

# Manual



## Dining Assistant Programs in Nursing Homes: Guidelines for Implementation



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# Introduction

What nursing home administrator or director of nursing has not cringed at the sight of half-eaten trays returned from the dining room, untouched supplements dumped in the trash, and monthly logs showing unintentional weight loss? Food and issues around dining are usually the top complaint in every nursing home satisfaction survey. A Dining Assistant (DA) program that could address and mitigate just a portion of these issues with a minimal investment of nursing home resources deserves consideration.

DA programs are flexible – they can involve only one or two residents or only several staff, and be implemented on only one unit or one shift. They can involve community volunteers or paid workers, or in-house non-nursing staff looking for opportunities to advance to direct care work. They can be scaled up or back depending on the needs of the residents and resources of the nursing home (NH). If the decision is made to train non-nursing staff, the DA program can be the nursing home's first step toward culture change.

While the Centers for Medicare & Medicaid Services (CMS) and the majority of states now allow the use of dining assistants in long-term care facilities, relatively few nursing homes have implemented their own programs. We believe this is due to the limited resources currently available to educate decision-makers on designing and implementing dining assistant programs and insufficient understanding of the advantages to the resident and the NH overall of a Dining Assistant Program.

Several stakeholder organizations—e.g., the American Health Care Association (AHCA), the American Dietetic Association (ADA), and the Colorado Department of Public Health and Environment— have developed and published training manuals. These training manuals are discussed in Chapter 6 and provide staff developers with complete lesson plans that prepare trainees to safely and effectively assist residents during mealtimes. They do not, however, address the decision-making process that nursing home management face as they attempt to determine whether or not a DA Program is appropriate for their NH.

*Dining Assistant Programs in Nursing Homes: Guidelines for Implementation* is a manual intended to guide management staff through a step-by-step process of assessment, goal identification, program design, implementation, and planning for program sustainability. It includes specific guidance to assist management with:

- ❖ Assessing their NH in terms of their strengths and weaknesses around dining quality;
- ❖ Determining if a DA program is an appropriate addition to current programming;
- ❖ Designing a DA program that meets the residents' needs using the NH's resources; and
- ❖ Successfully implementing a DA program that improves residents' quality of care, residents' and families' satisfaction around dining, and encourages and promotes staff involvement and advancement.

In addition to program descriptions and guidance throughout the chapters of the manual, we provide *DA Program Implementation Worksheets* (see Appendix A), designed to be copied from the manual and used by nursing home staff developers and others to assess and plan DA programs.

Developed by Abt Associates and Vanderbilt University with funding and input from CMS and the Agency for Healthcare Research and Quality (AHRQ), the manual is the culmination of three years of research that involved an inventory of state programs in all 50 states, site visits to DA programs in several states to observe the programs and interview staff, and implementation of pilot programs in two sites in two states. The research team consists of experienced long-term care nurses, nationally- known nutrition experts and a gerontologist, along with CMS and AHRQ staff.

The manual is further enhanced by the invaluable contributions of nursing home staff developers who have implemented DA Programs in their NHs. They generously shared with us lessons learned from their experience with the program, recommended viable options for recruitment and retention, and offered suggestions on how to implement an optimal program. Additional contributions to this manual come from other stakeholder groups such as long-term care affiliate organizations (e.g., AHCA; American Association of Homes and Services for the Aging (AAHSA)) and the ADA.

It is our hope that this manual will encourage nursing home management to consider whether a DA Program could benefit their NH, as well as provide a valuable resource for developing and instituting a successful program.

# Federal and State Requirements for a Dining Assistant Program

In 2003, CMS published a *Federal Register* notice allowing long-term facilities to use Dining Assistants<sup>1</sup> to supplement the services of certified nursing assistants (CNAs) during mealtimes (see Appendix B). The legislation had two immediate goals: 1) to increase the availability of staff during mealtimes, and 2) to provide a set of minimum training and supervision standards for DA Programs.

