

Kentucky Paid Feeding Assistant Manual



Cabinet for Health & Family Services

Office of the Inspector General



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INTRODUCTION TO THE PAID FEEDING ASSISTANT PROGRAM

WHAT YOU WILL LEARN

- **Preface**
- **Requirements for Training Competency**

Preface

The Commonwealth of Kentucky, Office of the Inspector General, Division of Health Care Facilities and Services has developed and approved this Paid Feeding Assistant Curriculum in order to improve the quality of life for residents of Long Term Care facilities. The Centers for Medicare & Medicaid Services (CMS) adopted regulations effective October 27, 2003, which allow the use of paid feeding assistants in Long Term Care facilities that participate in the Medicare and Medicaid program. The federal regulations give each state the flexibility to allow Long Term Care facilities to use Paid Feeding Assistants to supplement the services of Certified Nurse Assistants if their use is consistent with state law, and if the feeding assistants successfully complete a state-approved training program.

The curriculum presented in this manual was designed for the implementation of the Federal Centers for Medicare and Medicaid Services (CMS) 42CFR 483.35(h), 42CFR 483.75(e)(1)(q) and 42CFR 483.160 and (Kentucky State Regulation to be filled in) relating to the use of paid feeding assistants in Long Term Care Facilities. A Paid Feeding Assistant is an individual who meets the requirements specified in 42CFR 483.35(h)(2) and who is utilized by the facility to feed residents. The regulations do not apply to licensed nursing personnel or nurse aides. They do not apply to volunteers, families or friends. However, any facility employee who feeds residents, if only for a short time each day or occasionally, must successfully complete the state-approved paid feeding assistant training as they are functioning as a feeding assistant. This includes individuals whose services at the facility may be paid under contract with another employing agency.

The Paid Feeding Assistant position will provide facilities with additional support to enhance the resident's quality of life and ensure the resident receives adequate nutrition. Paid feeding assistants will work directly with residents by providing assistance during meals and helping residents to maintain as much independence as possible. The facility has the discretion to allow these specially trained employees to help Long Term Care residents eat and drink. This additional position will give facilities the ability to offer residents one-on-one interaction during meals while providing Nurses and Nurse Aides the opportunity to focus on residents with more complicated feeding problems. The Paid Feeding Assistants will be under the supervision of the licensed nursing personnel and the facility administrator, who has the ultimate responsibility for assuring the feeding assistant's successful completion of the course and competency in the feeding skills.

Requirements for Training and Competency

The training course for Paid Feeding Assistants must utilize this state approved curriculum manual in its entirety, for a minimum of 8 hours training. Additional components that expand the curriculum may be added, but not substituted. The training course includes the following:

- Feeding techniques
- Assistance with feeding and hydration
- Communication and interpersonal skills
- Appropriate responses to resident behavior
- Safety and emergency procedures, including the Heimlich maneuver
- Infection control
- Resident Rights
- Recognizing changes in residents that are inconsistent with their normal behavior

The training course shall be taught by a Registered Nurse licensed in the Commonwealth of Kentucky or a Licensed Practical Nurse under the supervision of a Registered Nurse.

The curriculum includes a written skills competency test that must be passed with a minimum score of 75%. Documentation must be maintained by the facility for all individuals who have successfully completed the training/competency course for Paid Feeding Assistants.

The approved training/competency course for Paid Feeding Assistants is not considered portable from one Kentucky nursing home to another Kentucky nursing home. Before a facility utilizes a paid feeding assistant that has received training from another entity the facility shall:

- Obtain written verification from the entity that provided the training to verify that the feeding assistant successfully completed the training required by Section 3 of this administrative regulation;
- Require the feeding assistant to retake and successfully pass the written and skills competency test;
- Ensure that the paid feeding assistant is aware of current facility policy and procedures related to the program; and
- Issue the feeding assistant a new certificate of training.

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FEDERAL REGISTER

September 26, 2003

rebate regulation for the Medicaid drug rebate program. This document corrects the effective date.

EFFECTIVE DATE: The effective date of the August 29, 2003 final rule (68 FR 51912) amending 42 CFR part 447 is corrected from October 1, 2003 to January 1, 2004.

FOR FURTHER INFORMATION CONTACT: Marge Watchorn, (410) 786-4361.

SUPPLEMENTARY INFORMATION:

I. Background

On August 29, 2003, we published in the *Federal Register* a final rule with comment period entitled, "Medicaid Program; Time Limitation on Price Recalculations and Recordkeeping Requirements Under the Drug Rebate Program." The rule establishes requirements for recordkeeping and time limits on price recalculations. The effective date of these requirements as stated in the August 2003 rule is October 1, 2003.

The Office of Management and Budget (OMB) declared that the August 2003 final rule is a major rule. Thus, we should have given January 1, 2004 as the effective date in accordance with 5 U.S.C. 801(a)(4). However, we erroneously incorporated an incorrect effective date of October 1, 2003. We have identified and corrected that error in the "Correction of Errors" section below.

II. Correction of Errors

In FR Doc. 03-21548 of August 29, 2003 (68 FR 51917), make the following correction:

- On page 51912, in column one, in the "Dates" section, remove "October 1, 2003" and replace it with "January 1, 2004."

III. Waiver of Notice of Proposed Rulemaking and Delay of the Effective Date

We ordinarily publish a general notice of proposed rulemaking in the *Federal Register* and invite prior public comment on a proposed rule. Final rules generally have a 30-day or longer prospective effective date. However, this document merely provides a correction to the effective date of the final rule with comment published on August 29, 2003. This correction is being made based on OMB's decision that the August 2003 final rule is a major rule. Thus, we should have given January 1, 2004 as the effective date in accordance with 5 U.S.C. 801(a)(4). However, we erroneously incorporated an incorrect effective date of October 1, 2003. It would be impracticable, unnecessary and contrary to the public interest to publish a proposed rule and solicit

comments since this document is technical in nature and does not impose new limits on the substantive rights of the industry or the public. Similarly, given the imminence of the effective date, it would serve no useful purpose to further delay the effective date of this technical correction. Therefore, to the extent that 5 U.S.C. 553 applies to this action, we find good cause to waive notice and comment procedures and our usual delay in the effective date.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: September 24, 2003.

Ann C. Agnew,

Executive Secretary to the Department.

[FR Doc. 03-24550 Filed 9-25-03; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 483 and 488

[CMS-2131-F]

RIN 0938-AL04

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

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

ACTION: Final rule.

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

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

FOR FURTHER INFORMATION CONTACT: Nola Petrovich, (410) 786-4671.

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

I. Background

Legislation

Sections 1819(a) through (e) and 1919(a) through (e) of the Social Security Act (the Act) set forth the requirements that long term care facilities must meet to participate in the Medicare and Medicaid programs, respectively. Sections 1819(f)(2) and 1919(f)(2) of the Act contain requirements for nurse aide training and competency evaluation programs (NATCEP). Sections 1819(g) and 1919(g) of the Act contain the criteria that we use to assess a facility's compliance with the requirements. These statutory provisions were mandated by the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) (Pub. L. 100-203, enacted December 22, 1987). The requirements for long term care facilities are codified at 42 CFR part 483, subpart B; the nurse aide training and competency evaluation program requirements are codified at 42 CFR part 483, subpart D; and the survey, certification and enforcement procedures are codified at 42 CFR part 488, subparts E and F.

Sections 1819(b)(5)(F) and 1919(b)(5)(F) of the Act and regulations at § 483.75(e) define a nurse aide as any individual furnishing nursing or nursing-related services to residents in a facility, who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide services without pay. Sections 1819(f)(2) and 1919(f)(2) of the Act set forth the requirements for approval of a nurse aide training and competency evaluation program, but do not define "nursing" or "nursing related" skills. Section 483.152 of the regulations specifies nurse aide training requirements. These include, for example, basic nursing skills, personal care skills, communication and interpersonal skills, infection control, safety and emergency procedures, mental health and social service needs, residents' rights, care of cognitively impaired residents, and basic restorative services.

On March 29, 2002, we published in the *Federal Register* a proposed rule, "Requirements for Paid Feeding Assistants in Long Term Care Facilities" (67 FR 15149), that offered long-term care facilities the option to use paid feeding assistants, if consistent with State law.

Current Program Experience

Currently, there is no provision in the regulations for the use of single-task workers, such as paid feeding assistants, in nursing homes. To ensure the safety

of facility residents, we require that qualified nursing staff provide assistance with eating and drinking, although there is some question whether or not all residents need medical supervision. This group of personnel includes registered nurses, licensed practical nurses, and certified nurse aides who have completed 75 hours of training. However, volunteers, who are usually family members, may also feed residents, because the law and regulations exclude volunteers from the definition of certified nurse aide.

Nursing homes in many States report a continuing shortage of certified nurse aides.^{1, 2, 3} Nursing homes are finding it increasingly difficult to train and retain sufficient numbers of qualified nursing staff, especially certified nurse aides. Certified nurse aides perform the majority of resident care tasks. Other employers often pay similar wages for less physically and emotionally demanding jobs. This makes it harder for nursing homes to employ enough nursing staff to perform routine nursing care and to feed residents who need minimal help or just encouragement at mealtimes. Feeding residents is often a slow process and competes with more complex tasks, such as bathing, toileting, and dressing changes, as well as urgent medical care.

For many elderly nursing home residents, physical and psychological changes often interfere with eating ability and meal consumption. Residents may need assistance with feeding if they have, for example, cognitive impairment, impaired swallowing due to muscular weakness or paralysis, a tendency to aspirate or choke, poor teeth, ill-fitting dentures or partial plates, or poor muscular or neurological control of their arms or hands, as with Parkinson's disease.

Current Trends

Nursing homes are caring for an aging population that has more acute clinical conditions than in the past. The result is a higher percentage of nursing home residents who need higher levels of care, which takes more staff time and leaves less time for routine tasks, such as ensuring that residents eat their meals and drink enough fluids.

In addition, evidence suggests that there has been a recent increase in assisted living facilities that house many individuals with minimal medical needs who previously would have been cared for in nursing homes. Both of these trends have resulted in a frailer nursing home population than previously, with residents who are more dependent on nursing staff for basic needs, such as feeding and personal care. A critical shortage of certified nurse aides in many parts of the country has resulted in a need for staff who are specially trained to help residents eat at mealtimes, to supplement, not replace certified nurse aides.

Some residents only need encouragement or minimal assistance, which does not require nursing training. Properly trained non-nursing personnel could provide this type of assistance. Nurse aides and other nursing staff receive training so that they are able to feed residents with all kinds of feeding problems. A higher level of training is required of nurse aides because nurse aides need to be able to deal with complicated feeding problems. However, when there is a nurse aide shortage, it is often the case that residents without complicated feeding problems receive little or no assistance at mealtimes with eating or drinking, while the nursing staff focuses on feeding residents with complicated problems. We believe there is a place in nursing homes for the use of feeding assistants who, after proper basic training in feeding techniques and working with the elderly, are able to feed residents who do not have complicated feeding problems. It is reasonable to require that feeding assistants receive a lower level of training than a nurse aide because feeding assistants would not handle complicated feeding cases. This would allow facilities, if they choose, to train other facility employees as feeding assistants so that available staff can feed residents at mealtimes.

Facility Staff Shortages

Because of the shortage of certified nurse aides and the increasingly complex medical needs of residents, facilities in some States have used paid feeding assistants to supplement certified nurse aides to ensure that residents take in adequate food and fluids. Generally, feeding assistants used by these facilities are part-time workers, often retired individuals, or homemakers who are available for a few hours a day. They may also be older students who come into the facility between 1 and 2 hours either at the noon or evening meal. In other facilities,

staff shortages are so acute that all nonmedical employees, including the administrator of the facility, are required to complete training and help feed residents at mealtimes. Training facility personnel for functions other than their primary position is known as cross-training. There is anecdotal evidence that cross-training of personnel in nursing homes increases coordination and continuity of care.⁴ It also contributes to increased morale and lower staff turnover.

There is no provision in Federal regulations for the employment of nursing home workers who perform only a single task without completing 75 hours of nurse aide training. Currently, residents must be fed by a registered nurse, licensed practical nurse, or a nurse aide who has completed 75 hours of training and who has been certified as competent to perform all nurse aide tasks. Volunteers may also feed residents. The reason for this existing policy is to ensure that residents who cannot, or do not, feed themselves are fed by trained nursing staff. This is intended to protect residents from unskilled workers who might injure a resident by not recognizing serious medical complications associated with eating.

Wisconsin and North Dakota are two States in which nursing homes have had serious difficulty hiring enough certified nurse aides and have used feeding assistants as a supplement to certified nurse aides. Other States have expressed interest in using paid feeding assistants, including Ohio, Minnesota, Florida, California, and Illinois. Florida and Illinois have both passed laws that permit the use of single task workers in their States, but they have not yet implemented the provisions.

Wisconsin nursing homes have been using single-task feeding assistants for more than 7 years. Wisconsin uses a structured, formal program that requires a facility wanting to implement a feeding assistant program to submit an application for approval by the State. The classes are taught by a registered nurse, with a registered dietitian teaching the dietary elements of the program. A facility's approved program must include the following core areas: Interpersonal communication and social interaction; Basic nursing skills (including infection control); Personal care skills (assisting with eating, hydration); Basic restorative services (assistive devices for eating); Resident

¹ Stone, R.I. (2001) Frontline workers in long-term care: Research challenges and opportunities. *Generations*, 25(1), 40-57.

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

³ United States General Accounting Office. *Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides is a Growing Problem*. (Washington, DC., May 2001)

⁴ Stone, R.I., Reinhard, S.C., Bowers, B., Zimmerman, D., Phillips, C.D., Hayes, C., Fielding, J.A., and Jacobson, N. (2002). *Evaluation of the Wellspring Model for Improving Nursing Home Quality*.

rights; and special problems associated with Dementia (specialized feeding and intake problems). Participants who complete the training must demonstrate skills and pass a written test with a score of 80 percent or better. Feeding assistants are used solely for feeding residents who have no feeding complications. They are permitted to feed residents only in the dining room and operate under the direction of a registered nurse or licensed practical nurse. Feeding assistants serve to supplement care delivered by certified nurse aides, which frees up more extensively trained aides to perform more complex resident care tasks.

North Dakota has used paid feeding assistants for a number of years and has a slightly less formal program than that of Wisconsin. The residents to be fed are selected by the dietary and nursing staff. If a facility has a nurse aide training program, the training coordinator and dietitian work together to train new feeding assistants individually. After training and orientation, a new feeding assistant is assigned to one resident who needs minimal assistance. As the assistant gains skill and confidence, he or she is assigned to more residents at a meal or to a resident who requires a higher level of skill to feed. Typically, feeding assistants work only about 1½ hours per day, providing assistance at either the noon or evening meal.

