain resident dignity at end of life by establishing a peaceful atmosphere in their final hours. Keep the resident comfortable. Play soft music to set the mood. Ensure the resident's religious needs are being met. Continue to speak to the resident even if they are no longer responsive. Assume they can still hear you as the sense of hearing is one of the last senses to go.
- Encourage life story-telling: Talk to the person about their life, which can help them maintain their identity and thereby enhance dignity. This can also help caregivers better know and respect the person, and reveal previously unknown needs.
- Help the person say goodbye. If the person is interested, help them plan and say their goodbyes to their loved ones.
- Support reflection. Allow the person time to think about their life, and ensure they receive professional support as needed.
- Encourage meaningful activity. Help the person do things they find fulfilling and hold conversations that are important to them. Such activities will contribute to their sense of self-worth and purpose.
- Keep a caring, positive attitude. Maintain a warm, sincere manner with the resident. Provide companionship, as well as care. Emphasize the person, not just their illness.

In its simplest form, maintaining resident dignity boils down to treating the individuals in your care the way you would like to be treated. When residents are treated with respect, it creates a greater sense of trust and well-being.

Module 5 – Infection Control and Sanitation

Objectives

At the end of this module, you will be able to:

- Explain the importance of food safety for residents
- Describe good personal hygiene
- Identify proper methods for handwashing and state when handwashing should be done
- State when gloves should be used and when gloves should be changed
- Explain and demonstrate the safe serving of food (i.e., how to handle utensils, cups, plates, bowls, and trays); and
- Explain how to test the temperature of food prior to feeding a resident

This module includes the following topics:

- Definition
- How infections are spread
- Food safety
- How to prevent infection
- Handwashing
- Serving food safely

Goal of Infection Control

Infection prevention and control measures aim to ensure adequate protection of those who might be vulnerable to acquiring an infection both in the general community and while receiving care due to health problems…the basic principle of infection prevention and control is hygiene.

World Health Organization

- Policies to prevent the spread of infection from resident to resident and from staff to residents
- Residents in long-term care are at high risk for infection.
- Weaker immune systems mean infections can be much more dangerous for them

Definitions

Infection:

- A condition caused by the growth of pathogens or germs in the body

Infection control:

- The method used in health care facilities to prevent the spread of pathogens or germs

How Infections are Spread

- Infections are commonly spread by:
- Direct contact such as touching the source of infection
- Indirect contact such as touching contaminated objects
- Airborne routes such as inhaling small pathogens floating in the air (Measles, tuberculosis)
- Droplet spread such as contacting drops of secretions placed in the air when someone sneezes, coughs, or talks (Pneumonia, influenza, mumps, rubella, pertussis)

Food Safety and Feeding Assistants

- You must serve food to residents in a sanitary manner
- Residents are at a higher risk of developing a foodborne illness. This is because they may have a weakened immune system and their resistance to infections is weaker than normal.

Foodborne illness occurs when foods are not prepared or served properly, or when they are contaminated by people who are ill or who have poor personal hygiene.

- Prevent Foodborne Illness
- Practice good personal hygiene
- Practice general cleanliness
- Use proper handwashing techniques
- Serve food safely

Importance of Food Safety:

- Why is food safety so important? According to the Centers for Disease Control (CDC), about 76 million people get sick from a foodborne illness each year. That's about one out of every four people in the United States.
- A main reason why so many people get sick is that food contaminants present an "invisible challenge" because you cannot see them AND they do not usually change the appearance, taste, or odor of the food you eat.
- Did you know that foodborne illnesses also lead to about 5,000 deaths each year? This number might seem staggering, but in 1994 the number of deaths per year was closer to 10,000.
- There are 3 main reasons why there are fewer deaths related to foodborne illness:
  - Better education on food safety
  - Better government inspections of food
  - Greater public awareness of unsafe food

High Risk Population Groups

There are certain population groups who have a higher risk of contracting a foodborne illness than an average healthy individual. The reason is because their immune systems are in a weakened state, making them less able to fight off infection from contaminants such as bacteria.

The Food and Drug Administration (FDA) calls this category "highly susceptible populations." The 4 main high-risk groups are pregnant and lactating women, infants and children, the elderly, and people with impaired immune systems. Let's take a closer look at the groups you are likely to see as a feeding assistant.

When it comes to the elderly, their systems become weaker with age. The lifestyle of senior citizens can also be a contributing factor for foodborne illness. As people retire, they may travel on cruise ships, visit foreign countries, or participate with volunteer organizations which can expose them to viruses and other harmful microorganisms. Some of the elderly also undergo outpatient care, visiting hospitals and doctors several times a year. Contagious diseases can be transmitted in these environments.

The last high-risk population group is people with impaired immune systems. Some examples of impaired immune systems are people with diabetes, cancer, leukemia, and organ transplants. People who fall into this category have persistently impaired immune systems and are consistently more susceptible.

So why is it important to know about these high-risk population groups? Have you ever heard the old saying, “a chain is only as strong as its weakest link?” When you pull on a chain, the first thing that breaks is the weakest link in the chain. In the same way, if you’re serving questionable or contaminated food, the high-risk population groups will be the first ones to get sick or maybe even die.

You serve food to the entire population. So, you want to make sure that the food you are serving is safe for everyone who might be eating it. Your establishment, as the source of foodborne illness, is something to always avoid.

Foodborne Illness

So, what is foodborne illness? Simply put, it is anything food-related that can make you sick. According to the World Health Organization (WHO), foodborne illnesses are defined as diseases, usually either infectious or toxic in nature, caused by agents that enter the body through the ingestion of food. Every person is at risk for foodborne illness.

There are 2 types of foodborne illnesses:
Foodborne infection and foodborne intoxication. A foodborne infection is caused by eating food that contains living, disease-causing microorganisms also known as pathogens. These pathogens grow in the body, especially in areas around the stomach and intestines.

Foodborne intoxication is caused by eating food containing toxins produced by bacteria. Foodborne intoxication can also result from chemical contamination such as cleaners accidentally used as a food ingredient. It is important to note that toxins cannot be killed by conventional cooking temperatures when heating or cooling.

So, any food suspected of being contaminated with foodborne intoxication should be thrown away. Intoxication results in a rapid onset, meaning that you feel the effects right away. Two common bacteria associated with foodborne intoxication are: staphylococcus aureus and clostridium botulinum.

These foodborne illnesses can cost the food industry more than $35 billion each year when you consider factors such as medical costs and a decrease in productivity.

The good news is that many foodborne illnesses can be treated. Increasing the fluid intake will restore the lost fluids and restore hydration in the body. More severe cases may require blood transfusions and kidney dialysis. If symptoms from foodborne illnesses are painful, or if they persist for more than a couple of days, a doctor should be consulted for immediate assistance.

There are 4 main sources of contamination: biological, physical, chemical and cross-contamination. Biological is anything pertaining to life or living things. Some main examples of biological contaminants are bacteria, viruses, parasites, and fungi. Physical contaminants are objects seen with the human eye such as nails, hair, and bandages. Chemical contamination can occur if an employee uses a chemical in an unsafe manner. Cross-contamination is the transfer of pathogens or disease-causing microorganisms from one food to another. These will be discussed in greater detail later in this presentation.

Practicing Proper Personal Hygiene

Did you know that the number one cause of foodborne contamination is poor personal hygiene? Food workers can transfer dangerous bacteria such as E coli and Salmonella by simply not washing their hands after using the restroom. Practicing proper personal hygiene is important to protecting your establishment from foodborne illnesses. Practicing proper personal hygiene means having good health habits such as showering regularly, wearing clean clothing, and frequent hand washing. Poor personal habits are serious hazards in food establishments. Saliva, sweat, and other bodily fluids can be harmful sources of contamination if they get into food. Clean clothing and uniforms are not only aesthetically pleasing, they prevent further spread of bacterial infections. Wearing street clothes increases the chance of contaminants on your food, equipment, and food prep surfaces. A good practice is to have employees change into their work clothes in an available dressing room or locker room at the establishment.

Improper food tasting should be strictly prohibited. Harmful germs can be transferred to food when an employee uses a utensil more than once to taste food. Smoking should never be permitted when preparing or handling food. Saliva from the smoker's fingers can transfer to the food and possible infect others with a Staph infection. Hair should be properly restrained to prevent contamination of food. Hair nets or clean baseball caps are recommended to prevent hair from dropping into the food.

Food service employees must have short, clean nails to minimize the possibility of food stuck behind the nails, which may result in cross contamination. Nail polish and acrylic nails are not allowed as they represent possible physical as well as chemical contamination. The excessive use of jewelry by food service personal is prohibited. Jewelry such as watches can contain high levels of bacteria because they are not cleaned on a regular basis. An employee could be wearing a loose bracelet and spread dirt and other particles into the food. A plain band such as a wedding band is permitted. Earrings should be close to the ear and away from hair.

Gloves can cause contamination just like hands. Always remember to treat gloves as if they are your actual hands or a second layer of skin. For minor cuts, wash the cut, put on a waterproof bandage and then wear a disposable glove. For any major cuts, call 911 immediately. Minor burns should be treated with cold running water.

If your employees are sick, can they still be allowed to work? The answer is it depends on the type of sickness. You might be asking yourself, "How do I know if an employee is contagious with one of these illnesses?" Look for symptoms focused around the intestinal area which include vomiting, diarrhea, or jaundice. What if someone has a headache or sore throat? Does this person need to be sent home? Not necessarily. If employees exhibit mild symptoms such as a headache or sore throat, they can still perform general housekeeping duties away from food preparation areas.

Good Personal Hygiene
Handwashing is the single most important measure you can do to prevent and control infections.

- Wear clean clothes to work. Bathe daily
- Wash your hands
- Do not eat or drink while assisting residents
- Cuts, sores, and burns should be properly cleaned and covered
- If your hands are bandaged, wear clean gloves at all times to protect the bandage and to prevent it from falling off into food.
- Carry trays away from your body
- Avoid touching your face and hair
- Do not chew gum or eat while assisting residents

General Cleanliness
If you are ill with a cold, respiratory or gastrointestinal symptoms:

- Do not assist residents (i.e., do not feed residents or serve meal trays)
- Do not share personal care items

If you perform other duties in the facility in addition to being a feeding assistant, it might be a good idea to wear disposable aprons and to keep a change of clothes handy in case your work clothes get dirty.

- Keep your fingernails short and clean
- Nail polish and artificial nails are difficult to keep clean and can break off into food. Don't wear them while handling food.

Handwashing
Handwashing is the single most important thing you can do to prevent infection and foodborne illness. According to the CDC, did you know that 80,000 people die each year from bacteria infecting their bodies? One speck of dirt in your fingernails can represent over one million bacteria. This fact makes proper handwashing all the more important. So, do you know how to properly wash your hands? Do you wash your hands often enough?

When Do You Wash Your Hands?
Wash your hands before assisting a resident and between residents.

After each of the following, wash your hands:

- Using the restroom
- Touching your hair, ears, nose, or any area of your body
- Scratching any part of your body
- Picking items up off the floor
- Smoking or chewing tobacco
- Clearing away or scraping used dishes and utensils
- Touching cleaning cloths
- Eating food or drinking beverages
- Touching clothing or aprons
- Taking out the garbage
- Sneezing
- Assisting a resident with eating
- Making direct contact with a resident's mouth or body or the eating end of the utensils

Proper Handwashing Method

Proper handwashing is more complicated than just running water and soap over the hands. The proper procedure is:

- Turn the water on and let it run to a temperature as hot as your hands can comfortably stand
- Wet your hands under the water and apply soap to them, rubbing your hands together
- Pay particular attention to the areas between the fingers and around the nails. Do not forget forearms since they can be exposed to daily splashes and drips and are not covered by a standard glove.
- Rub one hand against the other for 20 seconds. With 10-15 seconds focused on the actual rubbing of hands.
- Rinse thoroughly under hot running water
- Do not touch the sink
- Using a clean paper towel, dry your hands from the tips of the fingers up to the wrists. Dry hands using only single-use disposable paper towels or a hot air machine dryer.
- Dispose of the towel without touching the waste container
- It is also recommended that a paper towel be used to turn off the water and grab the handle of the door when leaving the restroom.

Also, any exposed part of the hand or arm that might come into contact with food must be properly washed. We all need to adopt a culture of proper hand washing. A majority of food establishments get shut down for foodborne illness. One main cause is that their employees simply do not wash their hands or do not wash them properly.

The toilet handle, flush handle, sink, paper towel handle, urinal handle, door handle, and the floor all contain high levels of bacteria. It is not surprising that when an inspection is being conducted, often times the inspector will use their foot to flush the toilet. Remember, if your facility has a hand washing sink, it cannot be used for any purpose other than washing hands. Some states require a specific minimum water temperature of 100 degrees. Conversely, handwashing should never be done in a three-compartment dishwashing sink, a vegetable rinsing sink, or near thawing food if you happen to have access to the kitchen. There should be posted signs on how to properly wash hands.

Hand Sanitizers
In addition to handwashing, hand sanitizing lotions and chemical hand sanitizing solutions may be used by food employees. Remember that hand sanitizers are not an acceptable substitute for washing hands. Hand sanitizers should not be used as a substitute for hand washing. If you use hand sanitizers, you must still wash your hands. If your hands are contaminated or soiled, a hand sanitizer is not adequate.

Gloves
Gloves should never be used to avoid hand washing. You must wash your hands before putting on gloves. Gloves should not be washed and should never be reused. Bacteria and perspiration build up under gloves so you should change them frequently. When you take off your gloves, you must wash your hands before putting on a new pair. You should wear gloves when handling the resident's food. You should also wear gloves during feeding, when you have a sore on your hand, or when your hands will come into direct contact with the resident's mouth.

Change your gloves:
- As soon as they become soiled or torn
- Before beginning a different task

Serving Food Safely

Once your food is properly cooked, how do you serve it safely? How you serve food can be just as important as the quality of the food. These are some best practices:
- Do not chew gum, eat or drink while assisting residents
- Avoid touching hair, face or other body parts during the feeding process
- When assisting more than one resident, take extra care to touch only the handles of the utensils and outsides of glasses and cups
- Replace dropped or thrown utensils with clean utensils
- Do not touch the ends of utensils (e.g., tips of spoons or drinking edge of cups or glasses)
- Deliver trays in a sanitary manner
    - Carry trays away from the body
    - Carry one tray at a time

How to Handle Dishes, Utensils, and Certain Food Items
Cups and Glasses:
- When serving, do not stack cups or coffee cups
- Carry one glass or cup in each hand
- Do not put your fingers in glasses
- Keep your hands by the base of the glass
- Do not put hand or fingers near the rim of a glass or cup
- Hold coffee cups by the handles
- Use a tray if you are serving more than two cups or glasses

Plates:
- Do not touch the eating surface
- Hold the plate from underneath
- Keep food items separate

Spoons, Forks and Knives:
- Hold spoons, forks and knives by the handles
    - Touch only the handles or outsides
    - Replace dropped utensils with clean ones

Handling Bread:
If you are receiving bread from the kitchen for a resident, transport it on a plate or in a bread bag. Do not carry it with your hands. Use a napkin or glove.

