

Enhancing the Quality of Nursing Home Dining Assistance:

New Regulations and Practice Implications

Creating Home in the Nursing Home II Symposium

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The Paid Feeding Assistant Regulation

In 2003 the Centers for Medicare and Medicaid Services (CMS) issued a new federal regulation that made it possible for nursing homes to hire single task workers or train staff within the facility to help residents to eat (Medicare and Medicaid Programs, 2003). The federal regulation, "*Requirements for Paid Feeding Assistants in Long Term Care Facilities*" (Federal Register 2003, 68 FR 55528) requires that individuals trained as dining assistants receive the following:

- minimum of eight training hours provided by a licensed nurse
- competency testing of skills (written *or* performance-based)
- assignment to residents without complicated feeding assistance care needs
- training and supervision provided by a licensed nurse

The impetus for this new federal regulation was a growing concern among many long term care stakeholder groups that a significant proportion of nursing home residents were at risk for under-nutrition and dehydration due to sub-optimal nutritional care. This concern was well supported by a series of research studies showing that assistance was often inadequate and of poor quality during meals (Amella, 1999; Kayser-Jones, 1996; Simmons, Babineau, Garcia & Schnelle, 2002; Simmons, Garcia, Cadogan et.al., 2003) and nurse aide reports they lacked sufficient time to adequately help all of the residents for whom they were responsible (Kayser-Jones, 1996; Kayser-Jones & Schell, 1997). There also was a growing recognition among both long term care providers and federal and state regulators that many U.S. nursing homes did not have a sufficient number of direct care staff (nurse aides) to provide dining assistance to all residents in need. Again, this concern was underscored by research studies illustrating the impact that direct care staffing levels had on the quality of multiple daily care processes, including mealtime care. A significant proportion of residents in need of assistance during meals received little to no attention from staff in most facilities, and this problem was even more

pronounced in lower staffed facilities (Schnelle, Simmons, Harrington et. al., 2004). The need for more direct care staff to provide assistance also was supported by testimony from the American Nurses' Association and a report to congress on the minimum nurse aide staffing required to provide best practice care in nursing homes (Mondoux, 1998; Schnelle, Cretin, Saliba & Simmons, 2000).

Thus, the new federal regulation was intended to give long term care providers a feasible way to augment their existing, often insufficient, direct care staffing resources for mealtime care provision. There were, however, a number of concerns expressed by various stakeholder groups (e.g., National Citizen's Coalition for Nursing Home Reform, Service Employees International Union, Alzheimer's Association) about the new regulation (Remsburg, 2004). First, the regulation requires that single-task workers receive eight hours of training, substantially less than is required for a certified nurse aide (i.e., 75 hours), who are typically the direct care staff responsible for dining assistance. Thus, one concern was that inadequate training and supervision of staff responsible for providing assistance would result in poor quality assistance. A second concern also related to training was that resident safety would be jeopardized by allowing inadequately trained staff to assist residents with "complicated feeding assistance care needs" (e.g., swallowing difficulties). A third concern related to single-task nursing home workers was that facilities would use these workers to provide other aspects of daily care for which they had not received proper training (e.g., transferring residents into or out of bed; assisting residents to the bathroom, dress, and/or walking). The potential misuse of staff trained as dining assistants was a concern that stemmed from evidence that most nursing homes do not have adequate nurse aide staff available to provide care in a number of daily care areas including, but not limited to, dining assistance (Schnelle et al., 2000; Schnelle et al., 2004). Finally, there was concern that facilities would use single-task workers to

replace existing nurse aide staff who require more training, supervision, and higher pay, thus resulting in lower overall staffing and complaints among existing nurse aide and licensed nurse staffing with these training programs.

In response to these concerns, CMS and AHRQ (Agency for Healthcare Research & Quality) jointly sponsored an evaluation study to determine the number of states that had passed state-level legislation related to the regulation and the impact of the regulation on dining assistance care quality in a sample of facilities in states with active programs. As of 2005, dining assistant programs were approved in 28 states. An additional 16 states had state regulations that were pending and the remaining states had no regulations (Abt Associates, 2007). Reasons for no regulations included many of the same concerns initially expressed about the federal regulation (e.g., adequacy of training and oversight, resident safety). Researchers visited a sample of seven facilities in three states with active programs to evaluate program impact. Several key results emerged from this initial evaluation study (Bertrand, Moore, Hurd et al., 2008; Simmons, Bertrand, Shier et al., 2007).

First, the majority (84%) of the staff trained as dining assistants were staff from other departments within each facility (e.g., housekeeping, laundry, social activities) or nurse aides who worked in other facilities (8%), as opposed to single task workers hired from outside the facility (8%). Second, the quality of assistance provided by trained staff was comparable to, and in some cases better than, that provided by nurse aides according to five care processes measured by research staff observations of mealtime care. For example, staff trained as dining assistants spent significantly more time providing their assigned resident(s) help to eat during the meal, relative to their nurse aide counterpart. Third, there were no changes in existing staffing levels for nurse aides or licensed nurses following program implementation based on staff interviews, so these workers were not being used to replace nurse aides. Finally, the majority of staff at all levels (management, supervisory and direct care) reported positive program benefits for both staff and residents (Bertrand et al., 2008; Simmons, et al., 2007).