Conclusion

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

II. Provisions of the Proposed Regulations

We proposed that feeding assistants must complete successfully a State-

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

We proposed that each facility that uses feeding assistants maintain a record of the individuals who have successfully completed the feeding assistance training. Facilities would be required to report to the State any incidents in which a feeding assistant has been found to neglect or abuse a resident, or misappropriate a resident's property. The State must then maintain a record of all reported incidents.

We proposed that a facility may use a paid feeding assistant to feed residents who do not have a clinical condition that would require the training of a nurse or nurse aide. Selection of residents to be fed would be made by the professional nursing staff, using the comprehensive assessment. Nurses or nurse aides would continue to feed residents who require the assistance of staff with more specialized training, such as those residents with recurrent lung aspirations, difficulty swallowing, or those residents on feeding tubes or parenteral/IV feedings. Feeding assistants would work under the direct supervision of registered nurses (RN) or licensed practical nurses (LPN), who are in the unit or on the floor where the feeding assistance is furnished. In proposed § 483.75(e), we revised the definition of "nurse aide" to clarify that paid feeding assistants are not performing nursing or nursing-related tasks.

Feeding assistants could be paid by the facility or paid under an arrangement with another agency or organization (§ 488.301). Facilities would be able to use staff who are not health care personnel as feeding assistants if they successfully complete the training program. This might include the administrator, activity staff, clerical, laundry, housekeeping staff, or others who see residents on a daily basis. However, feeding assistants are intended to supplement certified nurse

aides, not substitute for certified or licensed nursing staff.

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

III. Analysis of and Responses to Public Comments

We received over 6,000 public comments on the proposed rule. About 99 percent of commenters were overwhelmingly supportive of the proposal, but raised a large number of issues and offered many suggestions for clarifications and revisions to the final regulation. Commenters supporting the proposal included for-profit and not-for-profit nursing homes, national and State nursing home associations, national and State health care associations, State health and human services agencies, United States Congresspersons, and private citizens. Many beneficiary advocates and employee unions opposed giving facilities the option to use paid feeding assistants. A summary of the major issues and our responses follow.

Facility Option To Use Feeding Assistants

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

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

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

Response: Our review of the law indicates that there is nothing that would prohibit the use of feeding assistants and we believe that we have the authority and discretion under the law to implement this practice. Although commenters have focused on the language of the statute, at sections 1819(b)(5)(F) and 1919(b)(5)(F) of the Act that requires persons engaged in nursing or nursing related care to be trained either as a nurse or nurse aide, we do not consider the kinds of tasks facilities may ask feeding assistants to

provide as either nursing or nursing related. While feeding has been part of the nurse aide training curriculum, that requirement was predicated on the nurse aide having to tend to persons with pronounced eating complications (such as swallowing disorders) for which specialized training is essential. What facilities would be free to do as a result of this rule, however, is to use persons who have had a lesser level of training to assist residents who have no feeding issues that require any specialized attention. Thus, we do not consider feeding assistants who may be used by facilities under this rule to be engaged in nursing or nursing related activities.

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

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

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

Response: We are not aware of any data that would suggest that there is an

improvement in the quality of care when residents are helped to eat by feeding assistants, nor are we aware of any data that would suggest a decline in quality of care. We are relying on support for the use of paid feeding assistants that has been provided by the Wisconsin and North Dakota survey agencies. Neither agency has indicated that use of feeding assistants has resulted in diminished quality of care.

Comment: A few commenters recommended that we prohibit a facility from training feeding assistants when it has certain deficiencies, in the same way we currently prohibit a facility from training nurse aides. For example, commenters suggested that we prohibit facilities from training feeding assistants if the facility has (1) any deficiency at level F or above; (2) a deficiency at any level in the area of nutrition, staffing, and residents' rights; (3) imposed against it a per instance civil money penalty (CMP) of \$5,000 or more, a per day CMP of \$5,000 or more cumulatively, a State monitor, or temporary manager; (4) an approved nurse-staffing waiver.

Several consumer advocacy groups recommended that we limit the authority for a facility to use feeding assistants to facilities that are authorized to conduct nurse aide training programs. In other words, if a facility loses the right to train nurse aides, it should also lose the right to train feeding assistants. Many providers took the opposite position, that a facility that loses nurse aide training rights should retain the right to train feeding assistants.

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

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

Comment: Many commenters said that they did not want us to limit hours worked by feeding assistants to mealtimes and advocated permitting feeding assistants to work whenever

needed by a facility. Some facilities thought that feeding assistants could be used full time to provide snacks and liquids to residents, particularly those who cannot leave their room. These commenters believed that this would be a good way to reduce the potential for dehydration since assistants would have time to deliver liquids, provide social stimulation, and encourage bedfast residents to drink more fluids.

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

Comment: Many providers and individuals expressed strong support for the use of existing staff as feeding assistants, after proper training. A large number of providers reported that they favor this because existing staff, such as clerical, dietary, and housekeeping staff, are already trained in facility policies, are usually well acquainted with residents, and have time available to devote to feeding residents.

A number of other commenters were opposed to using existing staff as feeding assistants, citing their full-time responsibilities and concern about added burden.

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

Comment: Some commenters suggested requiring that facilities assign feeding assistants to certain residents to ensure continuity of care.

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

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

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

ensure that a feeding assistant receives proper training.

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

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

Comment: Two senators and one congressman wrote in support of the proposal, noting the success of one state that used feeding assistants and experienced reduced weight loss and dehydration among nursing home residents. These commenters also reported that the Board of Nursing of one state had defined feeding as a nursing task and was concerned that this might prevent the state from using feeding assistants. (In the proposal, we indicated that feeding assistants would not be performing nursing or nursing-related tasks.) Another commenter believed that feeding is a nursing-related service and should not be performed by an individual with minimal training.

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

Staffing Issues

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

Response: We believe that facilities that request to use or use feeding assistants should be surveyed in the same way as any other facility. Surveyors should use the investigative protocol for staffing only when systemic problems relate to insufficient nursing staff.

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

Response: A provision in the Medicare, Medicaid & State Child Health Insurance Program (SCHIP) Benefits Improvement & Protection Act of 2000 (BIPA) requires facilities to post daily for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. This provision is effective January 1, 2003. Because paid feeding assistants do not qualify as licensed or unlicensed nursing staff, facilities do not need to post the numbers of feeding assistants used by the facility. However, we will consider at a later date whether this might be useful and what additional burden it may impose on facilities.

With regard to name tags, we believe it is probably a good idea, but leave that decision to each facility and do not see the need for us to make this a requirement.

Use of Volunteers

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

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

Payment Issues

Comment: Some providers were concerned about how they would be

paid for the training and services of feeding assistants. A few commenters recommended that we allocate payment for feeding assistants to the nursing cost center.

Response: Skilled nursing facilities will not receive additional Medicare payment for the costs of using feeding assistants. Medicare payment for residents in skilled nursing facilities is made through a prospective payment system, which covers all costs (routine, ancillary, and capital) of covered skilled nursing facility services furnished to beneficiaries under Part A of the Medicare program. For Medicare payment, the term and concept, "nursing cost center," is outdated, but still may be used in some State Medicaid programs. The Medicare SNF PPS per diem payment rate is based, in part, on levels of care and resources required and received by residents, established by the resident assessment instrument specified in § 483.20. The system does not require that tasks performed by a staff person fit within a direct care or indirect care category (such as a nursing cost center).

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

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

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

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

Determining Which Residents Can Be Fed by Feeding Assistants

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

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

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

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

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

Response: We believe that the clinical decisions as to which residents may be fed by feeding assistants are best left to the professional judgment and experience of RNs and LPNs who work in the facility and have personal knowledge of a resident's day-to-day condition. If we were to define clinical conditions, we would only be substituting the judgment of

professional nurses employed by the Federal government for the judgment of nurses working in facilities. We believe that professional nurses conclude that certain clinical conditions relating to eating and drinking would require the skills and knowledge of an RN or LPN. These conditions include, but are not limited to, recurrent lung aspirations, difficulty swallowing, and tube or parenteral/IV feedings.

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

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

Supervision

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

Response: Facilities are required by § 483.30, Nursing services, to have sufficient qualified nursing staff available on a daily basis to meet residents' needs for nursing care. The requirement in § 483.30, Nursing services, is that, unless waived, a facility must have a RN on duty 8

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

However, we recognize that the supervision requirement is unclear and subject to a variety of interpretations. Therefore, we are revising § 483.35(h)(2) by removing the word, "direct" from the phrase, "direct supervision," because it may unintentionally imply visual contact between a feeding assistant and a supervisory nurse. This is not possible in most facilities, especially if assistants are feeding residents in their rooms. Next, we are removing the requirement that a nurse be in the unit or on the floor where the feeding assistance is furnished and immediately available to give help. As commenters noted, this sentence is unclear. While we are not prescribing the precise means by which facility RNs or LPNs assert their supervisory responsibilities, we will expect that facilities do so in a way that avoids negative outcomes for their residents. Additionally, we are requiring that a feeding assistant call a supervisory nurse on the resident call system when there is an emergency or a need for help. All facilities are currently required to have a resident call system.

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

Response: We share commenters' concerns about adequate supervision of feeding assistants to ensure the safety of residents. We are equally concerned, however, that those residents who are

unable or unwilling to go to a congregate dining area receive needed feeding assistance in their rooms. We are confident that the nurse in charge, using his or her professional judgment in assessing residents who are appropriate for feeding assistance, will be able to select residents who can safely be fed in their own rooms.

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

Response: Adequate supervisory staff is just one factor that a facility needs to consider when deciding whether or not to use feeding assistants. If a facility chooses to use paid feeding assistants, it would be the facility's responsibility to ensure that it has sufficient RNs and LPNs available to adequately supervise feeding assistants without adding undue burden on the staff. When using feeding assistants, there will be a need for a facility to balance the increase in staff available to meet resident needs with the increased need to supervise these assistants.

Training

State-Approved Training Course

Comment: Several providers asked whether facilities would be able to hire paid feeding assistants if the State does not approve a training program for feeding assistants. Many providers supported giving facilities maximum flexibility to implement the proposal without lengthy state approval requirements. One commenter suggested that we require all states to mandate feeding assistant programs in all facilities.

Other commenters believed that, before facilities may opt to use feeding assistants, States should be able to decide whether implementing feeding assistant programs is in the best interest of the State or consistent with State law.

Several providers, provider organizations, and States asked that we remove the requirement that a training course for feeding assistants be State approved, citing potential burden on States, cost, and delays in implementing feeding programs. One State with a large number of facilities and a shortage of resources was concerned about the potential burden of approving a large number of feeding programs.

Commenters, instead, suggested that we require that an individual complete a training course that meets the requirements of § 483.160. In this case, the facility would maintain documentation of compliance with the requirements and surveyors would review the training records at annual surveys.

Many states and providers asked for clarification on our expectations in terms of state approval. They wondered whether other entities, such as community colleges, would be permitted to offer the training. One commenter noted that travel to community colleges and cost would discourage individuals from taking the training. There was also a question about the frequency with which a state would need to review or reapprove a feeding assistant program. Another commenter suggested that we offer more specific guidance to states to assist them in establishing criteria for training programs and others suggested using established models from Wisconsin and North Dakota.

Response: We have chosen to retain the requirement that States approve training programs for feeding assistants. We believe that this will give States the necessary control and flexibility to structure approval processes for training programs to fit the needs of each State. States that have large numbers of facilities and resources that are stretched to the limit may want to minimize any burden associated with State approval of training programs, while States with fewer facilities may structure approval in a very different way.

However, States also have the flexibility not to implement a program for approval of feeding assistant training programs. If a State does not implement an approval program, the result is that facilities in that State will not be able to hire any paid feeding assistants.

Training Content

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

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

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

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

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

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

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

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

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

emphasize the need for a feeding assistant to call for help immediately, and then, if necessary, begin a procedure like the Heimlich.

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

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

Comment: Commenters suggested a number of additions to the general training requirements. One suggestion was to require that training programs explicitly include feeding problems of the cognitively impaired, since 80–70 percent of nursing home residents are cognitively impaired. Other suggestions included training in dementia, food and drug interactions, diet consistencies, how much and how to feed, resident preferences, difficulty swallowing, and emphasis on performing only feeding tasks for which training has been provided. A consistent concern of commenters was a need for a training emphasis on recognition and prevention of emergency situations associated with feeding, such as dysfunctional swallowing, tracheal aspiration, esophageal obstruction, and other potentially severe emergency situations.

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

Comment: Several commenters suggested that we address payment for training in the same way that we do in the regulations for nurse aides. One commenter asked that we prohibit facilities from charging potential feeding assistants for training. Another asked if a facility may require that a trained feeding assistant repay the facility for training if he or she leaves? A commenter asked if a facility can require that a trained feeding assistant work for a set period of time.

Response: Judging from provider comments received, there will be a strong demand for feeding assistants and it is unlikely that facilities will

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

Qualifications of Instructors

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

Several commenters strongly recommended that we prohibit feeding assistants from teaching each other on-the-job.

Response: It is apparent that a number of options are available in terms of the variety of licensed or certified health care professionals that may be qualified to conduct training for feeding assistants. Some, RNs and LPNs, are employed full time in facilities and would be available without additional cost to conduct the training. Dietitians may be employed by a facility full time, part time, or on a consultant basis. Other health care professionals may be available at additional cost; however we believe that it would be inappropriate to permit a feeding assistant to train another. Consistent with the flexibility for States to develop a State-approved training program, we are deferring to States the decision as to which individuals would be qualified to teach the feeding assistant training.

Maintenance of Records

Comment: Several commenters pointed out that there is no requirement

for states to maintain a formal registry of feeding assistants or to check with other states for background information. One commenter suggested that states report information on feeding assistants to the nurse aide registry and provide this information to facilities for hiring purposes. Others suggested that we require facilities to check with the nurse aide registry before employing individuals as feeding assistants in case the individual had worked as a nurse aide previously.

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

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

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

Reporting Abuse, Neglect, and Misappropriation of Residents' Property

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

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

Response: We agree with the commenter regarding requirements in proposed § 483.160(c). Paragraph (c) is unnecessary because it repeats certain provisions of existing § 488.335. Since § 488.335 already establishes state requirements for review of allegations of neglect, abuse, misappropriation of property, and procedures for investigation of complaints and hearings, we are removing proposed paragraph (c) in § 483.160.

Definition of Paid Feeding Assistant

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

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

IV. Provisions of the Final Regulations

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

- We are reorganizing and revising § 483.35(h) so that paragraph (h)(1) applies to State approval of training courses for feeding assistants. We are adding the requirement that a feeding

assistant must successfully complete a State-approved training course, and do so before feeding residents.

- Also, in revised § 483.35(h)(1), we are clarifying that a facility may use a paid feeding assistant if it is consistent with State law.

- In revised § 483.35(h)(2), we are revising the supervision requirement to remove the word, "direct," from the phrase, "direct supervision."

- Also, in revised § 483.35(h)(2), we are removing the requirement that a supervisory nurse be in the unit or on the floor where the feeding assistance is furnished and is immediately available to give help, if necessary. In place of that sentence, we are adding the requirement that a feeding assistant call a supervisory nurse for help during an emergency on the resident call system.

