# State-approved curriculum for Dining Assistants

Indiana State Department of Health
Division of Long Term Care

May 2005

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# TITLE 410 INDIANA STATE DEPARTMENT OF HEALTH

**410 IAC 16.2-1.1-19.3 "Dining assistant" defined**

**Authority: IC 16-28-1-7; IC 16-28-1-12**

**Affected: IC 16-28**

**Sec. 19.3. "Dining assistant" means an individual who is paid to feed residents by a facility or who is used under an arrangement with another agency or organization.** *(Indiana State Department of Health; 410 IAC 16.2-1.1-19.3; filed Aug 11, 2004, 11:00 a.m.: 28 IR 189)*

**410 IAC 16.2-3.1-53 Dining assistants**

**Authority: IC 16-28-1-7; IC 16-28-1-12**

**Affected: IC 16-28-5-1; IC 16-28-13-3; IC 25-23-1-1**

**Sec. 53.** (a) Each dining assistant shall successfully complete a sixteen (16) hour training program for dining assistants that has been approved by the department.

(b) A dining assistant training program must obtain approval from the department prior to providing instruction to individuals.

(c) The facility shall do the following:

(1) Ensure that resident selection for dining assistance is based on the charge nurse's assessment and the resident's most recent assessment and plan of care.

(2) Not allow the dining assistant to assist more than two (2) residents at any one (1) time.

(3) Ensure the dining assistant is oriented to the following:

(A) The resident's diet, likes, and dislikes.

(B) Feeding techniques appropriate to the individual resident.

(4) Document the use of a dining assistant on the resident's care plan and review at each care plan conference.

(5) Check the nurse aide registry prior to training an individual as a dining assistant.

(6) Use only individuals as dining assistants who have successfully completed a department-approved training program for dining assistants.

(d) The scope of practice for dining assistants is as follows:

(1) A dining assistant shall work under the supervision of a licensed nurse who is on the unit or floor where the dining assistance is furnished and is immediately available to provide assistance as needed.

(2) In an emergency, a dining assistant shall call the supervising nurse using the resident call system or any other method available.

(3) A dining assistant shall assist only residents who do not have complicated eating problems, which include, but are not limited to, the following:

(A) Difficulty swallowing.

(B) Recurrent lung aspirations.

(C) Tube or parenteral/IV feedings.

(e) The dining assistant training program shall consist of, but is not limited to, the following:

(1) Eight (8) hours of classroom instruction prior to any direct contact with a resident that includes the following:

(A) Feeding techniques.

(B) Regular and special diets.

(C) Reporting food and fluid intake.
(D) Assistance with feeding and hydration.
(E) Communication and interpersonal skills.
(F) Infection control.
(G) Safety/emergency procedures including the Heimlich maneuver.
(H) Promoting residents' independence.
(I) Abuse, neglect, and misappropriation of property.
(J) Nutrition and hydration.
(K) Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting these changes to the supervising nurse.
(L) Mental health and social service needs including how to respond to a resident's behavior.
(M) Residents' rights including the following:
(i) Privacy.
(ii) Confidentiality.
(iii) Promoting residents' right to make personal choices to accommodate their needs.
(iv) Maintaining care and security of residents' personal possessions.
(v) Dignity.

(2) Eight (8) hours of clinical instruction that consists of, but is not limited to, the following:
(A) Feeding techniques.
(B) Assistance with eating and hydration.

(f) The dining assistant training program and training facility, if applicable, must ensure that clinical instruction provides for the direct supervision of the dining assistant by a licensed nurse.

(g) Each training program shall have a qualified instructor responsible for program oversight who at a minimum:
(1) possesses a valid Indiana registered nurse license under IC 25-23-1-1;
(2) possesses two (2) years of licensed nursing experience, of which at least one (1) year of experience is in the provision of long term care services; and
(3) completed a department-approved training program.

(h) An approved program director of a department nurse aide training program constitutes a qualified instructor under subsection (g) and may conduct dining assistant training without additional training.

(i) Dining assistant training may only be provided by:
(1) a registered nurse;
(2) a licensed practical nurse;
(3) a qualified dietician;
(4) an occupational therapist; or
(5) a speech-language pathologist.

Certified nurse aide and qualified medication aide personnel shall not participate in or provide any dining assistant training.

(j) In order to issue a certificate or letter of completion to the dining assistant, the dining assistant training program shall ensure that the dining assistant demonstrates competency in all areas of instruction using a checklist approved by the department.

(k) Each approved program shall maintain a student file that:

(1) is retained for a minimum of three (3) years; and
(2) contains:
(A) individualized documentation of the:
(i) classroom training that includes dates of attendance and areas of instruction; and
(ii) clinical instruction that includes dates of attendance and areas of instruction including procedures and activities completed during the clinical experience; and
(B) a copy of the certificate or letter confirming successful completion of the dining assistant training program, which shall be signed and dated by the instructor and bear the name and address of the training program.
(l) The department may revoke an approved dining assistant training program if evidence exists that the program has not been administered in accordance with this section.
(m) For purposes of IC 16-28-5-1, a breach of:
(1) subsection (a), (b), (c), (d), (e), (f), (g), or (j) is a deficiency;
(2) subsection (h) or (i) is a noncompliance; and
(3) subsection (k) is a nonconformance.

*(Indiana State Department of Health; 410 IAC 16.2-3.1-53; filed Aug 11, 2004, 11:00 a.m.: 28 IR 192)*

**410 IAC 16.2-5-13 Dining assistants**
**Authority: IC 16-28-1-7; IC 16-28-1-12**
**Affected: IC 16-28-5-1; IC 16-28-13-3; IC 25-23-1-1**

**Sec. 13**. (a) Each dining assistant shall successfully complete a sixteen (16) hour training program for dining assistants that has been approved by the department.
(b) A dining assistant training program must obtain approval from the department prior to providing instruction to individuals.
(c) The facility shall do the following:
(1) Ensure that resident selection for dining assistance is based on the charge nurse's assessment and the resident's most recent assessment and plan of care.
(2) Not allow the dining assistant to assist more than two (2) residents at any one (1) time.
(3) Ensure the dining assistant is oriented to the following:
(A) The resident's diet, likes, and dislikes.
(B) Feeding techniques appropriate to the individual resident.
(4) Document the use of a dining assistant on the resident's care plan and review at each care plan conference.
(5) Check the nurse aide registry prior to training an individual as a dining assistant.
(6) Use only individuals as dining assistants who have successfully completed a department-approved training program for dining assistants.
(d) The scope of practice for dining assistants is as follows:
(1) A dining assistant shall work under the supervision of a licensed nurse who is on the unit or floor where the dining assistance is furnished and is immediately available to provide assistance as needed.

(2) In an emergency, a dining assistant shall call the supervising nurse using the resident call system or any other method available.
(3) A dining assistant shall assist only residents who do not have complicated eating problems, which include, but are not limited to, the following:
(A) Difficulty swallowing.
(B) Recurrent lung aspirations.
(C) Tube or parenteral/IV feedings.
(e) The dining assistant training program shall consist of, but is not limited to, the following:
(1) Eight (8) hours of classroom instruction prior to any direct contact with a resident that includes the following:
(A) Feeding techniques.
(B) Regular and special diets.
(C) Reporting food and fluid intake.
(D) Assistance with feeding and hydration.
(E) Communication and interpersonal skills.
(F) Infection control.
(G) Safety/emergency procedures including the Heimlich maneuver.
(H) Promoting residents' independence.
(I) Abuse, neglect, and misappropriation of property.
(J) Nutrition and hydration.
(K) Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting these changes to the supervising nurse.
(L) Mental health and social service needs including how to respond to a resident's behavior.
(M) Residents' rights including the following:
(i) Privacy.
(ii) Confidentiality.
(iii) Promoting residents' right to make personal choices to accommodate their needs.
(iv) Maintaining care and security of residents' personal possessions.
(v) Dignity.
(2) Eight (8) hours of clinical instruction that consists of, but is not limited to, the following:
(A) Feeding techniques.
(B) Assistance with eating and hydration.
(f) The dining assistant training program and training facility, if applicable, must ensure that clinical instruction provides for the direct supervision of the dining assistant by a licensed nurse.
(g) Each training program shall have a qualified instructor responsible for program oversight who at a minimum:
(1) possesses a valid Indiana registered nurse license under IC 25-23-1-1;
(2) possesses two (2) years of licensed nursing experience, of which at least one (1) year of experience is in the provision of long term care services; and
(3) completed a department-approved training program.
(h) An approved program director of a department nurse aide training program constitutes a qualified instructor under subsection (g) and may conduct dining assistant training without additional training.

(i) Dining assistant training may only be provided by:
(1) a registered nurse;
(2) a licensed practical nurse;
(3) a qualified dietician;
(4) an occupational therapist; or
(5) a speech-language pathologist.

Certified nurse aide and qualified medication aide personnel shall not participate in or provide any dining assistant training.

(j) In order to issue a certificate or letter of completion to the dining assistant, the dining assistant training program shall ensure that the dining assistant demonstrates competency in all areas of instruction using a checklist approved by the department.

(k) Each approved program shall maintain a student file that:
(1) is retained for a minimum of three (3) years; and
(2) contains:
(A) individualized documentation of the:
(i) classroom training that includes dates of attendance and areas of instruction; and
(ii) clinical instruction that includes dates of attendance and areas of instruction including procedures and activities completed during the clinical experience; and
(B) a copy of the certificate or letter confirming successful completion of the dining assistant training program, which shall be signed and dated by the instructor and bear the name and address of the training program.

(l) The department may revoke an approved dining assistant training program if evidence exists that the program has not been administered in accordance with this section.

(m) For purposes of IC 16-28-5-1, a breach of:
(1) subsection (a), (b), (c), (d), (e), (f), (g), or (j) is a deficiency;
(2) subsection (h) or (i) is a noncompliance; and
(3) subsection (k) is a nonconformance.

*(Indiana State Department of Health; 410 IAC 16.2-5-13; filed Aug 11, 2004, 11:00 a.m.: 28 IR 194)*

# Administrative Standards
# Indiana State Department of Health
# Dining Assistant Training Program

**Standard 1: Qualified Personnel**

Each dining assistant shall successfully complete a sixteen (16) hour training program for dining assistants that has been approved by the department.

**Standard 2: Training Program**

I. The dining assistant program must obtain approval from the department prior to providing instruction to individuals.

II. The dining assistant training program shall consist of, but is not limited to, the following:

A. Eight (8) hours of classroom instruction prior to any direct contact with a resident that includes the following:

1. Feeding techniques.
2. Regular and special diets.
3. Reporting food and fluid intake.
4. Assistance with feeding and hydration.
5. Communication and interpersonal skills.
6. Infection control.
7. Safety/emergency procedures including Heimlich maneuver.
8. Promoting residents' independence.
9. Abuse, neglect, and misappropriation of property.
10. Nutrition and hydration.
11. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting these changes to the supervising nurse.
12. Mental health and social service needs including how to respond to a resident's behavior.
13. Residents' rights including the following:
    a. Privacy
    b. Confidentiality
    c. Promoting residents' rights to make personal choices to accommodate their needs.
    d. Maintaining care and security of residents' personal possessions.
    e. Dignity

B. Eight (8) hours of clinical instruction that consists of, but is not limited to, the following:

1. Feeding techniques.
2. Assistance with eating and hydration.

III. The dining assistant training program and training facility, if applicable, must ensure that clinical instruction provides for the direct supervision of the dining assistant by a licensed nurse.

IV. Each training program shall have a qualified instructor responsible for program oversight who at a minimum:
    A. Possesses a valid Indiana registered nurse license under IC 25-23-1-1;
    B. Possesses two (2) years of licensed nursing experience, of which at least one (1) year of experience is in the provision of long-term care services; and
    C. Completed a department approved training program.

V. An approved program director of a department approved nurse aide training program constitutes a qualified instructor under subsection (g) and may conduct dining assistant training without additional training.

VI. Dining assistant training may only be provided by:
    A. A registered nurse;
    B. A licensed practical nurse;
    C. A qualified dietician;
    D. An occupational therapist, or;
    E. A speech-language pathologist.
    F. Certified nurse aide and qualified medication aide personnel shall not participate in or provide any dining assistant training.