The results of this evaluation study suggest that the new regulation is serving its intended purpose of making it possible for facilities to augment their existing staffing levels during mealtime to improve dining assistance, for at least some residents. As a follow-up to this study, CMS and AHRQ jointly funded a demonstration study (Bertrand, Porchak, Moore, Hurd, Sweetland & Simmons, 2009). The intent of the demonstration study was to replicate and extend the evaluation study through the implementation and evaluation of a new dining assistant program in two nursing homes, each located in a separate state. One of the main purposes of the demonstration study was to develop a reference manual that nursing home providers could use to effectively initiate and sustain a new dining assistant training program (Abt Associates, Inc., 2009; accessible via www.abtassociates.com and www.VanderbiltCQA.org under “weight loss prevention” module). The results of this demonstration study did, in fact, replicate the results of the initial evaluation study in several important ways. First, most of the staff trained as dining assistants were staff from within each facility and the quality of care provided by these trained staff was comparable to, or better than, that provided by nurse aides within the same facilities. In addition, there also were no changes in licensed nurse or nurse aide staffing levels as a result of new program implementation. However, despite these very promising findings, the demonstration study also revealed a number of significant challenges to program implementation and maintenance and highlighted areas of the regulation that require further clarification and, in some cases, expansion.

Challenges to Program Implementation

- *Initial Recruitment of Staff:* Facilities that participated in either the initial evaluation study (Bertrand et al., 2008; Simmons, et al., 2007) or the demonstration study (Bertrand et al., 2009) varied in their recruitment efforts. Some gave staff a modest pay raise for completion of training and assisting during one meal per scheduled work shift. Other facilities required staff from certain departments to receive training, and staff had a mixed response to this requirement. Most facilities relied on staff to volunteer for

training, and many did but then subsequently chose not to participate in the program due to competing work demands of their primary job role (see Program Coordination).

- *Program Coordination with Nurse Aide and Dietary Staff:* In order for trained staff to assist their assigned resident(s) during a designated mealtime period, nurse aide staff often had to provide other aspects of care for the resident prior to the meal (e.g. transfer out of bed, incontinence care, dressing) and kitchen staff had to have the resident's meal prepared and delivered to the unit within a predictable timeframe. This often did not occur which meant that trained staff spent a significant portion of their allotted time away from their primary job duties waiting for either the resident and/or their meal. As a result, several trained staff became too frustrated with the process to remain active in the program. This illustrates the critical importance of coordination among multiple departments and services for an effective program.
- *Concerns about Survey:* Many facilities were concerned about having a new program in place for the first time during state survey. Specifically, staff were concerned that a new training program would invite even more scrutiny as part of their annual survey and, not yet being comfortably familiar with the new regulations, one site chose to discontinue the program prior to survey and then had difficulty getting the program reinstated following survey. New approaches to staff training and resident care provision should be encouraged by the survey team, especially when these new activities are a direct result of new regulations. Nursing home care providers are so used to survey being a punitive process they are wary of instituting new practices, even if those practices might be in the best interest of the resident. These concerns extend beyond a new dining assistant program to include other novel approaches to food service and dining such as buffet style dining, family style dining, allowing family members to bring food and help residents to eat, allowing residents to choose which items they want to be served as opposed to strict adherence to serving a required number of items to each resident, even when the

resident expresses dislike for certain items. The culture change movement and focus on resident-centered care is now encouraging staff to be more creative and flexible in multiple aspects of daily care delivery, including dining. Based on research findings, we offer the following recommendations for changes to current regulations.

Areas to Address in the Regulations

- *Identification of Residents Appropriate for the Program:* Residents “without complicated feeding assistance care needs” requires further clarification in the regulation. This requirement was interpreted differently across sites in both the evaluation and demonstration studies. Examples of specific diagnoses (e.g., dysphagia), choking risk (e.g., history of aspiration), or types of prescribed diets (e.g., thickened liquids) inappropriate for trained staff would be helpful to supervisory nurses as guidance. Many licensed nurses and staff developers struggled with the identification of residents appropriate for the program due to lack of clear guidelines and, as a result, often unnecessarily limited the number of residents included in the program. Residents who require full physical assistance (spoon-to-mouth help to eat) and/or modified texture diets (mechanical soft, puree) should be considered as potentially eligible, if there are no other safety concerns, because many of these residents eat slowly and, thus, require a significant amount of staff time (average 45 minutes/meal).
- *Licensed Nurse Supervision:* Clarification is needed in the regulations about the requirement that staff who receive training continue to work under the supervision of a licensed nurse. This requirement was interpreted by some as constant, direct visual contact between a Registered Nurse supervisor and each trained staff member responsible for providing assistance throughout each care episode. This interpretation translated into the exclusion of any resident who dined in his or her room from being assigned to a trained staff member, even though these residents were otherwise appropriate for the program (e.g., no safety concerns, poor oral intake). This

interpretation also limited the number of residents included in the program due to limitations in licensed nurse staffing. It is clear in the regulation that the initial training needs to be led by a licensed nurse and the identification of residents appropriate for the program also should be conducted by a licensed nurse in the context of the care planning team. It is also clear that staff trained to provide assistance need to receive ongoing supervision by a licensed nurse (continued assessment of the resident's appropriateness and staff ability to feed) and have a licensed nurse accessible to them during the assistance care episode, in case they have a question or problem. However, supervision through continuous visual contact does not appear to be necessary or even feasible for any care activity or employee group within the nursing home care setting.