Condiment Packages (ketchup, dressing):
- Open packets with scissors or tear with your hand
- Do not open packets with your teeth or mouth

Remember …. Food contact areas of plates, bowls, glasses, and cups should not be touched. Dishes should be held by the bottom or the edge. Cups should be held by their handles and glassware should be held by the middle, bottom, or stem. For example, water glasses are held by the bottom of the glass to avoid leaving fingerprints on the top of the glass. Glassware and dishes should not be stacked when serving. The rim or surface of one plate can be contaminated by the one above it. Flatware and other utensils should be held by the handle. They should also be stored so that servers grasp handles and not the food contact surfaces. Minimize bare hand contact with food that is cooked or ready to eat by handling it with tongs, deli sheets, or gloves. Use ice scoops or tongs to get ice. Servers should never scoop ice with their bare hands or use a glass since it may break or chip. The ice scooper should then be stored in a separate compartment away from direct contact with ice.

Testing Food Temperatures

- You should check the temperature of hot food before feeding a resident (especially for coffee, soup, and pureed foods)
- Hot foods can cause serious burns.
- Do not test temperatures with your fingers or hands. Do not put fingers in resident’s food.
- Using a spoon or fork, place a drop of food on the back of your wrist to check the temperature. If it is too hot on your wrist or causes you discomfort, it is too hot for the resident to eat.
- By placing your hand above (and not touching) a plate or bowl of hot food, you can feel heat rising. You can also look for steam rising. The food may be too hot for the resident to eat. It needs to cool some.
- Do not blow on the resident's food to cool it. This spreads germs. Allow the food to cool on its own. Stirring the food will help it cool.

Food allergies

Did you know that at least 12 million people have a foodborne allergy in this country? Every year, at least 150 people in America die from allergic reactions due to food. 30,000 people seek emergency room treatment each year. One major cause is anaphylactic shock which can include hives, tightness of throat, itching, swelling, or death.

What is a food allergy? A food allergy is the response by the immune system to a food that the body mistakenly believes is harmful. Once the immune system decides that a particular food is harmful, it creates specific antibodies to it. The next time the individual eats that food, the immune system releases massive amounts of chemicals including histamines in order to protect the body. These chemicals trigger a cascade of allergic symptoms that can affect the respiratory system, gastrointestinal tract, skin, and/or cardiovascular system.

The eight major allergenic foods are: milk, eggs, fish, shellfish, nuts derived from a tree, soybeans (tofu), wheat and peanuts. The most common allergens can include shrimp and peanuts. People can also be allergic to MSG (monosodium glutamate) and sulfites. When an individual says they have an allergy to a specific food, it is important to pass that information along to those who prepare the food so that the person (or any foods they eat) are not exposed to any of the specified allergenic foods. Allergies need to be taken seriously. You never know how severe a person’s allergy might be. If you are not completely sure of the ingredients in a particular dish or food, take the conservative approach and say, “I don’t know, but I will check.”

Module 6 – Feeding the Resident

Objectives
At the end of this module, you will be able to:

- Describe how to prepare a resident for a meal
- Describe how to serve/pass trays
- Describe and demonstrate basic feeding techniques
- List three things you might provide help with for residents who need minimal assistance
- List three verbal cues or physical prompts that you might provide for residents who are easily distracted
- List eating problems you must report; and
- Describe adaptive devices for eating and their use

This module includes the following topics:

- Preparing the dining area
- Preparing the resident before meals
- Serving (passing) trays
- Guidelines for assisting residents
- Guidelines for feeding residents
- Eating problems you must report
- Adaptive devices
- Restorative dining defined
- Feeding problems and interventions

Preparing the Dining Area

Facility staff should sanitize and dry the table. Ensure the dining area is a pleasant, enjoyable atmosphere by eliminating odors and controlling lighting. Ensure table heights are appropriate for the residents to comfortably reach the food. (Ideally, wheelchair arms should fit underneath the table.)

Preparing the Resident for Meals
Before eating, we normally do several things to prepare for mealtimes. You should care for residents as you would care for yourself or for your loved ones.

Before the meal:

- Ensure the resident is comfortable and clean. This requires communicating with the nurse aides and nurses to ensure the resident has been toileted, has had their face and hands washed, and has good oral hygiene.
- Be sure the resident has dentures in, glasses on and clean, and hearing aides in, as appropriate
- Provide clothing protectors as needed
- Ensure the resident is positioned appropriately (ask facility staff to reposition the resident if needed).

Meal Set-Up

Set- up
There are many considerations when setting up the meal tray for a resident. Each of the strategies listed below may help residents experience more success when eating.
Place tray in visual field.

Residents may be unable to see all of the items on the tray if it is not placed where they can see it. At times it is necessary to place the tray either to the right or to the left side of a resident to ensure all parts are visible.

Place tray within reach
To encourage independence and participation during the meal, place the tray within the resident's reach. Always place the food and utensils on the resident's stronger side.

Cut food
A resident may be unable to use a fork and knife and need you to cut food into bite sized pieces.

Open lids and containers if needed
Making a meal accessible increases the likelihood of all items being eaten. Opened juice and milk containers will increase the resident's chance of receiving appropriate fluid intake.

Remove unnecessary items from tray
This strategy helps residents focus on the important items that need to be eaten. For example, remove lids and wrappers, and leave only the utensils and food.

Give only one item at a time
Position one dish at a time in front of the resident to reduce confusion or impulsivity.

Provide adapted utensils
When appropriate, ensure special utensils are available at every meal and are washed and sanitized after every meal.

How to Serve Trays

- Carry the tray away from your body, one tray at a time
- Identify the tray by the name on the tray card
- Verify that the tray contains the right food for the resident
- Identify the resident and place the tray within easy reach of him or her

You MUST make sure the right resident gets the right tray with the right food

Encouraging Independence

You should promote independence in eating by encouraging residents to do whatever they can for themselves. Encourage them to hold and eat finger foods, hold and use a napkin, and participate in feeding any way they can. Independence with eating may have an impact on the residents' feelings of self-worth and good health.

Special feeding devices (also called adaptive devices) may be very helpful in promoting independence. Self-feeding is frequently the last activity of daily living that residents can do independently, and it is very difficult when they become dependent on others for such a basic human need.

The facility may have special instructions for individual residents available in the dining room or on the tray card. Check for special instructions and follow them as needed. Nurse aides and nurses may tell you some specific needs of a resident.

Residents who are mostly independent but need occasional help need to be checked on throughout the meal to ensure all their needs are met.

Watch for those who don't eat 75% of their meal, or who leave a whole food item. Encourage residents to eat their food. Ask if the resident would like something to replace an uneaten item, then request a substitute from the kitchen.

You should:

- Assist those who spill food
- Obtain extra condiments if needed; and
- Refill coffee cups as needed

Basic Guidelines for Assisting Residents

- Feed a resident the way you would want to be fed
- Offer assistance in an unobtrusive manner. Don't offer help when none is needed.
- Be guided by the resident's wishes
- Don't control the resident's food choices. Respect their individuality
- Don't rush residents
- Sit with residents. Don't stand above residents when assisting
- Always use positive comments to describe the food. Example: "This is spaghetti and meat sauce and boy does it smell good!"
- Identify pureed foods for residents. The pureed diet is usually the same as the regular diet, but if you are not sure what the food is, be sure to ask.
- Take time to talk to the resident and socialize with the resident. Make him or her feel comfortable with the process.
- Offer liquids at intervals between solid foods
- Use a straw for liquids if the resident can manage it
- Offer liquids that meet the resident's preferences

Techniques for Improving Swallowing

- Tell the resident who you are and what you will be doing
- When feeding, if possible, sit down on a chair in front of the resident
- Resident should be positioned according to the instructions of the SLP and may need to be repositioned during the meal. Unless otherwise noted, residents are generally positioned upright with head in the neutral position.
- Describe the menu
- Tell the resident when the feeding utensil is near his/her mouth
- Present food at the mouth level so the resident does not need to lift his/her head while eating
- Do not use a straw unless instructed by therapy
- Tell the resident to take small bites and sips
- Place food on the strong side of the mouth
- Ask the resident to dry swallow to clear food lodged in the throat (as frequently as instructed by therapy).
- Alternate solids and liquids

- When feeding the resident, place the utensil gently on the mid-portion of the resident's tongue.
- When the resident is swallowing, ensure that his/her lips are closed
- Give the resident regular, verbal cues
- To reduce confusion, place only one dish in front of the resident at a time
- After eating, have the resident remain sitting up for at least 30 minutes
- Check for pocketing. Food in mouth may need to be cleared prior to the next presentation
- Do not use a syringe to feed

Before and after each meal, the caregiver should provide complete oral care to ensure no food is in the Mouth. Resident may be safe to eat only foods and liquids of specific textures, be certain to check the diet order before feeding:

- Resident may not be safe to use a straw.
- Ensure dentures fit well. The resident may eat better without the dentures or denture adhesive may be used to improve chewing.
- Allow adequate time for eating

Residents Who Need Assistance with Eating

Residents have several levels of need. Feeding assistants will offer different types of assistance based on the resident's needs.

There are three types of assistance:

- Minimal assistance
- Cueing and prompting (provided along with minimal assistance)
- Total assistance (or feeding the resident)

Minimal Assistance
Residents who need minimal assistance may be able to feed themselves but have difficulty with setting up their meals.

These residents may need help with the following tasks:

- Putting on a clothing protector
- Unwrapping or uncovering drinks, opening milk cartons, or placing straws in beverages.
- Uncovering food
- Spreading margarine on toast or bread
- Adding margarine to hot cereal
- Cutting meat
- Opening condiment packages

You should:

- Offer to add salt and pepper, cream and sugar, syrup, jelly, and other condiments to the food items served. (Never add any of these without first asking the resident. Some residents may be able to do this themselves).
- Offer to cut sandwiches into quarters (four)

Verbal Cueing and Prompting

This is the next level of assistance. Residents who need verbal cueing and prompting can feed themselves but may be easily distracted or have difficulty staying on task. They need minimal assistance as well as some cueing or prompting.

Verbal Cues
You may say something to get the resident back on track. Cues should be very brief directions. Avoid multiple step instructions.

Examples:

- Resident stops eating
    - "Take a bite of your eggs, Mrs. Smith" or "Take another bite"
- Resident doesn't drink liquids during the meal
    - "Take a drink now"
- Resident plays with food
    - "Pick up your spoon, Mr. Jones"
- Resident forgets to chew (has food in the mouth)
    - "Chew, Mrs. Johnson" or "Chew some more"

Verbal encouragements and directions

There are many ways to help a resident eat. The resident may simply need help to understand what is on the meal tray, what to eat next and how to eat it. Verbal prompts are important and can help guide a resident through all the steps of a meal. At times, residents may only require encouragement or praise for trying.

Identify foods on the tray by name or taste

- This helps residents who have difficulty seeing the tray and its contents

Tell the resident where the food is or which utensil to use

- Help the resident get started by telling them where the food is or which utensils to use

Tell the resident what to do next

- Residents who have trouble knowing the next step to eating will need you to tell them what to do

State the resident's name as often as necessary

- Residents who are easily distracted or tend to drift off during the meal may benefit from having their names called to alert and redirect them to the task of eating

Praise and encourage the resident

- Everyone likes to know they are doing well. Encourage the resident to continue what they are doing right

Physical Prompts

- You may use touch to get the resident back on track

Examples:

- Resident stops eating. Point to the food
- Resident stops eating while holding a fork or spoon. Touch the resident's hand to draw attention to the fork or spoon.

Hand-over-hand Feeding Technique
Hand-over-hand feeding is a method that may serve as a prompt for the resident to complete the task on his or her own.

- Place your hand over the resident's hand and complete the task together. Be sure to sit on the same side as the hand you are assisting. If a resident is weak but knows what to do, using the hand-over-hand technique helps the resident maintain or improve self-feeding ability.

When the Hand- over-hand Technique is Useful
The hand-over-hand technique may be used when a resident:

- Forgets how to eat
- Is unable to cut food
- Is unable to spread margarine or jelly on toast or bread
- Cannot lift utensils
- Cannot pierce food with a fork; or
- Is too tired to feed him- or herself as the day progresses

Total Assistance (Feeding a Resident)

This next level of assistance is provided when the resident needs to be fed.
Guidelines for Feeding a Resident:

- Fill the spoon half full and offer from the tip of the spoon. Place the spoon in the middle of the resident's tongue.
- Continue at an unhurried pace
- Offer most nutritious foods first: meat, milk, starch, vegetable, etc. Offer desserts and supplements last.
- Alternate liquids and solids to make the meal more enjoyable and to ease swallowing. This also helps to ensure the resident gets needed fluids.
- Do not indicate impatience with residents who eat slowly. Allow residents ample time to eat. Try to make mealtime relaxing and enjoyable.
- Wipe the resident's face with a napkin as needed
- Be sure to offer alternatives or substitutes if the resident does not like what is offered, or if the resident is not eating well (eats less than 75% of his or her meal).

Physical guidance

Some residents may only be able to participate in feeding at certain times, or only able to complete certain aspects of feeding. Independence during mealtimes should be encouraged whenever possible. Place the food on the spoon and then hand it to the resident.
Some residents are able to move their hand to their mouth for eating but cannot get the food onto the utensils properly. By placing the food on the spoon and then handing it over, you are encouraging the resident to play an active role in eating.

Hand the cup to the resident
Residents who cannot get started may need you to hand them a cup in order to drink. They may not be able to reach for the cup on their own but are able to hold it and drink from it.

Hand finger foods to the resident
To encourage participation, hand finger foods to the resident. For some residents, it is not always obvious that finger foods, such as a sandwich, can be picked up.

Initiate and then allow the resident to take over
Help the resident get started, as they may only need help to begin eating rather than be fed the whole meal.

Take turns
Take turns with the resident in getting the food to the mouth. Alternating gives the resident the opportunity to participate, learn from your actions, and receive additional support. Mealtime assistants should establish and maintain a controlled rate of intake during the meal.

Provide hand-over-hand assistance
Hand-over-hand assistance helps guide the resident. Gently, put your hand over or around the resident's hand to hold the utensil, or move the hand to the mouth.

Alert the resident by gently touching forearm
Touching a resident's forearm during meals can help to maintain attention and level of alertness.

Monitoring Mealtime

- Allow all residents (regardless of the level of assistance they require) ample time to eat
- Encourage socialization
- Remain pleasant and unhurried
- Try to avoid or control unpleasant situations
- Monitor the intake of residents during mealtime and identify problems with eating
- Notify the charge nurse of residents who are absent or who appear to have eating problems

Removing Trays
Remove the tray after the resident has finished eating

- Ensure that meal intake is recorded by the person responsible before removing the tray (or follow your facility's policy).
- Place used trays on the cart AFTER all the clean trays have been served
- Wash your hands

Observing and Reporting

WHAT do you report?
Report the following to the charge nurse or nurse supervisor. These eating problems could signal the resident has a problem with chewing and/or swallowing.