In addition to the federal regulations, many states have published their own requirements for DA Programs. Most state requirements go beyond those mandated under the federal legislation by requiring, for example, increased DA training and more skilled supervision during meals. These federal and state regulations are fundamental to the DA Program because they provide a minimum set of compliance standards.

Although instituting a dining program is optional, compliance with the federal and state-specific regulations is compulsory once NH management have decided to implement a program. Therefore, a preliminary step before considering a DA program is to make sure your State allows the program and to become familiar with both federal requirements and those mandated by your specific State. This chapter presents an overview of the federal regulations, and provides a guide for locating relevant information on the DA Program in your State.

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<sup>1</sup> We have replaced the terminology used in the Federal regulation, “paid feeding assistant,” with the term “dining assistant” to more accurately represent these workers who are not necessarily paid or paid beyond their regular salary for this service. Further, we believe that the term “dining assistant” is more sensitive to residents’ sense of dignity.

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# Federal Regulations

The 2003 *Federal Register* notice includes a list of regulations that serve as a minimum set of standards for nursing home administrators to adhere to when they are interested in training individuals to help feed residents during mealtimes. The Federal Register notice is printed in its entirety in Appendix B and also can be found at: <http://www.gpoaccess.gov/nara/index.html>. Following is a list of the regulations that are included in the Federal Register notice that should be considered when developing a program:

- ❖ *Dining Assistants* must complete a state-approved training course, that includes:
  - ✓ A minimum of eight hours of training.
  - ✓ Specific Training Topics:
    - 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.
  - ✓ State-specific training requirements.
- ❖ *Nursing homes* must ensure their DA Program meets the following requirements:
  - ✓ DAs work under the supervision of an RN or LPN.
  - ✓ DAs may not train other feeding assistants.
  - ✓ Resident selection must be based on the charge nurse's assessment, the resident's latest assessment, and plan of care.
  - ✓ DAs feed only residents who have no complicated feeding problems such as difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.
  - ✓ Management must maintain a record of individuals who have been trained and are serving as DAs.
  - ✓ The program must follow state-specific program requirements.

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## State Regulations

As stated above, not all states allow DA programs, so NH management interested in establishing a program should first make sure that it has been approved by the state. If the program does not have state approval it cannot be implemented. If the DA Program has been approved in the state, it is important to read and understand the state-specific requirements. The state of interest may have a unique approval process and/or require additional program or training requirements beyond those published in the *Federal Register* notice.

❖ Additional state requirements may include:

- ✓ More hours of training than the federally mandated eight hours.
- ✓ More training topics than the federally mandated topics.
- ✓ Competency testing with a skills demonstration, written examination, or a combination of both skills and written exam.
- ✓ Training instructor qualifications.
- ✓ State-specific curriculum.
- ✓ Training requirements for Volunteers.
- ✓ Annual in-service for Dining Assistants.

To locate information on state requirements, see Appendix C that provides state contact information. The appendix, current as of September 2008, includes web-based links and/or other contact information to assist nursing homes to locate state-specific DA Program regulations.



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## Compliance with State Surveys

In 2005, the Abt Associates and Vanderbilt research teams conducted telephone interviews with state agency representatives engaged in the regulation of long-term care facilities to explore the extent to which NHs across the nation were implementing the DA Program and to understand the reasons why many NHs had not chosen to implement it. We also visited a small sample of NHs that had implemented a DA Program.

Some NH administrators expressed concerns that the presence of DAs during a state survey would be a “red flag” and result in greater scrutiny of nutrition- and dining-related compliance issues. However, a program that is implemented according to federal and state guidelines should not risk a compliance violation.

During the state survey, the objectives of the investigative protocol for state surveyors are to determine, for a nursing home that uses paid feeding assistants (or DAs):

- ❖ If individuals used as DAs successfully completed a state approved training course.
- ❖ If sampled residents who were selected to receive assistance from Dining Assistants were assessed by the charge nurse and determined to be eligible to receive these services based on the latest assessment and plan of care.
- ❖ If the DAs are supervised by an RN or LPN.