- *Cross-contamination risk:* Clarification is needed concerning “cross-contamination” as staff interpret this as meaning they are not allowed to provide assistance to multiple residents who need various types of assistance (meal set-up, verbal cueing, physical assistance) simultaneously. In many facilities staff trained as dining assistants were assigned to assist only one or two residents during any given mealtime period, thus limiting the benefit and positive impact of the program to just a few select residents. The training of these additional staff to augment existing direct care staff could be utilized better if staff could help multiple residents simultaneously through the provision of verbal cueing and reminders, social interaction, meal set-up and other basic types of assistance.
- *Expand the role of staff facility-wide without the requirement for 8-hours of specialized training for some, specific mealtime tasks.* There are a number of competing tasks that must be completed during a typical mealtime period, almost all of which are typically the responsibility of nurse aides, which limits the time nurse aides have available to provide effective assistance to all residents in need. Some of these tasks require specialized training (e.g., spoon-to-mouth help to eat, meal delivery and the necessary knowledge of

resident's prescribed diet orders); however, many other tasks do not require eight hours of specialized training but remain time consuming when provided to many residents.

Tasks that require less specialized training and could be performed by staff other than nurse aides include:

- (a) *Transport of residents to/from the dining room for meals*, which can be done by most any level of staff, including volunteers, presuming that nurse aides provide other aspects of care to prepare the resident for transport (e.g., transfer out of bed, incontinence care, dressing).
- (b) *Meal delivery and pick up* is often done by nurse aide staff and could be done by kitchen/dietary staff instead. Alternatively, with minimal training related to orientation of the resident's name and diet order on the meal ticket, other types of staff could be trained in meal delivery or, minimally, meal pick up.
- (c) *Meal set-up*: Many residents who otherwise eat independently benefit greatly from meal set up such as opening containers, pouring fluids from cartons to cups and placing a straw in the cup, cutting up meat. Observations reveal items completely untouched by residents during the meal because staff never opened the container for the resident. Meal set-up is a relatively simple type of assistance but still requires an extra few minutes per resident/meal and often goes unnoticed by busy, direct care staff. Staff could provide this service for all residents, with minimal training.
- (d) *Percent eaten documentation*: Low intake is defined on the Minimum Data Set as "leaves 25% or more of food uneaten at most meals". Thus, nursing home staff document each resident's estimated total percent eaten (0% - 100%) either per meal or daily. Several research studies have shown this documentation is erroneous and consistently reflects an *over-estimate* of residents' intake by as much as 15% to 20%, on average. Moreover, there is a systematic error in the direction of the bias such that the lower the intake for an individual resident, the greater the over-estimation by staff

(Simmons & Reuben, 2000). There are a number of reasons for the erroneous estimates of food and fluid consumption but one major reason for the error is that nurse aide staff are often keeping track of these estimates for 10 to 15 different residents during any given mealtime period and documentation is often done several hours after the meal because staff are too busy during the meal. In short, there are too many competing demands on the nurse aides for them to accurately estimate and document consumption in addition to deliver meals and provide assistance. Assigning 1-2 designated trained observers (with a pocket calculator) to estimate intake would greatly increase the accuracy of these estimates which would, in turn, allow supervisory nurses to make better decisions related to nutritional care plans. It is most important to accurately identify residents with poor oral intake, and residents who consistently consume less than 50% of most meals are at a significantly higher risk for unintentional weight loss (Gilmore et.al., 1995). In addition, poor oral intake precedes a weight loss event and offers an opportunity for early nutrition intervention as opposed to relying on monthly weight values alone to identify a nutritional problem. An alternative to documenting residents' intake per meal/day would be to have a trained, supervisory person use a standardized tool (see Appendix A and below section *The Need for Standardized Assessments in the Survey Process*) to intermittently observe a sample of meals each week for targeted residents as part of a continuous quality improvement effort. These observations would accurately identify residents with poor oral intake as well as other nutritional care quality issues that might need to be addressed by staff (e.g., residents in need of assistance who are not receiving it).

- (e) *Provision of verbal cueing, reminders to eat.* Many residents capable of eating independently still eat poorly on their own but benefit greatly from verbal encouragement and reminders to eat (e.g., "How is your lunch today?"; "Try a bite of your soup. It looks good."). Some of these residents are easily distracted due to cognitive impairment and

others have a loss of interest and/or appetite due to medications, apathy or depression. Regardless, intermittent prompts from any one (no special training required!) to re-orient the resident to the meal and encourage consumption can have a significant impact on the oral food and fluid intake of many residents (Kayser-Jones, 1996; Lange-Alberts & Shott, 1994; Simmons, Osterweil & Schnelle, 2001; Simmons & Schnelle, 2004).