- In revised § 483.35(h), we are adding a new paragraph (3) concerning resident selection criteria to replace proposed § 483.35(h)(1)(ii). In new paragraph (3), we are replacing the term, "clinical condition" with the phrase, "complicated feeding problem."

- In § 483.35, we also specify that a complicated feeding problem includes, but is not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.

- Also, in § 483.35, we provide that a facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.

- In § 483.160(a), we are adding a requirement that the State-approved training course include a minimum of 8 hours of training covering the topics listed in § 483.160(a).

- In § 483.160(c), we are removing the requirement that a facility report to the State all incidents of a paid feeding assistant who has been found to neglect or abuse a resident, or misappropriate a resident's property, and that a State must maintain a record of all reported incidents. This paragraph unnecessarily duplicates existing requirements in § 488.335, Action on complaints of resident neglect and abuse, and misappropriation of resident property.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-day notice in the *Federal Register* and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether OMB should approve an information collection, section 3506(c)(A) of the Paperwork Reduction

Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Nursing homes in two States currently use feeding assistants and eight other States have expressed an interest in implementing this policy. While public comments from nursing homes and provider organizations indicated strong support for the use of feeding assistants, only 13 States responded to the proposal. Some States indicated interest and others had concerns about the cost of implementation and other issues, so we do not now have a better idea of how many States will choose to approve the use of feeding assistants in nursing homes. In addition, it remains a facility option, so we still do not know how many facilities in which States will choose this option, nor do we know how many feeding assistants would be used by each facility. There are approximately 17,000 nursing homes in the nation, and they are not evenly distributed within States. Wisconsin reported that about 25 percent of nursing homes in the State used feeding assistants. On a nationwide basis, we believe that it is reasonable to project that 20 percent of facilities will use feeding assistants. We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements:

Section 483.160(b)

1. Requirement

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

2. Burden

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

keeping system. Some months, facilities may have no information to add. With 3,400 facilities at 8 hours/year, the total would be 20,400 hours for facilities. Using a clerical wage cost of \$10 per hour, the total facility burden is estimated to be \$204,000.

We are submitting a copy of regulation § 483.180 to OMB for its review of the information collection requirements. The revision is not effective until OMB has approved it.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following addresses:

Centers for Medicare & Medicaid Services, Office of Information Services, Information Technology Investment Management Group, Attn.: Julie Brown, Room C5-18-03, 7500 Security Boulevard, Baltimore, MD 21244-1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, CMS Desk Officer.

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

VI. Regulatory Impact Statement

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 18, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). This rule is not a major rule. The costs of using feeding assistants will be covered by existing Medicare payment and, most likely Medicaid payment, depending on how a State establishes payment rates. Skilled nursing facilities receive an all-inclusive per diem Medicare payment rate for each resident's care. This includes all costs (routine, ancillary, and capital) of covered skilled nursing facility services

furnished to beneficiaries under Part A of the Medicare program. Skilled nursing facilities will not receive additional Medicare payment for the costs of using feeding assistants.

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

State costs associated with feeding assistant training programs are considered administrative expenses and are funded under Medicaid with matching funds at 50 percent Federal financial participation. Any information we have on potential State costs of implementing feeding assistant programs comes from States that have used such programs in the past. One State, Wisconsin, has a well-structured program and has experienced relatively minimal costs. One registered nurse spends approximately 10 percent of her time reviewing and approving facility feeding assistant training programs. This represents 10 percent of a full-time equivalent position (FTE), which is reported by Wisconsin to be a cost of about \$7,000 per year. At a time when the use of feeding assistants was highest, a quarter of Wisconsin's 420 nursing homes, or 100 to 110 facilities, used feeding assistants. The number of feeding assistants used by each facility varies according to the size of the home, with the maximum number estimated to be 5 for a large, 200- to 250-bed home. Feeding assistants are typically paid at the same minimum wage. The number of hours each feeding assistant works at a facility is also variable and different for each worker and facility. Further, some facilities use only existing staff as trained feeding assistants. Because of the number of hours worked by each feeding assistant is variable, we do not have an exact estimate of the total cost to Wisconsin for using feeding assistants. However, this summary of Wisconsin's program may be helpful to other States, which are interested in establishing feeding assistant programs.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small

government jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$6 to \$29 million in any 1 year. For purposes of the RFA, all long-term care facilities are considered to be small entities. Individuals and States are not included in the definition of a small entity. The Small Business Administration considers 62 percent of long term care facilities to meet their definition of small entity (those facilities with total revenues of \$11.5 million or less in any 1 year). We have determined that this rule will affect these entities, but, in general, we expect any cost to be covered by Medicare and Medicaid program payments.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. This final rule does not affect small rural hospitals.

For these reasons, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined that this rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$110 million. This final rule will not have a cost greater than \$110 million on the governments mentioned or on the private sector. In general, we believe that existing Medicare and Medicaid payments will cover the facility costs of using feeding assistants. Costs associated with surveys of long term care facilities are Federally funded, as are costs of State approval of training programs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We believe that this rule contributes to State flexibility by giving States the option to allow the use of feeding

assistants, control over how to structure the process of the approval of facility feeding assistant programs, and over elements of training, including instructor qualifications. In this way, States can establish policies that fit their unique circumstances. We believe that this rule will not have a substantial effect on State or local governments.

B. Anticipated Effects

These provisions will affect long term care facilities. We expect the provisions to be a substantial benefit both to facilities that are short-staffed and to residents who need help with eating and drinking. By using feeding assistants to help residents with eating and drinking, facilities can use trained, certified nurse aides to perform other, more complex resident care tasks.

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

State-Approved Training Programs

We require that a feeding assistant successfully complete an 8-hour State-approved training course, which meets the Federal requirements in § 483.160(a). We have established no requirements on how States are to approve these programs, thereby giving each State the flexibility to decide what method makes the most sense in terms of use of its resources. There are several ways in which States may approach approval of training programs. States might choose to develop a model training program that complies with Federal requirements and require that any facility that trains and uses feeding assistants use that specific program. One model might be based on an existing training program already established, such as those conducted in Wisconsin

or North Dakota. A State might choose to do a paper review of each facility's training program, or the State might insist on a site visit to review a facility's program. Lastly, a State might initially deem each facility's training program approved and then review the program when the facility is next surveyed. For some of these options, a State may need additional staff hours to review and approve training programs. However, States already review and approve training programs for nurse aides, so there is an existing administrative structure in place. There is the potential for increased State costs associated with review and approval of facility feeding assistant programs. However, any cost will depend on the approval method that is chosen by each State.

1. Effects on the Medicare and Medicaid programs.

There are approximately 17,000 facilities nationally. Long term care facilities that participate in the Medicare and Medicaid programs must provide the necessary care and services to residents so that they attain or maintain the highest practicable physical, mental, and psychosocial well being. To do this, facilities must employ sufficient staff on a 24-hour basis, including nursing staff, administrative, medically-related social services, dietary, housekeeping, and maintenance staff.

The Medicare program pays for skilled nursing facility services to eligible beneficiaries through a prospective payment system that covers all costs of covered services furnished to residents on a per diem basis. This Medicare SNF PPS per diem payment rate is based, in part, on levels of care and resources required and received by residents. The payment rate covers all care required and received by a resident and does not require that tasks performed by a staff person fit within a direct or indirect care category. Therefore, the Medicare program would not pay a skilled nursing facility any additional funds if the facility chooses to use feeding assistants.

Medicaid payments for nursing facilities are established by each State. Therefore, it would be up to individual States to determine whether they would need to change their payment rates for those facilities that use feeding assistants and how the rates would be changed.

C. Alternatives Considered

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

majority of resident care in a long term care facility and are the lowest paid workers, while RNs and LPNs receive higher wages commensurate with their advanced training, experience, and supervisory responsibilities.

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

D. Conclusion

We believe that both residents and providers will benefit from these provisions. Residents will receive more assistance with eating and drinking, both at meals and at snack time. Facilities will be able to use existing staff to assist at mealtimes and hire additional staff to meet the needs of residents, freeing certified nurse aides to perform more complex tasks that require their training.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 483

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

42 CFR Part 488

Health facilities, Medicare, Reporting and recordkeeping requirements.

3

**FEDERAL
REGULATIONS**

■ 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 4120-02-U

LEGAL SERVICES CORPORATION

45 CFR Part 1626

Alien Eligibility for Representation by LSC Programs

AGENCY: Legal Services Corporation.

ACTION: Final rule.

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

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

FOR FURTHER INFORMATION CONTACT: Mattie C. Condray, Senior Assistant General Counsel, Legal Services Corporation, 3333 K Street, NW., Washington, DC 20007-3522; (202) 295-1824; 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

4

**STATE
REGULATIONS**

902 KAR 20:390. Paid Feeding Assistants

RELATES TO: KRS 194A.050, 216.532, 216.789, 216.936, 216B.040, 314.011(5), (9), 42 C.F.R. 483.75(q), 483.160, 488.301

STATUTORY AUTHORITY: KRS 194A.050(1), 216B.042(1), 216B.075, 42 C.F.R. 483.35(h)

NECESSITY, FUNCTION AND CONFORMITY: KRS 216B.042(1) requires the Cabinet for Health and Family Services to establish licensure standards to ensure safe, adequate and efficient health care facilities. KRS 216B.075 requires the cabinet to promulgate administrative regulations respecting application and review procedures to comply with any federal laws and regulations promulgated thereunder. 42 C.F.R. 483.35 (h) authorizes the state agency to develop an approved training and practical skills program that establishes standards for paid feeding assistants and mandates supervision by a registered nurse or licensed practical nurse. This administrative regulation establishes certification requirements for the employment of paid feeding assistants in licensed nursing facilities and skilled nursing facilities to assist residents who only need encouragement or minimal assistance during mealtime.

Section 1. Definitions.

(1) "Complicated feeding problem" means a condition that requires supervision and assistance by a licensed nurse or certified nurse aide and includes:

- (a) Difficulty with swallowing;
- (b) Recurrent lung aspiration;
- (c) Assistance through tube or parenteral/IV feedings; or
- (d) Any other condition requiring the assistance of a licensed nurse or a certified nurse aide.

(2) "Licensed practical nurse" is defined by KRS 314.011(9).

(3) "Nursing facility" means a facility that is licensed under 902 KAR 20:300.

(4) "Paid feeding assistant" means a person who has completed the training and received a satisfactory score on the examination required by this administrative regulation and is employed or contracted by a nursing facility or skilled nursing facility to provide feeding assistance to a resident who does not have a complicated feeding problem.

(5) "Registered nurse" is defined by KRS 314.011(5).

(6) "Skilled nursing facility" means a facility that is licensed under 902 KAR 20:026.

Section 2. Use of a paid feeding assistant.

(1) A licensed nursing facility or skilled nursing facility may employ a paid feeding assistant on a full- or part-time basis to assist with feeding a resident who shall:

(a) Not have a complicated feeding problem; and

(b) Be approved to receive the assistance based on the charge nurse's assessment and the most recent resident assessment and plan of care.

(2) A paid feeding assistant shall:

(a) Have successfully completed the training established in Section 3 of this administrative regulation;

(b) Have received orientation from the facility employing the paid feeding assistant that covers the following facility-specific areas:

1. Confidentiality of resident care and records;

2. Monitoring resident nutrition intake and output;

3. Emergency procedures;

4. Specific needs of the resident who will be assisted;

5. Use of the facility's emergency call system; and

6. Laws pertaining to resident abuse, neglect and exploitation of a resident's property;
 - (c) Work under the supervision of a registered nurse or licensed practical nurse; and
 - (d) Not be employed if employment is prohibited by KRS 216.532, 216.936, or 216.789.
- (3) In a medical emergency involving a resident who is being assisted by a paid feeding assistant, the paid feeding assistant shall immediately utilize the resident call system to summon the assistance of a supervisory nurse.
- (4) Before a facility employs a paid feeding assistant who received training from another individual or entity, the facility shall:
 - (a) Contact the individual or entity that provided the training and document verification that the feeding assistant successfully completed the training required by Section 3 of this administrative regulation;
 - (b) Require the feeding assistant to retake and successfully pass the written and skills competency test; and
 - (c) Issue the feeding assistant a new certificate of training.
- (5) The facility shall maintain a current list of residents who are approved to receive feeding assistance from a paid feeding assistant.
- (6) A feeding assistant who is seeking employment and who has not been employed during the prior two (2) years as a paid feeding assistant shall be required to repeat and successfully complete the training and pass the examination before assisting a resident with feeding.
- (7) A facility shall provide quarterly in-service training for paid feeding assistants concerning:
 - (a) Amendments to this administrative regulation; and
 - (b) Changes in pertinent facility policies and procedures.

Section 3. Training Program.

- (1) A paid feeding assistant shall receive a minimum of eight (8) hours training in the current version of the curriculum published by the Cabinet for Health and Family Services, Office of Inspector General, entitled "Kentucky Paid Feeding Assistant Manual".
- (2) Review of all curriculum material, a score of seventy-five (75) percent or greater on the written examination, and a score of one hundred (100) percent on the skills competency test established in the curriculum shall be required to successfully complete the paid feeding assistant training.
- (3) The training shall include information on:
 - (a) Feeding techniques;
 - (b) Assistance with feeding and hydration;
 - (c) Communication and interpersonal skills;
 - (d) Appropriate responses to resident behavior;
 - (e) Safety and emergency procedures, including the Heimlich maneuver;
 - (f) Infection control;
 - (g) Resident rights; and
 - (h) Recognition of changes in the condition of a resident which are inconsistent with the resident's normal behavior and the importance of reporting changes to a supervisory nurse.
- (4) The training shall be conducted by:
 - (a) A registered nurse; or
 - (b) A licensed practical nurse working under the supervision of a registered nurse.
- (5) Before conducting paid feeding assistant training, the nurse shall:
 - (a) Read the "Kentucky Paid Feeding Assistant Manual";

- (b) Complete the instructor assessment in Section 15 of the “Kentucky Paid Feeding Assistant Manual”; and
 - (c) Complete the instructor attestation form in Section 15 of the “Kentucky Paid Feeding Assistant Manual”.
- (6) A person who has successfully completed training and passed the examination shall be issued a certificate of training as established in Section 15 of the “Kentucky Paid Feeding Assistant Manual”.
- (7) A facility shall maintain a record of training and certification for all persons employed by the facility as paid feeding assistants.
- (a) The documentation shall include:
- 1. Name and social security number of the person trained;
 - 2. Name of the person who conducted the training;
 - 3. Test scores of the written and skills competency tests;
 - 4. Date of training;
 - 5. Duration of training;
 - 6. Location of training; and
 - 7. Documentation of the successful completion of the training course for paid feeding assistants.
- (b) A complete and accurate copy of the training and certification records pertaining to each paid feeding assistant employed by the facility shall be maintained on site and be available for inspection by representatives from the Office of Inspector General, and shall be maintained for at least three years following the last day of the paid feeding assistant’s employment.