The complete CMS-issued guidance for surveyors in assessing compliance with the regulations concerning DAs is presented in Appendix D.

# Deciding on a Dining Assistant Program: Program Fit

The DA Program is a viable solution for increasing staffing during mealtime. It can serve as a preventive measure against unintentional weight loss and dehydration, and it can directly contribute to improving the quality of residents' lives. This is because DAs are likely to have more time to spend interacting with residents than CNAs who are often pulled away from the dining room to provide more "hands on" resident care. As a result, DAs are in a position not only to ensure better nutrition and hydration, but also to engage residents in social interactions and improve the overall quality of their dining experience. Congregate meals are intended to encourage social interaction; yet all too often residents eat meals isolated in their rooms, or sit alone and disengaged in the dining room. The use of trained DAs can help to alleviate this problem.

## ***From the Field:***

Because Joe is available and has been trained as a Dining Assistant, we are able to bring Mary to the dining room for the noon-time meal. Joe is outgoing and willing to chat with the residents. Although Mary does not communicate well verbally, she smiles and laughs throughout the meal when she is assisted by Joe. It has made a big difference in the quality of her meal-time experience (Staff Developer, Massachusetts, 2008).

Note. Names used in these field notes are not the actual names of the Dining Assistant and resident.

Some nursing homes may not need to implement a full DA Program because they do not have a history of nutrition problems such as unintentional weight loss and/or dehydration. Other NHs may not have the physical space or staffing resources to accommodate such a program. For example, DAs are often recruited from the Laundry and Housekeeping departments. If a NH subcontracts these workers through an outside agency, it is unlikely that their contract will allow them to perform duties beyond those for which they are subcontracted.

Nonetheless, with the exception of unusual cases, some type or model of the DA Program will prove beneficial to residents and staff in most NHs. This chapter presents options and assessment ideas for how to create a facility-specific DA Program.

## Addressing Concerns about a Dining Assistant Program

During our visits to NHs that have implemented DA programs, we obtained feedback from upper-level staff regarding concerns they may have had prior to program implementation. In addition to the concerns about state survey noted above, some staff expressed concerns about the implications of the DA Program for resident care

and safety. These included that dining assistant training and supervision would not be adequate, that assignment of residents to dining assistants may not be appropriate (i.e. residents with complicated feeding assistance needs such as swallowing difficulties would be selected), and that training non-nursing staff in dining assistance could increase the likelihood that they will be used to provide other aspects of daily care (e.g., transferring, toileting, dressing).

We understand that many administrators who are contemplating the implementation of a DA Program may have some of these concerns. However, evidence from early studies indicates these concerns can be mitigated by a well-designed program that adheres to state and federal guidelines and incorporates the guidance in this manual which was compiled from field experience and input from staff developers who have implemented the program in other NHs.

For example, some administrators or other NH management may be concerned that the minimum federal requirement of eight hours of training is not enough. Most of the authors of the published training manuals that we reviewed seem to agree with this concern; the training manuals that are referenced in Chapter 6, *Training Dining Assistants*, present curricula that are longer than the minimum eight hours. Further, Chapter 6 offers some ideas for supplementing the basic eight hours of training.

Proper training will set parameters within which DAs can work. For example, they will be taught that they cannot assist residents with daily living tasks that are unrelated to dining. They will also be trained to recognize and appropriately respond if a resident is observed having difficulty swallowing. It is very important to also train the nursing staff who will be involved with the program in the proper supervision of DAs, and to require that a supervisor be available whenever a DA is assisting residents.

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# Models of a Dining Assistant Program

Although the DA Program has the potential to be beneficial to all residents and staff, one type or model of program may be more appropriate than another for a specific NH. Through onsite observations during mealtimes, the Abt Associates and Vanderbilt University research teams observed several DA Program models. In some homes, DAs' roles were restricted to delivering and setting up resident trays, whereas in other NHs they engaged in all meal-related tasks including physical assistance with eating.