- (f) *Socialization during mealtime:* Similar to the provision of verbal cueing, social interaction among residents and staff during the mealtime period has been shown to have a positive influence on residents' oral food and fluid intake (Simmons et.al., 2001; Simmons & Schnelle, 2004). In general, older adults who dine with other people eat more than those who dine alone. This is true for community-dwelling elderly and it continues to be true for older adults in long term care (De Castro, 2002; Musson, Kincaid, Ryan et.al., 1990). Socialization also can impact quality of life and depressive symptoms and mealtime offers three scheduled opportunities each day for socialization to occur. Just like verbal cueing, anyone can do it.
- (g) *Offers and Retrievals of Alternatives to the Served Meal:* Both types of staff, nurse aides and staff trained as dining assistants, rarely offered alternatives to the served meal, even when a resident's intake was low (Bertrand et al., 2008; Simmons et.al., 2003; Simmons et.al., 2007). Interpretive guidelines issued by CMS regarding nutritional care include an explicit statement that nutritionally at-risk residents should be offered a choice among foods and fluids that are "palatable, attractive and nutritious" both during and between meals (Interpretive Guidelines, State Operations Manual, 2008). These interpretive guidelines are further supported by the culture change movement in long term care to create a more home-like environment and resident-centered care. The availability of choice, both during and between meals, is an important aspect of resident-centered care. Again, staff with minimal training could be present in the dining room for meals to notice when a resident is eating poorly (e.g., less than half of the served meal) and ask

the resident, “You don’t seem to like your lunch today. Would you like something else instead?” Similarly, it is beneficial to offer residents second helpings of preferred items in lieu of refusals of other items. These simple approaches provide resident choice and result in improved food and fluid intake; however, nurse aides often do not make these offers due to competing demands on their time and the extra time needed to request the alternatives/extra helpings and retrieve the items from the facility kitchen. Other types of staff could assist in this valuable role.

- *Extend the assistance provided by trained staff beyond scheduled meals to between meal periods:* Most facilities claim to have “hydration” and/or “snack” programs in place, either facility-wide or for at-risk residents. However, observation studies have shown that residents rarely receive additional foods and fluids between meals and, when they do, staff often does not provide an adequate amount of assistance or encouragement to promote consumption (Simmons & Schnelle, 2004). This is true even for residents with physician or dietitian orders to receive an oral liquid nutrition supplement multiple times per day (Kayser-Jones, Schell, Porter et.al., 1998; Simmons & Patel, 2006). Similar to mealtime assistance, the provision of additional foods and fluids between meals relies mostly on the nurse aides and the inconsistency of the delivery is usually due to competing demands on their time (e.g., other daily care tasks they are responsible for such as assisting residents to the bathroom or with showering). Thus, staff trained as dining assistants also could provide nutritional care to residents between meals as an extension of their valuable role during mealtime. Expansion of a dining assistant program to include both meal and between-meal time periods provides more options for trained staff to help in the context of their primary job role and a broader program impact for nutritionally at-risk residents.

General Recommendations related to Federal Regulations and Dining

In addition to the specific recommendations just reviewed, there were a number of other general recommendations supported by the CMS and AHRQ sponsored studies as well as other research studies on nutritional care issues in the long term care setting.

Terminology: “*Paid Feeding Assistant*” is no longer an appropriate term for this regulation most often in practice, staff within the facility as opposed to single task workers are trained as dining assistants. We rephrased the term in our studies as “Dining Assistants” and recommend the same wording change for the regulation (Bertrand et al., 2008; Simmons et.al., 2007).

Assessment of a Resident’s Assistance Care Needs: Oral intake should be considered when documenting a resident’s need for assistance to eat (Minimum Data Set [MDS] eating dependency item and resident’s daily care plan) because a significant proportion of residents rated by staff as “independent” or requiring only “supervision” have low intake and will increase their food and fluid consumption with more staff attention during the meal (verbal encouragement, reminders to eat; offers of alternatives to the served meal) and/or the provision of snacks between meals (Simmons, et.al., 2001; Simmons & Schnelle, 2004). Staff has a tendency to rate a resident’s assistance care needs solely based on their physical ability to eat independently without considering their need for other forms of staff attention. Standardized evaluations can be done to determine a resident’s need for mealtime assistance versus additional foods and fluids between meals. Research has shown that approximately 40% - 50% of residents with low food and fluid intake will show a significant increase in their intake in response to staff attention during meals; where as, most of the remaining residents will increase their total daily caloric intake in response to staff offers of additional foods and fluids between meals multiple times per day. Overall, almost 90% of the residents with poor oral intake will consume significantly more foods and fluids daily with either mealtime assistance and/or snacks between meals (Simmons, et.al., 2001; Simmons & Schnelle, 2004; Simmons, Keeler, Xiaohui

et.al., 2008). These evaluations can be completed in a two-day period to determine which nutritional approach is most effective for an individual resident in increasing total daily caloric intake. A resident's need for assistance is much more complex than their physical ability to eat independently; the assessments conducted by nursing home staff should reflect a consideration of their oral intake, dining and food preferences and response to different nutritional care approaches.