Report when the resident:

- Complains about the taste of food
- Complains about eating food, such as “too hard” or “too cold”
- Changes in alertness
- Changes in his or her ability to stay in an upright position for eating
- Changes from usual meal intake
- Bites down on utensils
- Cannot or will not chew
- Has food or liquid coming out of his or her nose
- Is unable to gather food with his or her tongue
- Will not open his or her mouth
- Has poor lip closure or has food falling out of his or her mouth
- Holds food in his or her mouth
- Does not take food off utensils
- Experiences food sticking to the roof of his or her mouth; or
- Bites his or her tongue or cheek

Eating Problems

The resident chews constantly or over- chews food

- Tell the resident to stop chewing and to swallow after food has been appropriately chewed. Encourage or offer smaller bites.

The resident eats too fast

- Encourage the resident to set his or her spoon or fork down between bites to slow down the eating rate. Explain the benefits of slower eating to the resident (i.e., avoid choking, enjoy the meal by being able to taste the food, and improve digestion by taking time to chew food thoroughly).

The resident eats too slowly

- Provide verbal cues such as "chew," "take another bite," or "try some more." Praise the resident for positive efforts to feed him- or herself within a reasonable time frame.

Techniques for Improving Self-Feeding

- Use a pleasant voice to greet residents by name and inform them it is mealtime
- Check to see that residents have their dentures, eyeglasses or any necessary adaptive equipment before transporting them to the dining room. If residents are able to walk or wheel to the dining room, allow them to do so and offer assistance as needed.
- Assist residents to achieve correct positioning:
    - Transfer to regular chair if possible
    - Ensure hips and knees are positioned at 90-degree angles (or as close as possible)
    - Ensure feet are flat on the floor or on foot pedals
    - Position the resident as close to the eating surface as possible
    - Ensure the table is positioned at elbow height
    - Encourage the resident to bring his head slightly forward
    - Position the resident so he is facing the table squarely
- Present food, describing what items are on the plate
- Set up food according to therapist recommendations, or resident preference

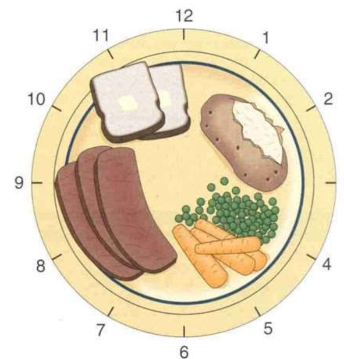
- Remove plate from tray if possible (trays give a cafeteria appearance, and are often too big and cumbersome for the table)
- Arrange the food in an appetizing or restaurant style format

- Allow the resident time to set up his/her own plate of food such as cutting food, pouring beverages, seasoning food or buttering bread. If he/she has difficulty, assist in set up of the tray.
- Use the "clock" method to set up food for those visually impaired to assist in locating food items (see diagram below). When setting up the clock program, ask the resident the preferred placement of food items. Stay consistent with food placement. For example:
  - Meat or entrée at 4:00
  - Vegetable at 1:00 – 2:00
  - Potato at 10:00

VISION-IMPAIRED PATIENT

USE THE CLOCK METHOD TO HELP THE VISION-IMPAIRED PATIENT WITH EATING.

THE LOCATION OF THE FOOD IS COMPARED TO THE FACE OF A CLOCK.



- Place a towel or napkin in the resident's lap to protect clothing. Avoid using bibs as this can be degrading for the elderly population.
- Ask the resident if there is anything else he/she needs
- Encourage the resident to independently self-feed without rushing and allowing rest breaks when needed.
- If a resident has made an effort to self-feed, but now seems tired, assist with the remainder of the meal. Attempt to make the meal as pleasant as possible.
- Incorporate adaptive equipment and specific feeding techniques as outlined by the referring OT or SLP.
- For a neurologically impaired resident with perceptual deficits, other special arrangements may improve the self-feeding abilities. Food placement may be:
  - To the affected side (to increase visual scanning)
  - To the unaffected side (to increase self-feeding independence and facilitate efficient oral clearance)
  - Within the resident's visual field
  - With pressure added from utensil (to increase sensation on the tongue)
  - The Speech Therapist will instruct on these techniques if needed
- For a confused resident, presentation of one food item at a time or use of finger foods may be effective methods for the resident. If the resident seems distractible or has a short attention

span, it may be best to position so he/she cannot observe other people. If easily distracted by noise, it may be necessary to work individually in a quiet room.

- Provide a pleasant eating environment. Mealtime is a social time. It is important to normalize the meal for residents. It is a proven fact that a pleasant environment directly affects the success of self-feeding. Have a newspaper on hand to incorporate discussion of current events.
- Residents should be seated with people they enjoy being around to encourage socialization. Try to group resident with similar difficulties together, such as those using adaptive equipment, those who eat only finger foods (sandwiches, fresh fruit, crackers, etc.), or those with impaired coordination who are messy eaters.

Resident Positioning for Swallowing and Self-Feeding

- Arrange for the resident to eat meals out of bed whenever possible
- Use pillows, wedges, or lap tables to assist the resident in maintaining the proper position
- Place the resident's arms on the table or tray-assure proper shoulder positioning
- Adjust the table height to reach between the resident's waist and mid-chest
- Place food within a 12-inch reach

When the resident is ready to eat, have the resident place his/her head slightly forward
Always check:

- Positioning of resident
- Positioning of the eating surface

Incorrect Dining Position

- Table too high
- Not seated close to table
- Not facing table
- Head straining forward
- Sliding forward in chair
- Feet unsupported

Proper positioning of the resident is essential during meals

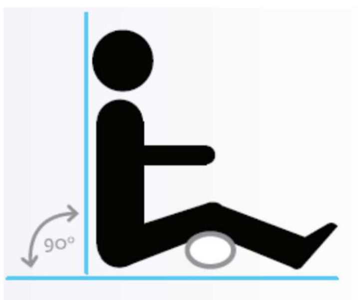
These are the general guidelines for proper positioning in a chair or wheelchair.

- Upright and centered.
- Not leaning excessively to one side.
- Pelvis (hips) or buttocks should touch the back of the chair to prevent slipping forward.
- Resident's back should touch the chair's back to prevent slipping forward.
- Resident's back should be straight or slightly forward.
- Feet should be resting on the wheelchair's footrests.
- Elbows supported on chair or table.
- Head should be positioned so that it is upright or flexed very slightly forward.
- Residents who are lying back, or who have an arched or hyper-extended neck should not be fed, as this creates an open airway, making it easier to choke.

Close proximity to table

The following general guidelines assure proper positioning in bed while eating

- Roll the head of the bed up to a 90-degree angle
- Ensure the resident's body is aligned with and supported by the surface of the bed
- If the resident cannot tolerate sitting at this angle, try to position the head at a 75 to 90-degree angle using a small pillow, foam wedges or rolled blankets behind the shoulders, and/or head.
- The head should be positioned so that it is upright or flexed very slightly forward.



Why is positioning important?

- Positioning the resident's hips in a 75 to 90-degree angle and the chin tucked downward slightly allows gravity to keep the food bolus toward the front of the oral cavity. It is important to prevent the bolus from sliding directly to the back of the oral cavity where it can descend prematurely and increase the risk of choking/aspirating.
- Residents should never be physically moved by those who have not been trained to do so properly.
- If the resident is not in the proper position to begin his/her meal (e.g. turned on one side, moved
  downwards in the bed), a nurse should always be called to help with repositioning.
- Once properly positioned, seat yourself beside and slightly in front of the resident, so that good eye contact is established. This enables the resident to maintain the slight chin-tuck position necessary for safe eating. It also promotes social interaction and comfort. Please make sure that the resident does not tilt the head backward, as this opens the airway and places the resident at higher risk of choking/aspirating

How should residents be positioned once the meal is complete?

- After a meal, position the resident to remain comfortably upright for at least one hour
- If the resident is in bed, the head of the bed may be lowered slightly to no lower than a 60-degree angle.
- This helps gravity to promote the downward progress of the meal and prevent reflux of food content that can cause aspiration pneumonia.

Adaptive Devices

Sometimes, adaptive measures or tools are needed for the resident's comfort and independence. Adaptive equipment or eating utensils are substitutes for motions lost due to a resident's disability. The resident's disability may be from different causes such as the loss of use of a hand or arm, weakness, vision problems, or tremors (shaking that a resident cannot control).

Knowledgeable professionals, such as an occupational therapist, should select adaptive devices for residents. The adaptive device should be provided to the resident at every meal.

Selecting and Using Adaptive Equipment During Self-Feeding

Use adaptive equipment to:

- Assist in self-feeding
- Increase independence
- Help with safe swallowing
- Decrease the chance of choking

Choose adaptive equipment for residents with:

- Limited range of motion
- Upper extremity weakness
- Poor coordination
- Paralysis, especially one-sided
- Blindness
- Swallowing problems

Frequently used adaptive equipment includes:

- Finger foods
- Plate guard
- Scoop dish
- Dycem place mats
- Utensils with built up handles
- Weighted utensils
- Swivel utensils
- Rocker knife
- Quad grip or universal cuff utensils holder
- Nosey cup
- Sip control cup
- 2-handled cup

Examples of Adaptive Devices

Long-handled utensils:

- Utensils with long handles

Nosey cup or nose cutout cup:

- A cup with a cutout "u" for the nose to allow the resident to drink without bending his or her head back.
- Be sure that cut out faces away from the mouth

Universal Cuff

- Use a universal cuff (utensil holder) when the resident cannot grasp or pinch.
- The cuff fits around the palm and has a pocket where the utensil is inserted.

Weighted Insulated Mug

- Used for individuals with Parkinson's or other illness which cause hand tremors

Built-Up Handle Angled Cutlery

- Used by individuals with limited upper extremity movement

Weighted Utensils

- The added weight helps to reduce tremors and keep hands steady while eating

Divided Plate

- This plate makes it easier for persons with poor coordination, or the use of only one hand to "scoop" their food onto their fork or spoon

Plate Guard

- A metal or plastic ring that snaps onto the edge of the plate. The resident is able to gather food on a spoon by pushing the spoon against the edge of the plate guard. Practical for people who tend to push food off the plate because of a lack of coordination

Keep Warm Dish

- Keeps food warm for individuals that take a longer time eating

Non-Skid Bowl

- Designed for individuals with limited upper extremity muscle control, the blind or with use of only one hand. The non-slip dish will help to keep items from sliding off a table or tray

Spork

- This utensil combines the bowl of a spoon with the tines of a fork.
- It eliminates the need to switch utensils.
- It is used with a cuff or splint.

Sandwich Holder

- This utensil holds the sandwich and has a handle.
- Use when a resident cannot pick up a sandwich.

Rocker Knife

- Use to stabilize and cut meat and other foods
- This utensil has a sharp curved blade that cuts when rocked over the meat

Dycem

- Non-skid surface that prevents dishes from sliding
- Useful for one-handed self-feeding
- Wet towel or wet sponge-cloth will work, too

Utensils

- Use utensils weighted for stability
- Use enlarged handles to assist with the resident's grasp
- Plastic-coated utensils will protect the resident/s teeth

If the resident's pinch or grasp is limited:

- Select built-up or enlarged handles on utensils
- Temporarily built-up handles with a washcloth, foam rubber, or
- Other material wrapped around the handle and secured
- Use commercial utensils with plastic handles
- Utensils should be lightweight to reduce resistance

Residents with Poor Coordination:

- Select a cup that has a sipping spout to prevent spills
- Prepare the resident's food before he/she attempts to self-feed
- Cut into small pieces
- Butter toast, rolls, etc.
- Mix the milk in cereal, etc.

Residents who are Blind:

- Tray set-up
- Tell the resident where each item is placed on his/her tray as he/she explores the placement of dishes, glasses, utensils with his/her hands.
- Allow him/her to explore the location of the food by using the fork to taste the food
- Tell the resident to distinguish salt from pepper by taste
- Tell the resident to find the edge of the food with the fork
- Tell the resident to move the fork one bite size inward on the meat/food
- Tell the resident to cut the food, keeping the knife in contact with the fork

Common Adaptive Equipment

Plate Guard

Universal Cuff

Nosey Cup

Angled Utensils

Foam for Built Up Handles

Sandwich Clip

High-Rimmed Scoop Dish

Suction Bowl

Dycem

Rocker Knife

Restorative Dining

Restorative dining refers to a program that provides increased assistance for residents. The restorative dining room may be a table, a corner of the dining room, or a separate dining room. A trained therapist determines whether residents benefit from an individualized therapy plan.

Our goal is to help our residents continue to live their lives with the dignity and respect we all want, while aging means changes in our bodies, we do not like having to give up our independence.

To best provide assistance, we have to be aware that a resident may not ask for help or may say that they do not need help even when they are unable to provide themselves with adequate food.

Module 7 – Appropriate Responses to Resident Behaviors

Objectives
At the end of this module, you will be able to:
- list three unacceptable behavior
- describe interventions for difficult behaviors when assisting residents at meals
- describe behaviors that should be reported; and
- distinguish between normal behavior and changes in normal behavior.

This module includes the following topics:
- Normal behaviors
- Behavioral problems and considerations for care
- Causes of behaviors
- Difficult behaviors and suggestions for responding
- Reporting difficult behaviors

Normal Behaviors

The community defines normal behavior at mealtime. There are some reasonable expectations for behavior at mealtime. Normal behavior has meaning and purpose.

Normal behaviors may include the following actions:
- Wearing clean and appropriate clothing
- Having a clean face and hands
- Being able to eat and drink using appropriate utensils
- Being able to communicate within one's own abilities, in socially acceptable methods

Difficult Behaviors

Occasionally older adults may display behaviors that are considered socially unacceptable. This may be usual behavior for some residents or an isolated incident for others. It is important that you report any inappropriate behaviors or changes in behavior to the nurse in charge.

Context of Challenging Behaviors
Very common in residents with dementia
As dementia progresses these behaviors can become more frequent or more severe in nature

Unacceptable Behaviors
- Unacceptable or challenging behaviors may include the following actions:
- Yelling, screaming, or cursing in a disruptive manner during the meal
- Verbal or physical aggression
- Spitting
- Taking another resident's food
- Dropping or throwing food onto the floor or table or at others
- Inability to keep food in the mouth for chewing and swallowing
- Agitation
- Wandering
- Pacing
- Shouting

- Aggression
- Kicking
- Hitting
- Biting
- Spitting
- Refusing care

Sometimes unacceptable behaviors are unavoidable due to mental conditions, medical diagnosis, or physical limitations. In those situations, special feeding techniques and adaptive equipment may be used to overcome the undesirable behaviors. If the resident displays unacceptable behaviors intentionally or on a continued basis, approaches must be found to deal with them. Residents with known difficult behaviors are evaluated by their doctor or nursing staff and have a written plan of care for interventions for the undesirable behaviors.