VII. In order to issue a certificate or letter of completion to the dining assistant, the dining assistant training program shall ensure that the dining assistant demonstrates competency in all areas of instruction using a checklist approved by the department.

**Standard 3: Facility Responsibility**

The facility shall:
    A. Ensure that resident selection for dining assistance is based on the charge nurse's assessment and the resident's most recent assessment and plan of care.
    B. Not allow the dining assistant to assist more than two (2) residents at any one (1) time.
    C. Ensure the dining assistant is oriented to:
        1. The resident's diet, likes and dislikes.
        2. Feeding techniques appropriate to the individual resident.
    D. Document the use of a dining assistant on the resident's care plan and review at each care plan conference.
    E. Check the nurse aide registry prior to training an individual as a dining assistant.

F. Use only individuals as dining assistants who have successfully completed a department approved training program for dining assistants.

**Standard 4: Scope of Practice**

The scope of practice for dining assistants is as follows:

A. A dining assistant shall work under the supervision of a licensed nurse who is on the unit or floor where the dining assistance is furnished and is immediately available to provide assistance as needed.
B. In an emergency, a dining assistant shall call the supervising nurse using the resident call system or any other method available.
C. A dining assistant shall assist only residents who do not have complicated eating problems, which include, but are not limited to, the following:
    1. Difficulty swallowing.
    2. Recurrent lung aspirations.
    3. Tube or parenteral/IV feedings.

**Standard 5: Student Files**

Each approved program shall maintain a student file that:

A. Is retained for a minimum of three (3) years;
B. Contains:
    1. Individualized documentation of the following:
        a. Classroom training that includes dates of attendance and areas of instruction; and
        b. Clinical instruction that includes dates of attendance and areas of instruction including procedures and activities completed during the clinical experience; and,
    2. A copy of the certificate or letter confirming successful completion of the dining assistant training program, which shall be signed and dated by the instructor and bear the name and address of the training program.

**Standard 6: Revocation**

The department may revoke an approved dining assistant training program if evidence exists that the program has not been administered in accordance with this section.

## Lesson 1: Health Care Delivery

**Objectives:**

- Identify the different providers in the health care delivery system
- Identify the health care team's role in the health care delivery system
- Identify importance of the comprehensive care plan

**Terminology:**

**Activities of Daily Living (ADL) -** means mobility, eating, dressing, bathing, toileting, and transferring

**Advocate –** one who defends the rights of another

**Communicate –** exchange information

**Comprehensive Care Plan –** a written plan or action developed by the health care team to meet each resident's highest functional, medical, nursing, mental and psychosocial needs

**Continuity of Care –** getting everyone from every department on all shifts working towards the same goals using compatible methods

**Disciplines -** a branch or domain of knowledge, instruction or learning

**Maintenance Care –** care that preserves function

**Needs –** Something required or essential

**Preventive Care –** care that stops disease or injury from happening

**Psychosocial Needs –** need for independence, a supportive environment, recognition as an individual, spiritual fulfillment, and social interaction

**Resident –** an individual that lives in a long-term care facility

**Restorative Care –** care aimed at regaining health and strength

**Spiritual –** the search for meaning in life usually through religion

## Lesson 1: Health Care Delivery

I. The health care system is composed of different parts designed to work together to make health care accessible to everyone. The health care system includes:
   A. Hospitals – provide acute care (treatment for illnesses which come on suddenly and usually of short duration) and either general or specialized care (children's, cancer, psychiatric, AIDS).
   B. Doctor's offices and clinics – provide maintenance and preventative care.
   C. Long term care facilities – provide sub acute care, rehabilitative services, and long term care services.
   D. Home health agencies – provide care within the person's home.
   E. Hospices – provide care to the terminally ill (treatment for the dying person to improve comfort and quality of life).

II. Long term care can be provided to an individual in their home or in a facility. If the care is provided in a facility it must:
   A. Provide a home-like and safe living environment with daily routines designed to meet the resident's specific needs.
   B. Coordinate resident care through the efforts of the health care team.
   C. Provide activities for the resident.
   D. Be subject to inspections by the federal government, the state department of health, and local health and fire departments.

III. Care is provided to the resident by a health care team. The health care team is a group of professionals and non-professionals with special skills who work together. The health care team's purpose is to create the highest quality of care necessary to meet the resident's needs. The health care team accomplishes this when information is shared, care is coordinated, and a comprehensive care plan is developed for each resident. The health care team members may include some or all of the following, depending on the resident's individual needs:
      A. Resident – efforts made to meet needs and maintain quality of life.
      B. Resident's Family – provides information about resident to staff; may make a decisions if resident is unable.
      C. Physician – responsible for treatment of disease and illness.
      D. Nursing Staff – monitors and promotes health, identifies needs, assists with activities of daily living (ADLs). Staff includes registered nurses (RNs), licensed practical nurses (LPNs), certified nurse aides (CNAs), qualified medication aides (QMAs), and dining assistants.
      E. Ombudsman – resident advocate who investigates complaints and helps achieve agreement between parties.

F. Social Worker – counsels resident, family, and staff and obtains needed services.
G. Activity Director – plans and carries out appropriate activities for residents.
H. Physical Therapist – works with muscle groups to maintain and increase the resident's physical abilities.
I. Occupational Therapist – works with fine motor skills to improve the resident's use of hands for all activities and communication.
J. Speech Therapist – works with resident who has difficulty with speech, communication, and swallowing.
K. Dietitian – plans menus, special diets, and monitors nutritional needs of the resident.
L. Spiritual Counselor– provides guidance and coordinates religious services for the resident.
M. Administrator – manages all departments within the facility, establishes the policies/procedures and is responsible for compliance with state and federal rules and regulations.
N. Building Maintenance – keeps building and grounds in good repair.
O. Laundry – cleans resident's clothing and maintains linens.
P. Dentist – provides routine and emergency dental care for the resident.
Q. Podiatrist – provides foot care for the resident.
R. Optometrist – provides eye care for the resident.
S. Respiratory Therapist – provides breathing treatment and special equipment for respiratory conditions.
T. Housekeeping – keeps the facility clean and sanitary.
U. Qualified Medication Aide – a CNA that is trained to pass medication.
V. Qualified Mental Retardation Professional (QMRP) – person who is trained and experienced in treating the mentally retarded.
W. Power of Attorney/ Health Care Representative or Guardian – makes decisions regarding care if resident is unable.

IV. Observations and discussions made by all members of the health care team provide the information necessary to complete the Minimum Data Set (MDS). The MDS is a form used to identify the physical, mental, and psychosocial status of each resident. The MDS provides the guidelines that help develop the comprehensive care plan.

V. The comprehensive care plan fosters continuity of care. The plan includes:
A. Identification of the cause and nature of the resident's needs.
B. Short term and long-term goals for the residents.
C. Individualized approaches to reach the goals.
D. Disciplines responsible for monitoring the goals.

**Questions:**

What is the purpose of the health care team?

What is the purpose of the comprehensive care plan?

## Lesson 2: Role of the Dining Assistant

**Objectives:**

- Acknowledge the scope of practice of the dining assistant
- Identify certification process of a dining assistant
- Identify requirements necessary prior to resident contact

**Terminology:**

**Dining assistant –** any individual who has successfully completed the state approved dining assistant curriculum training

## Lesson 2: Role of the Dining Assistant

I. The dining assistant is any individual who has successfully completed the state approved dining assistant curriculum in accordance with the State Rules 410 IAC 16.2-1.1-19.3.

II. Dining assistants are required to have completed the following:
   A. Criminal history check completed in accordance with IC 28-13-3, prior to any resident contact.
   B. T.B. testing or chest x-ray and a health screen, prior to any resident contact.
   C. At least eight (8) hours of classroom instruction, prior to any resident contact, that includes:
      1. Feeding techniques.
      2. Regular and special diets.
      3. Reporting food and fluid intake.
      4. Assistance with feeding and hydration.
      5. Communication and interpersonal skills.
      6. Infection control.
      7. Safety / emergency procedures including the Heimlich maneuver.
      8. Promoting residents' independence.
      9. Abuse, neglect, and misappropriation of property.
      10. Nutrition and hydration.
      11. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting these changes to the supervising nurse.
      12. Mental health and social service needs including how to respond to a resident's behavior.
      13. Residents' rights including the following:

a. Privacy.
b. Confidentiality.
c. Promoting residents right to make personal choices to accommodate their needs.
d. Maintaining care and security of residents' personal possessions.
e. Dignity.

D. Eight (8) hours of clinical instruction that consists of but is not limited to:
    1. Feeding techniques.
    2. Assistance with eating and hydration.

III. The facility is required to do the following:
A. Ensure that the resident selection for dining assistance is based on the charge nurse's assessment and the resident's most recent assessment and plan of care.
B. Not allow the dining assistant to assist more than two (2) residents at any one (1) time.
C. Ensure the dining assistant is oriented to the following:
    1. The resident's diet, likes and dislikes.
    2. Feeding techniques appropriate to the individual resident.
D. Document the use of a dining assistant on the resident's care plan and review at each care plan conference.
E. Check the nurse aide registry prior to training an individual as a dining assistant.
F. Use only individuals as dining assistants who have successfully completed a department approved training program for dining assistants.

IV. Scope of practice for the dining assistant includes:
A. Dining assistant shall work under the supervision of a licensed nurse who is on the unit or floor where the dining assistance is furnished and is immediately available to provide assistance as needed.
B. In an emergency, a dining assistant shall call the supervising nurse using the resident call system or any other method available.
C. A dining assistant shall assist only residents who do not have complicated eating problems, which include, but are not limited to, the following:
    1. Difficulty swallowing.
    2. Recurrent lung aspirations.
    3. Tube or parenteral/IV feedings.

V. Each dining assistant shall be issued a certificate / letter of completion from the training entity upon successful completion of the sixteen (16) hour dining assistant course.

VI. Important points to remember:
   A. The dining assistant does not give nursing care.
   B. Dining assistants should only perform those tasks for which they have been trained.
   C. Dining assistants should only feed residents selected by the charge nurse.

**Questions:**

What must a person do to become a dining assistant?

How many residents can a dining assistant assist during a meal?

What resident conditions or eating problems would not allow a dining assistant to assist?

## Lesson 3: Feeding Techniques

**Objectives:**

- Identify routine serving steps
- Understand feeding instructions for different types of residents
- Identify the different types of cuing and assistive devices
- Identify and recognize the importance of special needs

**Terminology:**

**Adaptive Equipment** – see Assistive Devices

**Aspiration** – the breathing of food or fluid into the windpipe or lungs

**Assistive Devices** – equipment that assist a resident with the performing of task

**Cuing** – giving the resident suggestions as to what to do; prompting

**Dysphagia** – difficulty in or inability to swallow

**Pocketing** – during feeding, the accumulation of food between the teeth and cheek

**Stroke** – a sudden impairment of circulation in one or more of the blood vessels supplying the brain. Also known as Cerebrovascular Accident (CVA)

## Lesson 3: Feeding Techniques

I. Swallowing is an important part of the feeding process.

II. Swallowing is a sequence of events that involves several different structures.

   A. Mouth - food / liquids are put into the mouth where saliva starts preparing the food/ liquids for swallowing and digestion.

   B. Teeth - chew or break the food into smaller piece.

   C. Tongue - moves the food inside the mouth and mixes the pieces of food with the saliva. The tongue then moves the food to the back of the mouth causing the swallowing reflex to be initiated.

   D. Pharynx - is the muscle that joins the mouth and esophagus. The swallowing reflex moves the food into and through the pharynx.

   E. Larynx - (voice box) during the swallowing reflex the larynx shuts and breathing stops as the food / liquid pass through the pharynx. This is to avoid food/ liquid from entering the lungs.

F. Esophagus - is muscle that connects the pharynx to the stomach. Contraction (peristalsis) of this muscle causes the food/liquid to move through the esophagus and into the stomach for continued digestion.

III. Serving the tray or meal:

A. Know facility policy related to how meals are served. Serving can be from a food cart, directly from the kitchen, all courses together or separate courses.

B. Residents should be seated upright and comfortable. Do not re-position the resident; notify a qualified team member to correct position.