Appropriately Estimating Staff Time to Provide Dining Assistance Care: Several studies have shown assistance that both enhances a resident's independence in eating and encourages an adequate amount of food and fluid consumption requires a significant amount of staff time and greatly exceeds the amount of time nursing home staff typically spend on nutritional care (Simmons et.al., 2001; Simmons & Schnelle, 2004; Simmons et.al., 2008). The insufficient number of direct care staff available to provide assistance is one major reason for poor care quality, which underscores the need for the "paid feeding assistant" regulation (Schnelle et.al., 2004). Beyond that, however, it is also important to recognize that residents who are physically capable of eating independently but who require meal set-up, verbal cueing and encouragement to promote an adequate amount of consumption can be just as time-consuming for staff as residents who are totally physically dependent for eating (Simmons & Schnelle, 2006a). The typical assumption in the regulations and Resource Utilization Group (RUG) reimbursement system is that residents who are rated by staff as physically dependent in activities of daily living require more staff time; but, at least in the case of eating, this is an erroneous assumption (Simmons & Schnelle, 2006a). Thus, the RUGs data, which is based on the time nursing home staff actually spend providing care to residents, may under-estimate the time to provide assistance to residents who are physically capable of eating independently but who have poor oral intake. Time estimates for this group should be based on the time required to provide assistance that both enhances independence and encourages oral intake, which will likely

exceed the time spent under usual care conditions (Simmons et.al., 2008; Simmons et.al., 2001; Simmons & Schnelle, 2004; Simmons & Schnelle, 2006a).

The Need for Standardized Assessments in the Survey Process: The survey process has been criticized for its lack of consistency among survey teams both between and within states, and efforts to improve the consistency of the survey process through more standardized assessments of care quality are underway. A standardized mealtime observation tool has been developed and validated for use in long term care facilities (Schnelle, Bertrand, Hurd et.al., 2009; Simmons et. al., 2002; Simmons et. al., 2003; Appendix A). The tool provides observation-based measures of dining assistance care processes that can be summarized into overall quality scores at the resident, unit or facility level. We have taught nursing home providers how to use the tool for on-going quality improvement efforts (Simmons & Schnelle, 2006b). There are some aspects of nutritional care that are applicable to all residents (e.g., the importance of social interaction during meals, availability of alternatives to the served meal) and other aspects that are specific to the individual (e.g, type of assistance that is most appropriate to maximize independence and oral intake). Surveyors need to recognize that only about one-half of residents who eat poorly during meals will respond to mealtime assistance, but these same residents should still receive socialization and choice, for example. Similarly, many nutritionally at-risk residents should be receiving offers of additional foods and fluids between meals multiple times per day to enhance their total daily caloric intake (Simmons & Schnelle, 2004).

A significant proportion of residents can be interviewed about their dining and food preferences with simple questions, including those with mild to moderate cognitive impairment (Simmons, Cleeton & Porchak, 2009; Simmons, Lim & Schnelle, 2002). For example, many residents are able to answer the question: "If you don't like the food you are given, can you get something else instead?" Alternatively, standardized observations can be used to determine the

proportion of residents who eat poorly (less than half of the served meal) and for whom staff does not offer an alternative during a given mealtime period. The key aspect of offering alternatives to the served meal is staff recognition the resident is eating poorly. While it technically meets the interpretive guidelines to post menu choices in advance of the meal or even ask the resident immediately prior to the meal which of two entrees s/he prefers, it is most important for nutritional risk management for staff to recognize when a resident is eating poorly during a given mealtime period and ask, “would you like something else instead?”

Summary. The “paid feeding assistant” regulation offers a promising approach to enhancing the staffing resources available in nursing homes for nutritional care provision. Further clarification and expansion of the regulation will make it possible for nursing home care providers to extend the use of trained staff both during and between meals for broader program impact and benefit to more residents.

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PIONEER NETWORK / CMS SYMPOSIUM
Sandra F. Simmons, PhD & Rosanna Bertand, PhD
*“Enhancing the Quality of Nursing Home Dining Assistance:
New Regulations and Practice Implications”*

Recommendations / Comments Specific to Regulation:

“Paid Feeding Assistant” – not an appropriate term based on what, most often, happens in practice which is training internal staff from various departments (e.g., social activities, administrative, housekeeping) as opposed to hiring single task workers – renamed in our study “Dining Assistant”

Licensed Nurse Supervision: Clarification is needed about the requirement that “dining assistants” work under the supervision of a licensed nurse. This is often interpreted as requiring constant, direct visual contact between an RN supervisor and staff responsible for providing dining assistance throughout the care episode. In our study, this interpretation meant that residents who ate in their rooms were automatically excluded from being assigned to “dining assistants”, even though these residents were otherwise appropriate for the program. It is clear that training needs to be done by licensed nurse, that the identification of residents appropriate for the program should be done by a licensed nurse, and that a licensed nurse should be readily available if a problem occurs, but there should not need to be direct, visual contact between a licensed nurse and a trained staff member during each care episode.

Identification of Residents Appropriate for the Program: “Residents without complicated feeding assistance care needs” needs further clarification. This was interpreted differently across sites. Suggestions: residents with a diagnosis of dysphagia, documented risk for aspiration (e.g., requires thickened liquids). Residents who require full physical assistance and/or modified texture diets should be eligible because so many of these residents eat slowly and require a lot of staff time.

Cross-contamination risk: Clarification is needed concerning “cross-contamination” as staff interpret this as meaning they cannot sit at a table with multiple residents who need various forms of assistance (meal set-up, verbal cueing, physical feeding) and provide assistance to more than one resident simultaneously.