Causes of Behavioral Problems and Considerations for Care

All behaviors have a purpose. Many experts believe that the purpose of behavior is to satisfy unmet needs. In an alert, oriented resident, the unmet need is usually psychosocial. In a confused resident, the unmet need is usually physical. An example of an oriented resident's unmet need may be that he or she wants attention. Examples of a confused resident's unmet needs may be that he or she is hungry, needs to go the restroom, or wants to go to bed.

Behavior problems may also result from fears. Be patient, understanding, and respectful when feeding the resident.

Residents experience some loss of control over their lives due to many types of limitations. Offer choices whenever possible to add to the resident's sense of control and to reduce frustrations.

Consider that many older adults continue to use the same behavioral responses that they learned and used throughout their lives.

Causes of Challenging Behaviors
Challenging behaviors are often a result of an unmet need, or a way to express an unmet need.

Self-actualization
- Morality
- Creativity
- Spontaneity
- Problem solving
- Lack of prejudice
- Acceptance of facts

Esteem
- Self-esteem
- Confidence
- Achievement
- Respect of others
- Respect by others

Love/belonging

- Friendship
- Family
- Sexual intimacy

Safety/security of:

- Body
- Employment
- Resources
- Morality
- The family
- Health
- Property

Physiological

- Breathing
- Food
- Water
- Sex
- Sleep
- Homeostasis
- Excretion

Physical

- Pain
- Constipation
- Dehydration
- Infection
- Fatigue
- Side effects of medication

Emotional

- Fear
- Loneliness
- Anxiety

Environmental

- Overstimulation
- Disorientation
- Cluttered spaces
- Poor lighting

Staff approaches to resident (care) and reactions to behaviors

Behavior problems vary widely. Those included here are some of the common behavior problems seen in nursing homes. Consequences of challenging behaviors:

- Potential safety issues
- Creates resident and caregiver stress
- Creates an additional care burden

What does the resident need?
Responding to Resident Behaviors: Guidelines

- The guidelines provided here are suggestions because no single method will work for all residents or situations.
- Provide care that meets the residents' needs and promotes residents' rights, dignity, privacy, and independence.

The nurse in charge will be able to help you learn to control unacceptable resident behaviors. The charge nurse should show you, or you should ask to see, the resident's written plan of care before assisting the resident at meals. Observe the resident closely to learn his or her likes and dislikes.

You should know and understand the residents in your care. You should learn at least one effective measure to comfort or distract each resident such as:

- objects (such as a favorite pillow, doll, or something new and interesting)
- activities (such as a favorite topic of conversation, music, TV, rocking chair, holding hands)
- a favorite caregiver who is effective in calming the resident
- Meet the unmet need
- Re-direct the resident
- Remove the source of resident’s frustration
- See out nurse or supervisor for specific practices in resident’s care plan
- Strategy used one day may not work the next day

Take a minute to review your interaction with the resident.

- What did you learn about the resident and/ or situation?
- Is there a way to prevent that same behavior from happening again?
- Use these measures at the first signs of distress to try to avoid more serious behavior problems
- Share your observations of comfort measures, likes, and dislikes with the charge nurse to assist others in working with the resident
- Respond to appropriate behavior with genuine compliments, praise, and comments
- Do not respond negatively to inappropriate behavior. Never laugh or ridicule the resident's behavior.

Remember to:

- Stay calm
- Maintain respect & dignity for resident
- Use positive body language
- Think about the reason for the behavior

How to Respond to Resident Behaviors — Examples and Suggestions

Assisting Residents who are Complaining or Demanding

- Talk with the resident to determine the nature of the complaint or demand and report objective observations to the charge nurse.
- If the complaint or demand is justified, you should correct or meet it (if you are trained to do so) as instructed by the charge nurse.

Example:
The resident is demanding a second slice of bread. You check with the nurse, and the resident's diet allows for bread, so you get a slice of bread for the resident.

If the complaint or demand is unjustified or cannot be met immediately:

- Assure the resident that his or her complaint was heard and reported to the charge nurse
- Be a good listener and provide support
- If complaints are related to care, stay neutral and do not become defensive, take sides, or argue with the resident.
- Try to distract the resident with a favorite object or activity as appropriate
- Provide care (feeding the resident) to eliminate the cause of the behavior
- Follow the instructions of the charge nurse and the resident's plan of care

Be a good listener!

How to Respond to Resident Behaviors — Examples and Suggestions

Assisting Residents who are Yelling or Screaming

- Try to distract the resident with a snack or discuss a favorite topic. It is difficult to yell while eating or talking.
- Look for the cause of the behavior such as over- or under- stimulation, boredom, fear, pain, or unmet needs (hunger, thirst, or the need to use the restroom).
- Try to provide care (feeding the resident) to eliminate the cause of the behavior
- Follow the instructions of the charge nurse and the resident's plan of care

Assisting Residents who are Verbally or Physically Aggressive

- Verbal aggression is arguing, threatening, or accusing, usually in a loud and angry voice. Physical aggression or combative behavior is fighting.
- Remain calm and reassuring and use non-threatening body language
- Do not become defensive, argue, or try to reason with the resident
- Move other residents out of harm's way
- If attack is directed at you, leave if you can safely do so or request the assistance of a caregiver
- Attempt to redirect interest or distract the resident
- For physical aggression, the following safety precautions may be appropriate:
    - Notify the charge nurse quietly but promptly and obtain needed assistance
    - Take threats seriously and keep your distance
    - Do not try to touch or turn your back on a combative resident
    - Do not back resident into a corner, especially if the fight is about space

Assisting Residents who Have Cognitive Impairment

Cognitive Impairment means impaired or damaged thinking. The main symptoms are loss of memory and confusion. Dementia is a brain disorder that results in cognitive impairment. Alzheimer's disease is a progressive brain disease that slowly destroys cognition. Become aware of your own responses and reactions to the resident's behavior and modify your behavior if needed.

Reinforce the resident's feelings of belonging and safety
Examples:

- "You're safe here" or "You are all right."
- Call the resident by the name he or she prefers
- Maintain calmness in your voice and your non-verbal communication (body language)

Find and confirm a true and accepted fact of the moment. Try to move forward from the accepted fact to the present. Examples:

- "I really like the blue shirt you're wearing today" or "It's raining outside again today," followed by "We're having a great lunch today. The chicken and mashed potatoes on your tray look delicious."

Acknowledge the resident's feelings
Examples:

- "I can see you are feeling sad" or "I can see you are feeling afraid"
- Avoid isolating the resident. Isolation leads to more confusion

Eating Inedible Items

- Remove paper products, wrappers, etc. from the table

Throwing Food

- Identify cause of combativeness
- Sit on resident’s nondominant side
- Use non-breakable dishes
- Give resident one food at a time

Pacing During Mealtime

- Provide finger foods
- Use rituals as a cue to the resident (music, saying grace, etc.)
- Give resident a beverage as soon as they are seated for the meal

Refuses to Open Mouth

- Offer fluids or something sweet
- Offer alternative food items
- Have another staff member attempt to assist resident

Forgets She Has Eaten

- Regularly provide resident with high calorie snacks

Reporting Difficult Behaviors

Since you are working closely with residents, it is important to note and report any difficulties encountered while assisting at meals. Reporting should be done daily. The facility's procedure will determine whether you:

- Report verbally to your nurse supervisor; or
- Report verbally to your nurse supervisor and write your observations down.

You should always report a change in the resident's behavior on the day that it occurs

Behaviors to Observe for and Report to the Charge Nurse
What to report:

- Changes in the behavior of the resident that might indicate problems
- Possible causes of the behavior
- Effective measures to comfort or distract the resident
- Approaches that did not work
- Problems in managing the behavior or protecting the resident's safety

These may be changes that are not consistent with the resident's normal behavior:

- Residents untying a restraint or releasing a self-release seat belt
- Residents walking or wheeling away from the table
- Coughing; having wet, gurgly voice or a weak cough during or after swallowing
- Sudden complaints about all food
- Disorientation, i.e., the resident is uncertain of his or her surroundings
- Residents who seem sad or depressed
- Any threats of suicide or threats of harm to other people or property

What to Include in Your Report?
You should be alert for the following types of details and include these when reporting to the charge nurse or facility staff:

- Specific description of unusual behavior (e.g., he tried to stand up and leave the table, or she threw her fork and spoon on the floor and walked out of the dining room).
- What happened prior to the unusual behavior (e.g., another resident took the resident's food off of his tray, or the television was just turned on in the dining room, or several visitors entered the dining room at the same time).

Report Changes in Normal Behavior

Normal behavior for each resident varies. No two residents are alike. Individual resident plans of care address unique behaviors and responses to those behaviors.
To determine what is normal or usual for a resident:

- Familiarize yourself with the resident's plan of care; and
- Discuss the resident's behavior with the certified nurse aides and nurses who care for that resident.

Normal behavior for one resident (Resident X) will not necessarily be "normal" behavior for a different resident (Resident Y). For example, Resident X may drop small amounts of food onto the floor as an attention seeking behavior and may do this at all meals. This may be considered "normal" for Resident X and this behavior may be addressed in the resident's written plan of care with planned staff responses.

Resident Y may not usually show any behaviors but suddenly begins to drop small amounts of food onto the floor throughout a meal. The behavior of Resident Y should be reported to the nurse supervisor.

Tips for Sensitive Interactions and Communication with Clients with Dementia
The following are tips for improved communication with dementia residents. These can be helpful during one-to-one interactions as well as in group settings. All therapists could find these tips beneficial in learning how to present information so that the resident can understand and use it. The tips are presented below and are listed according to the severity of dementia; however, they also build upon each other.

Mild Dementia

- Use simple, concrete words. Say what you mean! Use words that frequently occur in language (e.g., “fork” instead of “utensil)
- Provide multi-modal input, being sure that gestures and facial expressions match the words you are saying. Exaggerated facial expression, gestures and body movements may be helpful.
- Speak slowly
- Speak in a quiet, calm voice, but do not whisper
- Use simple sentences. Grammatically complex sentences increase the load on the resident’s memory. (For example, say “a friend came to visit” instead of “a lady who went to school with me came by the house today for a visit.”)
- Give the resident sufficient time to process information and respond. When waiting for the dementia client to respond, try counting slowly from one to ten. Then repeat your question.
- Label things, either in writing or orally
- Keep the environment consistent
- Reduce noise levels or distractions
- Have the resident learn information in the form of a motor act
- Be sure the resident knows the context of the conversation as this may assist with word finding and comprehension. (For example, explain that you are going to talk about baseball. The resident will be more likely to comprehend “bat” as a baseball bat rather than the winged mammal.)
- Write instructions for the resident or use pictures
- Make sure the resident wears any glasses and/or hearing aids
- Be literal. Avoid metaphors and analogies because the resident may interpret them literally.
- Acknowledge that the resident may no longer respond to reasoning and that behavioral problem approaches may be more effective

Advanced Dementia

- Get the resident’s attention before attempting to communicate by calling his/her name and through gentle touch.
- Talk about objects when the objects are visible. For example, ask “do you want an orange?” while showing the resident an orange.
- Determine pleasant events for the resident, such as meals, music, time outside in the garden, etc. and then use these to stimulate activity and communication.
- Use yes/no questions

Importance of Non-Verbal Communication
It is important to assume that the client is trying to communicate and not just rambling on

- Start by being an active listener and observer
- Listen to the words. Do they make sense?
- Can you relate them to an event?
- Observe the body language. Is it relaxed or agitated?
- A good bit of the nonverbal message will be in the head, face and arms
- Watch for smiles, frowns, fast or slow hand movements

Notice the environment. Noisy, active or hectic environments are disturbing and can result in aggressive behaviors. Before attempting to communicate, have your client look at you. People who close their eyes are turning off the conversation. Establish and maintain eye contact unless the eye contact is exacerbating anxious or angry feelings.

Your client is ready to communicate if he/she leans toward you. Moving the head in a downward position often means the conversation is over. Whenever possible approach the client from the front to avoid startling him/her. If you must approach from behind, gently call the client by name.

Avoid large rapid gestures. These can be threatening. Think of things as moving in slow(er) motion.
If your client is agitated, stop the task and come back to it later. Vocalics or vocal sounds are also nonverbal behaviors. The words may not have meaning but frequently the sounds will convey the client's feelings.

Clients can sometimes be calmed or stimulated by music. The sound of your voice can do the same.
Convey information such as surprise, happiness, sadness or enjoyment through the tone of your voice.

Tips to Follow

These are various strategies nursing and/or the feeding assistant can use during functional tasks to improve resident participation and function. Not all will be appropriate for every resident. Nursing and therapy should collaborate to determine which are appropriate for the resident. Some things that all staff can do to improve function with the person with dementia include:

- Provide one-step commands
- Use short, simple sentences
- Use an active, not passive voice
- Speak slowly; repeat and rephrase sentences as needed
- Be flexible
- Use nouns, concrete vocabulary and specific names; be as literal as possible
- Communicate with the resident, not “at” the resident
- Utilize gestures and facial expressions along with speech
- Monitor tone of voice and keep a calm demeanor
- Allow adequate time to process information and to respond
- Use the same procedure, routine or verbal direction for functional tasks throughout the task
- Grade activities based on resident response
- Keep tasks simple and of interest to the resident
- Provide soothing activities (e.g., brushing hair, applying lotion)
- Praise and encourage the resident often
- Encourage automatic responses and keep conversations going with comments such as “Oh, how nice,” or “That’s great”
- Limit distractions in the environment
- Use routines and keep the environment and approach consistent and familiar
- Design activities and interactions to perform with the resident, not “for” the resident
- Encourage resident to use other senses such as touch, taste and smell to recognize objects
- Make the environment secure and as hazard-free as possible
- Tolerate pacing and wandering providing the resident is safe
- Continue the same topic of conversation as long as possible
- Always establish eye contact prior to addressing a resident
- Avoid open-ended questions -- instead pose yes/no questions or offer choices
- Label objects in the environment
- Educate staff and family to these same tips

Cueing Strategies to Improve Functional Performance

- Repeat functional questions several times with a short delay (about 5 seconds) in between
- Demonstrate the activity to the resident; use series of pictures that symbolize activity
- Use hand signals, pictures and facial expressions
- Provide one or two visual choices
- Provide familiar visual stimuli within environment (e.g., memory notebook, personal blanket)
- Provide familiar sounds within environment
- Provide tactile stimulation along with verbal instruction
- Talk about familiar and directly observable topics; provide cues when changing topic
- Use redirections (e.g., redirect resident to given topic/task if have decreased attention)
- Use a Hand-over-hand technique during functional activities
- Utilize multi-modality cueing (e.g., visual, verbal, tactile, initiation, signage)

Some additional strategies …
Be courteous and respectful. Always, always, make sure residents are treated with courtesy and respect. Treating residents has become simply a job for many healthcare professionals. They manifest boredom with their jobs by treating residents indifferently. That's not professional and it's bad business!