C. Check diet card for each resident, if present. Checking of the diet card is very important to avoid mistakes and problems that can occur if a resident is given the wrong diet or foods. Diet card should have:

1. Resident's name.
2. Diet information.
3. Food likes and dislikes.
4. Allergies.
5. Other important or special instructions.

D. Provide resident with a clothing protector, if desired. (To maintain the resident's dignity do not refer to clothing protectors as "bibs").

E. Routine serving procedure hand washing should be done prior to serving trays (See Lesson 8: Infection Control).

1. Prepare the dining area by being certain it is clean and free of unpleasant odors.
2. Allow the resident to wash hands and face before the meal.
3. Allow resident time to pray before the meal to show respect and caring, if desired.
4. Check the resident's menu card for name, diet, restrictions, likes and dislikes and be certain that the tray is complete and correct.
5. Meals should be delivered so hot food is hot and cold food is cold. Serve food at the temperature the resident desires. If food is cold, return to dietary and request a replacement.
6. Allow residents to do as much as possible for themselves.
7. Serve all residents at table before serving another table.
8. Slow eaters may need more time, serving them first may be a benefit.
9. Dishes and flatware should be placed on the table, not left on the tray.
10. Open or offer to open condiment packages.

11. Assist or offer to assist with seasoning.
12. Prepare or offer to prepare bread and butter.
13. Cut food if needed. Remember to cut in small bite-sized pieces.
14. Open and pour beverages into cup or glass. Provide straw if resident able to use and request (some residents may use shorter straws for drinking).
15. Peel, stir or prepare other foods as needed (example: peel fruits, stir coffee/tea after adding condiments, prepare baked potato or add condiments to a sandwich).
16. Do not make inappropriate remarks about the food (example: "That smells awful").
17. Remove plate covers or trays from area after serving.
18. Ask if resident needs anything before leaving.

IV. Feeding, cuing and assisting with eating in bed.

A. Feeding instructions for residents who cannot feed themselves:

1. Sit at eye level with the resident, never lean over the resident.
    a. If you are right handed sit on the right side of the resident.
    b. If you are left-handed sit on the left side of the resident.
    c. Never feed a resident standing up.
    d. If you are feeding two residents make sure food and utensils are kept separate.
2. Protect resident's clothing with covering.
3. Offer food on a spoon, and fill it only half full (use a spoon from which the resident can easily remove the food).
4. Give food from the tip of the spoon.
5. Identify the food with each bite.
6. Be aware of food temperatures.
    a. Warn the resident if the food is hot.
    b. Allow the food time to cool.
    c. Never blow on the food to cool the food.
7. Feed slowly and in small amounts to prevent choking and aspiration.
8. Don't mix the foods together unless the resident prefers to be served that way.
9. Place spoon on unaffected side of mouth, if resident has weakness or paralysis on one side.
10. Be sure the resident's mouth is empty before offering more food.

11. Allow the resident enough time to chew and swallow the food before offering more food.
12. Offer fluids at regular intervals.
13. Offer liquids with a straw if the resident prefers and not contraindicated.
14. Use napkin to wipe mouth at intervals.
15. Be patient, empathetic and encouraging, don't force food.
16. After the meal, clean resident's face and hands as needed.
17. Dining assistant's hands must be washed before and after assistance with feeding.

B. Cuing – Some residents may require cues during the meal. The cues can be verbal or physical. Cues should be short and clear. Allow the resident sufficient time to complete one cue before giving another.

1. Verbal Cues – involve speaking and giving instructions.
    a. Give verbal cues slowly.
    b. Give verbal cues one at a time, in a gentle and respectful manner.
    c. Examples of verbal cues:
        i. Pick up your spoon.
        ii. Get some carrots on the spoon.
        iii. Lift the spoon to your mouth.
        iv. Open your mouth.
        v. Put the spoon in your mouth.
        vi. Take the spoon out.
        vii. Chew the carrots.
        viii. Swallow the carrots.
    d. Verbal cues can be used individually or in a sequence.

2. Physical Cues - involve using your hand over the resident's hand and guiding. Verbal cues are also used with physical cues.
    a. Always tell the resident what to do.
    b. Guide or assist the resident.
    c. Allow the resident to do as much as possible independently.
    d. Examples of physical cues:
        i. Say "here is your spoon" then place the spoon in their hand.
        ii. Say "get some carrots on the spoon" then put your hand over the resident's hand and guide to carrots and place carrots on spoon.

iii. Say "lift the spoon to your mouth" then guide the resident's hand and spoon to their mouth.
iv. Say "put the spoon in your mouth" then guide the spoon into the resident's mouth.

e. Physical cues can be used individually or in a sequence.

C. Assisting a resident with eating in bed – Some residents may need to be fed in bed due to weakness, illness or preference. When assisting a resident in his /her room, always check the room and resident prior to serving the tray. Resident's room should be clean (no bedpans or urinals) and have sufficient light. Resident should also be in the correct position. A dining assistant does not position a resident; check with nurse or have qualified staff position resident. (Reminder – always remember to knock on door and wait for permission before entering a resident's room).

1. Wash hands.
2. Offer a clothing protector.
3. Check the resident's diet card and verify that resident has the correct tray.
4. Place the tray on the overbed table in front of resident and prepare or assist with serving as needed.
5. Sit at eye level with the resident (If the resident's bed is high you may need to stand while assisting, check with nurse).
6. Encourage resident to assist and use cues as needed.
7. Prepare food as needed (See serving routine).
8. Assist resident with eating and drinking (See feeding instructions).
9. When meal is completed, assist to wipe hands and face as needed and remove clothing protector.
10. Before leaving make sure resident has call light and water, if allowed, within reach.
11. Remove tray, check tray for any personal items (glasses, dentures, etc).
12. Wash hands.
13. If a resident does not need assistance with feeding:
    a. Make sure resident is prepared and positioned properly.
    b. Make sure tray is prepared.
    c. Make sure call light is within reach.
    d. Check on resident at intervals during the meal.

V. Assistive devices and special needs

A. Assistive devices or adaptive equipment are special items that can be used by residents with certain conditions to assist with feeding. Residents need to be instructed in the use of these items. Assistive devices include:

1. Non-skid mat – placemat that prevents dishes from sliding.
2. Plate guard – metal or plastic rim that attaches to the plate that keeps food from being pushed off plate.
3. Scoop bowl – a bowl with a rounded over rim that prevents food from spilling over.
4. Lidded cup – prevents liquid from going too quickly into resident mouth and prevents spilling.
5. Cutout cup – cup that is notched for resident's nose, so resident does not have to bend head back.
6. Glass or cup holder – curved handles that fit over resident's hand; used for residents that cannot grasp or hold glasses or cups.
7. Built-up handles – foam tubing that is placed over the handles of flatware. Utensils with large handles can also be used.
8. Weighted forks and spoons or resident wrist weights– utensils that are heavier or weights attached to resident's wrist; used for residents with hand tremors.
9. Angled forks and spoons – utensils that are bent or shaped at different angles to assist residents who cannot bend their wrists.
10. Rocker knife or rocking T-knife - allows residents to cut food using only one hand.

B. Special Needs

1. Difficulty in swallowing.
   a. Symptoms include:
      i. "Pockets" food in cheeks.
      ii. Resident states the food won't go down.
      iii. Excessive drooling.
      iv. Coughing before, during or after swallowing food or liquid.
      v. Hoarseness, change in tone of voice or gurgling when breathing.
   b. The dining assistant should report these symptoms to the nurse.

c. If the resident displays these symptoms the dining assistant should discontinue feeding the resident.

2. Aspiration is the breathing of food or fluid into the windpipe or lungs. Aspiration is a serious condition that can occur in residents with swallowing difficulty. Dining assistants are not permitted to feed residents with difficulty swallowing. If a resident should develop signs and symptoms of difficulty swallowing, stop feeding immediately and report to the nurse.
3. A dining assistant should NOT feed stroke residents with dysphagia. If dysphagia is not present:
   a. Make sure plate and utensils are within the resident's field of vision.
   b. Utilize appropriate adaptive feeding utensils specific for the resident's needs.
   c. Place the spoon of food on the unaffected side of the resident's mouth.
   d. Encourage one sip of liquid after each bite has been swallowed.
   e. Observe for signs of choking.
   f. Approach the resident from the unaffected side.
4. Blindness:
   a. Tell the resident what is on the tray.
   b. Describe the food on the resident's plate like the face of a clock, (example: Carrots at 3:00, potatoes at 6:00,etc).
5. Hearing impaired:
   a. Get the resident's attention by clearly saying their name, do not touch as this may startle or scare the resident.
   b. Speak up, but do not shout and pronounce all the syllables in each word.
   c. Make sure the resident is looking at you when you speak.
   d. Make sure the resident has heard what you said.

VI. Dining atmosphere – a pleasant atmosphere lets the residents enjoy their meal

A. Preparing the resident for meal

1. Allow resident to wash their hands and face.
2. Make sure residents have glasses, hearing aids and dentures.
3. Make sure residents are comfortable.
4. Make sure residents are at correct table.

B. Things to remember
    1. Avoid unnecessary noise with tray and dishes.
    2. Avoid excessive personal conversation.
    3. Check independent residents at intervals.
    4. Pay attention to the residents.

**Questions:**

Where should the dining assistant be when feeding a resident?

How should a resident be given food?

What are some signs that a resident is having difficulty swallowing?

What should a dining assistant do if a resident exhibits swallowing difficulty?

When serving tray what information should be checked on the diet card and why?

**Lesson 3: Feeding Techniques**

**Related Procedure:**

**Procedure 1: Assist to Eat**

| Step | Rationale |
|---|---|
| 1. Dining assistant to wash hands, | |
| 2. Assist the resident to wash hands and/or face as needed. | 2. Promotes good hygiene and prevents spread of infection. |
| 3. Make sure the resident is in a comfortable sitting position. | 3. Resident will be more comfortable when eating, and puts resident in a natural position. |
| 4. Check the meal card for name and diet. Check tray for correct food, condiments, and utensils. | 4. Since resident's diet is ordered by the doctor, tray should contain foods permitted by the diet. |
| 5. Serve tray with main course closest to the resident. | |
| 6. Offer the resident a napkin. | 6. Protects the resident's clothing. |
| 7. Cut and season food, butter bread, and open cartons as required. | 7. The resident should do as much as possible to improve independence and self-esteem. |
| 8. Check resident frequently for dining assistance help. | 8. Allows the dining assistant to provide assistance for the resident's safety. |
| 9. When the resident has finished eating, remove the napkin and tray. | |
| 10. Assist the resident to wash hands and face as needed. | 10. Promotes self-esteem and prevents to spread of infection. |
| 11. Report any uneaten food or fluid portions to the nurse. | 11. Provides the nurse with necessary information to properly assess resident's condition. |
| 12. Dining assistant to wash hands upon completion of assisting the resident. | |

**Lesson 3: Feeding Techniques**

**Related Procedure:**

**Procedure 2: Feeding**

| Steps | Rationale |
|---|---|
| 1. Dining assistant to wash hands. | |
| 2. Assist the resident to wash hands/face as needed. | 2. Promotes good hygiene and prevents spread of infection. |
| 3. Make sure the resident is in a comfortable sitting position. | 3. Resident will be more comfortable when eating. |
| 4. Check the meal card for name and diet. Check tray for correct food, condiments, and utensils. | 4. Since the diet is ordered by the doctor, tray should contain foods permitted on the diet. |
| 5. Set tray on over bed table or dining table and describe the food. | |
| 6. Place napkin or clothing protector under the resident's chin and across chest. | 6. Protects resident's clothing. |
| 7. Ask the resident what food they prefer to start with. | 7. Resident has the right to choose. |
| 8. Fill spoon half full with food. Direct food to unaffected side of mouth. | 8. Resident will be able to chew and swallow smaller amounts of food offered on the strong side. |
| 9. Allow the resident time to chew and swallow. Offer fluids as resident wishes. | 9. Minimizes choking |
| 10. Wipe resident's mouth as needed. | 10. Promotes self-esteem and prevents spread of infection. |
| 11. Remove the napkin or clothing protector and tray when the resident is finished eating. | |
| 12. Wash the resident's hands and face as needed. | |
| 13. Report any uneaten portions of food or fluid to the nurse. | 13. Provides nurse with necessary information to properly asses resident's condition and needs. |
| 14. Dining assistant to wash hands upon completion of assisting the resident. | |

## Lesson 4: Regular and Special Diets

**Objectives:**

- Identify the need for diets and/ or special diets
- Acknowledge the different types of diets
- Recognize the importance of following prescribed diets

**Terminology:**

**Consistency** – texture of density, firmness or viscosity

**Diabetes** – a disorder of carbohydrate, protein and fat metabolism that prevents the body from properly converting foods into energy for carrying out vital functions

## Lesson 4: Regular and Special Diets

I. Dietary requirements are necessary for all residents.
   A. Diets are ordered by the physician. The resident's diet is determined by conditions, problems, diagnoses or preferences.
   B. Medications may also interact with certain foods and require alteration in diet.
   C. Diets, menus and meals are planned and reviewed by the dietician and dietary department.