Provide a list of specific tasks other types of staff are allowed to do during meals WITHOUT 8-hours of training as a dining assistant:

- (h) Transport residents to/from the dining room for meals
- (i) Meal delivery and pick up (as long as they are taught to pay attention to resident name/diet order)
- (j) Meal set-up help: opening containers, pouring fluids from cartons to cups, placing straw, cutting up meat, buttering bread.
- (k) Percent eaten documentation (given training in just this area)
- (l) Provision of verbal cueing, reminders to eat
- (m) Provision of social interaction

- (n) Asking residents who are eating poorly if they like their meal, would like something else and then (based on resident's name and diet order on meal ticket), retrieving an appropriate alternative from the kitchen

Typically, nurse aides are primarily responsible for all of these other tasks, in addition to dining assistance, which limits the time they have available to focus on helping residents to eat. Staff does not have to receive 8 hours of training to help with these tasks.

Extend use of trained staff to between-meal nutritional care delivery: Staff trained as dining assistants also can provide foods, fluids (snacks) and supplements between meals to resident in need of additional daily calories.

General Recommendations related to Regulations and Feeding:

- (o) Oral intake should be considered when documenting a resident's need for assistance to eat (MDS eating dependency item and daily care plan) because a significant proportion of residents rated by staff as "independent" or requiring only "supervision" have low intake and would increase consumption with more staff attention (verbal encouragement, reminders to eat; offers of alternatives to the served meal)
- (p) It is erroneous to assume that physically dependent residents require more staff time than residents who still need staff attention to eat but are physically capable of eating independently. Residents who require only verbal reminders and encouragement require just as much staff time to enhance oral intake as those who require physical assistance to eat.
- (q) Surveyors need standardized assessment tools to determine the quality of mealtime assistance and residents' preferences related to dining. Observation and resident interview tools have been developed and validated in the long term care setting and should be used by surveyors and nursing home staff for quality improvement efforts.

CONTINUOUS QUALITY IMPROVEMENT FOR MEALS

1. Name:		2. Name:		3. Name:		4. Name:	
Food/Fluid items	%	Food/Fluid items	%	Food/Fluid items	%	Food/Fluid items	%
TOTAL PERCENT EATEN		TOTAL PERCENT EATEN		TOTAL PERCENT EATEN		TOTAL PERCENT EATEN	
5. Name:		6. Name:		7. Name:		8. Name:	
Food/Fluid items	%	Food/Fluid items	%	Food/Fluid items	%	Food/Fluid items	%
TOTAL PERCENT EATEN		TOTAL PERCENT EATEN		TOTAL PERCENT EATEN		TOTAL PERCENT EATEN	

GUIDELINES FOR ESTIMATING FOOD AND FLUID CONSUMPTION

- List each food and fluid item on the tray at the point of meal tray delivery and record resident consumption of each item at the point of meal tray pick-up.
- Use a continuous percentage scale, from 0% to 100%, for estimation instead of percentage categories, such as 0%, 25%, 50%, 75%, 100%, which usually result in overestimates of intake.
- Each food and fluid item on the meal tray is counted equally as opposed to assigning differential values to different items (e.g., meat = 30%, dessert = 20%), which results in error due to the complexity of the calculations.
- Ideally, consumption of fluids should be recorded in ounces (or cc), in addition to percent consumed, to allow for an accurate measure of fluid intake. In our assessments, we did not count optional fluids served independent of the meal tray, such as hot coffee or hot tea, in this estimate but some facilities do count these fluids and that is okay as long as all staff count the same fluids. In addition, we did not count food items with a high fluid content as fluids (e.g., soup, jello, ice cream) and instead counted these items as foods, to avoid confusion among staff.
- Oral liquid nutrition supplements consumed *during* the meal should *not* count in the total percent consumed estimation, though the amount consumed (in ounces) of the supplement should be recorded separately to allow an estimate of total calories during meals. Supplements are intended to be given *between* meals. However, we recognize that some residents prefer supplements as their fluid item with the served meal. Staff should offer appropriate meal alternatives (e.g., different entrée or sandwich choices with sides) and adequate assistance before giving a supplement during the meal, unless the supplement is actually requested by the resident.

CONTINUOUS QUALITY IMPROVEMENT FOR MEALS: AN OBSERVATIONAL TOOL

Date: ___ / ___ / ___

Staff Observer: _____

Begin Time: ___:___ am pm

End Time: ___:___ am pm

Meal: ___ Breakfast ___ Lunch ___ Dinner Location: ___ Dining Room ___ Room/Hall

Identify 4-8 residents who should receive feeding assistance (e.g., rated on MDS as requiring assistance to eat, history of weight loss). Observe during the meal and record all information below. Residents should be observed continuously for at least for the initial 20 minutes of the meal.

Resident Name	1	2	3	4	5	6	7	8	Comments (resident complaints about meal or staff offers of alternatives?)		
	Physical Assist	Verbal Instruction	Social Stimulation	Supplement	Assist Time		Total % Eaten			Medical Record	
				Yes Consumed	More 5 min	Less 5 min	> 50	< 50		Total % Eaten	Assistance Provided
					OZ						
					OZ						
					OZ						
					OZ						
					OZ						
					OZ						
					OZ						
					OZ						

Calculate Feeding Assistance Care Process Measures Below as a Percentage (0% to 100%) for Residents Observed During This Meal:

1. Of those who received physical assistance (column 1), how many also received verbal instruction (column 2)? _____%																		
2. Of the total number of observed residents, how many received at least one episode of social stimulation from staff (column 3)? _____%																		
3. Of those who were given a supplement (column 4. yes), how many received more than 5 minutes of assistance (column 5)? _____%																		
4. Of those who ate less than 50% (column 6. <50), how many received more than 5 minutes of assistance (column 5)? _____%																		
5. Of those who ate less than 50% (column 6. <50), how many had documentation equal to or less than 60% (column 7: total % eaten)? _____%																		
6. Of those who ate less than 50% (column 6. <50), how many were offered an alternative to the served meal (see comments)? _____%																		
7. Of those who had documentation assistance was provided (column 8), how many received more than 5 minutes of assistance (column 5)? _____%																		
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; border-right: 1px solid black; padding: 2px;">Instructions</td> <td style="padding: 2px;">Mark as present all types of assistance provided by any type of staff during the meal (from tray delivery to tray pick up), even if it only occurs once.</td> </tr> <tr> <td style="border-right: 1px solid black; padding: 2px;">Physical Assistance/Physical Guidance</td> <td style="padding: 2px;">Staff holds utensil/cup and/or helps resident to hold utensil/cup to eat or drink (e.g., Aide feeds resident or physically assists resident to feed him or herself).</td> </tr> <tr> <td style="border-right: 1px solid black; padding: 2px;">Verbal Instruction (cueing, reminders)</td> <td style="padding: 2px;">A comment made by staff specifically directed toward eating (e.g., "pick up your spoon and take a bite"; "try some more of your soup").</td> </tr> <tr> <td style="border-right: 1px solid black; padding: 2px;">Social Stimulation</td> <td style="padding: 2px;">A social comment made by staff NOT specifically directed toward eating (e.g., How are you today? It's good to see you. You look nice today").</td> </tr> <tr> <td style="border-right: 1px solid black; padding: 2px;">Supplement</td> <td style="padding: 2px;">Record any type of oral liquid nutritional supplement (e.g., Resource, Ensure) given with the meal and amount consumed by resident.</td> </tr> <tr> <td style="border-right: 1px solid black; padding: 2px;">Assistance</td> <td style="padding: 2px;">Record estimated time spent by any type of staff (nurse aide, licensed nurse, activities) providing any type of assistance to encourage eating during the meal.</td> </tr> <tr> <td style="border-right: 1px solid black; padding: 2px;">Total Percent Eaten</td> <td style="padding: 2px;">Calculate on a 0% to 100% metric using the same measurement system required of nurse aides, or other designated staff, in the facility.</td> </tr> <tr> <td style="border-right: 1px solid black; padding: 2px;">Medical record</td> <td style="padding: 2px;">Documentation of total percent eaten and assistance provided by nurse aide or other staff for the same day and meal as observation.</td> </tr> <tr> <td style="border-right: 1px solid black; padding: 2px;">Comments</td> <td style="padding: 2px;">Record resident complaints about meal service or appetite, staff offerings of alternatives to the served meal or other relevant observations (e.g., refusal of food or help).</td> </tr> </table>	Instructions	Mark as present all types of assistance provided by any type of staff during the meal (from tray delivery to tray pick up), even if it only occurs once.	Physical Assistance/Physical Guidance	Staff holds utensil/cup and/or helps resident to hold utensil/cup to eat or drink (e.g., Aide feeds resident or physically assists resident to feed him or herself).	Verbal Instruction (cueing, reminders)	A comment made by staff specifically directed toward eating (e.g., "pick up your spoon and take a bite"; "try some more of your soup").	Social Stimulation	A social comment made by staff NOT specifically directed toward eating (e.g., How are you today? It's good to see you. You look nice today").	Supplement	Record any type of oral liquid nutritional supplement (e.g., Resource, Ensure) given with the meal and amount consumed by resident.	Assistance	Record estimated time spent by any type of staff (nurse aide, licensed nurse, activities) providing any type of assistance to encourage eating during the meal.	Total Percent Eaten	Calculate on a 0% to 100% metric using the same measurement system required of nurse aides, or other designated staff, in the facility.	Medical record	Documentation of total percent eaten and assistance provided by nurse aide or other staff for the same day and meal as observation.	Comments	Record resident complaints about meal service or appetite, staff offerings of alternatives to the served meal or other relevant observations (e.g., refusal of food or help).
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CONTINUOUS QUALITY IMPROVEMENT FOR MEALS: SCORING RULES AND RATIONALE

The information generated by the observational tool can be reported as feeding assistance care quality indicator scores (e.g., proportion of residents within a facility who had low oral intake but who did not receive assistance from staff during a particular meal) and used for quality improvement purposes. There are two primary advantages of a quality indicator (QI) score. First, a QI score has the potential to highlight care areas in need of improvement. Second, a QI score efficiently summarizes the data into understandable quality categories for which feeding assistance can be scored as either “passing” or “failing” for individual residents and mealtime periods. The percentage of residents who receive a “pass” or “fail” score provides a summary measure of the quality of care provision, which is useful for making comparisons within a facility over time (e.g., staff shifts, meals). These types of comparisons inform quality improvement because it provides an objective and specific way to track changes in staff behavior and identify problems with care delivery (e.g., specific meals or days of the week wherein there are quality issues). The rules and rationale that guide the scoring of 7 feeding assistance care QIs are presented below. These QIs are operationalized into specific nursing home staff behaviors that can be reliably observed during meals. The focus on care processes under the direct control of nursing home staff is critical to any quality improvement effort, because it is possible for poor clinical outcomes to occur (e.g., unintentional weight loss) in the context of optimal care quality. This observational tool is not intended to comprehensively assess all issues relevant to nutritional care; rather, it provides a tool that supervisory-level staff can use to monitor the quality of feeding assistance provided to residents as well as the accuracy of corresponding medical record documentation. Supervisory-level staff should conduct observations during one to three meals (breakfast, lunch, and dinner) per week to effectively monitor the adequacy and quality of daily feeding assistance care provision. The scoring rule for each of the QIs listed next reflects a liberal approach that maximizes the opportunity for staff to “pass”.