Section 4. Incorporation by Reference.

(1) Kentucky Paid Feeding Assistant Manual, April 2004 edition, is incorporated by reference.

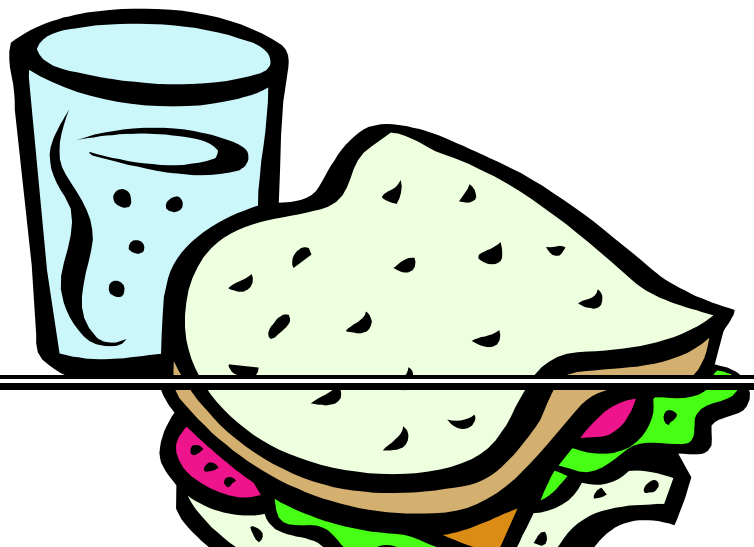
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5

FOOD AND WATER

WHAT YOU WILL LEARN

- **Physical Needs**
- **Food Groups**
- **Vitamins**
- **Factors that affect eating and nutrition**
- **OBRA dietary requirements**
- **Special diets**
- **Fluids**
- **Intake records**



Physical Needs



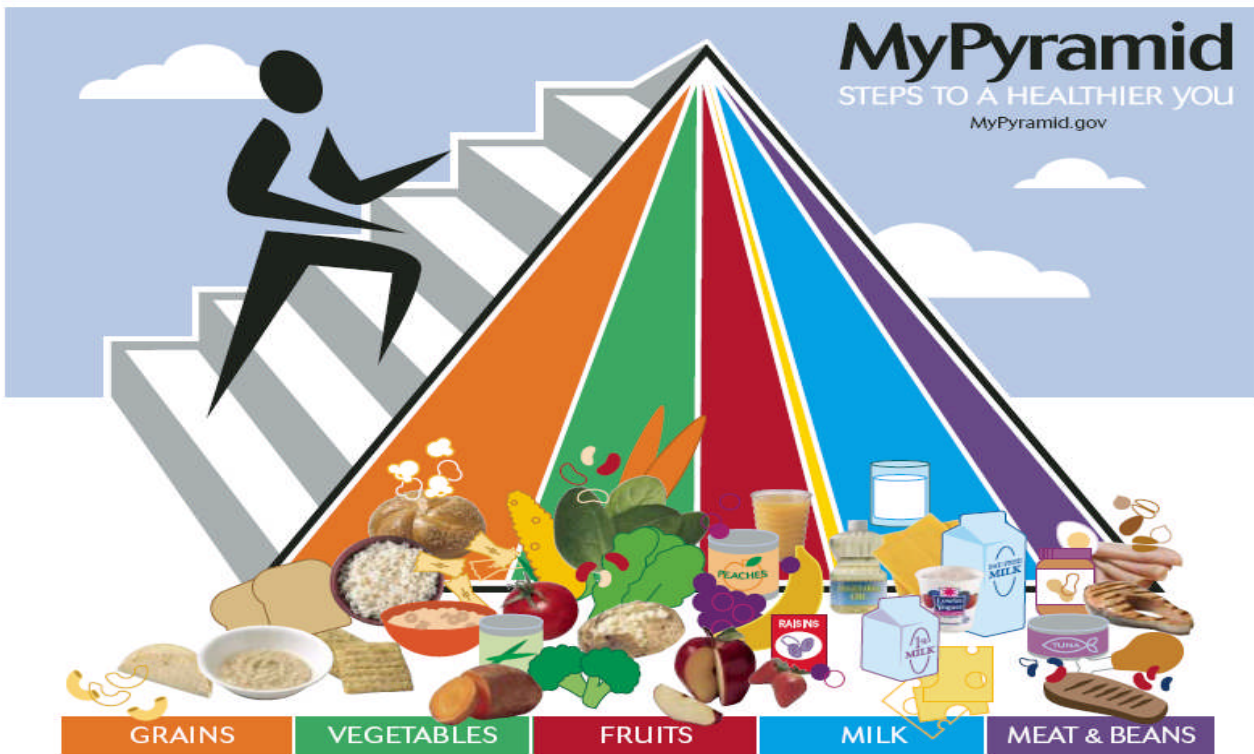
Food and water are physical needs. They are necessary for life. The amount and quality of the food and fluids in the diet affect physical and mental well being. Older and disabled residents may have special dietary needs. A poor diet or poor eating habits can increase the risk of infection, increase the risk for chronic illnesses, cause healing problems and cause changes in physical and mental function that can lead to an increased risk for accidents and injuries.

Eating and drinking provide pleasure. They often are a part of social times with family and friends. A friendly, social setting for meals is important. People may eat poorly when eating alone or in an unpleasant setting.



Many factors affect dietary practices including culture, finances and personal choice. Dietary practices also include selecting, preparing and serving food. The health care team considers these factors when planning to meet the resident's nutritional needs.





MyPyramid

STEPS TO A HEALTHIER YOU
MyPyramid.gov

GRAINS Make half your grains whole	VEGETABLES Vary your veggies	FRUITS Focus on fruits	MILK Get your calcium-rich foods	MEAT & BEANS Go lean with protein
<p>Eat at least 3 oz. of whole-grain cereals, breads, crackers, rice, or pasta every day</p> <p>1 oz. is about 1 slice of bread, about 1 cup of breakfast cereal, or 1/2 cup of cooked rice, cereal, or pasta</p>	<p>Eat more dark-green veggies like broccoli, spinach, and other dark leafy greens</p> <p>Eat more orange vegetables like carrots and sweetpotatoes</p> <p>Eat more dry beans and peas like pinto beans, kidney beans, and lentils</p>	<p>Eat a variety of fruit</p> <p>Choose fresh, frozen, canned, or dried fruit</p> <p>Go easy on fruit juices</p>	<p>Go low-fat or fat-free when you choose milk, yogurt, and other milk products</p> <p>If you don't or can't consume milk, choose lactose-free products or other calcium sources such as fortified foods and beverages</p>	<p>Choose low-fat or lean meats and poultry</p> <p>Bake it, broil it, or grill it</p> <p>Vary your protein routine – choose more fish, beans, peas, nuts, and seeds</p>

For a 2,000-calorie diet, you need the amounts below from each food group. To find the amounts that are right for you, go to MyPyramid.gov.

Eat 6 oz. every day	Eat 2 1/2 cups every day	Eat 2 cups every day	Get 3 cups every day; for kids aged 2 to 8, it's 2	Eat 5 1/2 oz. every day
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Find your balance between food and physical activity

- Be sure to stay within your daily calorie needs.
- Be physically active for at least 30 minutes most days of the week.
- About 60 minutes a day of physical activity may be needed to prevent weight gain.
- For sustaining weight loss, at least 60 to 90 minutes a day of physical activity may be required.
- Children and teenagers should be physically active for 60 minutes every day, or most days.

Know the limits on fats, sugars, and salt (sodium)

- Make most of your fat sources from fish, nuts, and vegetable oils.
- Limit solid fats like butter, stick margarine, shortening, and lard, as well as foods that contain these.
- Check the Nutrition Facts label to keep saturated fats, trans fats, and sodium low.
- Choose food and beverages low in added sugars. Added sugars contribute calories with few, if any, nutrients.



U.S. Department of Agriculture
Center for Nutrition Policy and Promotion
April 2005
CNPP-15

USDA is an equal opportunity provider and employer.

Vitamins

Vitamin	Major Function	Sources
A	Growth, vision, healthy hair, skin, mucous membranes, resistance to infection.	Liver, spinach, green leafy vegetables, yellow vegetables, yellow fruits, fish liver oils, egg yolks, butter, cream and milk.
B1 Thiamin	Muscle tone, nerve function, digestion, appetite, normal elimination, carbohydrate use.	Pork, fish, poultry, eggs, liver, bread, pasta, cereal, oatmeal, potatoes, peas, beans, soybeans, peanuts.
B2 Riboflavin	Growth, healthy eyes, protein and carbohydrate use, healthy skin and mucous membranes.	Milk and milk products, liver, green leafy vegetables, eggs, bread and cereal.
B3 Niacin	Protein, fat and carbohydrate use, nervous system function, appetite, digestive system function.	Meat, pork, liver, fish, peanuts, breads and cereals, green vegetables, dairy products.
B12	Formation of red blood cells, protein use, nervous system function.	Liver, meats, poultry, fish, eggs, milk, cheese.
Folic Acid	Formation of red blood cells, functioning of the intestines, protein use.	Liver, meats, fish, poultry, green leafy vegetables, whole grains.
C Ascorbic Acid	Formation of substances that hold tissues together, healthy blood vessels, skin, gums, bones and teeth. Wound healing, resistance to infection.	Citrus fruits, tomatoes, potatoes, cabbage, strawberries, green vegetables, melons.
D	Absorption of calcium and phosphorous, healthy bones.	Fish liver oils, milk, butter, liver, exposure to sunlight.
E	Normal reproduction, formation of red blood cells, muscle function.	Vegetable oils, milk, eggs, meat, cereals, green leafy vegetables.
K	Blood clotting	Liver, green leafy vegetables, egg yolk, cheese.

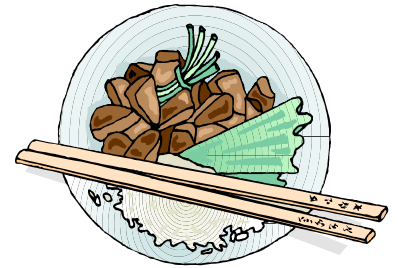
Factors That Affect Eating and Nutrition



Meeting a resident's nutritional needs requires a team approach. The Doctor, Dietician, Nurse, Speech/Language Pathologist, Occupational Therapist and Nursing Assistant are all involved. They develop and carry out the nutritional care plan. The resident is always part of the team and sometimes the family is even involved. The resident's likes/dislikes and lifelong habits must be considered. Some of these began during infancy, while others developed later in life.

Food Practices

Culture and religion can influence dietary practices, food preparation and choices. A resident may follow all, some, or none of the dietary practices of his or her faith. You must respect the resident's religious practices. Food preferences may vary among cultural groups. Rice and beans are mainstays in Mexico. Rice is also common in the Philippines. It is preferred with every meal. Eating beef is common in the United States, but in India, eating beef is forbidden.



Appetite

Appetite relates to the desire for food. When hungry, a resident seeks food. He or she eats until the appetite is satisfied. Aromas and thoughts of food can stimulate the appetite.

Appetite continued

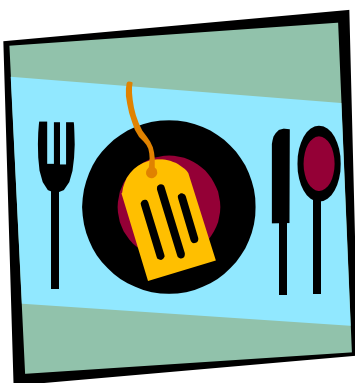
Loss of appetite, illness, drugs, unpleasant thoughts or sights, anxiety, pain and depression can cause anorexia. Decreased senses of taste and smell can cause loss of appetite in older residents. Appetite also usually decreases during illness and recovery from injury. However, nutritional needs increase at these times. The body must fight infection, heal tissue and replace lost blood cells. Other factors that can affect appetite are tooth and mouth pain, which may make eating painful.



Aging

With aging, changes occur in the gastrointestinal system. These changes can include:

- Dysphagia, or difficulty swallowing. Dysphagia can be caused by stroke, dementia, or other nervous system disorders.
- Diminished sense of taste and smell
- Decreased appetite
- Decreased secretion of digestive juices. This can make certain foods difficult to digest, causing discomfort.



Older residents need fewer calories than younger people do. Energy and activity levels are lower. Foods high in Calcium help prevent musculoskeletal changes. Protein is needed for tissue growth and repair. The diets of some older residents may be lacking in protein because high protein foods are often expensive.

OBRA Dietary Requirements

In 1987 the U.S. Congress passed the Omnibus Budget Reconciliation Act (OBRA). It is a federal law that requires that a facility provide care in a manner and in a setting that maintains or enhances each resident's quality of life, health and safety. OBRA has requirements for food served in long term care facilities.

These requirements are:

1. Each resident's nutritional and special needs are met.
2. The resident's diet is well balanced. It is nourishing and tastes good. Food is well seasoned, not too salty or sweet.
3. Food is appetizing and attractive with a pleasant aroma.
4. Hot food is served hot and cold food is served cold. Food servers keep food at the proper temperatures.
5. Food is served promptly.
6. Food is prepared to meet each resident's needs. Some people need food cut, ground or chopped. Others have special diets ordered by their doctor.
7. Each resident receives at least three meals per day. A bedtime snack is offered.
8. The facility provides any special eating equipment and utensils that are needed (adaptive equipment). Disease or injury can affect the hands, wrists or arms. Adaptive equipment lets the resident eat independently. Always make sure the resident has any adaptive equipment that they require.

Special Diets

Doctors may order special diets (therapeutic) for a nutritional deficiency or disease. They may also order them for weight control or to eliminate or decrease certain substances from the diet. Sometimes changes in the food texture are needed. Residents with swallowing difficulties may need to have the thickness of their food changed. Others may need to have their food pureed. A “regular diet”, “house diet”, or “general diet” means that the resident has no dietary restrictions. Some examples of therapeutic diets are the Sodium Controlled Diet and the Diabetic Diet.

Sodium Controlled Diet

Heart, liver and kidney disease, high blood pressure and some medications may require a sodium-controlled diet. Sodium causes the body to retain water. If there is too much sodium in the diet, the body retains water, causing additional fluid in the blood vessels. This extra fluid causes the heart to have to work harder. In residents with heart disease, this extra workload on the heart can cause serious problems. The doctor determines the amount of sodium restriction.

Diabetic Diet

Diabetes is a chronic disease characterized by a lack of insulin in the body. Insulin is produced by the pancreas and helps the body’s cells use sugar for energy. Without insulin, sugar builds up in the bloodstream. The cells are not able to use the sugar. Diabetes is treated with a combination of insulin or other drugs, diet and exercise. If a resident has diabetes, they must have their meals and snacks at regular times to maintain a certain blood sugar level. You must serve the resident’s meals and snacks on time. It is also very important to tell the nurse what the resident did and did not eat. If all food was not eaten, a between meal nourishment may be needed. The amount of insulin given also depends on daily food intake. Tell the nurse about changes in the resident’s eating habits.