II. Types of diets.
   A. Regular diet – requires no limitations or restrictions.
   B. Modified diet – altered in consistency.
      1. Clear liquid - consist of liquids such as tea, broth, juices or gelatin.
      2. Full liquid – consist of clear liquids and milk or milk products.
      3. Pureed – food that has been processed, blended or grinded to the consistency or texture of paste, mashed potatoes or baby food.
      4. Mechanical soft – food that has been ground or chopped to a fine consistency.
   C. Special or Therapeutic diets – diets that are necessary to treat a specific condition or diagnosis.
      1. Low-Sodium diet – heart disease, kidney disease, high blood pressure.
      2. Fluid-Restricted diet - heart disease, kidney disease.

3. Low-Protein diet – kidney disease, especially if receiving dialysis.
4. Low-Fat / Low-Cholesterol diet – elevated cholesterol levels, heart disease, liver disease.
5. Low sugar / Low Carbohydrate diet- insulin or non-insulin dependent diabetes.
6. Low Calorie diet – weight loss.
7. Allergies – reactions to certain foods that when eaten can result in minor to severe (life-threatening) conditions (some common food allergies can be milk, nuts, eggs, wheat, or fish).

D. Preference diets – diets that are personal choice of the resident
   1. Vegetarian diets – no meat or poultry (some vegetarians will eat fish).
   2. Vegan diet – no animal or animal products, such as eggs or milk.
   3. Kosher diet - specific dietary rules related to types of foods, preparation of food, mixing of foods that are associated with the Jewish faith.
   4. Religious dietary restrictions:
      a. Muslims – no pork
      b. Mormons – no caffeine
      c. Hindus – no beef
      d. Catholics – no meat on Fridays during Lent

III. Common dietary abbreviations
   A. NCS – no concentrated sweets
   B. NAS – no added salt
   C. RF – restricted fluids
   D. Na – Sodium
   E. NPO – Nothing by mouth
   F. ADA – American Diabetic Association
   G. CHO – carbohydrate

IV. The dining assistant's role:
   A. Follow the resident's diet card.
   B. Be aware that diet preference maybe related to religious beliefs.
   C. Dietary restrictions are usually related to health conditions and failure to follow proper diet can cause health problems for the resident.

**Questions:**

Who is responsible for the resident's diet?

What conditions may require special dietary considerations?

What is the importance of knowing if a resident has food allergies?

## Lesson 5: Reporting food and fluid intake

**Objectives:**

- Identify importance of reporting food / fluid intake
- Able to determine percentage of food consumption
- Able to convert fluid or liquid measurements

**Terminology:**

**Cubic Centimeter –** the metric unit used to measure volume (example: 30 cubic centimeter (cc / cm) = 1 ounce)

**Dehydration –** condition in which output exceeds intake

**Hydration –** the addition of water to a substance, tissue or person

## Lesson 5: Reporting food and fluids intake

I. Measurement and conversion of food / fluid.

A. Correct and accurate measurement of food/ fluid is necessary to determine that the resident is getting adequate nutrition and hydration.

B. Facility policy may vary in relationship to the recording method for measurement of food/fluid consumption, (example: measure total food or measure each food on plate). Dining assistant must know what the policy requires.

C. Accurate recording of food intake is important as poor intake or a change in amount of intake can be related to the resident's condition. The percentage of intake is an example for recording food consumption:

"R" = Refused = 0% or no food
"P" = Poor = 25% very small amount of food
"F" = Fair = 50% half of the food
"G"= Good= 75% almost all of the food
"A"= All = 100% all of food

D. Fluid intake is also important to prevent dehydration or other health problems. Most residents require at least six to eight glasses or 1500-2000cc (cubic centimeter) of fluids per day. Fluid intake can be measured in ounces or cubic centimeter The fluid conversion is

one (1) ounce equals 30 cc or cubic centimeters. Examples of container capacities:

Water glass = 8 oz. = 240 cc
Juice glass = 4 oz. = 120 cc
Coffee cup = 6 oz. = 180 cc
Styrofoam cup (3 in. tall) = 6 oz. = 180 cc
Ice cream = 3 oz. = 90 cc
Jello = ½ cup = 120 cc
Soup bowl = 8 oz. = 240cc
Cereal bowl = 8 oz. = 240 cc
Individual milk carton = 8 oz. = 240 cc

II. Recording of food / fluid intake.
   A. Recording must be correct and accurate.
   B. Recording should be done per facility policy.
      1. Nutrition record – usually for meals.
      2. Intake / Output record – records fluids taken in and output (fluids excreted).
   C. Recording must be legible.

**Questions:**

Why is reporting and recording intake important?

How many cubic centimeters are there in 2 ounces?

The facility policy on recording food consumption is not necessary for the dining assistant to know. True or False

## Lesson 6: Nutrition and Hydration

**Objectives:**

- Identify conditions that can contribute to nutritional changes
- Identify signs of dehydration
- Identify ways to improve food/fluid intake

**Terminology:**

**Nutrient** – foods or liquids that supply the body with the chemicals necessary for metabolism

## Lesson 6: Nutrition and Hydration

I. Nutrition is the process by which the body takes in food to maintain health. Good nutrition is important because it promotes physical and mental health, increases energy level and resistance to illness, and aids in the healing process. A balanced diet is necessary for good nutrition and health.

A. Nutrients include:

1. Carbohydrates – provide energy and fiber.
2. Proteins – promote growth and repair of tissue.
3. Fats – help the body use certain vitamins; provide a concentrated form of energy.
4. Vitamins – help the body function.
5. Minerals – build body tissue, regulate body fluids, and promote bone and tooth formation, affect nerve and muscle function.

B. Food Guide Pyramid – The U.S. Department of Agriculture has divided foods into six (6) groups. The food groups have been arranged in pyramid with the foods on the bottom making most of the diet and foods on the top used in smaller amounts.

1. Fats, oils, and sweets – use sparingly
2. Meat, poultry, fish, eggs, dry beans and nuts – 2-3 serving/ day
3. Dairy products – 2-3 serving/ day
4. Fruits – 2-4 serving / day
5. Vegetables – 3-5 serving / day
6. Grains (cereals, breads, rice and pasta) – 6-11 serving / day

C. Supplements and in-between meal snacks increase protein and calories, and can be ordered by the physician. Supplements can be served with a meal, at mid morning, mid afternoon, or at bedtime.

1. Types of nourishments include:

a. Milk
b. Juice
c. Gelatin
d. Custard, ice cream, sherbert
e. Crackers
f. Nutritional supplementation products (i.e. Ensure, Nutra-Shake, etc.)

2. When serving supplementary nourishments:
   a. Provide the necessary supplies (i.e. napkins, straws and flatware).
   b. Follow the facility policies for distribution and serving of supplementary nourishments to the residents.

II. Reasons that can cause decrease in nutrition.

A. Metabolism – slower, less active, muscles weaker, don't get as hungry, but still need the nutrients.
B. Sensory function:
   1. Vision - decreased sight can cause food to not look the same.
   2. Smell and taste - decreased or lack of smell or taste has and affect on the appetite.
C. Loss of appetite - due to illness, medication, changes in sensory function, less active, and / or depression.
D. Dental problems - lack of teeth or poor fitting dentures causes inability to chew (also chewing may cause pain).
E. Swallowing problems - caused by diseases or conditions, (a dining assistant does not feed residents with swallowing difficulty).
F. Digestive disorders - digestion takes longer and is less efficient. Residents may also have problems with constipation and food intolerance.

III Points to remember that can improve nutritional intake.

A. Serve smaller portions.
B. Serve a variety of food items.
C. Increase exercise.
D. Make meals a pleasant social event.
E. Make sure dining area is clean and free of odors.
F. Allow enough time.
G. Serve food at proper temperature.

IV. Hydration is the taking in and maintaining of adequate fluid. Failure to take in adequate fluids will result in dehydration. Changes or declines in physical and mental status can cause a resident not to recognize or express the need for fluids.

A. Causes of dehydration:
    1. Failure to drink or consume adequate fluids.
    2. Fever.
    3. Vomiting.
    4. Diarrhea.
    5. Urinary tract infection.
    6. Exposure to heat.

B. Factors that can cause dehydration:
    1. Unable to recognize or express thirst.
    2. Fear of incontinence.
    3. Decrease in kidney function.
    4. Medications.
    5. Swallowing difficulty.

C. Signs of dehydration:
    1. Confusion.
    2. Dry or cracked lips.
    3. Dry eyes.
    4. Dry mouth.
    5. Drowsiness.
    6. Weakness.
    7. Changes in urine color and amount.

D. Prevention of dehydration:
    1. Give fluids on frequent and regular basis (handing a glass of water often works better than asking if resident would like a drink).
    2. Encourage fluid intake.
    3. Provide fluids that resident likes.
    4. Assist with glass or straw if necessary.

**Questions:**

What are the basic nutrients?

What are factors that can cause decrease food intake?

How can a dining assistant prevent dehydration?

## Lesson 7: Communication and Interpersonal Skills

**Objectives:**

- Understand the four elements of successful communication
- Understand the steps to effective communication
- Identify the need for listening skills
- Identify barriers to communication and necessary interventions in response to those barriers

**Terminology:**

**Aphasia** - inability to express oneself properly through speech, or loss of verbal comprehension

**Cognitive** – mental process by which an individual gains knowledge

**Communication** - the exchange of information; a message sent is received and interpreted by the intended person

**Feeling** - state of emotion, not able to be measured; subjective data

**Paraphrase** - repeat a message using different words

**Rapport** - a close relationship with another

**Reporting** - a verbal or written account of resident care and observations

**Sensory** - relating to sensation involving one or more of the five senses (seeing, hearing, touching, smelling, tasting)

## Lesson 7: Communication and Interpersonal Skills

I. Four elements of successful communication.
   A. Formulating the message – must be organized, complete and understandable.
   B. Sending the message through:
      1. Verbal communication – written or spoken words.
      2. Nonverbal communication – facial expressions, tone of voice, posture, gestures, touch (body language) or call light.

C. Receiving the message – listener must prepare to receive the message, concentrate on the content and actively listen.
D. Observing the feedback – sender must interpret the verbal and nonverbal response of the listener (what is observed may be more important than what is heard).

II. Steps to effective communication:
A. Speak clearly and slowly using a gentle tone.
B. Be at eye level looking directly at the person.
C. Use appropriate nonverbal communication.
D. Use language that the listener is familiar with.
E. Use words with only one meaning.
F. Allow time for the listener to process the information.
G. Give facts, not opinions, unless specifically requested.
H. Make message logical and brief.
I. Repeat a message, using exactly the same words, if necessary.

III. Active listening skills promote good relationships and influence relationships with others. To actively listen:
A. Use body language that shows interest and concern (eye contact, lean forward).
B. Avoid interrupting the speaker (let the person finish his/ her thought).
C. Give the speaker feedback, both verbal and nonverbal, to demonstrate active listening.
D. Avoid judging the other person based on your own personal opinions and beliefs.
E. Elements that influence relationships with others include:
1. Prejudices.
2. Frustrations.
3. Attitudes.
4. Life experiences.

IV. Barriers to effective communication include:
A. Cultural differences – beliefs, values, habits, diet and health practices that relate to a person's culture and religion.
B. Age – people of different ages and eras with different values and communication styles.
C. Practice of:
1. Labeling.
2. Talking too fast.
3. Avoiding eye contact.
4. Belittling a resident's feeling.