Feeding Assistance Care Quality Indicators for Meals

1. *Staff ability to provide verbal instruction to residents who receive physical assistance at mealtimes.*

Scoring Rule: Score as “fail” any resident who receives physical assistance to eat from staff without also receiving at least one episode of verbal instruction directed toward eating (e.g., “Try a bite of your soup.”).

Rationale: Verbal instruction, or cueing, increases residents’ independent eating behaviors and oral food and fluid intake. Staff often provides excessive physical assistance to residents who could otherwise eat independently with just verbal encouragement, reminders to eat. Ideally, the verbal instruction should precede physical assistance to encourage independence in eating; but, the scoring rule for this indicator allows staff to “pass” if verbal instruction is provided at any point during the meal (before, during or after physical assistance).

2. *Staff ability to provide social interaction to all residents during mealtimes.*

Scoring Rule: Score as “fail” any resident who does not receive at least one episode of social interaction (i.e., verbal interaction that does *not* include a specific instruction to eat, “how are you today?”) during the meal.

Rationale: Social interaction has been shown to enhance oral food and fluid intake in residents. Social interaction during meals is also important to residents’ quality of life and should not be limited to those with low oral intake.

3. *Staff ability to provide adequate feeding assistance to residents who receive an oral liquid nutrition supplement during mealtimes.*

Scoring Rule: Score as “fail” any resident who receives an oral liquid nutrition supplement and less than five minutes of staff assistance to eat during the meal.

Rationale: Oral liquid nutrition supplements are most effective in increasing daily caloric intake when provided *between* regularly-scheduled meals as opposed to *with* meals. Supplements are often inappropriately given with meals and may be used as a substitute for quality feeding assistance or treated as a substitute for the main entrée. Thus, residents should not be given a supplement during the meal unless staff has provided assistance to encourage the resident to eat the served meal.

4. *Staff ability to provide assistance to at-risk residents.*

Scoring Rule: Score as “fail” any resident who consumes less than 50% of the food and fluid items on his or her meal tray based on observation and who receives less than five minutes of assistance from staff during the mealtime period.

Rationale: If a resident who consumes less than 50% of a meal also receives less than five minutes of assistance from staff, then staff is providing potentially substandard feeding assistance, failing to recognize an

oral intake problem, or both. Residents who receive less than five minutes of assistance typically receive only tray delivery and set-up with no additional help; whereas, those who receive more than five minutes receive, on average, 15 to 20 minutes of staff attention.

5. Staff ability to accurately identify residents with clinically significant low oral food and fluid intake during meals.

Scoring Rule: Score as “fail” any resident who consumes less than 50% of the food and fluid items on his or her meal tray based on observation, but who is identified by staff (i.e., medical record documentation of percentage intake for the same meal as the observation) as consuming equal to or greater than 60%.

Rationale: The federal (MDS) criterion for low oral intake is defined as “leaves 25% or more of food uneaten”, or consumes less than 75% of most meals. Recent evidence, however, suggests that residents who consistently consume less than 50% of most meals are at a significantly higher risk for weight loss. Thus, if staff document that a resident consumed more than 60% of a meal when, in fact, the resident ate less than 50%, it is likely staff are failing to identify a clinically significant oral intake problem for that resident.

6. Staff ability to offer meal alternatives to residents who do not like the served meal.

Scoring Rule: Score as “fail” any resident who eats less than 50% of the food and fluid items on his or her meal tray based on observation, and who is not offered an alternative to the served meal (i.e., substitution) at any point during the meal by any staff member.

Rationale: Residents often do not like the served meal or certain items on the meal tray; however, most residents will not complain directly to staff about the meal service or request something else. Thus, it is important for staff to notice if a resident is not eating well and offer him or her alternatives to the served meal or individual foods or fluids (e.g., sandwich, fruit, orange juice instead of apple juice, sausage instead of bacon). Staff receive a “pass” score just for *offering* the alternative(s) to the resident, even if the resident refuses the offer or accepts an alternative but doesn’t consume it.

7. Staff ability to accurately document feeding assistance care provision.

Scoring Rule: Score as “fail” any resident who receives less than five minutes of assistance from staff but who has medical record documentation for the same day and meal that feeding assistance was provided.

Rationale: Studies have shown that feeding assistance is documented in the medical record as provided for all residents at risk for weight loss (those rated on the MDS as requiring assistance to eat and/or those with a history of weight loss), even though most of these residents actually receive less than five minutes of assistance. Thus, medical record documentation related to feeding assistance care provision is not accurate or specific enough to be useful for quality improvement efforts. Supervisory-level staff should be aware of the inaccuracy of this documentation to inform improvement efforts.