Never show indifference to residents. Many otherwise competent professionals give residents the feeling they are an inconvenience and a bother. Residents should not be made to feel inferior and misinformed.

Don't contradict, argue or match wits. Telling residents they are wrong about anything is just plain rude. Even when they have incorrect information, they still should be accorded respect. If you disagree with them, politely explain why their point of view isn't necessarily correct. Your goal should be to explain and communicate, and then to continue to explain and communicate. Help residents understand what is going on. Residents should feel they are just important, in the scheme of things, as you are.

Good manners will get you everywhere. Good manners are part and parcel of confidence and competence. Don't hide the truth even if it creates problems for you. Treat residents the way you'd want to be treated. Saying the appropriate words can show respect. Establishing eye contact is also part of good manners. Go way out of your way to show respect to others!

Stay in touch with residents. Many healthcare professionals don't think they have the time to stay in touch with residents after care is rendered. It’s okay to stop back later to their room and say “hello,” or just to check in.

Keep your promises. Many promises made to residents are never kept. The difference between empty talk and promises is that promises must be kept. And if it turns out you overpromised, own up to it. Being honest will pay off later.

Module 8 – Safety and Emergency Procedures

Objectives
At the end of this module, you will be able to:

- Identify situations that call for emergency action
- Describe what the letters R, A, C, E stand for in reference to fire emergencies; and
- Describe the Heimlich maneuver and its purpose.

This module includes the following topics:

- General safety
- Potential hazards
- Situations that call for emergency action
- Your role in emergency procedures
- Emergency measures for:
    - Power outages
    - Fire
    - Finding a resident on the floor
    - Choking/Heimlich maneuver
    - Finding an unresponsive resident
    - Seizures
    - Wandering or lost residents
    - Severe weather

General Safety

It is necessary for all staff to be alert to safety concerns for the residents. Some safety concerns are unique to mealtimes, but you need to be able to identify situations that may endanger residents at other times as well.

You could easily be in the facility when an emergency occurs. Since emergencies arise unexpectedly, it is important for you to know what your role is and what you need to do in each situation.

You should be prepared. Your own common sense is a great safety device. You will need to learn the facility's procedures for emergencies. It is a good idea for you to participate in emergency drills, such as fire drills.

Training in the use of a fire extinguisher, Heimlich maneuver, and Cardio-Pulmonary Resuscitation (CPR) are left up to the discretion of the instructor and your facility's policy.

You need to know where to go and how to get there in the event of an emergency. You should know how many doors you have to pass through to exit the building.

Potential Hazards to Resident Safety

You should identify potential hazards to resident safety:

- Errors (wrong trays)
- Unsafe, improperly placed, or non-working call lights
- Lack of proper lighting. Glares are especially hazardous to the elderly.
- Sources of falls. Falls are the greatest threat to residents. Be alert to all situations, such as spills, that may pose a hazard.
- Unsafe equipment, such as electrical cords
- Slippery floors or spills
- Improper use of smoking materials
- Cluttered hallways
- Unsafe or non-working equipment
- Mealtime hazards
    - Wrong tray given to wrong resident
    - Food that is too hot

Situations That Call for Emergency Action

- Power outage
- Fire
- Finding a resident on the floor
- Choking
- Finding an unresponsive resident
- Seizures
- Wandering or lost residents
- Severe weather

Emergency Situations — General Guidelines

Power Outage

- Open window shades to allow more light inside
- Stay with residents until help arrives
- Know where flashlights and batteries are located throughout the building
- Do not use candles or other types of open flame for lighting
- Do not use elevators. If trapped in elevator, call for help

If the power is out for less than 2 hours, the food in the refrigerator and freezer will be safe. While the power is out, keep the refrigerator and freezer doors closed as much as possible to keep the food cold. If the power is out for longer than 2 hours:

- For the freezer section: A freezer that is half full will hold food safely for up to 24 hours. A full freezer will hold food safely for up to 48 hours. Do not open the freezer door if you can avoid it.
- For the refrigerator section: Pack milk, other dairy products, meat, fish, eggs, gravy, and spoilable leftovers into a cooler surrounded by ice.
- Use a digital quick-response thermometer to check the temperature of your food right before you cook it or eat it. Throw away any food that has a temperature of more than 40F.

Safe Drinking Water

When power goes out, water purification systems may not be functioning fully. Use bottle water for eating and drinking. If you do not have bottled water, and are not sure that the tap water is safe, follow these directions to purify tap water:

- Boil the water vigorously (water should be bubbling and rolling) for 1 minute
- If you cannot boil water, add 6 drops of newly purchased liquid household bleach per gallon of water, stir it well, and let the water stand 30 minutes before you use it.
- You can also use water-purifying tablets from your local pharmacy

Fire Emergencies

What Causes a Fire?
It is a scientific fact that if three elements are present in the right proportions, there will be a fire. These three elements of fire are heat, fuel, and oxygen.

- Heat: Heat could come from something like an electrical socket or from an open flame. By itself, heat is not dangerous; when combined with the other two elements, a danger exists.
- Fuel: This is the component that will burn, such as a solid, liquid, or gas. Solids could be wood, paper or glass. Flammable liquids could be oil, kerosene, or oil. Flammable gases could be vapors from gasoline or paint. Adding fuel to the heat will not start a fire without the third element.
- Oxygen: Without oxygen being combined with heat and fuel, a fire will not start

So, when you look around your facility, think about these three elements and remember, if all three are present in the same area, a fire has a greater chance of occurring.

Sometimes these three elements are viewed as a triangle. Whenever one of the elements, or sides, is missing, the fire, or triangle, is not complete. For example, whenever there is not enough heat being generated the fire will go out. When the fuel, otherwise known as the object that is burning, is either removed, exhausted or isolated, the fire will die out. Also, if the supply of oxygen gets smaller, the fire will get smaller.

What are the stages of fire?

There are three main stages of fire, when the three main elements, heat, fuel and oxygen, combine:

- **Ignition -** During this stage, the fuel is combined with heat and oxygen and begins to burn.
- **Smoke** - During this stage, the fire begins to smolder. You can tell that smoldering has become because you can see a by-product being released or emitted. This by-product is the smoke.
- **Flame** - This is the glowing, heated and gaseous stage of fire, where flames become visible.

What are some fire hazards in a Center?
Being aware of these common types of hazards in a senior care setting you can help prevent fire from occurring.

Blocking, not marking, or inappropriately locking exits. If a fire occurs, and doorways and exits are not available for staff or residents to go through, a person’s life could be jeopardized. It is important to take personal responsibility to ensure all doorways and exits are clear at all times.

Having flammable solids or liquids close to where a resident is having oxygen therapy. Since oxygen is one of the three main elements of fire, it is important to not combine it with anything that could cause a fire. Therefore, keep all lighted matches, open flames, and cigarettes away from visible oxygen.

Flammable liquids such as oils, alcohol, nail polish, aftershave, lotions, perfume, and hair spray are also hazardous and should be kept at a distance. As well, electrical equipment such as radios, hair dryers, electric razors, and heating pads are equally hazardous and should never be used when a resident has oxygen near them.

Broken or faulty smoke detectors and fire alarms. Smoke detectors and fire alarms are crucial for a quick response to fire because they signal at the first sign of smoke or fire. Test them on a routine basis and be sure they are properly installed and functioning within your facility. Taking these steps will help you be better prepared for responding safely to a fire.

- Electrical sources: Incorrectly installed wiring, old, worn, or damaged appliance cords, appliances that are incorrectly used, and overloaded circuits.
- Smoking. Because of the obvious fire danger, it is very important that staff members are aware of the rules and procedures for smoking in and around senior care facilities, by staff as well as residents.

What can the Center and Staff do to be prepared?

There are a number of important actions that the Center and staff can do to be well prepared in the event of a fire.

Fire safety training should be conducted on a regular basis by each facility, until all staff members are completely secure with the necessary steps of the fire procedures and reviewed with the staff on a regular basis.

Role-playing emergency procedures can be a useful learning approach. Let the staff members try dealing with different scenarios such as an injured resident or a smoke-filled room. During training, the written fire procedures should be shared with any staff responsible for knowing and carrying out their part of the plan. This staff might include doctors, nursing staff, kitchen staff, maintenance, volunteers, and others. The written fire procedures should be understood and practiced by all staff.

Learn the location of all escape routes. Have detailed maps placed around the facility that show fire escape routes Make sure that all staff members know where these maps are located. Being prepared before a fire even starts can prevent unnecessary injuries when a fire does occur.

Know where emergency equipment is located and how to properly operate it. On the fire escape route maps listed previously, there should also be clear labels for where the emergency equipment is located. Have a clear "code word" agreed upon beforehand for the facility to alert other staff in case of fire. When a fire starts, the staff would call out this code word, alerting staff, initiating the fire response plan.

What should I do in case of a fire?

The following are steps that should be taken if there is a fire:

- **Step One** – Remain Calm
  While carrying out the fire evacuation plan, remember that the residents may be confused and frightened for various reasons, so it is important to remain calm. By remaining calm, you are giving yourself the opportunity to think more clearly about what actions you must take next. Your calm demeanor will then help the residents to feel calmer. They will be able to trust you more because they do not see you panicking.
- **Step Two** – Move Residents in Immediate Danger to Safety
  When a fire occurs, residents need to be removed from immediate danger and it is your responsibility to get them moved to where they need to be. If there is access to a wheelchair, calmly help the resident into the chair and wheel them out of the fire area; oftentimes this will be faster and safer than having them walk. Another wise safety measure is to move residents safely behind closed doors to keep them safe. Closing doors and windows behind you will slow the spread of the fire. Also, double-check all adjacent rooms, such as any bathrooms or closets for residents during this rescue process so that no one is missed. Your goal is to have every resident moved out of immediate danger.
- **Step Three** – Activate the Nearest Fire Alarm
  Every staff member needs to be aware of the location of every fire alarm in the building and how they are activated. When a fire occurs, it is critically important for you to activate one of these fire alarms so everyone else in the facility knows there is a fire and can take the appropriate steps, just as you are. If your facility is not on an automatic notification system with the local fire department or unit when you activate the fire alarm, you must also call 911. When calling 911, the necessary information such as the building and location of the fire must be near the phone and this information must be conveyed in a clear manner to the 911 operator. Staff members must also know the location of phones and emergency numbers should be posted at every phone station in your facility.
- **Step Four** – Qualified Staff Members are to Use the Fire Extinguisher
  If the fire is small enough to control, locate the nearest fire extinguisher and put the fire out at the base as you have been properly trained to do. If you haven’t been trained, do not use it.
- **Step Five** – Contain the Fire and Clear the Area Around the Fire
  After a fire alarm has been sounded, the fire should be contained or confined by closing doors and windows manually if the facility does not have automatic fire doors. All hallways must also be cleared of all residents. All pieces of equipment that will burn must also be cleared from the fire area. If the fire is large and spreading rapidly, all residents and staff must be evacuated from the building immediately.
- **Step Six** – Continue to Follow the Evacuation Plan for your Facility
  Though most fire evacuation plans have similar policies and procedures, each facility should customize their own plan to fit the building layout and the type of residents they have. Other items you may need to address depending on your facility’s plan are turning off air conditioning units, as well as electrical equipment and oxygen units currently in use. Also ensure no one uses an elevator during a fire evacuation. You should continue to follow the plan of your facility until the fire department has arrived or the management tells you otherwise.

What about smoke?
Smoke from fire is very dangerous because it can suffocate you. If you are in a smoke-filled area, stay as close to the floor as possible because it has the most oxygen available during a fire since smoke rises to the top. If you can crawl to an exit, cover your mouth and stay on your knees, with your head toward the floor. If possible, it is best to take short breaths through your nose to avoid inhaling too much smoke. Before entering a room, touch the door with the back of your hand. If the door is hot to the touch, do not open it. If you are trapped in a room and the door is hot to the touch, stay in the room and place wet blankets or towels under the door to keep the smoke out. Opening the door could cause the fire to enter explosively. If you touch the door and it feels cool, open it cautiously, being prepared to close it quickly if the room or corridor is filled with smoke.

What is "Stop, Drop and Roll"?

If your clothing happens to catch on fire and the floor is not on fire, remember the phrase STOP, DROP, and ROLL.

- Stop. First, you should stop what you are doing. Stop all movement. The more you move, the more oxygen you are feeding to the flame.
- Drop. Next, drop to the floor carefully. Make sure before you fall to the floor, that you do not see any smoke or flames there.
- Roll. Finally, you should roll around to extinguish the flames. When you roll and press your clothing on the hard surface of the floor, you are helping to cut off the oxygen supply to the fire. This should suppress the flames.

No matter what, it is important that you do your best to remain calm. To be better prepared, it is important to practice this procedure ahead of time so that you will know what to do in case this happens to you.

If a co-worker or a resident catch on fire, this same motto applies. Tell them to stop what they are doing and drop to the ground if they are able. You can help them put the fire out with a fire blanket. Instead of telling them to roll around on the floor, you can instead wrap them in the fire blanket to extinguish their burning clothes.

If a fire has started:
If you think you smell smoke behind a door, feel the door with the back of your hand first. If the door is too hot to touch, DON'T OPEN IT! Otherwise, open the door slowly.

Don't ever hesitate to sound the alarm if you think there may be a fire in your facility. Pull one of the wall fire alarms to quickly alert the fire department and facility staff.

If there is a fire in your facility, take steps to try to confine the fire to keep it from spreading.
These doors help keep fire and smoke from spreading. Always keep these doorways clear so they can close. Never prop fire doors open.

What are some of the fire safety features of modern healthcare facilities?
Healthcare facilities these days are built with safety features that prevent fires from spreading too rapidly.

- Doors: There are special doors that will close automatically when the fire alarm sounds. Closed doors can help prevent the spread of fire because they block out oxygen, one of the three elements of fire.
- Automatic Sprinkler Systems: Automatic sprinkler systems react quickly, reducing the fire's heat, flames and smoke. These systems can be a helpful method of slowing down the fire before emergency personnel have the opportunity to get to the scene.
- Escape Route: Having a safe and quick escape route is the most important component of fire safety. Fire exits ensure a greater opportunity for the safe evacuation of residents and staff.
- Smoke Alarms: Also contributing to a safe evacuation are smoke alarms. Your ability to get out of the facility depends on advance warning of smoke alarms.

Fire-Rated Materials
Many materials used on the floors, doors, walls, and furnishings are fire-rated, which means they take longer to burn.

Fire is a common yet serious hazard that one could very likely encounter in a healthcare facility. While proper procedures and training can minimize the chances of an accidental fire, everyone must still be prepared to deal with a fire emergency when it does occur. All staff members must be knowledgeable about the basics of fire extinguishers and all facilities must develop a written plan for fire drills and evacuation.

Only try to extinguish the fire if it is small and contained.

What about fire extinguishers?

Depending on the Center's policy, management may only want certain staff to be trained on using a fire extinguisher, or they may want everyone trained. It is important to know the requirements of your particular facility.