5. Physical distance.
6. Changing the subject.
7. False assurances and clichés.
8. Giving advice.
9. Ineffective communication.
    a. Disguised messages.
    b. Conflicting messages.
    c. Unclear meanings.
    d. Abstractions.
    e. Perceptions.

D. Impairments – physical and /or mental limitations requiring special considerations when communicating.
    1. Visual – relies on verbal cues, including words and tone of voice.
        a. State your name before beginning a conversation.
        b. Describe persons, things and environment.
        c. Tell the resident when you are entering or leaving the room.
        d. Explain in detail what you are doing and ask the resident what he/she would like to do for himself.
        e. Sit where the resident can easily see you if the resident has partial vision.
    2. Hearing – relies on nonverbal cues including body language, sign language and writing.
        a. Speak slowly and distinctly.
        b. Use short sentences.
        c. Face the resident.
        d. Be certain that the light source is on you and behind the resident.
        e. Use facial expressions and gestures.
        f. Reduce outside distractions.
        g. Use sign language and message boards if appropriate.
        h. Be certain that the resident's hearing aid is in, if applicable.
    3. Cognitive – relies on both verbal and nonverbal cues.
        a. Repeat messages frequently using exactly the same words.
        b. Use short sentences.
        c. Use simple words.
        d. Avoid words with more than one meaning.
        e. Be brief.
        f. Avoid other distractions.

4. Speech – relies on both verbal and nonverbal cues.
    a. Unable to express thoughts or feelings.
    b. Can become frustrated easily.
    c. Allow sufficient time.
    d. May need to write or use gestures.

V. Interpersonal skills needed to form positive relations between people include:
    A. Patience – the capacity to be even- tempered and calm.
    B. Courtesy – the capacity to have respect and consideration for others.
    C. Tact – a sense of what to do or say in order to maintain good relations with others and avoid offending.
    D. Empathy – the ability to understand another's point of view and share in another's feelings or emotions.

VI. The dining assistant's role:
    A. Always use tact.
    B. Use gestures and posture to show you care.
    C. Practice active listening.
    D. Be patient with residents who have difficulty communicating.
    E. Develop positive relationships with residents and coworkers.
    F. Never say, "I know how you feel", because you don't.
    G. Always include the resident in the conversation if more than one person is involved.
    H. Offer choices when appropriate.
    I. Be polite and courteous at all times.

**Questions:**

What are the four elements of effective communication?

What are some barriers to effective communication?

How can active listening skills be improved?

## Lesson 8: Infection Control

**Objectives:**

- Recognize the manner in which infection is spread
- Identify interventions which will break the chain of infection

**Terminology:**

**Disinfect** - using chemicals or boiling water to reduce the number of microorganisms

**Mantoux Test** - skin test to determine past or present exposure to Tuberculosis

**Microorganism** - a tiny living thing that can only be seen with a microscope

**Nosocomial Infection** - an infection acquired during a stay at a health facility

**Pathogen** - microorganism capable of producing disease

**Personal Hygiene -** cleanliness including bathing, using deodorant, mouth care and wearing clean clothing

**Sterilize** - process of killing all microorganisms (done by steam or chemical solutions)

**Vaccine** - weakened or killed disease-producing organism taken orally or by injection to protect against disease

## Lesson 8: Infection Control

I. Infection control means preventing the spread of microorganisms by following certain practices and procedures. Microorganisms:
   A. Compose the largest population of life forms on earth.
   B. Are everywhere—water, air, soil, plants, animals, minerals, humans.
   C. Cannot be seen with the naked eye.
   D. May be harmful—harmful microorganisms that may cause Infections are called pathogens (germs) and include bacteria, viruses, fungi and protozoa.

II. The "infection chain" explains how pathogens move from one place to another. The six links which make up the chain include the:

A. Pathogen—the causative agent: bacteria, viruses, fungi, and protozoa.

B. Reservoir—the place where pathogens live and multiply (especially places that are warm, dark, and moist): on linen, equipment, surfaces, animals, and humans.

C. Portal of exit—the way pathogens leave the body: in urine, feces, saliva, tears, drainage from wounds, sores, blood, excretion from respiratory tract or genitals.

D. Route of transmission—how pathogens travel: Through the air, in contaminated soil and water, on objects (dirty linen, your clothing, equipment), by insects (flies, mosquitoes, maggots), and on people, especially on hands.

E. Portal of entry—the way pathogens get into the body: mouth, nose, skin breaks, urinary tract and anus.

F. Susceptible host—the person who can be infected: the very young, the elderly, persons who are not in good health, people who are exposed to large numbers of pathogens, and people who do not follow proper infection control practices.

III. Breaking the chain of infection controls the spread of infection. To prevent the spread of infection while assisting residents with dining needs:

A. Use good hand washing technique (hand washing is the best way to prevent the spread of infection).

B. Follow employee health policies—stay home when ill, take advantage of vaccines such as flu and pneumoccoal vaccines, have a Mantoux test or chest x-ray as indicated, be familiar with the facility's exposure plan policy.

C. Take care of yourself—good personal hygiene, good nutrition, adequate fluid, rest and exercise.

D. Practice medical asepsis—keep clean away from dirty, handle linen properly, remove and clean dirty articles and equipment quickly, handle food and food tray properly.

E. Use standard precautions.

F. Follow facility policy regarding the separation of persons with infections from others, which helps prevent nosocomial infection.

IV. Standard precautions are guidelines developed by the Center for Disease Control (CDC) to reduce the risk of transmission of pathogens from both known and unknown sources of infection in a health care setting. Every person is treated as potentially infectious. Sources of infection include: blood, all body fluids, secretions and excretions (except sweat) regardless

of whether or not they contain visible blood, non-intact skin, and mucous membranes. Standard precautions include:

A. Wearing gloves when indicated for resident care.
   1. Before assisting a resident with the dining experience, consider
      the possibility of contact with body fluids:
      a. Are isolation precautions in effect?
      b. When feeding a resident who spits or drools.
      c. Do you have a rash or open area on your hands?

B. Washing your hands at appropriate times.

C. Cleaning common use equipment between residents.

VII. Isolation (Transmission Based) precautions may be ordered to prevent the transmission of pathogens.

A. Airborne precautions—pathogens are transmitted on dust particles in air currents. Examples include tuberculosis, chickenpox, and measles.

B. Droplet precautions—pathogens are transmitted in droplets when a person coughs, sneezes or talks. Examples include pneumonia, influenza, and scarlet fever.

C. Contact Precautions—pathogens are transmitted by direct contact (skin to skin) with the resident or indirect contact with surfaces or care items in the resident's environment (examples include conjunctivitis, scabies, and impetigo).

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VI. Some infections of concern in long term care include:

A. Hepatitis—contagious disease of the liver caused by a virus and spread by exposure to infected blood, sexual contact and fecal/oral contact (symptoms are flu-like; severe infection can cause permanent liver damage and death).

B. Scabies—skin infection caused by a mite and spread by direct contact (symptoms include itching, skin irritation in the form of a rash. All contacts, bedding, and clothing must be treated to prevent spread and re-infestation).

C. Tuberculosis (TB)—chronic bacterial infection that usually affects the lungs but may affect other parts of the body such as the kidneys, bones, and brain. TB is spread through air in droplets from sputum of persons with active disease (symptoms include fever, loss of appetite, fatigue, productive cough and night sweats).

D. Acquired Immune Deficiency Syndrome (AIDS)—results from infection with Human Immunodeficiency Virus (HIV) which destroys the body's ability to fight infection. The virus is spread

through infected blood and body fluid. Early symptoms are flu-like followed by a symptom free period which can last many years (one to ten or more). No cure is known.

E. Methicillin resistant staphlococcus aureus (MRSA)—bacteria that no longer responds to antibiotics normally used to treat staphylococcal infections. It is spread on the hands of health care workers (to prevent the spread, follow standard precautions).

VII. The dining assistant's role:

A. Wash your hands before and after serving food or feeding a resident.
B. Clean spills quickly.
C. Follow standard precautions.
D. Remove gloves immediately after completing a task, and wash your hands.
E. Never wear gloves in the hallway unless you have a rash, or an open sore.
F. Keep the environment clean.
G. Keep linen away from your clothing.
H. Consider all blood, body fluids, and excrement contaminated.

**<u>Questions</u>:**

Define pathogens and give examples.

Explain infection control.

What is the best and easiest way to prevent the spread of infection?

What is a nosocomial infection?

What are standard precautions?

When should gloves be worn while assisting a resident with dining needs?

What is the purpose of isolation precautions?

**Lesson 8: Infection Control**

**Related Procedure:**

**Procedure 3: Hand washing**

| Step | Rationale |
|---|---|
| 1. Adjust water to acceptable temperature. | 1. Hot water opens pores, which may cause irritation. |
| 2. Angle arms down holding hands lower than elbows. Wet hands and wrists. | 2. The hands are most contaminated. Water should run from cleanest to dirtiest. |
| 3. Put soap on hands. | |
| 4. Lather all areas of hands and wrists, rubbing vigorously for at least 10-15 seconds. | 4. Lather and friction loosen skin oils and allow pathogens to be rinsed away. |
| 5. Clean fingernails by rubbing fingernails on palm of other hand.<br><br>*Note: Acrylic or artificial nails are difficult to clean under and may harbor bacteria.* | 5. Most pathogens on hands come from beneath the nails (McGinley et al, 1988) |
| 6. Rinse thoroughly, running water down from wrists to fingertips. | 6. Wrists are cleanest, fingertips dirtiest. Soap left on skin may cause irritation and rashes. |
| 7. Pat dry with paper towel. | 7. Skin may chap if left damp. |
| 8. Turn off faucet with paper towel and discard towel immediately. | 8. Hands will be re-contaminated if you touch the dirty faucet with clean hands or if the towel is used after turning off the faucet. |

## Lesson 8: Infection Control

**Related Procedure:**

### Procedure 4: Gloves

| Step | Rationale |
|---|---|
| 1. Wash hands (according to procedure #3) | |
| 2. Put on gloves | |
| 3. Check for tears | 3. Damaged gloves do not protect you or the resident. |
| 4. Perform feeding assistance as needed. | |
| 5. Remove one glove by grasping outer surface just below the cuff. | 5. Both gloves are contaminated and should not touch unprotected skin |
| 6. Pull glove off so that it is inside out. | 6. The dirtiest part of glove is concealed. |
| 7. Hold the removed glove in your gloved hand. | |
| 8. Place two fingers of ungloved hand under cuff of other glove and pull down so first glove is inside second glove. | 8. Touching the outside of the glove with an ungloved hand causes contamination. |
| 9. Dispose of gloves without contaminating hands. | 9. Hands may be contaminated if gloves are rolled or moved from hand to hand. |
| 10. Wash hands (according to procedure #3) | |

## Lesson 9: Safety And Emergency Procedures

**Objectives:**

- Assist in any disaster or emergency
- Recognize emergency situations
- Identify factors necessary for a safe environment

**Terminology:**

**Airway Obstruction** – blockage of the windpipe

**Choking** – upper airway obstruction

**Heimlich Maneuver** – an emergency intervention implemented on a person observed to be choking in an effort to cause the person to expel the object

## Lesson 9: Safety And Emergency Procedures

I. Safety – providing an environment in which the resident feels safe and secure is an important goal of each member of the health care team. Each member must strive to maintain a safe environment to prevent an emergency and must also know how to respond should an emergency occur. To promote and provide safety for the residents includes:

A. Environment:

1. Keep the traffic patterns clear in residents' rooms and hallways.
2. Walk, never run, and stay to the right.
3. Clean up spills immediately. Use "Wet Floor" signs when necessary.
4. Place litter in proper containers.
5. Approach swinging doors with care.
6. Report potentially hazardous conditions to the nurse immediately.
7. If you don't understand something, ask for explanation.

B. Infection Control:

1. Wash hands properly.
2. Use standard precautions at all times.
3. Handle linen and equipment according to infection control practice.