Special Diets Continued

Thickened Liquids

People who have difficulty swallowing thin liquids often must drink thickened liquids. Drinking thickened liquids can help prevent choking and stop fluid from entering the lungs. The three common consistencies of thickened liquids are nectar-thick, honey-thick, and pudding-thick. A doctor or speech therapist should determine what consistency a resident's liquids should be. As a general rule:

- **Nectar-thick liquids** are easily pourable and are comparable to apricot nectar or thicker cream soups.
- **Honey-thick liquids** are slightly thicker, are less pourable, and drizzle from a cup or bowl.
- **Pudding-thick liquids** hold their own shape. They are not pourable and are usually eaten with a spoon.

Food Consistency

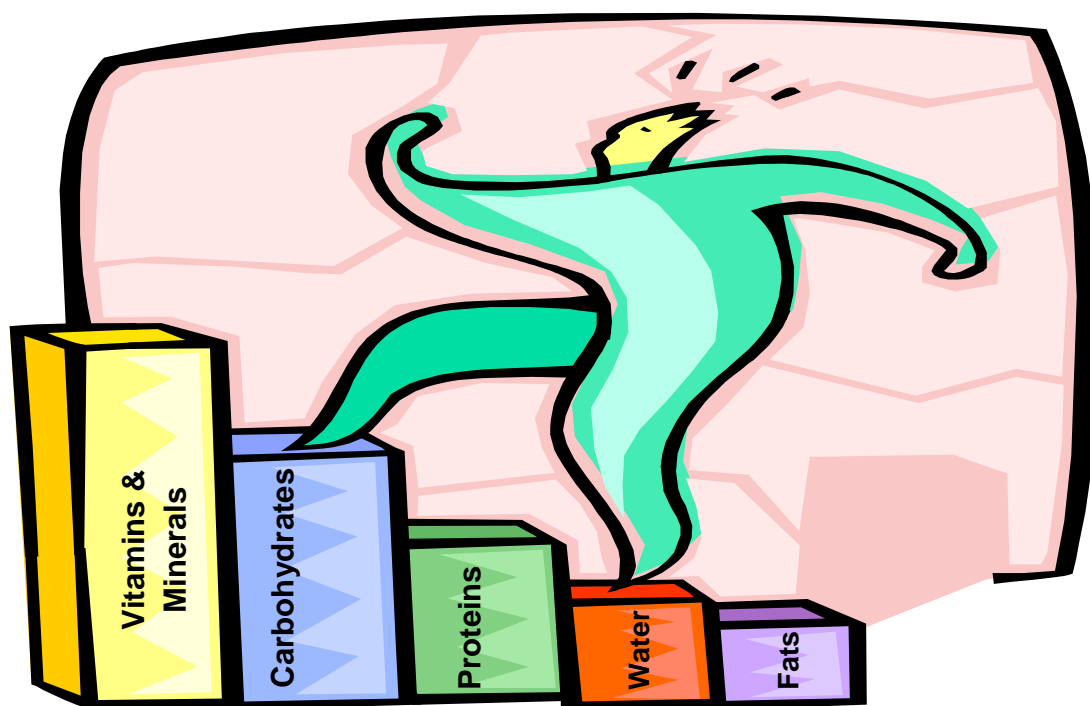
Individuals affected by dysphagia (chewing and swallowing problems) are at risk for malnutrition and dehydration. To assure that these residents receive adequate calories, protein and fluids to maintain health, it is often necessary to have the consistency of their food altered. As a general rule:

- **Mechanically Altered** food is cohesive, moist and semi-solid and requires some chewing ability. Meats are ground or minced and fruits and vegetables are fork-mashable. Most bread products, crackers and other dry foods are excluded.
- **Pureed** food is generally cohesive, mashed potato or pudding-like consistency. Food is pureed in a food processor to achieve a consistent smooth and easy to swallow product.

NOTE

A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, tube or parenteral feedings.

Essential Nutrient Groups



	Nutrient	Function
1	Vitamins and Minerals	Regulate body functions, build and repair body tissues
2	Carbohydrates	Provide heat and energy
3	Proteins	Build and repair body tissue, Provide heat and energy
4	Water	Carries nutrients and wastes to and from body cells, regulates body functions
5	Fats	Provide fatty acids needed for growth and development, provide heat and energy



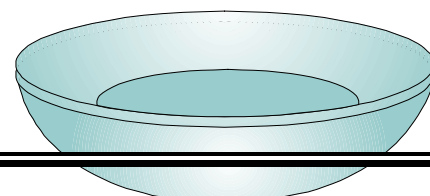
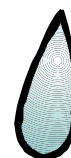
Fluids

Balance

Everyone needs water to live. Death can result from too much or too little water. You take in water through foods and fluids. You lose water through urine and feces. Water is lost through the skin in the form of perspiration and in the lungs through expiration. Fluid balance is required for health. The amount of fluid taken in and the amount lost should be equal. If the fluid taken in exceeds the fluid lost, tissues swell with water, and this is called edema. Edema is common in those residents with heart and kidney diseases. Dehydration is a decrease in the amount of water in body tissues and happens when fluid output is greater than intake. Some of the causes of poor fluid intake are vomiting, diarrhea, bleeding, excess sweating and increased urination.

Normal Requirements

Every adult needs 1500 ml. of water in 24 hours to survive. About 2000 to 2500 ml. of fluid per day is required for normal fluid balance. The need for water increases with hot weather, exercise, fever, illness and excess fluid loss. Older persons may have a decreased sense of thirst. Their bodies need water, but they may not have thirst. You need to offer water frequently. Some residents have special fluid orders.



Special Orders

The physician may order differing amounts of fluid that a resident can have during a 24-hour period. This is done to help maintain fluid balance. The following are examples of common orders:

- **Encourage fluids** – The resident needs to drink more fluid. The order outlines the amount of fluid to be ingested. Intake records are kept. The resident is given a variety of different fluids allowed on his/her diet. Fluids are kept within reach. Fluids are offered frequently to residents who cannot feed themselves.
- **Restrict Fluids** – Fluids are restricted to a certain given amount. They are offered in small amounts and in smaller containers. The water pitcher is removed from the resident's room or kept out of sight. Intake records are kept. This resident may need frequent oral hygiene to keep mucus membranes moist.
- **Nothing by Mouth** – The resident cannot eat or drink anything. NPO is the abbreviation used. NPO is ordered for some laboratory tests or x-ray procedures and for certain illnesses. Those residents who are tube fed may be NPO. Some facilities post a NPO sign above the bed. The water pitcher and glasses are removed from the room. Frequent oral hygiene is important for these residents but no fluid should be swallowed. Some residents could be ordered NPO status for 6-8 hours prior to a laboratory test or x-ray.
- **Thickened liquids** – All fluids the resident consumes are thickened. The thickness depends on the resident's ability to swallow. Thickening is added before the fluids are served. Some commercial fluids are provided already thickened.

Intake Records

A doctor or nurse may order fluid intake measurements. This means keeping accurate records. These records are used to evaluate fluid balance that is the function of the kidneys. They help in the evaluation of medical treatment. They also are kept when a resident has special orders pertaining to fluid.

All fluids taken by the resident are measured and recorded – water, milk, coffee, tea, juices, soups and soft drinks. Some soft or semi-soft foods that become liquid at room temperature (i.e., ice cream, sherbet, custard, pudding, creamed cereals, gelatin and Popsicles) are included. The nurse measures the fluid intake records, IV Fluids and tube feedings.

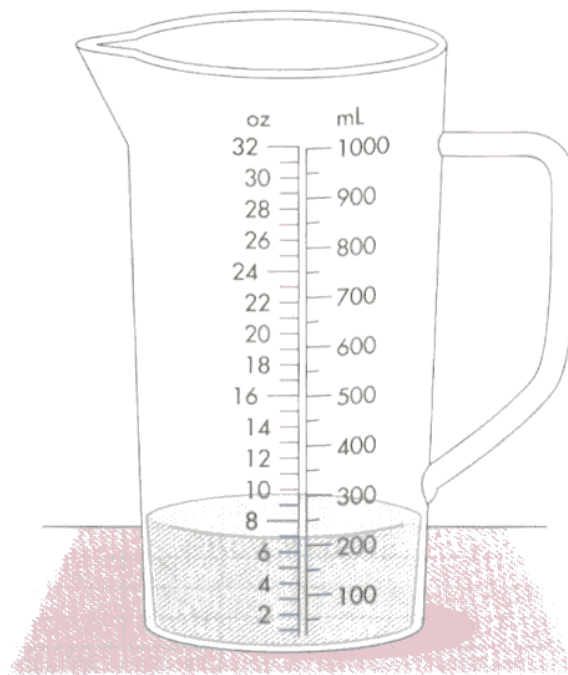


FIG. 19-10 A graduate marked in milliliters.

6

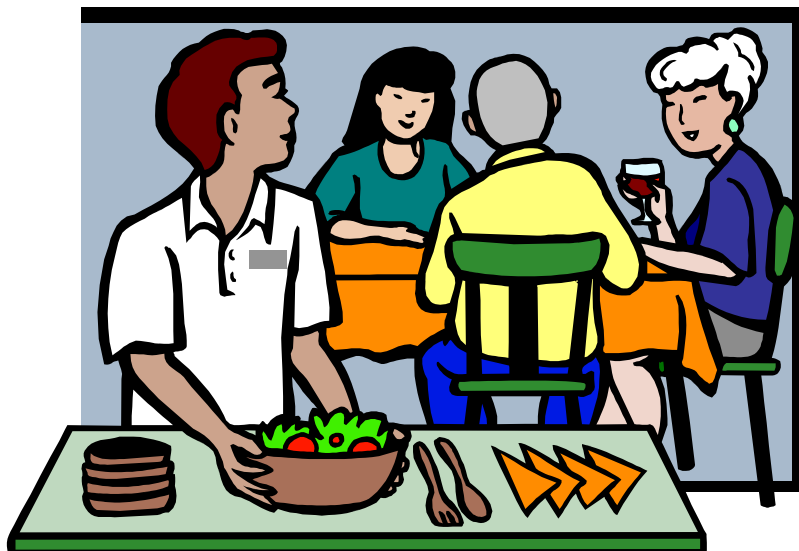
FEEDING TECHNIQUES

WHAT YOU WILL LEARN

- **Preparing for meals**
- **Serving Meal trays**
- **Feeding a resident**
- **Procedure checklist**

Preparing for Meals

The comfort of the resident is important during the meal service. The setting should be free of unpleasant sights, sounds and odors. Residents should be properly prepared. They need to have had their oral care and elimination needs met. Persons who are incontinent should be clean and dry. Residents with dentures, eyeglasses and hearing aids should have these devices in place before the meal. To increase mealtime enjoyment and comfort, unnecessary equipment should be removed from the room. Make sure the resident is in a comfortable position to eat.



Before preparing a person for a meal, you should obtain the following information from the nurse:

- ◆ How much assistance the person needs
- ◆ Where the person is to eat (i.e., dining room or resident's room)
- ◆ How the resident is to be positioned
- ◆ If the resident wears hearing aids or eyeglasses
- ◆ How the resident gets to the dining area (i.e., by self or with help)
- ◆ If the person uses a wheelchair, walker or cane

Serving Meal Trays

Meal trays are served after residents are prepared for meals. Trays are served promptly. They have containers that keep hot food hot and cold food cold. OBRA guidelines require that food be served at the desired temperature when the resident receives it.

Serve trays in the order assigned by the health team. Residents seated at the same table are served at the same time. If a tray is not served within 15 minutes, the appropriate discipline should check the temperature of the food. If the food is not at the appropriate temperature, another tray may have to be obtained for the resident. Some facilities allow re-heating of hot foods in a microwave oven.

Before serving meal trays, you need to obtain the following information from the nurse:

- ◆ What equipment for adaptation does the resident use?
- ◆ How much help does the resident need with opening cartons, cutting food, buttering bread etc?
- ◆ Is the resident's intake measured?
- ◆ Is the resident on a calorie count?



Safety Alert

Always check food temperatures after re-heating. Food that is too hot can burn a resident's mouth.

Feeding a Resident

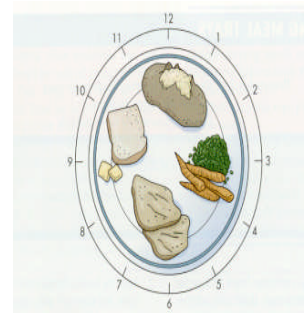
Weakness, paralysis, casts, confusion, and other limitations can make self-feeding difficult. Frequently, these residents are fed by staff.

Foods and fluids should be served according to the preference of the resident. Offer fluids during the meal. Fluids assist the person to chew and swallow.

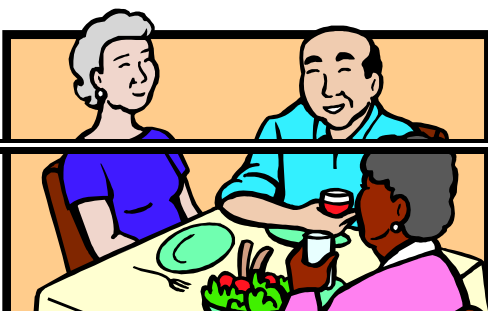
Spoons may need to be used because they are less likely to cause injury. The spoon should be only one-third full. This portion is chewed and swallowed easily. Some residents require smaller portions.

Some residents who require feeding are angry, humiliated, and embarrassed. Some display depression and are resentful or refuse to eat. Let them do as much as possible for themselves. Some can manage “finger foods” (i.e., bread, cookies, and crackers). If the resident is strong enough, let them hold their milk or juice. However, caution should be used with hot liquids. Always be aware of any food and fluid restrictions. Provide support when needed. Encourage them to try even if food is spilled while trying.

Residents who are visually impaired often are more aware of food aromas. They may know the food that is being served. The food on the tray should be explained to these residents. When feeding the visually impaired resident, tell them what you are offering. For those who feed themselves, describe the foods and fluid arrangement on the tray. Use the hands on a clock to describe the location.



Many residents prefer to pray before the meal. Allow enough time and privacy for prayer. This shows respect and caring about the resident.



Meals are an opportunity for social interaction and contact with others. Engage residents with pleasant conversation. However, time should be allowed for chewing and swallowing. Sit in a way that you face the resident. Sitting is more relaxing. It shows that you have time to devote to him or her. Standing communicates non-verbally that you are in a hurry. By facing the resident, you can better see how they are eating. You can also notice problems with swallowing.

Residents with Dementia

Dementia is the progressive deterioration of mental function. Persons with a diagnosis of dementia can become distracted while eating. It is hard for them to sit still long enough to eat an entire meal. Others forget what that knife, fork, and spoon are used for. Some resist efforts to assist them while eating. A confused resident could throw or spit food.