There are four different types or classes of fire extinguishers, each designed to extinguish a specific type of fire. These four types are labeled Class A, Class B, Class C, and Class D.

- Class A fires are fires caused by ordinary materials such as burning paper, lumber, cardboard and plastics. Look for the numerical rating on the Class A fire extinguisher to see how much it will extinguish. This numerical rating refers to the amount of water the extinguisher holds. The numerical rating also lets you know the amount of fire it will be able extinguish.
- Class B fires involve flammable or combustible liquids such as grease, gasoline, kerosene, and oil. The numerical rating for this class of fire extinguisher, which is labelled directly on the fire extinguisher, states the approximate number of square feet of a flammable liquid fire that a non-expert person can expect to extinguish. This numerical rating is based on tests that were conducted to determine the extinguishing potential for each size and type of the extinguisher. It is very important to pay attention to this numerical rating. If the fire exceeds the numerical rating, the Class B extinguisher will not be sufficient enough to put the fire out.
- Class C fires involve energized electrical equipment such as appliances, switches, panel boxes, power tools, and hot plates to name a few. The presence of the letter "C" indicates that the extinguishing agent does not contain water, but instead contains more of a powdery substance to adequately put out the electrical fire. If you do not have a Class C fire extinguisher, remember

to NEVER use water when putting out an electrical fire. Water can be a dangerous extinguishing agent for class C fires because of the risk of electrical shock.

- Class D fires involve combustible metals that are materials which burn at high temperatures and react violently with water, air, and other chemicals. Because of the great amount of materials that it reacts with, these fires must be handled with great care. This Class D fire extinguisher consists of a copper-based dry powder which smothers fire quickly, which is why it is the preferred extinguisher for combustible metals.

You may sometimes see a combination of letters on an extinguisher – such as Class AB or Class ABC, because fires often burn a combination of different materials, and these are rated for multiple purpose use.

Even though extinguishers come in a number of shapes and sizes, they all operate in a similar manner and should only be used on small fires. Larger fires should be handled by the fire department or other highly trained professionals.

So how should one operate a fire extinguisher? It is best to remember the acronym P.A.S.S. P.A.S.S. stands for Pull, Aim, Squeeze, and Sweep.

- **PULL**. First, PULL the pin at the top of the extinguisher that keeps the handle from being accidentally pressed.
- **AIM**. You should AIM the nozzle, horn or hose toward the base of the fire. If you aim at the flames, the extinguisher will go right through, doing nothing to stop the fire. It is far more effective to aim for the base of the fire where the fuel is located.
- **SQUEEZE**. After you have pulled and aimed, stand approximately 8 feet away from the fire and SQUEEZE the handle to discharge the extinguisher. When you release the handle, the discharge of the fire extinguisher will stop.
- **SWEEP**. The final part of the using a fire extinguisher safely and correctly is to SWEEP the nozzle back and forth at the base of the fire until it is extinguished. While you are sweeping, always watch the fire closely in case it reignites suddenly.

You usually cannot expect more than 10 full seconds of extinguishing power on a typical fire extinguishing unit. This amount could be significantly less if the extinguisher has not been properly maintained. To maintain a fire extinguisher, inspect it at least once a month, and sometimes more frequently, depending on the type of extinguisher. Replace any extinguisher that has been discharged or has had the pin pulled for any reason.

Also, always practice using a fire extinguisher before ever actually using one on an actual fire. That will help you to know what to expect ahead of time. Any time you practice, you are better preparing yourself to deal with the emergency in a calm, effective manner.

Remember – staff members are never required to fight a fire – ever. If there is the slightest doubt about the control of the situation, do not fight the fire. If you feel you are not in a position to fight the fire, don't. There are other means by which the fire can be put out or contained.

If there is a fire in your facility, the first thing you want to do is rescue residents who are closest to the fire. Because they are elderly, some residents may not be able to move very quickly in a fire emergency. They also might not be able to see very well in the smoke or hear what you are saying to them because of the fire alarm.

Residents may be drowsy or disoriented because of their medical condition or time of day, especially if the fire is at night. A person with severe Alzheimer's Disease may be physically capable of leaving the area, yet mentally unable to respond appropriately. Because of these reasons, residents may need more time to escape from a fire area and may need your help.

Rescue residents who can walk on their own or with little help first. This will give you more time to rescue the other residents. Sometimes, residents who can walk on their own and don't have physical challenges may present other challenges.

Elderly residents and residents with mental disorders may behave irrationally by ignoring the fire, by not being able to physically move when they see the fire, by resisting rescue efforts, or even by hiding under beds or in closets.

To rescue these residents, you need to give directions firmly and calmly. Try to take such residents one-on-one to a safe area if at all possible.

To rescue residents who cannot walk on their own or with little help, use wheelchairs or stretchers if available.

Evacuation routes are posted throughout the facility. It is important to become familiar with multiple evacuation routes for your work area before an actual fire occurs.

There are a number of basic principles to remember when evacuating:

- Do not evacuate until the order has been given to do so, unless emergency conditions clearly warrant such action
- Evacuate all persons to pre-assigned assembly areas
- Do not re-enter the burning building
- When traveling through smoke:
- Keep low to the floor, crawling if necessary
- Cover the face from the nose down with a wet cloth

Before opening any door, do this test procedure:

- Brace a shoulder against the door
- Brace a foot against the base of the door
- Place one hand on the doorknob
- Place one hand along the door opening about head level
- Open the door slowly
- Be sure your face is turned away from the door opening
- If smoke seeps in, close the door immediately and place a wet blanket or other cloth under the door. Wait for rescue

Do not touch anything

- Watch for falling wires and other debris
- If all exit ways and stairways are blocked, go to a room that is distant from the danger area until rescue personnel arrive
- Place a wet towel or cloth under the door to seal it

One employee should remain in each assembly area to ensure evacuees remain in the area

- Stay in the designated assembly area unless otherwise instructed
- Check everyone for injuries, burns and smoke inhalation
- Provide emergency first-aid treatment as necessary
- Transfer those with major injuries and second and third degree burns to a hospital as soon as practicable
- Report any missing persons to the person in charge

Remember ….

Actions to take when fire is discovered

- R – remove residents in immediate danger
- A – alert other staff
- C – confine the fire
- E – extinguish the fire if possible

Be prepared

- Know the location of fire extinguishers closest to your work area
- Know the location of the fire alarm closest to your work area
- Know how to use a fire extinguisher
- Know the quickest route to exit your work area
- Know the facility's plan for fire emergencies

Emergency Situations

- Finding a Resident on the Floor
- Stay with the resident
- Call for help immediately
- Do not attempt to move the resident

Finding an Unresponsive Resident

- Call the resident by name to determine unresponsiveness
- Call the nurse immediately and stay with the resident
- Assist the nurse as directed

Seizures

Seizures are sudden involuntary movement of muscles. The resident may be partially conscious or become unconscious.

- Stay with the resident
- Move obstacles out of the way to avoid injury (e.g., chairs)
- Call for the nurse immediately
- If instructed to do so:
    - Ease the resident to the floor
    - Roll the resident on his or her side
    - Do not restrain the resident's movements

Emergency Situations — General Guidelines

Wandering or Lost Residents

- You must report to the nurse immediately when you discover that a resident is missing
- Follow the nurse's instructions

Severe Weather

- A Tornado Watch means that conditions are favorable for a tornado to develop
- During a tornado watch, no actual tornado has been sighted
- A Tornado Warning means that an actual tornado has been spotted by a person on the ground or that a tornado has been visualized by radar.
- **TAKE COVER IMMEDIATELY!**

Preparing for a Hurricane

If you are under a hurricane watch or warning, here are some basic steps to take to prepare for the storm:

- Learn about your community's emergency plans, warning signals, evacuation routes, and locations of emergency shelters.
- Identify potential home hazards and know how to secure or protect them before the hurricane strikes. Be prepared to turn off electrical power where there is standing water, fallen power lines, or before you evacuate. Turn off gas and water supplies before you evacuate.
- Make sure you know the location of the fire extinguisher and how to use it
- Post emergency phone numbers at every phone
- Inform local authorities about any special needs, (elderly or bedridden people, or anyone with a disability).
- Each health care facility should have plans in place that are specific to their needs including staying at their facility and/or if the facility must evacuate. It must be noted that given the uncertainty of these types of storms, it may be necessary to switch from one plan to the other. No plan is 100% fool proof or takes into consideration all aspects of planning. The facility and its personnel must remain flexible in order to best meet the needs of the residents.

Extreme Heat

Staff should be aware of the risks of heat stroke, heat exhaustion, heat cramps and fainting. To avoid heat stress staff should:

- Drink a glass of fluid every 15 to 20 minutes and at least one gallon each day. Avoid alcohol and caffeine. They both dehydrate the body.
- Wear light colored clothes, loose fitting clothing
- When indoors without air conditioning, open windows if outdoors air quality permits and use fans.
- Take frequent cool showers or baths
- If you feel dizzy, weak or overheated, go to a cool place. Sit or lie down, drink water, and wash your face with cool water. If you don't feel better soon, get medical help quickly.

Heat stroke is the most serious heat illness. It happens when the body cannot control its own temperature and its temperature rises rapidly. Sweating fails and the body cannot cool down. Body temperature may rise to 106 or higher within 10 to 15 minutes. Heat stroke can cause death or permanent disability if emergency care is not given. Warning signs of heat stroke vary but can include:

- Red, hot and dry skin (no sweating)
- Rapid, strong pulse
- Throbbing headache
- Dizziness, nausea, confusion or unconsciousness
- An extremely high body temperature (above 103F)

If you suspect someone has heat stroke, follow these instructions:

- Immediately call for medical attention.
- Get the person to a cooler area.
- Cool the person rapidly by immersing him/her in cool water or a cool shower or spraying or sponging him/her with cool water. If the humidity is low, wrap the person in a cool, wet sheet and fan him/her vigorously.
- Monitor body temperature and continue cooling efforts until the body temperature drops to 100-102F.
- Do not give the person alcohol to drink. Get medical assistance as soon as possible

Extreme Cold:

- Hypothermia happens when a person's core body temperature is lower than 35C (95F). Hypothermia has three levels: Acute, Sub acute, or Chronic.
- Acute hypothermia is caused by a rapid loss of body heat, usually from immersion in cold water
- Sub acute hypothermia often happens in cool outdoor weather (below 10C or 50F) when a wind chill, wet or too little clothing, fatigue, and/or poor nutrition lower the body's ability to cope with cold.
- Chronic hypothermia happens from ongoing exposure, to cold indoor temperature (below 16 or 60F). The poor, the elderly, people who have hypothyroidism, people who take sedatives-hypnotics, and drug and alcohol abusers are prone to chronic hypothermia and typically misjudge cold, move slowly, have poor nutrition, wear too little clothing, and have poor heating systems.

Causes of hypothermia:

- Cold temperatures
- Improper clothing, shelter, or heating
- Wetness
- Fatigue, exhaustion
- Poor fluid intake (dehydration)
- Poor food intake
- Alcohol intake

Preventing hypothermia:

- Avoid working alone
- Change into dry clothing
- Adequate food, clothing, shelter and source of heat
- Electric blankets
- Layers of clothing
- Move around; physical activity raises body temperature

Helping someone who is hypothermic:

- Bring individual immediately to hospital or medical clinic
- Do not rub or massage the skin
- Severe hypothermia must be carefully re-warmed and temperatures must be monitored
- Give warm beverages
- Do not give alcohol or cigarette. Blood flow needs to be improved and these slow the blood flow.

Bomb Threats

The person receiving the call should obtain the following information:

- Where the bomb is located in the “open” or “concealed”
- Description of the bomb, size, type, etc.
- Identification of the caller
- Notify Administrator or Director of Nursing (or supervisors) who will notify the appropriate authorities.
- Notify the Police Department 911
- Follow instructions from Police Department

In the event of an actual bomb discovered in the Nursing Home:

- Do not handle or move the bomb
- Notify facility who will then notify Police and Fire Department by Calling 911
- If a bomb is outside near the facility, move all residents to a location furthest away from the bomb location.
- If the bomb is located in the building, use hurricane evaluation exits to leave the building
- Follow instructions from the police

During any evacuation procedure, it is imperative, that those hallways along the evacuation route remain free of unnecessary equipment, chairs, etc. It is important that the movement of residents from their rooms through the elevators and to the departure areas be accomplished in a smooth and coordinated manner. This will be the responsibility of all departments.

Once the evacuation process has begun, you may be asked to:

- Supervise and/or assist in clearing hallways along the evacuation routes and departure areas
- Take up positions at elevators and coordinate the movement of residents from floor to floor
- Assist in the transport of residents from rooms to departing areas as needed
- Be available to accompany residents to the receiving facilities and serve in any capacity necessary and remain there until release by the Administrator and executive in charge.
- Be available to serve in any capacity deemed necessary by the Administrator or executive in charge.

Choking

Choking: What is it?

- Blockage of the upper airway that prevents a person from breathing effectively
- Can be a complete blockage of the airway and lead to death
- Requires a fast, appropriate act

Choking: the anatomy

- Two openings in the back of the mouth:
  - Esophagus: leads to the stomach
  - Trachea: opening to the lungs
- When swallowing the trachea is covered by a flap that prevents food from entering the lungs
- Any object that enters the trachea will become stuck

Risks

- Dysphagia
- Poor chewing ability
- Bites that are too large
- Talking/ laughing while eating
- Poor fitting dentures
- Certain illnesses

Signs & Symptoms

- Sudden inability to speak
- Wheezing
- Turning blue
- Resident clutching his throat

Choking – Emergency Procedures
Stop feeding immediately and seek nursing attention if the resident experiences these conditions:

- Excessive coughing
- Gagging/gasping for air/struggling to breathe
- Grabbing at the throat
- Turning blue in the lips and face
- Indicates that something is stuck in his/her throat

In all cases of choking, always stay with the resident and follow this procedure:

- STOP feeding
- Call for help
- If a resident is coughing but is able to breathe, do not intervene. If the person is able to cough or breathe, encourage him or her to keep coughing and throw their arms in the air to help dislodge the object.
- You should continue to observe until coughing stops and the resident continues with activity.
- Keep the resident in an upright position
- Do not pat the victim on the back. Whatever is causing the choking may lodge permanently in the throat.

If the resident cannot speak or answer, then the airway is completely obstructed and he needs emergency attention

Clutching the neck with one or both hands is the universal distress signal or sign for choking.

- Ask the resident "Are you choking?"
  - If there is a "yes" head nod, begin the procedure for clearing an obstructed airway or immediately call the nearest staff member.

Abdominal Thrust/Heimlich Maneuver

YOU MAY ONLY PERFORM THE ABDOMINAL THRUST/HEIMLICH MANEUVER IF YOU HAVE BEEN TRAINED TO PERFORM THIS PROCEDURE.