C. Resident Safety:
    1. Keep frequently used items within resident's reach.
    2. Use wheelchair locks when needed.
    3. Make sure resident's arms and legs are protected.
    4. Use care when pushing wheelchairs; always push forward, do not pull wheelchairs behind you.
    5. Make sure resident is properly positioned for meals, do not re-position, notify qualified staff for assistance.
    6. Always verify resident's identity before giving food or fluids.
    7. Use care when handling hot items.
    8. Follow supervisory nurse's instruction related to resident.

D. Oxygen precautions:
    1. Oxygen is highly flammable; use electrical appliances with caution.
    2. Keep open flames away from oxygen (matches, lighter, and cigarettes).

II. Emergency procedures:

A. Choking - happens when food or other object becomes stuck in the throat. Resident will start coughing when something is stuck in their throat.
    1. What to do if resident starts choking:
        a. Stay with the resident.
        b. Encourage the resident to cough it out.
        c. Send someone for the nurse or yell for help.
        d. Do not hit the resident on the back – this may cause the object to lodge in the windpipe causing airway obstruction.
    2. Risk factors related to choking:
        a. Too large or not chewed properly bites of food.
        b. Food that is too dry.
        c. Too much talking or laughing.
        d. Poor fitting dentures.
        e. Illness or weakness.

B. Airway obstruction - happens when food or other object blocks the windpipe.
    1. Partial airway obstruction – resident is able to speak, has a weak cough and may have difficulty breathing. There

may be a high-pitched sound (whistle) when the resident inhales.
   a. Stay with resident.
   b. Call for or send someone for help immediately.
   c. Do not hit the resident on the back.
2. Complete airway obstruction – this is a life-threatening situation. The body cannot receive oxygen. The resident is unable to speak, usually grabs or gestures at the throat. If assistance is not given the resident will become unconscious. Signs of airway obstructions are:
   a. Resident is unable to speak.
   b. Resident is unable to breath.
   c. Resident becomes unconscious.
   d. Resident's skin turns blue.
3. Heimlich Maneuver – an emergency technique for dislodging food or an object from the windpipe of a person; the following steps should be followed:
   a. Call for nurse and stay with the resident.
   b. Ask the resident if he/she can speak or cough.
   c. If resident cannot speak or cough, move behind resident and slide arms under the resident's armpits and around the resident's waist.
   d. Place fist with the thumb side against the abdomen midway between the waist and ribcage.
   e. Grasp fist with other hand.
   f. Press fist into abdomen with quick inward and upward thrusts.
   g. Repeat until object is expelled.
   h. Report observations and action to the nurse.

C. Fire

1. Common causes of fire emergencies in a facility:
   a. Faulty electrical wiring or equipment.
   b. Careless or unsupervised smoking.
2. Fire prevention for oxygen use:
   a. Do not allow any smoking or open flames near oxygen.
   b. Use electrical appliances cautiously when oxygen is in use.
3. Follow smoking regulations.
   a. If smoking is permitted in the facility, resident and staff are to smoke only in designated areas (refer to facility smoking policy).

b. Provide ashtrays and dispose of contents into approved containers.

4. In the event of a fire, apply the principles of RACE:
   a. R = remove residents from the immediate fire area to a place of safety.
   b. A = activate the fire alarm.
   c. C = contain the fire by closing doors and windows.
   d. E = extinguish the fire.
5. Fire extinguishers are rated A, B, or C according to the type of fire they may put out.
   a. A = paper, wood, cloth.
   b. B = oil, grease.
   c. C = electric.
6. Most extinguishers in facilities are rated all 3 (ABC) and may be used for all types of fire. To use a fire extinguisher:
   a. P = pull pin.
   b. A = aim nozzle.
   c. S = squeeze handle.
   d. S = sweep from side to side.
7. If a fire occurs:
   a. Never use an elevator.
   b. Avoid inhaling smoke, stay low and cover mouth with a wet cloth.
   c. Be familiar with the facility's emergency policy and procedure.
   d. Know which residents will require the most assistance due to physical or cognitive impairment.

D. Disaster emergency – a sudden event that has widespread damage to property, and causes injuries or death; may include flood, tornado, earthquake, blizzard, fire or explosions.
   1. Be familiar with community and facility disaster plans.
   2. Know the facility evacuation plan.
   3. Remain calm.
   4. Remove residents from immediate danger.
   5. Follow the nurse's instruction.

E. Other emergencies – Dining assistant will need to call for help and stay with the resident until assistance arrives; other emergencies include, but are not limited to:
   1. Heart attacks.
   2. Seizures.

3. Falls.
4. Poisonings.
5. Bleeding.
6. Fainting.
7. Scalds / burns.

III. Dining assistant's role:
   A. Be aware of safety at all times.
   B. Observe and report unsafe situations to the nurse immediately.
   C. Know the facility policy / procedure for emergencies or disasters.
   D. Be knowledgeable in symptoms that need to be reported.
   E. Understand that safety is an important consideration for the dining assistant and the resident.

**Questions:**

What are the signs of airway obstructions?

What are the signs of choking?

What does RACE mean?

**Lesson 9: Safety and Emergency Procedures**

**Related Procedure:**

**Procedure 5: Fire**

| Steps | Rationale |
|---|---|
| 1. Remove residents from area of immediate danger. | 1. Residents may be confused, frightened, or unable to help themselves. |
| 2. Activate fire alarm. | 2. Alerts entire facility of danger. |
| 3. Close doors and windows to contain Fire. | 3. Prevents drafts that could spread fire. |
| 4. Extinguish small fire with fire extinguisher if possible. | 4. Prevents fire from spreading. |
| 5. Follow all facility policies and procedures. | 5. Facilities have different methods of dealing with emergencies. Follow the policies and procedures of your facility. |

**Lesson 9: Safety and Emergency Procedures**

**Related Procedure:**

**Procedure 6: Choking**

| Steps | Rationale |
|---|---|
| 1. Call for the nurse and stay with the resident. | 1. Allows you to get help yet continuously provide for the resident's safety and comfort. |
| 2. Ask the resident if he/she can speak or cough? | 2. Identifies sign of a blocked airway (not being able to speak or cough). |
| 3. If the resident is seated, as the resident to stand if possible. Move behind the resident and slide your arms under the resident's armpits. Place one leg between the resident's legs, and your other leg slightly behind you. If the resident is unable to stand, move behind the resident and proceed to slide your arms under the resident's armpits. | 3. Puts dining assistant in correct position to perform procedure. |
| 4. Place your fist with thumb side against abdomen midway between waist and ribcage. | 4. Positions fist for maximum pressure with least chance of injury to resident. |
| 5. Grasp your fist with your other hand. | 5. Allows you to stabilize resident and apply balanced pressure. |
| 6. Press your fist into abdomen with quick inward and upward thrusts. | 6. Forces air from lungs to dislodge object. |
| 7. Repeat until object is expelled. | |
| 8. Report observations and actions to the nurse. | |
| 9. Dining assistant should wash hands following procedure. | |

## Lesson 10: Abuse, Neglect and Misappropriation of Property

**Objectives:**

- Know and define abuse, neglect and misappropriation of property
- Identify different types of abuse
- Recognize examples of abuse, neglect or misappropriation of property

**Terminology:**

See lesson plan

## Lesson 10: Abuse, Neglect and Misappropriation of Property

I. Abuse / Neglect/ Misappropriation of Property – Resident has a right to be free of verbal, sexual, physical, and mental abuse. This includes corporal punishment and involuntary seclusion. Resident's personal possessions must be safe at all times.

A. Resident must not be subject to abuse or neglect by anyone, including, but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies providing service to the resident, family members, legal guardians, friends or other individual.

B. All facilities must have a policy related to abuse, neglect and misappropriation of property. This policy includes steps to follow to report possible incidents. Supervisory personnel must be notified of any incidents.

C. Guidelines

1. Abuse – means any physical or mental injury or sexual assault inflicted on a resident in the facility, other than by accidental means.
2. Verbal abuse – is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability (examples of verbal abuse includes, threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see their family again).

3. Sexual assault – includes sexual harassment, sexual coercion, or sexual assault.
4. Physical abuse – includes hitting, slapping, pinching and kicking (it also includes controlling behavior through corporal punishment).
5. Mental abuse – includes humiliation, harassment, and threats of punishment or deprivation.
6. Involuntary seclusion – is defined as separation of a resident from other residents or from his/her room or confinement to his/her room (with or without roommates) against the resident's will, or the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.
7. Neglect – means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.
8. Misappropriation of resident property – means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.
9. Fraud – means a deception deliberately practiced in order to secure unfair or unlawful gain.

II. Examples of abuse / neglect / misappropriation of property

A. Abuse

1. Threatening or frightening a resident.
2. Pinching, slapping, kicking or pushing a resident.
3. Withholding food or fluids from a resident as punishment.
4. Leaving a resident in soiled linen or clothing.
5. Yelling angrily at or making fun of a resident.
6. Humiliating a resident.
7. Making disparaging, or derogatory remarks to a resident.
8. Sexual coercion or harassment.
9. Verbal harassment.
10. Yelling at resident for spilling food.

B. Neglect

1. Weight loss.
2. Refuse to provide care.

3. Dehydration.
4. Pressure sores.
5. Not bathing or providing personal care.
6. Not answering call lights or a resident's request.
7. Not dressing the resident properly or clothing that is dirty.
8. Leaving a resident unattended when injury may occur.

C. Misappropriation of property
   1. Temporary or permanent use of resident's property.
   2. Taking resident's money for personal use.
   3. Taking or using resident's credit cards, checking account, telephone, social security number, etc.

III. Dining assistant role
   1. Know facility's policy on reporting and follow policy; if you do not report incidents you become part of the abuse, neglect or misappropriation of property.
   2. Report immediately any abuse, neglect or misappropriation of property that is witnessed.
   3. Report immediately any abuse, neglect or misappropriation of property that a resident may tell you about.
   4. Always treat residents with respect.
   5. Report changes in resident's condition or behavior.

**Questions:**

Who is responsible for reporting abuse and neglect?

What are some examples of abuse that can occur during a meal?

What are the different types of abuse?

## Lesson 11: Recognizing and Reporting Changes

**Objectives:**

- Identify physical, sensory and psychosocial changes that occur with the aging process
- Identify different types of observation
- Recognize importance of reporting observation and information

**Terminology:**

**Physical** – pertaining to the body

**Psychosocial** – pertaining to both psychological and social factors

**Sensory** – pertaining to or related to the senses

## Lesson 11: Recognizing and Reporting Changes

I. The aging process is a series of physical, sensory and psychosocial changes that occurs over many years.

II. Physical changes occur in all body systems causing body processes to slow down.
   A. Respiratory system—lung capacity decreases as chest wall and lungs become more rigid. Deep breathing is more difficult. Air exchange decreases causing the person to breathe faster to get enough air when exercising, ill, or stressed.
   B. Circulatory system—blood vessels become more rigid and narrow. The heart muscle has to work harder which may result in high blood pressure and poor circulation.
   C. Gastrointestinal (stomach) system—taste buds lose sensitivity causing decreased appetite. Tooth and gum problems result in inability to eat properly. Digestive secretions decrease causing constipation and food intolerance problems.
   D. Urinary system—kidney function decreases slowing removal of waste. Bladder tone decreases resulting in more frequent urination, incontinence, bladder infections and urinary retention.
   E. Endocrine system—insulin production decreases possibly causing excess

sugar in blood. Adrenal gland secretions decrease reducing the ability to handle stress. The thyroid gland secretions slow down decreasing metabolism.

F. Reproductive system—hormone production decreases. Decreased estrogen in females causes menopause. Decreased testosterone in males slows sexual response. The prostate gland may become enlarged causing difficulty when urinating.

G. Integumentary system (skin)—loss of fat and water in skin causes increased sensitivity to cold, wrinkling and sagging. Decrease oil production causes dry skin and hair. Decrease sweat gland function causes loss of ability to regulate body temperature. Changes in pigmentation (skin color) causes gray hair and liver spots. Loss of capillary (vein) function causes yellowing of skin, thickening of nails, and thinning of hair.

H. Musculoskeletal system (muscles)—bones become more brittle and porous and may fracture easily. Loss of muscle strength and tone causes weakness and feeling tired. Less flexible joints make moving more difficult. Changes in spine and feet result in height loss, postural changes and difficulty walking.