You must be patient. A quiet and calm dining area is often helpful. Special mealtimes can also be helpful. The confused resident may eat small amounts more often than 3 times a day. Talk to the nurse if you have feelings of impatience or are upset. Remember each resident has the right to be treated with respect and dignity.

Before feeding, you will need the following information from the nurse:

- ◆ Why does the resident need help?
- ◆ How much help does the resident require?
- ◆ Can the resident manage finger foods?
- ◆ Are there any activity limits?
- ◆ Are there any dietary restrictions?
- ◆ Signs of aspiration/choking
- ◆ What size portion should the resident be fed? 1/3 spoonful or less?
- ◆ What observations need to be reported and recorded?
- ◆ The amount and kind of food eaten
- ◆ Complaints of nausea

Positioning

Correct positioning is one of the most important requirements for safe and comfortable dining. A resident who is not positioned correctly will be uncomfortable and unable to fully enjoy their meal and is at high risk for choking or aspiration.

The correct position for dining is as follows:

- ◆ Head held forward with chin down slightly
- ◆ Trunk upright
- ◆ Hips bent as closely to a 90 degree angle as possible
- ◆ Knees and ankles at 90 degrees

NOTE: It is important to check for correct position before starting to assist a resident with a meal. Residents with special physical problems can be a challenge. Always check for positioning requirements, specific to each resident.

Only a licensed/certified staff member can properly position the resident.

Hand-Over-Hand

The hand-over-hand technique is done just as it says. Place your hand over the resident's hand and complete the task together. Be sure to sit on the same side as the hand you are assisting. If your right hand is over the resident's right hand, sit on the resident's right side. Sometimes the technique serves as a prompt for the resident to complete the task on his or her own. In other cases, the resident knows what to do but is unable to because of weakness or other physical problems. Using hand-over-hand technique for these individuals helps preserve or even improve self-feeding ability. Participating even in this limited way promotes a better sense of independence than being passively fed.

Circumstances when hand-over-hand is especially helpful include when a resident:

- ◆ Cannot lift utensils
- ◆ Is unable to cut food
- ◆ Is unable to pour beverages
- ◆ Cannot stab food with a fork
- ◆ Is unable to spread toppings on food, such as jelly on toast
- ◆ Is too tired to feed self, as the day progresses
- ◆ Forgets how to eat

Cueing

Cueing is giving a verbal prompt for the resident to do something. In other words, you say something to get the resident back on track. Examples of cueing would be to remind the resident to "Take a bite of your chicken" or to ask "Would you like another bite of potatoes".

Quality of Life

Always knock before entering a resident's room. Address the resident by name. Introduce yourself by name and title.

Procedures Checklist

Pre-Procedure

- ✓ Follow the guideline when feeding a resident.
- ✓ Explain the procedure. Mrs. Right, my name is Paula Esquire.
I am a feeding assistant. I am here to help you eat lunch.
- ✓ Practice good hand washing hygiene.
- ✓ Ensure the resident is in a good sitting position.
- ✓ Ensure good placement of the dietary tray.



Procedure

- ✓ Identify the resident and check their dietary card. Address the resident by name.
- ✓ Some residents may require a napkin be draped across their chest and under their chin or the use of a clothing protector provided by the facility.
- ✓ Explain the foods and fluids on the tray.
- ✓ Prepare the foods for eating. Season food by the preferences of the resident.
- ✓ Serve foods in the order the resident prefers. Offer fluids alternating with solids. Use a spoon for safety. Do not rush. Allow enough time for the resident to chew and swallow.
- ✓ Use straws for liquids if the resident is unable to drink from a glass or cup. Use one straw for each different liquid on the tray. Provide short straws for those individuals who are weak.
- ✓ Talk with the resident in a pleasant manner.
- ✓ Encourage the resident to eat as much as possible.
- ✓ Encourage the resident to wipe their mouth with a napkin and assist if necessary.
- ✓ Record how much and which foods were eaten.
- ✓ Measure and record intake if required.
- ✓ Remove the tray.

Post Procedure

- ✓ Provide for the comfort and safety of the resident. For example, place the overbed table in reach of the resident, make sure the bed is in the lowest position, ask if they need anything and place the resident's call light within reach.
- ✓ Wash your hands.

√ Report and record your observations.

7

COMMUNICATION AND INTERPERSONAL SKILLS

WHAT YOU WILL LEARN

- **Communicating with the resident**
- **Rules of verbal communication**
- **Body language**
- **Communication methods**
- **Communication barriers**



Communicating With the Resident

You are communicating all the time. Verbally, you exchange information with others. Non-verbally, your body language is also communicating messages to other people. Residents and family members are aware of what you say, how you say it, and your body language. A resident who is confused and cannot understand the words you are speaking will get clear messages from your body language and tone of voice.

For effective communication between you and the resident, you must:

- ◆ Understand and respect the resident as a person.
- ◆ Appreciate the resident's problems and frustrations.
- ◆ Respect the resident's rights.
- ◆ Respect the resident's religion and culture.
- ◆ Give the resident time to process the information that you give.
- ◆ Ask questions to see if the resident understood you. Repeat information as often as necessary.
- ◆ Be patient. Residents with memory loss may repeat the same question many times.

Rules of Verbal Communication:

- ◆ Face the person you are speaking to.
- ◆ Control the volume and tone of your voice.
- ◆ Speak clearly, slowly and distinctly.
- ◆ Avoid using slang or profanity.
- ◆ Repeat information as needed.
- ◆ Ask one question at a time. Wait for a response.
- ◆ Do not shout, whisper and/or mumble.



Body Language

People send messages to other people through their body language. Sometimes your body language says something different than the verbal message you are trying to communicate. Body language includes posture, facial expressions, eye contact, hand gestures and appearance (dress, hygiene, etc.). Your body language should show caring and respect for the

resident. Control your reactions to odors. Many odors are beyond the resident's control. A negative reaction from you could cause the resident to feel embarrassed or humiliated.

Communication Methods

There are certain methods that can be used to help you communicate better with others. Better communication results in better relationships.

Listening

When you listen, you are focusing on the other person's verbal and non-verbal communication. You hear what the other person is saying and watch for non-verbal clues to confirm the message. Listening requires that you care and are interested. Follow these guidelines:

- ◆ Face the person.
- ◆ Make eye contact.
- ◆ Lean towards the person
- ◆ Respond to what the person is saying and ask questions



Paraphrasing

Paraphrasing means re-stating what the other person said in your own words. This shows you are listening and promotes further communication.

Direct Questions

Direct questions are requests for information. They can usually be answered with a “yes” or “no” response. An example of a direct question would be “Did you have a good visit with your son?”

Open-Ended Questions

These questions require more than a “yes” or “no” response. Open-ended questions invite the other person to share thoughts and feelings. An example of an open-ended question would be “Tell me about your visit with your son.”

Clarifying

Clarifying allows you to make sure that you understand what the other person is saying. You could ask them to repeat what they said, or paraphrase what you heard.

Focusing

Focusing is a way to keep the conversation on a particular topic. This is useful to use when the person you are talking to rambles or gets off the subject. For example, if a resident is talking at length about food that they do not like, but you need to know why they are not

eating their breakfast, you could say “Let’s talk about today’s breakfast, is there anything here that you would like to eat?”



Communication Barriers

There are certain barriers to communication. These barriers prevent messages from being received effectively. Some of the barriers that you need to be aware of are:

- ◆ Using unfamiliar language. Both parties must communicate in the same language.
- ◆ Changing the subject. This is usually done when the subject is uncomfortable.
- ◆ Giving your opinion. Giving an opinion involves judging and values. Do not make judgments or jump to conclusions.
- ◆ Failure to listen. Pretending to listen shows lack of respect and caring. This will result in poor responses.

8

RESIDENT BEHAVIOR

WHAT YOU WILL LEARN

- Behaviors
- Dealing with behavior issues

Behaviors

The following behaviors are common in nursing facilities:

Wandering

Confused residents do not know where they are. They could wander away and be unable to find their way back. This behavior puts the resident at risk for injury. A resident could wander into traffic, or become lost and suffer from exposure to the weather. Wandering may have no cause. Sometimes the wandering resident is looking for something like the bathroom, something to eat, or a familiar family member.



Sundowning

With Sundowning, confusion and restlessness increase as daylight ends. Sundowning may relate to being tired, or the darkness may cause the resident to see things that are not there.

Hallucinations

A hallucination is seeing or hearing things that are not really there. Sometimes poor hearing or vision can cause this.

Delusions

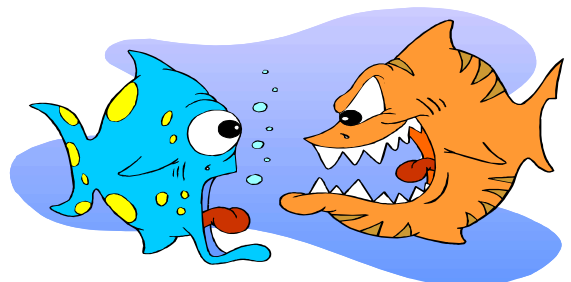
A delusion is a false belief. Sometimes residents with dementia may believe they are someone else, that they are in jail, or that someone is trying to kill them.

Agitation and Restlessness

The agitated resident may pace, yell, or hit other people.

Aggression and Combativeness

These behaviors include yelling, swearing, hitting, kicking or biting. Sometimes these behaviors are part of the resident's personality, but fear, pain,



fatigue, or too much stimulation can cause these behaviors.

Behavior Issues

Some people accept illness and disability as a normal part of aging. Other people do not adapt as well and may exhibit the following behaviors:

Anger

Anger is a very common emotion. Some causes of anger can be fear, pain, loss of function, loss of control, dying and death. Anger can also be a symptom of diseases that affect thinking. Some expressions of anger can include shouting, raised voices and rapid speech. Anger can escalate into violent behaviors.

Demanding Behavior

Efforts to please the resident are criticized. The resident wants all care given at certain times and in a certain way; however, nothing ever seems to please them. Demanding behavior can be caused by loss of independence and control, or by un-met needs.

Aggressive Behaviors

Aggressive behaviors can include swearing, biting, hitting, scratching and kicking. The causes of aggressive behavior can include fear, anger, pain and dementia.

Inappropriate Behavior

Some residents make inappropriate sexual remarks. They may touch other residents or staff, disrobe or masturbate in public. These behaviors may be deliberate, or they may be due to disease, confusion or dementia.

Resident behaviors can be unpleasant, but you cannot avoid the resident with behaviors, or lose control. Good communication is important.

Dealing with Behavior Issues

- ◆ Recognize situations which may be frustrating and frightening to the resident.
- ◆ Treat all residents as you would want to be treated.
- ◆ Treat residents with dignity and respect.
- ◆ Answer questions clearly and thoroughly.
- ◆ Always tell the resident what you are going to do before you do it.
- ◆ Stay calm if the resident is angry.
- ◆ Do not argue with the resident.

- ◆ Report behaviors to the nurse.

9

SAFETY AND EMERGENCY PROCEDURES

WHAT YOU WILL LEARN

- Fire Safety



Identifying Situations Which Call for Emergency Action

Fire

Major causes of fire include:

- ◆ improper use of smoking materials
- ◆ defects in heating systems
- ◆ Improper trash disposal
- ◆ misuse of electrical equipment
- ◆ spontaneous combustion



Actions to take when fire is discovered

- ◆ Remember to **RACE**:

Remove residents in immediate danger

Alert other staff

Confine the fire

Extinguish the fire if possible

- ◆ Follow the procedures of the facility

Use of fire extinguisher

Most fire extinguishers are the dry chemical type suitable for all types of fires.

To use:

- ◆ Remember to **PASS**:

Pull – safety pin (usually twist and pull)

Aim – nozzle at the base of the fire

Squeeze – trigger handle



Sweep – side to side at the base of the fire

10

HEIMLICH MANEUVER

WHAT YOU WILL LEARN

- Choking
- Clearing an obstructed airway



Choking

Choking is the hindrance of breathing due to an obstruction of the throat or windpipe. Choking is fairly common. Choking deaths commonly occur in children less than 3 years old and in senior citizens, but can occur at any age. The Heimlich maneuver has been valuable in saving lives and can be administered by anyone who has learned the technique.

Clearing the Obstructed Airway

If the resident is coughing but is able to breathe, do not intervene, but continue to observe until coughing subsides and the resident continues with activity.

Clutching the neck with one or both hands is the universal distress signal or sign for choking. If a resident shows signs of choking, begin the Heimlich maneuver:

- ◆ Ask the victim if he or she is choking.
- ◆ Determine if the victim can cough or speak.
- ◆ Stand behind the victim.
- ◆ Wrap your arms around the victim's waist.
- ◆ Make a fist with one hand. Place the thumb side of the fist against the abdomen. The fist is in the middle above the navel and below the end of the sternum.
- ◆ Grasp your fist with your other hand.
- ◆ Press your fist and hand into the victim's abdomen with a quick, upward thrust.
- ◆ Repeat the abdominal thrust until the object has been expelled or the victim loses consciousness.



Anytime the Heimlich maneuver is used or a resident demonstrates choking symptoms, immediately notify licensed facility staff.

11

INFECTION CONTROL

WHAT YOU WILL LEARN

- **Control measures**
- **Hand washing procedures**
- **Hand maintenance**
- **Glove usage**
- **Serving food properly**
- **Handling of utensils**



Infection Control

Older people have a hard time fighting infections. Therefore, the health team must prevent the spread of infection. Microbes are germs that cause infection. They are too small to be seen without a microscope. Microbes are everywhere. Microbes can enter the body through equipment used in treatments, therapies and tests. Staff can transfer microbes from one person to another and from themselves to other people. Asepsis means being free of disease causing microbes. Aseptic practices break the chain of infection.

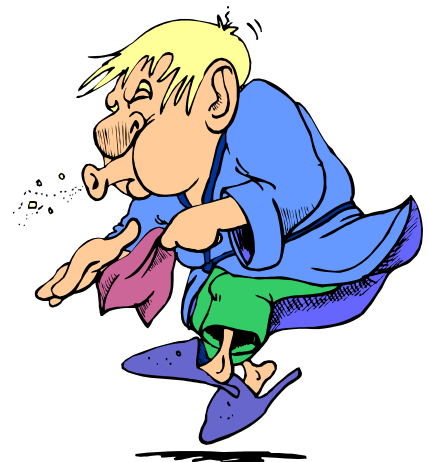
To prevent the spread of microbes, wash your hands:



- ◆ After using the restroom.
- ◆ After changing tampons or sanitary pads.
- ◆ After contact with your own or another person's body fluids or secretions.
- ◆ After coughing, sneezing, or blowing your nose.
- ◆ Before and after handling, preparing, or eating food.

Also do the following:

- ◆ Provide all residents with their own eating utensils, drinking glasses, toothbrush and other personal care items.
- ◆ Cover your nose and mouth when coughing, sneezing, or blowing your nose.
- ◆ Wash fruits and raw vegetables before eating or serving them.
- ◆ Bathe, wash your hair and brush your teeth regularly.