Key points include:

- Hand placement
- Stance behind the person
- Never practice on a LIVE person due to injury to the rib, abdominal organs

With the resident standing or sitting:

- Stand behind resident
- Wrap your arms around the resident's waist
- Make a fist and place the thumb-side of the fist at the midline of the abdomen just above the navel but well below the breastbone and ribcage
- Grab first with your other hand and press inward with quick upward thrust
- Avoid pressure on the ribs and breastbone

Heimlich if resident is lying down:

- Place or ensure resident is flat on his or her back
- While facing the resident, kneel astride the resident's hips
- With one of your hands on top of the other, place the heal of the bottom of the hand on the resident's abdomen
- Place the bottom hand over the navel and just below the sternum
- Press into the resident's abdomen with a quick upward thrust (toward sternum)
- Repeat until the foreign object or material is expelled (6 to 10 times) or until the resident becomes unconscious

In case of extreme obesity or late pregnancy, give chest thrusts. Stand behind the victim, place thumb of left fist against the middle of the breastbone, not below it. Grab fist with right hand. Squeeze chest four times quickly.

Your Role in Emergency Procedures

You can help by:

- Explaining the situation to residents and remaining calm;
- Offering to help wherever needed at mealtimes; and
- Checking with the nurse in charge for directions.

General Measures for Emergency Care

- Stay with the resident/victim and call for help. Be sure the charge nurse is notified.
- Do not move the resident/victim unless there is immediate danger.
- Remain calm and reassure the resident/victim.
- Assist the charge nurse as directed.
- Know the facility's procedures and phone numbers for reporting emergencies.

Glossary

Adaptive devices for eating - tools that are used for eating to substitute for motions that are lost due to a disability.

Agitation - change in physical activity, usually increased, such as wandering or pacing.

Aspiration - a condition when food or liquid go into the lungs instead of the stomach.

Alzheimer's disease - a type of dementia where there is ongoing loss of mental function, which gradually interferes with a person's normal life activities.

Cholesterol - a fat-like substance which performs different functions in the human body. Some functions promote health and some do not.

Cognitive impairment - mental decline which reduces awareness; thinking tasks become difficult.

Confidentiality - keeping private and not sharing spoken and written words about a resident.

Confusion - inability to distinguish or separate differences between things. This usually includes an inability to follow directions.

Dehydration - lack of or insufficient water or fluid in the body.

Dementia - a brain disorder that results in cognitive impairment.

Diet - food and fluids regularly consumed by a person as a part of normal living.

Dietary cholesterol - a fat like substance, which comes from food. It is found in foods of animal origin, such as eggs, meat, poultry, fish and dairy foods.

Dysphagia - any change in the normal process of swallowing.

Food-borne illness - a disease that is carried to humans by food.

Heimlich maneuver - an abdominal thrust used to dislodge items stuck in a person's airway (throat).

Intake - all liquids and food consumed.

Infection - a condition or disease where the body or part of the body is invaded by pathogens or germs which multiply and result in disease or harmful effects.

Infection control - the method used in health care facilities to prevent the spread of germs.

Isolation - practices to separate people or items especially those with easily transmitted diseases.

Nutrition - the processes by which the body takes in food and uses it for growth, repair and maintenance of health.

Nutritional needs - the food and fluid a person needs for growth, repair and maintenance of health.

Practicum - a course (or a part of a course) that is designed to give students supervised practical application of previously studied theory.

Pressure ulcer - skin with a reddened area or an open sore that develops as a result of pressure.

R. A. C. E. - an acronym used to describe the response needed in an emergency situation. R - rescue; A - alarm; C - confine; E - extinguish.

Restorative dining - a program that provides an individualized plan of increased assistance for residents.

Safety - practices that prevent harm or injury.

Seizure - sudden movements of muscles that are involuntary (that the person is unable to control). A person may be conscious or unconscious during a seizure

Therapeutic diet - a special diet ordered by a doctor to help in the treatment of a disease or condition.

Written plan of care - a written description of the care and services that a resident needs.

Module 2 – Nutrition, Hydration, and Therapeutic Diets
Checkpoint: To be completed by learner with onsite/facility instructor

Your instructor will review with you the nutritional approaches for weight loss and pressure ulcers that are used by your facility. The instructor should refer to the facility's Diet Manual and policies to ensure all facility approaches are reviewed here.

These are the approaches for weight loss and pressure ulcers that might be used in this facility:
____
____
____
____

The instructor should refer to the facility's Diet Manual and policies to ensure all facility terms are reviewed here.

The terms used in this facility to describe mechanically modified foods are:
____
____
____
____

Our facility's texture-modified Diets are:
____
____
____
____

The terms used in this facility to describe thickened liquids are:
____
____
____
____

Our facility's thickened liquids are:

____
____
____
____

All diets that are used by the facility should be reviewed here. The instructor should refer to the facility's menus and Diet Manual to ensure all facility diets are reviewed.

These are the diets used in this facility:

____
____
____
____

Our facility's therapeutic diets are:

____
____
____
____

Describe your facility's special or therapeutic diets.

____
____
____
____

Why is it important for residents to receive adequate nutrition and hydration?

____
____
____
____

Describe your facility's texture-modified diets and liquids.

____
____
____
____

Why is fluid intake in older adults important?

____
____
____
____

What is dysphagia?

____
____
____
____

What is aspiration?

____
____
____
____

TRUE OR FALSE?

The primary goal of feeding assistants is to help prevent weight loss in residents.

TRUE FALSE

Module 3 – Communication and Interpersonal Skills
Checkpoint: To be completed by learner with onsite/facility instructor

Communication is the process we use to: ____.

Aging causes changes in the ability to communicate. Some sensory losses that occur include ____________________________ and ____________________________.

List things you should consider when feeding a resident with a loss of vision, loss of hearing, or loss of touch.

____
____
____
____

List five techniques for effective communication.

____
____
____
____

Appropriate communication is important because it has positive effects on residents. List the positive effects of communication.

____
____
____
____

List appropriate topics to discuss with residents at meals.

____
____
____
____

Module 4 -- Resident Dignity and Rights
Checkpoint: To be completed by learner with onsite/facility instructor

The instructor will review your facility's policy for reporting of abuse, neglect, and exploitation. This should include who should be notified.

What is your facility's policy?

____
____
____
____

Where are the phone numbers for state complaint hotline (e.g., Texas Health and Human Services complaint hotline phone number) and the Ombudsman's phone number posted in your facility?

____
____
____
____

Describe resident rights in regard to:

Privacy

____
____
____
____

Abuse and neglect

____
____
____
____

Describe how the feeding assistant should act to avoid abuse, neglect, and misappropriation of resident property.

____
____
____
____

Whom should you notify if you suspect abuse, neglect, or misappropriation of resident property?

____
____
____
____

Where are the hotline phone numbers posted in this facility?

____
____
____
____

Module 5 – Infection Control and Food Safety
Checkpoint: To be completed by learner with onsite/facility instructor

Why is food safety important for residents and older adults?

____
____
____
____

List three things you can do to maintain good personal hygiene.

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____
____
____

Describe the proper method for washing your hands.

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____
____
____

Handwashing is important after many actions. List six.

____
____
____
____

When should you wear gloves? When should you change gloves?

____
____
____
____

Describe five techniques for serving food safely (i.e., how to handle cups, utensils, plates, etc.).

____
____
____
____

Explain how you would test the temperature of food before serving it to a resident.

____
____
____
____

Module 6 – Feeding the Resident
Checkpoint: To be completed by learner with onsite/facility instructor

What should you look for to ensure that the resident is prepared for the meal?

____
____
____
____

When passing trays to the residents, which of the following must you check?

a. The tray card for the resident's name
b. That the food on the tray matches the resident's tray card and diet order
c. That the resident's identification matches the tray in your hand
d. All of the above

The basic guidelines for feeding residents include all of the following EXCEPT:

a. Offer assistance in an unobtrusive manner.
b. Stand above residents when assisting them.
c. Use positive comments to describe the food.
d. Take time to talk to the resident.
e. Identify pureed foods.

List three things you might provide help with for residents who need minimal assistance.

____
____
____
____

List three verbal cues or physical prompts you might provide for residents who are easily distracted.

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____
____
____

List five eating problems that you must report to the nurse supervisor.

____
____
____
____

Describe two adaptive devices for eating and their use.

____
____
____
____

Module 7 – Appropriate Responses to Resident Behaviors
Checkpoint: To be completed by learner with onsite/facility instructor

Discuss your facility's procedure for reporting difficult behaviors. This facility's procedure for reporting difficult behavior is:

____
____
____
____

List three unacceptable behaviors.

____
____
____
____

Describe one response to a resident who is complaining.

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____
____

Describe one response to a resident who is yelling.

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____
____

Describe one response to a resident who is physically aggressive.

____
____
____
____

List four changes in resident behavior that should be reported to the charge nurse.

____
____
____
____

TRUE OR FALSE?

You should report a change in the resident's behavior to the charge nurse on the day that it occurs.

TRUE FALSE

Normal behavior is the same for all residents.

TRUE FALSE

Module 8 – Safety and Emergency Procedures
Checkpoint: To be completed by learner with onsite/facility instructor

This facility's procedures for a power outage are:
____
____
____
____

This facility's procedures for fire emergencies are:
____
____
____
____

This facility's procedures for finding a resident on the floor are:
____
____
____
____

This facility's procedures for what the feeding assistant will do when observing a resident having a seizure are:
____
____
____
____

This facility's procedures for severe weather are:
____
____
____
____

Choking: The instructor will notify you whether you will now be trained to perform the Heimlich Maneuver or what you should do in the event of a choking emergency.

This facility's procedures regarding a feeding assistant's role during a choking emergency are:
____
____
____
____

Which of the following are potential hazards to resident safety?

a. Uncluttered hallways
b. Safe equipment
c. Spills
d. Proper lighting

List six situations that call for emergency action.
____
____
____
____

List what the letters R, A, C, E stand for when they are used to describe actions you should take during a fire emergency.
R stands for: ________________________________
A stands for: ________________________________
C stands for: ________________________________
E stands for: ________________________________

A seizure is:
____
____
____
____

Describe the Heimlich maneuver and what it is used for.
____
____

____

____

TRUE OR FALSE?

During a power outage, you should close the window shades and light candles.

TRUE FALSE

If you find a resident on the floor, you should not attempt to move the resident.

TRUE FALSE

You may only perform the Heimlich maneuver if you are trained to perform it and if your facility's policy allows feeding assistants to perform the procedure.

TRUE FALSE

You may help during an emergency by remaining calm and explaining the situation to the residents.

TRUE FALSE

Before completing this training, ensure that you have received orientation from the facility that covers the following facility-specific areas:

- Confidentiality of resident care and records
- Monitoring resident nutrition intake and output
- Emergency procedures
- Specific needs of the resident who will be assisted
- Use of the facility’s emergency call system
- Laws pertaining to resident abuse, neglect and exploitation of a resident’s property

Handwashing Competency

Employee's Name/Credentials: ____

To master this skill, the student must successfully complete all steps, using principles of infection control. Failure to perform any step results in failure of this skill. To be completed by instructor (licensed nurse) during observation of 100% unassisted performance of the procedure by the trainee.

Equipment: Sink with faucet, soap, paper towels, waste basket, hand brush

Handwashing	**Yes** **Able To Perform**	**No** **Needs to Improve**	**Comments**
Assembles equipment if necessary.			
Stands away from sink. Clothing and hands must not touch sink. Does not lean on the sink or splatter clothes.			
Pushes sleeves and watch 4-5 inches up on arms.			
Turns on faucet with paper towel held between hand and faucet and adjusts temperature until warm. Wets hands and wrists with fingertips pointing downward without splashing.			
Applies soap to hands and wrists.			
Holds hands downward and lower than elbows while washing.			
Rubs hands together vigorously (using friction) for at least 15 seconds.			
Works up a good lather. Spreads lather over the entire area of hands and wrists (two inches above the wrist). Gets soap under nails and between fingers by rubbing against palms. Adds water while washing.			
Rinses thoroughly under running water, from wrists to fingertips, keeping fingertips down.			
Dries hands and wrists thoroughly with a clean paper towel.			
Uses a clean, dry paper towel to turn off faucet. Does not touch inside of sink with clean hands.			

Score:

_______ Pass: Yes (all tasks performed satisfactorily)

_______ No (not all tasks performed satisfactorily)

Instructor Signature:____ Date: ___________________________

The above signature attests that the evaluator did not prompt, give hints, or otherwise assist the individual in the performance of the skills, when the individual was being evaluated for competency.

Employee Signature:____ Date: ___________________________

Serving a Tray and Assisting a Resident Competency

Employee's Name/Credentials: ____

To master this skill, the student must successfully complete all steps. Failure to perform any step results in failure of this skill. To be completed by instructor (licensed nurse) during observation of 100% unassisted performance of the procedure by the trainee.

Equipment: damp washcloth (or disposable towelettes); paper towel or napkin; meal tray with food, condiments, and silverware; clothing protector, assistive devices as needed

Serving a Tray/Assisting a Resident	**Yes** **Able To Perform**	**No** **Needs to Improve**	**Comments**
Knocks before entering room.			
Greets resident and identifies self. Addresses resident in pleasant manner by Mr. or Ms. (or preferred name).			
Identifies the resident, explains procedure and obtains permission.			
Washes hands (in accordance with correct hand-washing procedure).			
Ensures the resident is in the proper position to eat. Asks someone to position the resident if necessary.			
Checks to be sure resident has correct tray, correct diet and any special instructions. Informs resident what is on the tray.			
Checks to make sure tray has everything needed (utensils, condiments, napkin, straw, etc.)			
Checks for food that looks or smells spoiled.			
Positions clothing protector as needed, clean resident's hands.			
Serves promptly. Food should be attractively served and placed within reach. Places according to need of the resident (e.g., weakness or paralysis on one side).			
Allows hot foods to cool before offering.			

Serving a Tray/Assisting a Resident	Yes Able To Perform	No Needs to Improve	Comments
Assists resident and prepares food as needed including removing covers, assists with placement of clothing protector, cuts meats (per instruction from diet card or supervising nurse), pours liquids or opens container and places straw in drink, butters bread, opens containers/condiments, stirs food if needed, peels fruit if needed, assists with sugar/sweetener.			
Encourages resident's independence to feed self as much as possible			
Offers a substitute if the resident does not like or want a food item on the tray.			
Has assistive devices ready (as directed): utensils with special handles, special plates with edges/guards, special cups or glasses. Note: This task scored only if using during procedure.			
For visually impaired: tells resident location of foods in clockwise order, asks resident if assistance is needed, aware of hot or cold food temps and advises resident of caution. Note: This task scored only if using during procedure.			
If only delivering tray to resident's room: knocks, identifies self, awaits permission to enter, adjusts over-bed table to correct height. Note: This task scored only if using during procedure.			
Removes tray when finished. Assists resident to clean hands and face.			