I. Nervous system—decreased blood flow to certain areas of brain causes decreased short-term memory. Nerve cells die causing decreased perception of sensory stimuli and less awareness of pain and injury.

III. Sensory changes affect how the older person perceives the environment. All information about the environment is sent to the brain through the senses:

A. Sight—changes in the eye affect visual perception. The lens becomes flattened and rigid and the small muscles lose elasticity, decreasing the ability to focus on things that are close. The lens becomes more yellow; therefore, greens and blues are difficult to see. Reds and oranges are easier to see. Pupil size becomes smaller, less light reaches the inner eye making it more difficult to see in low light.

B. Hearing—structures within the ear become stiff, causing the loss of hearing of high frequency sounds. Soft wax production decreases and hard, dry wax builds up causing hearing loss.

C. Smell—ability to smell decreases causing decreased appetite. Identifying smells becomes more difficult (i.e. body odors, smoke, chemicals).

D. Taste—taste buds are less perceptive, especially salty and sweet. More seasoning may be needed on food.

E. Touch—decreased sensitivity in the skin results in less information from touch. Hot items are difficult to detect causing burns. Injuries

from bumping are not readily felt and treated. Person may drop things more often.

IV. Psychosocial changes that occur with aging affect how people perceive themselves as individuals and as a part of society:
   A. Social changes—loss of friends and relatives, loss of ability to participate in social functions.
   B. Status changes—changes in the individual's role within a group (family, community, or workplace) may result in feelings of being less productive and less respected.
   C. Economic changes—changes in income and ownership. The person may have given up his/her home, car or other possessions.
   D. Positive self-esteem—becomes difficult to maintain.

V. Observing and reporting is the most important way to communicate within the health care team.
   A. Observation is the gathering of information about a resident through the use of your senses; methods of observation include:
      1. Objective observation – data available through the senses.
         a. Sight – skin color, level of consciousness, bruises.
         b. Sound – moans, cough.
         c. Smell – foul odor bad breath, odor to urine or stools.
         d. Touch – warm skin, rashes, cold skin.
      2. Subjective observation – data reported or said by a resident or another person about the resident (statements like "I'm dizzy", "That hurts" or "Mom, looks pale").
      3. Observation that indicate an acute condition and require immediate attention from the nurse may include, but are not limited to:

| | | |
|---|---|---|
| severe pain | anxiety | mood swings |
| fall or accident | confusion | depression |
| skin tears | bruises | loss of consciousness |
| odor | cold clammy skin | bleeding |
| seizures | swelling | choking |
| incontinence | difficulty breathing | vomiting |
| fever | behavioral changes | sudden changes |

   B. Report means informing the person in authority (the nurse) about information observed, received and care given. Telling another dining assistant, CNA or QMA about the observation, information or care is not reporting.
      1. Report information should always include:
         a. Resident's name.

b. Location.
c. Time.
d. Detailed description of event.

2. Types of reporting include:
    2. Objective – information that is factual. Information gathered through observation is obtained by looking, listening, smelling, and touching.
    3. Subjective – information that is based upon opinion; this is information that is based on interpretation of a situation or what is told to you; subjective information may not be factual.
    4. Routine – information about care given, this is information that is usually given at the end of the meal or shift.
    5. Immediate – information that needs attention due to urgency or safety, examples include, but are not limited to:
        i. Any change in a resident's alertness.
        ii. Falls or bleeding.
        iii. Change in resident's condition.
        iv. Complaints of not feeling well or pain.
        v. Dangerous situations, such as wet floors or broken glass.
        vi. Resident abuse or neglect.

**Questions:**

What are some of the physical changes that occur with aging?

What is the difference between objective and subjective observations?

What needs to be reported and to whom?

## Lesson 12: Mental Health and Social Service Needs Including How to Respond to a Resident's Behavior

**Objectives:**

- Identify causes of cognitive impairment
- Identify response to difficult behavior
- Identify intervention related to behaviors during meals

**Terminology:**

**Catastrophic reaction** – a strong emotional response often related to frustration

**Sun downing** – becoming more restless and confused in the evening

## Lesson 12: Mental Health and Social Service Needs Including How to Respond to a Resident's Behavior

I. Cognitive impairment may cause changes in resident's behavior. Understanding and responding to behaviors are important when dealing with residents that have cognitive impairment.

II. Cognitive impairment is a temporary or permanent change within the brain, which affects a person's ability to think, reason and learn.
   A. Temporary causes may include stress, medication, pain, depression, vitamin deficiency, thyroid disease, alcohol and head trauma.
   B. Permanent causes include severe head trauma, illness, disease, and brain damage at birth.

III. Disorders that may cause cognitive impairment include:
   A. Depression – emotional sadness and withdrawal, usually caused by loss of person, possession, health, choice or self-esteem.
   B. Anxiety – persistent feelings of fear and nervousness.
   C. Suspiciousness – distrust of others.
   D. Delusion – false belief not supported by reality.
   E. Paranoia – irrational feeling of being persecuted, suspiciousness, hostility.
   F. Schizophrenia – a psychotic disorder characterized by a distortion of reality, and disorganized or fragmented thoughts, perceptions, or emotional reactions.
   G. Mental retardation – process which slows or stops a child's brain from maturing; most common causes include difficult birth, Down's syndrome, high fever, drug or alcohol abuse during pregnancy.

H. Dementia – progressive mental deterioration due to organic brain disease, which causes structural changes within the brain; Alzheimer's disease is the most common.

IV. Dementia causes progressive deterioration of memory, judgment, orientation, physical skills, language and communication.
   A. Behaviors common to residents with advanced dementia include, sun downing, catastrophic reactions, wandering, pacing, pillaging, hoarding, agitation, anxiety, hallucination, and delusions.
   B. Techniques used to reduce the effects of advanced dementia and should be initiated only upon instruction from the nurse include:
      1. Reality orientation – helps resident remain aware of his/her environment, time and themselves.
      2. Validation therapy – helps resident improve dignity and self-worth by having his/her feelings and memories validated.
      3. Reminiscing – allows resident to talk about past experiences, especially pleasant ones.
   C. Dementia residents need assistance in the following:
      1. Safety - monitor resident's movement and environment for possible hazards.
      2. Nutrition - providing resident with appropriate amounts of food and/ or supplements.
      3. Hydration - offering and providing adequate amounts of fluids.

V. Difficult behavior may result from too much stimulation, change in routine or environment, physical pain or discomfort, reactions to medications, and fatigue. When responding to difficult behavior:
   A. Remain calm, speak slowly and clearly.
   B. Avoid approaching the resident from the side or back.
   C. Try to distract the resident's attention and redirect behavior.
   D. Allow the resident to express feelings if talking reduces agitation.
   E. Do not respond to verbal attacks. Do not argue or accuse the resident.
   F. Stay a safe distance from the resident.
   G. If resident is hitting or kicking move out of the way; never hit back.

VI. Intervention for common behaviors that dining assistants may encounter:
   A. Resident refuses to eat:
      1. Ask them why they are refusing.
      2. Encourage, but do not force, the resident to eat.

3. Offer favorite foods.
4. Report refusal to the charge nurse.

B. Resident does not open their mouth:
    1. Ask the resident to open his/her mouth.
    2. Gently place or touch the spoon to the resident's lip.

C. Resident bites down on the spoon:
    1. Ask the resident to open his/her mouth.
    2. Wait until the jaw relaxes; do not try to pull the spoon out (do not use plastic spoons for this resident because the spoon could break, causing injury).

D. Resident eats with their hands:
    1. Provide finger foods.
    2. Hand the spoon to the resident.

E. Resident holds food in their mouth:
    1. Remind to chew and swallow.
    2. Make sure resident has swallowed before next bite.
    3. Wait and watch for swallowing.
    4. Offer drink.

F. Resident pockets food:
    1. Remind to chew and swallow.
    2. Use small amounts on the spoon.
    3. Allow resident more time between spoonfuls.

G. Resident wanders away:
    1. Make sure food is ready when resident arrives.
    2. Keep noise and distractions at minimum.
    3. Maintain routine.
    4. Offer finger foods.

H. Resident plays with food:
    1. Serve one item at a time.
    2. Assist with eating.
    3. Use lids on cups or glasses.

**Questions:**

What are some causes of cognitive impairment?

How should a dining assistant respond when a resident exhibits a difficult behavior?

What are some common interventions for difficult behaviors during meals?

## Lesson 13: Resident Rights and Independence

**Objectives:**

- Identify resident rights
- Recognize the importance of maintaining resident independence
- Understand the dining assistant's role in protecting resident rights

**Terminology:**

**Confidentiality** – keeping information private

## Lesson 13: Resident Rights and Independence

I. Resident rights

A. Rights are both human privileges and legal protections. Residents have the legal rights of all United States citizens. Residents also have rights related to their everyday lives and care in a nursing facility. A facility must inform residents of their rights in writing.

B. Resident's rights include, but are not limited to:

1. Right to confidentiality - Personal information, medical records, written and telephone communications, medical treatment, personal care, behavior and meetings with family are not discussed unless appropriate. To maintain confidentiality:
    a. Never discuss a resident's personal or medical information with friends, family, news media, or others.
    b. Only discuss resident information with other members of the health care team in a private place.
2. Right to information - This includes the resident's right to see personal and medical records; right to be fully informed of total health status in a language the resident can understand; right to be informed of any changes in service that the resident is charged for and that he/she is not charged for, right to see financial records; right to be informed of advocacy groups' phone numbers and the most recent survey must be posted in the facility.
3. The right to choose - The resident has the right to refuse treatment and self administer medication, if deemed safe; to choose a personal physician; to participate in his/her care planning; to perform voluntary or paid services; to keep and use personal possessions as space permits; to participate in

activities in and out of the facility; to have space available for private meetings.

4. Right to privacy - To provide privacy the dining assistant should always:
    a. Knock on door and announce yourself to the resident.
    b. Never open mail or go through resident's belongings unless requested by the resident.
    c. Provide privacy when appropriate during the resident's dining experience.
5. Right to dispute services and file grievances - The resident can voice complaints without fear of retaliation, get prompt action on complaints, have the ombudsman program investigate complaints from the resident or family. To support this right the dining assistant should:
    a. Tell the nurse if the resident or family voices a complaint.
    b. Never let a complaint negatively affect how you assist a resident.
    c. Understand that if the resident complains about you the facility must investigate.
6. Right to be free of Abuse - this includes verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion (See Lesson 10).

C. Practices that a dining assistant should do to maintain resident's rights:
    1. Address the resident by their specific name as Mr., Mrs., or Miss or the resident's preferences (avoid terms such as "honey" or "sweetie").
    2. Be respectful and kind at all times.
    3. Make eye contact when talking with a resident.
    4. Allow the resident to complete sentences.
    5. Explain to the resident what assistance will be provided.
    6. Promote a positive attitude.
    7. Treat all residents equally.
    8. Never threaten or yell at residents.
    9. Allow resident to make choices.
    10. Immediately report any concerns to the supervising nurse.

II. Resident independence - means not having to rely on another person for routine activities, such as eating and drinking. People tend to take routine activities for granted until they are unable to perform them. This results in a loss of independence.

A. Loss of independence can cause:
    1. Negative self-image.
    2. Anger toward caregivers, other or self.
    3. Feelings of helplessness, sadness and hopelessness.
    4. Feelings of being useless.
    5. Increased dependence.
    6. Depression.
B. Prevent loss of independence:
    1. Encourage resident to do as much as possible for themselves.
    2. Be patient, allowing a resident to do for himself/herself may take more time.
    3. Allow the resident to make choices.
    4. Respect the resident's choice.

III. Role of the dining assistant in protecting resident's right:
    A. Understand that violating the resident's rights is against the law.
    B. The dining assistant is a resident advocate.
    C. Encourage the resident to exercise his/her rights.
    D. Report immediately anyone who abuses the resident's rights.
    E. Always treat residents the way you would expect to be treated if you were in their situation.
    F. Remember that privacy and confidentiality promote the resident's dignity and self-esteem.

**Questions:**

What are the six resident rights?

How can a resident's independence be maintained?

What are rights?