Hand Washing

Hand hygiene with soap and water is the easiest and the most important way to prevent the spread of infection. Your hands are used for almost everything. They are easily contaminated. Your hands can spread microbes if hand hygiene is not practiced before and after giving care.

Hand Washing Procedure

- ◆ Make sure you have soap, paper towels, orange stick and a wastebasket.
- ◆ Push your watch up 4-5 inches. Also push up your sleeves
- ◆ Stand away from the sink, so your clothes do not touch the sink. Make sure you can reach the soap and faucets.
- ◆ Turn on and adjust the water until it feels warm.



- ◆ Wet your wrists and hands under running water. Keep your hands lower than your elbows.
- ◆ Apply about 1 teaspoon of soap to your hands.
- ◆ Rub your palms together and interlace your fingers to work up a good lather. This step should last 15 seconds.
- ◆ Wash each hand and wrist thoroughly. Clean well between the fingers.

- ◆ Clean under the fingernails by rubbing your fingertips against your palms.
- ◆ Clean under the fingernails with a nail file or orange stick. This step is necessary for the first hand washing of the day and when your hands are heavily soiled.



- ◆ Rinse and dry your hands and wrists with a paper towel. Pat dry, starting at the fingertips.
- ◆ Discard the paper towels.

- ◆ Turn off the faucet with clean paper towels. This prevents you from contaminating your hands. Use a clean paper towel for each faucet, then discard.

Hand Maintenance

Fingernails should be kept short and clean. Nail polish, false fingernails and acrylic nails may be difficult to keep clean and can break off into food. Therefore they should not be worn while handling food.

Cuts and sores on hands, including hangnails, should be treated and kept covered with clean bandages. If hands are bandaged, clean form-fitted gloves should be worn at all times to protect the bandage and to prevent it from falling off into food.

Glove Usage

Gloves must never be used in place of hand washing. Hands must be washed before putting on gloves and when changing to a fresh pair. Gloves used to handle food are for single use only and should never be washed and re-used. Gloves should be changed:

- ◆ As soon as they become soiled or torn
- ◆ Before beginning a different task
- ◆ At least every four hours during continual use, and more often when necessary.

Serving Food Properly

Feeding assistants will carry trays and plates, uncover food items, use silverware to prepare and feed residents, butter bread and cut up meat. These things must be done in a sanitary manner. Feeding assistants should strive to meet resident's needs without directly touching the food.

- ◆ Avoid touching food with bare hands. Whenever possible, use utensils to cut and feed food items or wear gloves. If direct contact with food is necessary, always have clean, washed hands and limit contact to what is minimal.
- ◆ Do not test the temperature of food by touching it with your fingers. Warmth of food can be tested by holding your hand or wrist over the food item without touching it. The warmth of food can also be tested by touching the bottom of the plate, or by placing a small amount on the inside of your wrist.
- ◆ Do not blow on food to cool it off. If the food is too hot, stir it to incorporate air and cool it off, especially food re-heated in a microwave oven. You may want to start with a different food, a salad or a beverage while the hot food is cooling.

Handling of Utensils

Handle only the edges of plates. Handle utensils like forks and spoons by their handles only. For glasses and cups, handle only the sides or cup handles. Do not touch the rim. Do not carry glasses by the rim, or put fingers inside the container. Always use serving forks and spoons to serve food.

12

RESIDENT RIGHTS

WHAT YOU WILL LEARN

- Refusal of treatment
- Privacy and confidentiality
- Personal choice
- Disputes and grievances
- Work
- Participation
- Care and security of personal possessions
- Freedom from abuse, mistreatment and neglect

- **Freedom from restraints**
- **Quality of life**
- **Activities**

Resident Rights

In 1987 the U.S. Congress passed the Omnibus Budget Reconciliation Act (OBRA). It is a federal law that applies to all 50 states. OBRA requires that a facility provide care in a manner and in a setting that maintains or enhances each resident's quality of life, health and safety. Resident Rights are a major part of OBRA. Nursing facility residents have rights under state and federal law. They have rights as U.S. citizens. Residents also have rights relating to their everyday lives and care in the facility. The facility must promote and protect their rights. The facility can not interfere with the resident's rights. Some residents are incompetent, or unable to exercise their own rights. In that case, a responsible party (a spouse or adult child) or legal representative does so for them.

The facility must inform the resident or their responsible party, of the resident's rights. They must be informed verbally and in writing. Such information is usually given at the time of admission. It should be given in the language that the resident uses and understands.

Refusing Treatment

Residents have the right to refuse treatment. A resident, who refuses or does not give consent for a medical treatment, can not be given the medical treatment. The facility must find out what the resident is refusing and why. All refusals of care should be reported to the nurse.

Privacy and Confidentiality

Residents have the right to personal privacy. The resident's body must not be exposed unnecessarily. Only workers directly involved with care should be present. The resident must give consent for others to be present. A resident has the right to use the bathroom in private. Privacy is maintained for personal care measures as well. Residents have the right to visit with others in private, in an area where others can not see or hear them. If requested, the facility must provide private space. The right to visit in private also involves mail and telephone calls. No one can open mail the resident sends or receives

without the resident's permission. Information about the resident's care, treatment and condition is kept confidential. Providing for privacy and keeping the resident's information confidential shows respect for the resident. They also protect the resident's dignity.

Personal Choice

Residents can choose their own doctor. They have the right to take part in planning their own care and treatment. They have the right to choose activities, schedules and care based on their own preferences. For example, a resident chooses when to get up, when to go to bed, what to wear, how to spend their time and what to eat. Personal choice promotes quality of life, dignity and self-respect. You must allow personal choice whenever it is safely possible.

Disputes and Grievances

Residents have the right to voice concerns, questions and complaints about care or treatment. The facility must promptly try to correct the problem. No one can punish the resident in any way for voicing a grievance.

Work

The resident can not be required to work in order to receive care, personal items, other things or privileges. Residents are not required to perform services for the facility. A resident may work if they want to.

Participation in Resident and Family Groups

Residents have the right to organize and participate in resident and family groups. Also, the resident's family has the right to meet with other families from the facility. These groups can discuss concerns and make suggestions for facility improvements. The group can comfort and support group members. Residents also have the right to take part in social, religious and community activities. They have the right to assistance in getting to and from activities of their choice.

Care and Security of Personal Possessions

Residents have the right to keep and use personal items. Available space and the health and safety of others affect the type of personal items allowed. Treat the resident's property with care and respect. The items may not appear valuable to you, but they have

value and meaning to the resident. The facility must investigate reports of lost, stolen or damaged items. Police assistance is sometimes needed. Protect yourself and the facility from being accused of stealing. Do not ever go through a resident's closet, drawers, purse or other space without the resident's permission.

Freedom from Abuse, Mistreatment and Neglect

Residents have the right to be free from verbal, physical, sexual or mental abuse. No one can abuse, neglect or mistreat a resident. This includes staff members, volunteers, and staff from other groups, other residents, family members, visitors and legal guardians. Facilities must investigate suspected or reported cases of abuse. Facilities cannot employ individuals who have been found guilty of abuse, neglect or mistreatment.

Freedom from Restraints

Residents have the right not to have body movements restricted. Restraining devices and certain drugs can restrict body movement. The facility must assess the resident and determine that the restraint is necessary to improve the resident's quality of life. Restraints can not be used for discipline or for staff convenience.

Quality of Life

Facilities must care for residents in a manner that promotes dignity and self-esteem. It must also promote physical, psychological and emotional well being. Protecting a resident's rights promotes quality of life and shows respect for the individual. Residents should be spoken to in a polite and courteous manner.

Activities

Nursing facilities must provide activity programs that allow personal choice. They must promote physical, intellectual, social, spiritual and emotional well being.

13

ELDER ABUSE

WHAT YOU WILL LEARN

- **Reporting abuse**
- **Types of abuse**
- **Signs of abuse**
- **State laws**

Signs of Elder Abuse

- ◆ Living conditions are unsafe, unclean, or inadequate.
- ◆ Personal hygiene is lacking. The person is unclean, clothes are dirty.
- ◆ Weight loss – the person shows signs of poor nutrition and inadequate fluid intake.
- ◆ Assistive devices are missing or broken – glasses, hearing aids, dentures, or cane or walker.
- ◆ Frequent injuries – conditions behind the injuries are strange or seem impossible
- ◆ Old and new injuries – bruises, welts, scars and punctures
- ◆ Complaints of pain or itching in the genital area
- ◆ Bleeding and bruising in the genital area.
- ◆ Burns on the feet, hands, or buttocks. Cigarettes and cigars cause small circle-like burns.
- ◆ Pressure ulcers or contractures.
- ◆ The person seems very quiet or withdrawn
- ◆ The person seems fearful, anxious, or agitated
- ◆ The person does not seem to want to talk or answer questions.
- ◆ The person is restrained. Or the person is locked in a certain area for long periods of time. The person cannot reach toilet facilities, food and water, and other necessary items.
- ◆ Private conversations are not allowed. The caregiver is present during all conversations.
- ◆ The person seems anxious to please the caregiver.

- ◆ Drugs are not taken properly. Drugs are not purchased or too much or too little of the drug is taken.
- ◆ Visits to the emergency room may be frequent.
- ◆ The person may change doctors often. Some people do not have a doctor.

Reporting Abuse

Abuse is the intentional mistreatment or harm of another person. Abuse is a crime, and it must be reported according to state law KRS.209. Abuse has one or more of these features:

- ◆ Willfully causing injury
- ◆ Unreasonable confinement of an individual
- ◆ Intimidation (making the resident feel afraid using threats of force or violence)
- ◆ Punishment
- ◆ Depriving a resident of goods or services needed for physical, mental or psychosocial well being

Abuse causes physical harm, pain or mental anguish. Protection against abuse extends to persons in a coma. Child and elder abuse is usually caused by a family member. However, the abuser may be a friend, neighbor, landlord, or other person.

TO REPORT ELDER ABUSE IN KENTUCKY CALL: 1-800-752-6200

Forms of Elder Abuse

Physical Abuse

Can include grabbing, hitting, slapping, pushing, kicking, pinching, hair pulling, or beating. It also includes corporal punishment – punishment inflicted on the body. Beatings, lashings, or whippings are examples. Neglect is also a form of abuse. It involves depriving the person of needed medical services or treatment. Neglect is also failure to provide food, clothing, hygiene, and other basic needs. In nursing centers neglect includes but is not limited to:

- ◆ Leaving persons lying or sitting in urine or feces.
- ◆ Isolating persons in their rooms or other areas.
- ◆ Failing to answer signal lights.

Verbal Abuse

Using oral or written words or statements that speak badly of, sneer at, criticize, or condemn the person. It includes unkind gestures.

Involuntary Seclusion

Confining a resident to a certain area. Older people have been locked in closets, basements, attics and other spaces

Financial Abuse

The theft or usage of an older person's money. It is also misusing a person's property. For example, a son sells his mother's house without her consent.

Mental Abuse

Humiliation, harassment, ridicule, or threats of being punished. It also includes being deprived of needs such as food, clothing, care, a home, or a place to sleep.

Sexual Abuse

The person is harassed about sex or is attacked sexually. The person may be forced to perform sexual acts out of fear of punishment or physical harm.

Hiring Requirements

A facility must not employ any individual who has been found guilty of abusing, neglecting, or mistreating residents by a court of law or who has had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.

KRS 216.789

Prohibition against employing certain felons at long-term care facilities, in nursing pools providing staff to nursing facilities, or in assisted-living communities – Pre-employment check with Justice Cabinet – Temporary employment.

- (1) No long-term care facility as defined by KRS 216.535(1), nursing pool providing staff to a nursing facility, or assisted-living community shall knowingly employ a person in a position which involves providing direct services to a resident or client if that person has been convicted of a felony offense related to theft; abuse or sale of illegal drugs; abuse, neglect, or exploitation of an adult; or a sexual crime.
- (2) A nursing facility, nursing pool providing staff to a nursing facility, or assisted-living community may employ persons convicted of or pleading guilty to an offense classified as a misdemeanor if the crime is not related to abuse, neglect, or exploitation of an adult.
- (3) Each long-term care facility as defined by KRS 216.535(1), nursing pool providing staff to a nursing facility, or assisted-living community shall request all conviction information from the Justice Cabinet for any applicant for employment pursuant to KRS 216.793.
- (4) The long-term care facility, nursing pool providing staff to a nursing facility, or assisted-living community may temporarily employ an applicant pending the receipt of the conviction information.

Effective: July 14, 2000

History: Amended 2000 Ky. Acts ch. 141, sec. 17, effective July 14, 2000. --Amended 1998 Ky. Acts ch. 189, sec. 4, effective July 15, 1998; and ch. 380, sec. 2, effective July 15, 1998. -- Created 1994 Ky. Acts ch. 427, sec. 4, effective July 15, 1994.

KRS 216.532

Prohibition against long-term care facility's being operated by or employing a person on the nurse aide abuse registry.

Long-term care facilities as defined in KRS 216.510 shall not be operated by or employ any person who is listed on the nurse aide abuse registry required by 42 C.F.R. 483.156.

Effective: July 15, 1998

History: Created 1998 Ky. Acts ch. 424, sec. 1, effective July 15, 1998.

14

RECOGNIZING CHANGES IN RESIDENT CONDITION

WHAT YOU WILL LEARN

- **Signs and abnormal symptoms**
- **Dysphagia**

- **Aspiration**

Recognizing signs and abnormal symptoms that should be reported:

SIGNS

Shortness of breath

Rapid respirations

Fever

Cough

Blue color to lips

Vomiting

Drowsiness

Sweating

Breaks/tears in skin; bruising

Sudden increase in confusion

Memory loss, poor judgment

SYMPTOMS

Chills

Pains in the chest

Pain in the abdomen

Nausea
Excessive thirst
Pain on moving
Change in appetite
Any pain
Any change from resident's usual behavior
Difficulty in swallowing/chewing

Signs and Symptoms of a Potential Swallowing Problem Dysphagia

- ◆ Foods that need chewing are avoided.
- ◆ Food spills out of the person's mouth while eating
- ◆ Food "pockets" or is "squirreled" in the person's cheeks.
- ◆ The resident eats slowly, especially solid foods.
- ◆ The resident complains that food has trouble going down or is stuck.
- ◆ The resident frequently coughs or chokes prior, during, or after swallowing.
- ◆ Regurgitation of food occurs after meals.
- ◆ The resident spits out food suddenly and almost violently.
- ◆ There is a decrease in appetite
- ◆ The resident is hoarse-especially after eating.
- ◆ Food comes up through the person's nose.
- ◆ There is the presence of excessive drooling of saliva.
- ◆ The resident complains of heartburn frequently.
- ◆ After swallowing, the person makes gurgling sounds while talking or breathing.
- ◆ There is unexplained weight loss.
- ◆ The resident experiences recurrent pneumonia.

Recognizing safe swallowing

A slow swallow means the resident has problems getting enough food and fluids for good nutrition and hydration. An unsafe swallow means that food enters the airway (aspiration). Aspiration is breathing fluid or an object into the lungs.