Serving a Tray/Assisting a Resident	**Yes** **Able To Perform**	**No** **Needs to Improve**	**Comments**
Notes and reports the amount of food eaten or not eaten (intake) per instruction from supervising nurse.			
Provides comfort and places call bell/signal within reach after removing tray (score only if performed in resident's room).			
Reports any abnormal observations to the nurse/supervisor.			
Washes hands when finished.			
Demonstrates knowledge and ability related to infection prevention and control.			
Demonstrates knowledge and ability related to communication and interpersonal skills.			
Demonstrates knowledge and ability related to promoting resident independence and resident's rights.			
Demonstrates knowledge and ability related to appropriate response to resident behavior.			

Score:

_______ Pass: Yes (all tasks performed satisfactorily)

_______ No (not all tasks performed satisfactorily)

Instructor Signature:____ Date: _________________________

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Employee Signature:____ Date: _________________________

Feeding a Resident Competency

Employee's Name/Credentials: ____

To master this skill, the student must successfully complete all steps. Failure to perform any step results in failure of this skill. To be completed by instructor (licensed nurse) during observation of 100% unassisted performance of the procedure by the trainee.

Equipment: damp washcloth (or disposable towelettes); paper towel or napkin; meal tray with food, condiments, and silverware; clothing protector, assistive devices as needed

Feeding a Resident	**Yes** **Able To Perform**	**No** **Needs to Improve**	**Comments**
Knocks before entering room.			
Greets resident and identifies self. Addresses resident in pleasant manner by Mr. or Ms. (or preferred name).			
Identifies the resident, explains procedure and obtains permission.			
Washes hands (in accordance with correct hand-washing procedure).			
Makes sure resident is positioned correctly. Calls for assistance from trained staff to position.			
Obtains food tray. Checks to be sure resident has correct tray, correct diet and any special instructions. Describes the meal to the resident.			
Checks to make sure tray has everything needed (utensils, condiments, napkin, straw, etc.)			
Checks for food that looks or smells spoiled.			
Positions clothing protector as needed, cleans resident's hands.			
Serves promptly. Food should be attractively served and placed within reach. Places according to need of the resident (e.g., weakness or paralysis on one side).			
Allows hot foods to cool before offering.			

Feeding a Resident	Yes Able To Perform	No Needs to Improve	Comments
Assists resident and prepares food as needed including removing covers, assists with placement of clothing protector, cuts meats (per instruction from diet card or supervising nurse), pours liquids or opens container and places straw in drink, butters bread, opens containers/condiments, stirs food if needed, peels fruit if needed, assists with sugar/sweetener.			
Unless ordered otherwise, seasons food to resident's taste and allows the resident the choice of the order of food.			
Sits to feed the resident (if right-handed, sits on resident's right side; if left-handed, sits on resident's left side).			
Tells the resident what is served for each bite and allows the resident the choice of the next food item if resident is able to communicate and or respond. Obtains substitutes as requested or needed.			
Aware of hot or cold food temperatures and advises resident of caution. (Does not blow on food).			
Feeds alternate solids and liquids in a manner the resident prefers.			
Feeds slowly; does not offer more food until last bite was swallowed.			
Feeds from the tip of a half-filled fork or spoon.			
Does not over-fill spoon.			
Takes care that spoon has cleared the teeth.			
Does not mix food items unless resident requests it.			
Does not rake food from lips and returns to mouth.			
Provides adequate time to chew.			
When serving liquids with a straw (if appropriate), holds the straw in place while resident drinks.			

Feeding a Resident	**Yes** **Able To Perform**	**No** **Needs to Improve**	**Comments**
If necessary, tells the resident what he/she is eating.			
Wipes the resident's mouth and hands as necessary during feeding, using napkin.			
Observes that all food is swallowed and not pocketed in the cheek.			
Encourages resident to eat as much as possible without forcing.			
Removes tray as soon as resident is finished. Cleans resident's hands and face with napkin, towelette or washcloth.			
Notes and reports the amount of food eaten or not eaten (intake) per instruction from supervising nurse.			
Provides comfort and places call bell/signal within reach after removing tray (score only if performed in resident's room).			
Reports any abnormal observations to the nurse/supervisor.			
Washes hands when finished.			
Demonstrates knowledge and ability related to infection prevention and control.			
Demonstrates knowledge and ability related to communication and interpersonal skills.			
Demonstrates knowledge and ability related to promoting resident independence and resident's rights.			
Demonstrates knowledge and ability related to appropriate response to resident behavior.			

Score:

________ Pass: Yes (all tasks performed satisfactorily)

________ No (not all tasks performed satisfactorily)

Instructor Signature:____ Date: ___________________________

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Employee Signature:____ Date: ___________________________

Serving Fresh Drinking Water Competency

Employee's Name/Credentials: ____

To master this skill, the student must successfully complete all steps. Failure to perform any step results in failure of this skill. To be completed by instructor (licensed nurse) during observation of 100% unassisted performance of the procedure by the trainee.

Equipment: Cart, pitcher of fresh water, cups/glasses, trays, ice, scoop for ice, straws or other aids

Serving Fresh Drinking Water	**Yes** **Able To Perform**	**No** **Needs to Improve**	**Comments**
Receives directions from supervising nurse regarding residents with special needs (NPO, fluid restrictions, no ice).			
Washes hands (in accordance with correct handwashing procedure).			
Assembles supplies.			
Takes cart with clean supplies and adds ice (use scoop) to pitchers of water. Places on cart and delivers to each resident. Do not allow handle of scoop to touch ice.			
Fills cup with fresh water, adds ice (using scoop) as requested by resident.			
Places fresh drinking water within reach.			
If requested or needed, offers straw. Holds straw while resident drinks, if needed.			
Provides other assistance as requested or needed.			
Removes and discards cups/glasses when resident is finished.			
Returns cart containing any used supplies to kitchen to be washed.			

Serving Fresh Drinking Water	Yes Able To Perform	No Needs to Improve	Comments
Reports and records as directed per instruction from supervising nurse.			
Reports any abnormal observations to the nurse/supervisor.			
Washes hands when finished.			
Demonstrates knowledge/ability for infection prevention and control.			
Demonstrates knowledge/ability for communication/interpersonal skills.			
Demonstrates knowledge and ability related to promoting resident independence and resident's rights.			
Demonstrates knowledge and ability related to appropriate response to resident behavior.			

Score:

________ Pass: Yes (all tasks performed satisfactorily)

________ No (not all tasks performed satisfactorily)

Instructor Signature:____ **Date:** ___________________________

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Employee Signature:____ **Date:** ___________________________

Serving Supplemental Nourishments Competency

Employee's Name/Credentials: ____

To master this skill, the student must successfully complete all steps. Failure to perform any step results in failure of this skill. To be completed by instructor (licensed nurse) during observation of 100% unassisted performance of the procedure by the trainee.

Equipment: Nourishments, napkins, utensils, straws or other aids

Serving Supplemental Nourishments	**Yes Able To Perform**	**No Needs to Improve**	**Comments**
Receives directions from supervising nurse regarding residents with special dietary needs.			
Washes hands (in accordance with correct handwashing procedure).			
Assembles supplies.			
Allows each resident to choose from available nourishments.			
Places nourishment, napkin, eating utensils/aids within resident's reach.			
Provides assistance as needed or requested.			
Removes glasses or dishes after use and discards to designated area (i.e., returns to kitchen to be washed). Do not touch rims of glassware.			
Reports and records as directed per instruction from supervising nurse.			
Reports any abnormal observations to the nurse/supervisor.			
Washes hands when finished.			
Demonstrates knowledge/ability for infection prevention and control.			
Demonstrates knowledge/ability for communication/interpersonal skills.			
Demonstrates knowledge and ability related independence/resident's rights.			
Demonstrates knowledge/ability in responding to resident behavior.			

Score:

_______ Pass: Yes (all tasks performed satisfactorily)

_______ No (not all tasks performed satisfactorily)

Instructor Signature:____ Date: ___________________________

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Employee Signature:____ Date: ___________________________

Obstructed Airway Competency

Employee's Name/Credentials: ____

To master this skill, the student must successfully complete all steps. Failure to perform any step results in failure of this skill. To be completed by instructor (licensed nurse) during observation of 100% unassisted performance of the procedure by the trainee.

Equipment: None

Heimlich Maneuver	**Yes** **Able To Perform**	**No** **Needs to Improve**	**Comments**
Conscious victim:			
Asks the resident who appears to have choked who may or may not be coughing, "Are you choking?" "Can you talk?" or look for the universal choking sign (clutching the neck). If resident can speak, does not interfere.			
If the answer is an affirmative nod, or you determine the victim cannot expel object on own and state that you will help. Calls for help and/or sends someone for the nurse.			
If the foreign object or material does not dislodge, proceeds to apply the Heimlich Maneuver.			
If the resident is seated or standing:			
Stands behind the resident and wraps arms around him or her at the level of the waist.			
Make a fist with one hand, grasping the fist with the other hand.			

Heimlich Maneuver	Yes Able To Perform	No Needs to Improve	Comments
Puts the thumb side of one hand on the resident's abdomen (thumb should be tucked into fist). Places fist, thumb side in, against the resident's abdomen above the navel, but below the rib cage/tip of sternum.			
While bending the resident forward slightly and push into the resident's abdomen with a quick, upward thrust.			
Repeats thrust 6-10 times until object is dislodged.			
If the resident becomes unconscious, assists to the floor and the nurse will take over.			
Keeps calling for help. Licensed nurses and trained personnel must be summoned to activate CPR and to call 911.			
If resident is lying down:			
Places or ensures resident is flat on his or her back.			
While facing the resident, kneels astride the resident's hips.			
With one of your hands on top of the other, places the heal of the bottom of the hand on the resident's abdomen.			
Places the bottom hand over the navel and just below the sternum.			
Presses into the resident's abdomen with a quick upward thrust (toward sternum).			
Repeats until the foreign object or material is expelled (6 to 10 times) or until the resident becomes unconscious.			
Keeps calling for help. Licensed nurses and trained personnel must be summoned to initiate CPR and to call 911.			

Heimlich Maneuver	Yes Able To Perform	No Needs to Improve	Comments
Chests thrusts for obese victim:			
Stands behind victim.			
Places arms around victim directly under armpits.			
Form fist and place thumb side of fist against sternum, level with armpits.			
Grasps fist in opposite hand and administer thrusts, pulling straight back, until object is removed, victim starts to cough, or becomes unconscious.			
Unconscious victim with obstructed airway:			
Places victim on back.			
Activates EMS system.			
Fingers sweep mouth to remove object.			
If unsuccessful, opens airway with head-tilt/chin-lift maneuver.			
Try to ventilate; if still obstructed, reposition head, try to ventilate again.			
If ventilation unsuccessful, gives five abdominal thrusts			
Straddles victim’s thighs or kneels next to victim			
Places heel of one hand on abdomen above navel			
Places other hand in same position over first			
Keeps elbows straight and thrusts inward and upward five times			
If unsuccessful, fingers sweep mouth.			
Repeats until effective or EMS arrives			

Score:

_______ Pass: Yes (all tasks performed satisfactorily)

_______ No (not all tasks performed satisfactorily)

Instructor Signature:____ Date: ________________________

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Employee Signature:____ Date: ________________________

Paid Feeding Assistant Post-Test (Quiz)

1.	Allowing residents to make choices in their daily lives is a part of the: a. Resident's Rights b. R.A.C.E c. Durable Power of Attorney d. Vulnerable Adult Law
2.	Not sharing information about a resident is called: a. Patience b. Confidentiality c. Code of ethics d. Honesty
3.	Reporting suspected abuse is required by: a. Fire Marshal b. State and Federal law c. Code of ethics d. Center for disease control
4.	When discovering a fire, your first action should be: a. Alert other staff b. Extinguish fire c. Remove residents in danger d. Confine fire
5.	When finding a resident on the floor, you should: a. Help the resident up b. Call the family c. Call 911 d. Stay with the resident and send for help
6.	Which of these is important to remember when feeding a resident? a. Make sure there is no food left in the mouth when complete b. Be sure the food on the tray matches the diet order before feeding c. Don't rush, allow adequate time for eating d. All of the above
7.	The single most effective means of preventing the spread of infection is: a. Using a disinfectant b. Putting residents in isolation c. Wearing gloves d. Washing your hands
8.	The universal sign for choking is: a. Pointing at the mouth b. Holding the throat with hands c. Shouting "I'm choking" d. Holding up two fingers
9.	The exchange of information or messages is called: a. Confidentiality b. Nutrition c. Communication d. Abuse

10.	Which of the following is a guideline for communicating with a hearing-impaired resident? a. Shouting in their ear b. Face the resident when speaking c. Whispering d. Avoid eye contact
11.	Which of the following is an example of non-verbal communication? a. Shouting in their ear b. Facial expressions c. Whispering d. Talking loudly
12.	Which of these are best practices for serving food? a. Avoid touching hair, face or other body parts b. Take extra care to touch only the handles of the utensils and outsides of glasses and cups c. Replace dropped or thrown utensils with clean utensils d. All of the above
13.	When responding to residents who are verbally or physically aggressive, which of these should you NOT do? a. Remain calm and reassuring and use non-threatening body language b. Argue and/or reason with the resident c. Move other residents out of harm's way d. Attempt to redirect interest or distract the resident
14.	Which of these is NOT a sign of a possible swallowing problem that you should report to the nurse supervisor? a. Food or liquid leaking from mouth b. Eating and enjoying the entire meal c. Pocketing of food d. Spitting out food after chewing
15.	Not getting enough water can cause: a. Anemia b. Dehydration c. Infection d. Diarrhea
16.	A diet ordered by the doctor to help treat a disease is called: a. Therapeutic diet b. Regular diet c. Fad diet d. Modified diet
17.	Which of the following is not a special diet? a. Regular diet b. Pureed diet c. Low sodium diet d. Modified diet

18.	Recording fluid intake includes: a. Only fluids the resident drank b. All beverages and foods consumed that become liquid at room temperature c. All liquids that were served on the tray d. All the food and liquid consumed by the resident
19.	Recording meal percentage includes: a. All the food and liquid served b. Only fluids the resident drank c. All the food the resident consumed from the tray d. The foods the resident refused
20.	If there is an NPO sign on the resident's door, this means the resident: a. Is in isolation b. Can have nothing by mouth c. Is on a therapeutic diet d. Has difficulty swallowing
21.	If a resident does not like or refuses to eat an item on their tray, you should: a. Return the tray to the kitchen b. Come back later c. Offer the resident a substitute d. Tell the resident they must eat the item
22.	Progressive deterioration of mental function is called: a. Stress b. Ineffective coping c. Aging d. Dementia
23.	Circumstances where the hand-over-hand technique is helpful include: a. Resident cannot cut food b. Resident is too tired c. Resident forgets how to eat d. All of the above
24.	When communicating with residents who have Dementia, you should: a. Write directions on a piece of paper b. Use a loud voice so they will pay attention c. Move quickly before they forget d. Make eye contact and use simple short directions
25.	Breathing fluid or an object into the lungs is called: a. Hydration b. Aspiration c. Heimlich Maneuver d. Paralysis