## PROCEDURES:

1. Assist to Eat
2. Feeding
3. Hand Washing
4. Gloves
5. Fire
6. Choking

**Procedure 1: Assist to Eat**

| Step | Rationale |
|---|---|
| 1. Dining assistant must wash hands. | |
| 2. Assist the resident to wash hands and/or face as needed. | 2. Promotes good hygiene and prevents spread of infection. |
| 3. Make sure the resident is in a comfortable sitting position. | 3. Resident will be more comfortable when eating, and puts resident in a natural position. |
| 4. Check the meal card for name and diet. Check tray for correct food, condiments, and utensils. | 4. Since resident's diet is ordered by the doctor, tray should contain foods permitted by the diet. |
| 5. Serve tray with main course closest to the resident. | |
| 6. Offer the resident a napkin. | 6. Protects the resident's clothing. |
| 7. Cut and season food, butter bread, and open cartons as required. | 7. The resident should do as much as possible to improve independence and self-esteem. |
| 8. Check resident frequently for dining assistance help. | 8. Allows the dining assistant to provide assistance for the resident's safety. |
| 9. When the resident has finished eating, remove the napkin and tray. | |
| 10. Assist the resident to wash hands and face as needed. | 10. Promotes self-esteem and prevents to spread of infection. |
| 11. Report any uneaten food or fluid portions to the nurse. | 11. Provides the nurse with necessary information to properly assess resident's condition. |
| 12. Dining assistant must wash hands upon completion of assisting the resident. | |

I verify that these procedures were taught and successfully demonstrated according to ISDH Standards:
Dining assistant's name: _____Date: _____
Instructor's name: _____Date:_____

| Procedure 2: Feeding | |
|---|---|
| **Steps** | **Rationale** |
| 1. Dining assistant to wash hands. | |
| 2. Assist the resident to wash hands/face as needed. | 2. Promotes good hygiene and prevents spread of infection. |
| 3. Make sure the resident is in a comfortable sitting position. | 3. Resident will be more comfortable when eating. |
| 4. Check the meal card for name and diet. Check tray for correct food, condiments, and utensils. | 4. Since the diet is ordered by the doctor, tray should contain foods permitted on the diet. |
| 5. Set tray on over bed table or dining table and describe the food. | |
| 6. Place napkin or clothing protector under the resident's chin and across chest. | 6. Protects resident's clothing. |
| 7. Ask the resident what food they prefer to start with. | 7. Resident has the right to choose. |
| 8. Fill spoon half full with food. Direct food to unaffected side of mouth. | 8. Resident will be able to chew and swallow smaller amounts of food offered on the strong side. |
| 9. Allow the resident time to chew and swallow. Offer fluids as resident wishes. | 9. Minimizes choking |
| 10. Wipe resident's mouth as needed. | 10. Promotes self-esteem and prevents spread of infection. |
| 11. Remove the napkin or clothing protector and tray when the resident is finished eating. | |
| 12. Wash the resident's hands and face as needed. | |
| 13. Report any uneaten portions of food or fluid to the nurse. | |
| 13. Dining assistant to wash hands upon completion of assisting the resident. | 13. Provides nurse with necessary information to properly asses resident's condition and needs. |

I verify that these procedures were taught and successfully demonstrated according to ISDH Standards:
Dining assistant's name:_____ Date:_____
Instructor's name: _____Date:_____

| Procedure 3: Hand washing | |
|---|---|
| **Step** | **Rationale** |
| 1. Adjust water to acceptable temperature. | 1. Hot water opens pores, which may cause irritation. |
| 2. Angle arms down holding hands lower than elbows. Wet hands and wrists. | 2. The hands are most contaminated. Water should run from cleanest to dirtiest. |
| 3. Put soap on hands. | |
| 4. Lather all areas of hands and wrists, rubbing vigorously for at least 10-15 seconds. | 4. Lather and friction loosen skin oils and allow pathogens to be rinsed away. |
| 5. Clean fingernails by rubbing fingernails on palm of other hand.<br><br>*Note: Acrylic or artificial nails are difficult to clean under and may harbor bacteria.* | 5. Most pathogens on hands come from beneath the nails (McGinley et al, 1988) |
| 6. Rinse thoroughly, running water down from wrists to fingertips. | 6. Wrists are cleanest, fingertips dirtiest. Soap left on skin may cause irritation and rashes. |
| 7. Pat dry with paper towel. | 7. Skin may chap if left damp. |
| 8. Turn off faucet with paper towel and discard towel immediately. | 8. Hands will be re-contaminated if you touch the dirty faucet with clean hands or if the towel is used after turning off the faucet. |

I verify that these procedures were taught and successfully demonstrated according to ISDH Standards:
Dining assistant's name:_____ Date:_____
Instructor's name: _____ Date:_____

**Procedure 4: Gloves**

| Step | Rationale |
|---|---|
| 1. Wash hands (according to procedure #3) | |
| 2. Put on gloves | |
| 3. Check for tears | 3. Damaged gloves do not protect you or the resident. |
| 4. Perform feeding assistance as needed. | |
| 5. Remove one glove by grasping outer surface just below the cuff. | 5. Both gloves are contaminated and should not touch unprotected skin |
| 6. Pull glove off so that it is inside out. | 6. The dirtiest part of glove is concealed. |
| 7. Hold the removed glove in your gloved hand. | |
| 8. Place two fingers of ungloved hand under cuff of other glove and pull down so first glove is inside second glove. | 8. Touching the outside of the glove with an ungloved hand causes contamination. |
| 9. Dispose of gloves without contaminating hands. | 9. Hands may be contaminated if gloves are rolled or moved from hand to hand. |
| 10. Wash hands (according to procedure #3) | |

I verify that these procedures were taught and successfully demonstrated according to ISDH Standards:
Dining assistant's name:_____ Date:_____
Instructor's name: _____Date: _____

| Procedure 5: Fire | |
|---|---|
| **Steps** | **Rationale** |
| 1. Remove residents from area of immediate danger. | 1. Residents may be confused, frightened, or unable to help themselves. |
| 2. Activate fire alarm | 2. Alerts entire facility of danger. |
| 3. Close doors and windows to contain Fire. | 3. Prevents drafts that could spread fire. |
| 4. Extinguish small fire with fire extinguisher if possible. | 4. Prevents fire from spreading. |
| 5. Follow all facility policies and procedures. | 5. Facilities have different methods of dealing with emergencies. Follow the policies and procedures of your facility. |

I verify that these procedures were taught and successfully demonstrated according to ISDH Standards:
Dining assistant's name:_____ Date:_____
Instructor's name: _____ Date:_____

| Procedure 6: Choking | |
|---|---|
| **Steps** | **Rationale** |
| 1. Call for the nurse and stay with the resident. | 1. Allows you to get help yet continuously provide for the resident's safety and comfort. |
| 2. Ask the resident if he/she can speak or cough? | 2. Identifies sign of a blocked airway (not being able to speak or cough). |
| 3. If the resident is seated, as the resident to stand if possible. Move behind the resident and slide your arms under the resident's armpits. Place one leg between the resident's legs, and your other leg slightly behind you. If the resident is unable to stand, move behind the resident and proceed to slide your arms under the resident's armpits. | 3. Puts dining assistant in correct position to perform procedure. |
| 4. Place your fist with thumb side against abdomen midway between waist and ribcage. | 4. Positions fist for maximum pressure with least chance of injury to resident. |
| 5. Grasp your fist with your other hand. | 5. Allows you to stabilize resident and apply balanced pressure. |
| 6. Press your fist into abdomen with quick inward and upward thrusts. | 6. Forces air from lungs to dislodge object. |
| 7. Repeat until object is expelled. | |
| 8. Report observations and actions to the nurse. | |
| 9. Dining assistant should wash hands following procedure. | |

I verify that these procedures were taught and successfully demonstrated according to ISDH Standards:
Dining assistant's name:_____ Date:_____
Instructor's name: _____Date:_____

# DINING ASSISTANT TRAINING RECORD

**State Form**
Indiana State Department of Health – Division of Long Term Care

Name:_____

Address:_____

City:_____State:_____Zip:_____

Curriculum: ISDH_____ AHCA_____ Both_____

Training Program Name:_____

Address:_____

City:_____State:_____Zip:_____

## CLASSROOM INSTRUCTION:

| Lesson # | | ISDH | Date | Time | Instructor |
|---|---|---|---|---|---|
| ISDH | AHCA | | | | |
| 1 | NA | Health Care Delivery | | | |
| 2 | 1 | Role of Dining Assistant | | | |
| 3 | 3 | Feeding Techniques | | | |
| 4 | 2 | Regular and Special Diets | | | |
| 5 | 8 | Reporting Food and Fluid Intake | | | |
| 6 | 2 | Nutrition and Hydration | | | |
| 7 | 9 | Communication and Interpersonal Skills | | | |
| 8 | 7 | Infection Control | | | |
| 9 | 6 | Safety and Emergency Procedure | | | |
| 10 | 10 | Abuse, Neglect and Misappropriation of Property | | | |
| 11 | 8 | Recognizing and Reporting Changes | | | |
| 12 | 4 | Mental Health and Social Service Needs including how to respond to a Resident's Behavior | | | |
| 13 | 10 | Resident Rights and Independence | | | |
| **PROCEDURE** | | **Topic** | | | |
| 1 | | Hand Washing | | | |
| 2 | | Gloves | | | |
| 3 | | Fire | | | |
| 4 | | Choking | | | |
| 5 | | Assist to Eat | | | |
| 6 | | Feeding | | | |
| **DATE COMPLETED:** | | | | | |
| **NUMBER OF HOURS:** | | | | | |

## CLINICAL INSTRUCTION:

| Observation/Supervision | Date | Time | Instructor |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **DATE COMPLETED:** | | | |
| **NUMBER OF HOURS:** | | | |

**COURSE COMPLETION DATE:**_____ **TOTAL HOURS OF COURSE**_____

**PROGRAM DIRECTOR SIGNATURE:**_____

# *Certificate of Completion*

_____

*has successfully completed the sixteen hour program for*

*Dining Assistant*

Instructor_____ Date_____

Name of Training Program_____

Address of Training Program_____

■ For the reasons set forth in the preamble, CMS is amending 42 CFR chapter IV as set forth below:
■ A. Part 483 is amended as follows:

## PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

### Subpart B—Requirements for Long Term Care Facilities

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

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

■ 2. In § 483.35, the introductory text is republished, paragraph (h) is redesignated as paragraph (i), and a new paragraph (h) is added to read as follows:

**§ 483.35 Dietary services.**

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

* * * * *

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

(i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of § 483.160 before feeding residents; and

(ii) The use of feeding assistants is consistent with State law.

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

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

(3) *Resident selection criteria.*

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

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

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

* * * * *

**§ 483.7 [Amended]**

■ 3. Section 483.7 is amended as follows:
■ a. In paragraph (e)(1), the definition of "Nurse aide" is amended by adding a sentence to the end of the definition;
■ b. A new paragraph (q) is added.

The additions read as follows:

**§ 483.75 Administration.**

* * * * *

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

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

* * * * *

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

### Subpart D—Requirements That Must Be Met by States and State Agencies: Nurse Aide Training and Competency Evaluation; and Paid Feeding Assistants

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

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

**§ 483.160 Requirements for training of paid feeding assistants.**

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

(1) Feeding techniques.

(2) Assistance with feeding and hydration.

(3) Communication and interpersonal skills.

(4) Appropriate responses to resident behavior.

(5) Safety and emergency procedures, including the Heimlich maneuver.

(6) Infection control.

(7) Resident rights.

(8) Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.

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

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

## PART 488—SURVEY, CERTIFICATION, AND ENFORCEMENT PROCEDURES

### Subpart E—Survey and Certification of Long Term Care Facilities

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

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

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

**§ 488.301 Definitions.**

As used in this subpart—

* * * * *

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

* * * * *

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

Dated: May 22, 2003.

**Thomas A. Scully,**

*Administrator, Centers for Medicare & Medicaid Services.*

Approved: June 24, 2003.

**Tommy G. Thompson,**

*Secretary.*

[FR Doc. 03–24362 Filed 9–25–03; 8:45 am]
BILLING CODE 4120–03–U

## LEGAL SERVICES CORPORATION

### 45 CFR Part 1626

### Alien Eligiblity for Representation by LSC Programs

**AGENCY:** Legal Services Corporation.

**ACTION:** Final rule.

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

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

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

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