You Should

- ◆ Know the signs and symptoms of Dysphagia.
- ◆ Check the resident's position and if needed, **have licensed/certified staff position the resident.**
- ◆ Feed the resident according to the nurse and swallowing guide.
- ◆ Follow precautions for aspiration.
- ◆ Report changes in how the person eats.
- ◆ Report choking, coughing, or difficulty breathing or abnormal respiratory sounds.
- ◆ Report these observations immediately.

Aspiration Precautions

- ◆ Help the resident consume meals and snacks.
- ◆ Check to see that the resident is in an upright position in a chair for meals and snacks.
- ◆ If needed, **ask a licensed/certified staff member to properly position the resident.**
- ◆ Observe for signs and symptoms of aspiration during meals and snacks. Observe for signs of pocketing of food in the resident's mouth. Report your observations to the nurse.
- ◆ Check with licensed nurse regarding individual precautions for each resident prior to feeding.

15

TESTING

Skill 1

Hand Washing

Student Name _____

To master this skill, the student must successfully complete all steps, using principles of infection control. Failure to perform any step results in failure of this skill.

Equipment: Sink with faucets, soap, paper towels, and waste container.

	Procedure	Yes	No
1.	Stand away from sink. Clothing and hands must not touch sink.		
2.	Turn on water and adjust temperature.		
3.	Wet hands and wrists.		
4.	Apply soap over hands and wrists working into lather.		
5.	Use friction for at least 15 seconds.		
6.	Rinse hands and wrists under running water.		
7.	Dry hands and wrists		
8.	Turn off water using clean, dry towel.		
<p>Score: Pass _____ Fail _____</p>			
<p>Instructor Signature _____</p> <p style="text-align: center;">Licensed Nurse</p>			

Skill 2

Clear an Obstructed Airway On a Conscious Resident

Student Name _____

To master this skill, the student must successfully complete all steps.

	Procedure	Yes	No
1.	Ask the resident “Are you choking?” “Can you talk?” or look for the universal choking sign (clutching the neck).		
2.	If the answer is an affirmative nod, state “I can help.” Call or send someone for the nurse.		
3.	Stand behind the resident and wrap your arms around the resident’s waist.		
4.	Make a fist with one hand, grasping the fist with the other hand. Place thumb of fist against the abdomen, above navel and below rib cage.		
5.	Push into the resident’s abdomen with a quick, upward thrust.		
6.	Repeat thrust 4 times until object is dislodged. If the resident becomes unconscious, assist to the floor and the nurse will take over.		
<p>Score: Pass _____ Fail _____</p>			
<p>Instructor Signature _____</p> <p style="text-align: center;">Licensed Nurse</p>			

Skill 3

Feed a Resident

Student Name _____

To master this skill, the student must successfully complete 100% of the steps.

Equipment: Washcloth, towel, disposable hand wipes for resident use, clothing protector, meal tray with food and silverware

Procedure		Yes	No
1.	Knock before entering room.		
2.	Address the resident by name and introduce yourself.		
3.	Identify the resident, explain procedure and obtain permission.		
4.	Wash hands.		
5.	Ensure the resident is in the proper position to eat. Ask someone to position the resident if necessary		
6.	Check tray for correct name and type of diet. Inform resident what is on the tray.		
7.	Position clothing protector, clean resident's hands.		
8.	Prepare food by removing covers, opening cartons, cutting meat, buttering bread, salting items if requested.		
9.	Assist as needed while encouraging the resident to do as much as possible.		
10.	Allow hot foods to cool before offering.		
11.	Use a straw for liquids if appropriate.		

12.	Feed from the tip of a half-filled fork or spoon.		
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Skill 3

Feed a Resident

Page 2

Procedure		Yes	No
13.	If appropriate, tell the resident what he/she is eating.		
14.	Provide adequate time to chew.		
15.	Alternate solids and liquids.		
16.	If appropriate, wipe mouth as necessary.		
17.	Encourage to eat as much as possible, offer a substitute if the resident does not like or want a food item on the tray.		
18.	Observe that all food is swallowed and not pocketed in the cheek.		
19.	Wash hands when finished.		
20.	Provide comfort and safety with call bell in reach.		
21.	Report any abnormal observations to the nurse.		
22.	Record intake on consumption record.		

Score: Pass_____ **Fail**_____

Instructor Signature_____

Licensed Nurse

Skill 4

Measuring Intake

Student Name _____

To master this skill, the student must successfully complete 100% of the tasks.

Equipment: Consumption record and pen.

Procedure		Yes	No
1.	Identify container measurements used in your facility.		
2.	Identify the amounts of liquids consumed by the resident.		
3.	Record the amount of liquids consumed by the resident on the consumption sheet in ccs.		
4.	Identify the percentage of food eaten		
5.	Record the percentage of food eaten on the consumption record.		

Score: Pass _____ Fail _____

Instructor Signature _____
Licensed Nurse

Paid Feeding Assistant Exam

Student Name _____

Directions: Circle the one best answer. You must score 75% or better to pass.

(No more than 6 incorrect answers)

1.	Allowing residents to make choices in their daily lives is a part of the:			
	a.	Resident's Bill of Rights	c.	Durable Power of Attorney
	b.	R.A.C.E	d.	Vulnerable Adult Law
2.	Not sharing information about a resident is called:			
	a.	Patience	c.	Code of ethics
	b.	Confidentiality	d.	Honesty
3.	Reporting suspected abuse is required by:			
	a.	Fire Marshal	c.	Code of ethics
	b.	State law	d.	Center for disease control
4.	When discovering a fire, your <u>first</u> action should be:			
	a.	Alert other staff	c.	Remove residents in danger
	b.	Extinguish fire	d.	Confine fire
5.	When finding a resident on the floor, you should:			
	a.	Help the resident up	c.	Call 911
	b.	Call the family	d.	Stay with the resident and send for help
6.	A microbe is a:			
	a.	Germ	c.	A tool the doctor uses
	b.	Food group	d.	Disease

Paid Feeding Assistant Exam

Page Two

7.	The <u>single</u> most effective means of preventing the spread of infection is:		
	a.	Using a disinfectant	c. Wearing gloves
	b.	Putting residents in isolation	d. Washing your hands
8.	The universal sign for choking is:		
	a.	Pointing at the mouth	c. Shouting "I'm choking"
	b.	Holding the throat with hands	d. Holding up two fingers
9.	The exchange of information or messages is called:		
	a.	Confidentiality	c. Communication
	b.	Nutrition	d. Abuse
10.	Which of the following is a guideline for communicating with a hearing impaired resident?		
	a.	Shouting in their ear	c. Whispering
	b.	Face the resident when speaking	d. Avoid eye contact
11.	Which of the following is an example of non-verbal communication?		
	a.	Shouting in their ear	c. Whispering
	b.	Facial expressions	d. Talking loudly
12.	The recommended number of servings for each food group are found in:		
	a.	The food and drug handbook	c. The grocery store
	b.	OBRA dietary requirements	d. The Food guide pyramid
13.	Examples of carbohydrates are:		
	a.	Milk products	c. Meat and fish
	b.	Butter and oils	d. Bread and pasta

Paid Feeding Assistant Exam

Page Three

14.	Examples of proteins are:			
a.	Tomatoes and apples	c.	Bread and pasta	
b.	Meat and fish	d.	Butter and salad dressing	
15.	Not getting enough water can cause:			
a.	Anemia	c.	Infection	
b.	Dehydration	d.	Diarrhea	
16.	A diet ordered by the doctor to help treat a disease is called:			
a.	Therapeutic diet	c.	Fad diet	
b.	Regular diet	d.	Modified diet	
17.	Which of the following is not a special diet?			
a.	Regular diet	c.	Low sodium diet	
b.	Pureed diet	d.	Modified diet	
18.	Recording fluid intake includes:			
a.	Only fluids the resident drank	c.	All liquids that were served on the tray	
b.	All beverages and foods consumed that become liquid at room temperature	d.	All the food and liquid consumed by the resident	
19.	Recording meal percentage includes:			
a.	All the food and liquid served	c.	All the food the resident consumed the tray	
b.	Only fluids the resident drank.	d.	The foods the resident refused.	

Paid Feeding Assistant Exam

Page Four

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

Paid Feeding Assistant Exam

Answer Key

1.	A
2.	B
3.	B
4.	C
5.	D
6.	A
7.	D
8.	B
9.	C
10.	B
11.	B
12.	D
13.	D

14.	B
15.	B
16.	A
17.	A
18.	B
19.	C
20.	B
21.	C
22.	D
23.	D
24.	D
25.	B

16

INSTRUCTOR'S SECTION



PAID FEEDING ASSISTANT INSTRUCTOR CERTIFICATE

I certify that as a “Kentucky Paid Feeding Instructor”:

1. I am an RN____ LPN____, actively licensed in the state of Kentucky.

License Number _____ Expiration Date _____

2. Have successfully completed the “Paid Feeding Assistant Exam”

Completion Date _____

3. Have read and comprehend the “Paid Feeding Assistant Manual”

Completion Date _____

Paid Feeding Assistant Instructor

Date

I certify as of _____, _____ is designated as a
(Date) (Name of instructor)

Paid Feeding Instructor for _____.
(Name of facility)

Administrator

Date

**PAID FEEDING ASSISTANT
CERTIFICATE OF TRAINING**



Sponsored by the
Cabinet for Health and Family Services
Office of the Inspector General

_____ certifies that
Facility Name

Paid Feeding Assistant

has successfully completed the state approved
“Paid Feeding Assistant” training program
this _____ day of _____,

Instructor (Licensed Nurse)

Date

Administrator

Date

Requirements for Paid Feeding Assistants in Long Term Care Facilities

Qs & As

Q1: Will all facilities be required to use paid feeding assistants?

A1: No, the use of feeding assistants is an option that facilities may choose if consistent with state law and there is a state-approved training course in place.

Q2: What are the minimum requirements for training programs for paid feeding assistants?

A2: We require that a feeding assistant successfully complete an 8-hour state-approved training course that meets minimum Federal standards. These minimum standards include proper feeding techniques, infection control measures, safety and emergency procedures, and basic skills necessary to work with elderly and disabled residents, such as communication and interpersonal skills and appropriate responses to resident behavior. States are free to add any other training requirements that they believe are necessary to tailor a program to meet their needs. States have flexibility in determining the structure of these programs, as well as instructor qualifications.

Q3: Does this regulation only apply to paid workers or does CMS require that volunteers take this training?

A3: We encourage volunteers to take this training, but we do not require that they do so. Family members, friends, and other volunteers have always been able to assist residents when they visit nursing homes, helping to feed residents and perform other tasks that a worker would need nurse aide training to do. However, there is nothing in the final rule that would preclude a facility from requiring that all volunteers take the training.

Q4: Will CMS require that all facility employees who help residents eat and drink at mealtimes take this training?

A4: Yes, any facility employee who feeds residents, if only for a short time each day or occasionally, must take the feeding assistant training because he or she is functioning as a feeding assistant.

Q5: How will feeding assistants be supervised?

A5: Feeding assistants will work under the supervision of a registered nurse or licensed practical nurse.

Q6: Will feeding assistants be limited to assisting residents who are able to go to the dining area or may feeding assistants assist residents in their rooms?

A6: Feeding assistants may feed residents in either the dining room or in a resident's room.

Q7: How will a facility select residents who can benefit from the help of feeding assistants?

A7: A facility's professional nursing staff will determine which residents may be fed safely by a feeding assistant. The decision will be based on the charge nurse's assessment and the resident's latest assessment and plan of care. Feeding assistants will feed only residents who are either unable or unwilling to feed themselves, those with physical or cognitive disabilities. They will not feed residents who have complicated feeding problems, such as recurrent lung aspirations, difficulty swallowing, or those on feeding tubes or parenteral or IV feedings.

Q8: How will feeding assistants know what to do in an emergency?

A8: Each feeding assistant will be trained in safety and emergency procedures, including the Heimlich maneuver and to know when to ask for help from a supervisory nurse when a resident behaves differently than usual. In an emergency, we require that a feeding assistant call a supervisory nurse for help on the resident call system, which all facilities are required to have.

Q9: How will CMS monitor the training and competence of feeding assistants?

A9: We require that each facility retain a record of each individual it uses as a feeding assistant who has successfully completed the feeding assistance training. State surveyors may review the training records and view feeding assistants at work when they visit a facility on a survey.

Q10: What about those paid feeding assistants, who abuse, neglect, or steal from residents?

A10: Facilities are already required to report to the state any findings that an employee has abused, neglected, or misappropriated a resident's property.

Q11: How will the Medicare and Medicaid programs pay for feeding assistant services?

A11: Medicare payment for residents in skilled nursing facilities is made through a prospective payment system, which covers all costs (routine, ancillary, and capital) of covered skilled nursing facility services furnished to beneficiaries under Part A of the Medicare program. For Medicare, feeding assistant services are included in the total cost of care. Medicaid payments for nursing facilities are established by each state. Therefore, it is up to individual states to determine whether they need to change their payment rates for those facilities that use feeding assistants.

Q12: Some unions and advocates say that nursing homes may replace certified nurse aides with single-task workers, thereby reducing the quality of care and the continuity of care for residents. How will CMS ensure that these single-task workers protect the quality of care for residents?

A12: Trained feeding assistants have a limited function and are intended to supplement certified nurse aides, not substitute for them. Proper training will ensure that feeding assistants have the appropriate skills to do their jobs safely and protect residents. Use of feeding assistants will free nurses and nurse aides to assist residents with more complex care needs, for which they are trained. Ultimately, we expect that quality of care will improve when nursing homes are able to bolster their staff resources, especially at busy mealtimes.

Q13: Does this proposal also include a requirement for staffing ratios for nurse aides and feeding assistants?

A13: No, we do not require a staffing ratio for nurse aides and feeding assistants. Feeding assistants are intended to supplement the services of certified nurse aides, not substitute for other staff.

Paid Feeding Assistant Employment Information Form

Facility Name: _____
 Address: _____ City/Zip: _____
 Phone: _____ Fax: _____

Paid Feeding Assistant Roster

Name	SSN	Date of Hire	Date of Training	Test Scores		Successful Completion	
				Written	Skills	Yes	No

Name of person(s) no longer functioning as a Paid Feeding Assistant

Name	SSN	Effective Date	Reason

I certify as of _____, that the information submitted is accurate to the best of my knowledge.
 Date

Signature: _____ Date: _____

BIBLIOGRAPHY

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Eating Matters: A Training Manual for Feeding Assistants
CD- HCF

Minnesota Department of Health Paid Feeding Assistant Training
Program

North Carolina State Approved Curriculum for Feeding Assistants
NC Department of Health and Human Services, Division of Facility
Services

Mosby's Textbook for Long Term Care Assistants, 4th Edition

INSERT Facility Handout at the end of Section 5

1. Facility Input/Output recording form.
2. Facility method of calculating food consumption.