- ❖ By selecting one or some combination of the following meal-related tasks, a facility-specific model of the DA Program can be tailored to meet the dining needs of nearly all NHs:
  - ✓ Transport residents to and from the dining room.
  - ✓ Deliver and set up trays for residents in the dining room and in their rooms.
  - ✓ Circulate around the dining room and in and out of resident rooms to provide social stimulation.
  - ✓ Circulate around the dining room and in and out of resident rooms to identify residents who are not eating and to offer them, and obtain, substitute food items.
  - ✓ Provide physical guidance to residents in the dining room and in resident rooms who are able to eat on their own but need some level of physical guidance (e.g., hand them a fork with food on it; guide their hand to scoop food).
  - ✓ Provide full physical assistance to residents in the dining room or in resident rooms who are unable to eat on their own.
  - ✓ Offer residents between-meal snacks and fluids.

### ***From the Field:***

We have included a hydration component to the Dining Assistant Program. I methodically identify residents who require regular hydration and assign a Dining Assistant to offer them 8 ounces of fluids periodically throughout the day (Staff Developer, Tennessee, 2008).

Obviously, not all of the meal-related tasks identified above require formal DA training. However, participating in the minimal eight hours of training will prepare entry-level staff and/or volunteers to provide better service to residents across all of these tasks. Furthermore, it will prepare staff to engage in more-direct resident care such as full physical assistance with eating, if emergency staff shortages occur. In addition, a DA Program can be expanded beyond regularly scheduled meals to include offering residents additional foods and fluids (snacks, supplements) between meals to increase oral intake.

Basic DA Training Programs include modules on communication/ interpersonal skills, dealing with resident behaviors, and emergency procedures, among others (see Chapter 6, *Training Dining Assistants*). As an example of how DA training can improve resident

service, consider a non-nursing, untrained dining room helper who delivers and sets up trays during the lunch-time meal. This helper may routinely salt, pepper, and/or sweeten a resident's food as well as mix together various food items on the tray without soliciting the resident's preferences. The skills obtained during DA training will provide the staff member with information on how to approach the resident, communicate with the resident, and set up the tray according to the resident's preferences.

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# Resident and Facility Assessment

To implement the best DA Program model for the NH, residents' nutritional status and quality of life should be assessed, as well as NH policies and procedures. Following are quality of care and NH staffing issues that should be considered when determining the overall suitability of a DA Program, and used as a guide for constructing an appropriate facility-specific model for the Program. This section is organized by identification of the issue that may be problematic for the nursing home, followed by specific guidance for how to assess and address that issue. Appendix A includes a series of six worksheets designed to assist the NH in designing and implementing a DA program. Worksheet # 1 covers "Conducting the NH Dining Assessment" and may be used to "score" the nursing home's dining program.

## Resident Quality of Care Issues

### **Problem: Unintentional Weight Loss**

One of the most salient long-term goals that management identify as a reason for implementing a DA Program is to reduce the incidence of unintentional weight loss. This goal will be expanded upon in Chapter 4, *Creating Dining Assistant Program Goals*, but is mentioned here because it should be used as a primary determining factor for whether or not to implement a DA Program.

- ❖ Sources of information from which to determine the prevalence of residents with unintentional weight loss at your NH include:
  - ✓ Monthly resident weight documentation.
  - ✓ Quality Measure score for significant weight loss for long-stay residents.
  - ✓ Care plans.
  - ✓ Interviews with charge nurses.
  - ✓ Interviews with dietary staff.
  - ✓ Most recent state survey results to check for nutrition-related deficiencies.
  - ✓ Minimum Data Set (MDS) item K3a for problematic weight change (5 percent weight loss in the last 30 days, or 10 percent weight loss in the last 180 days).<sup>2</sup>

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<sup>2</sup> All references to the Minimum Data Set (MDS) throughout this Manual are to the 2.0 Version.



## Problem: Poor Meal Consumption

Although poor meal consumption is directly related to unintentional weight loss, we list it separately because using a DA in a NH that has a high number of residents with poor meal consumption can potentially preempt a weight-loss problem.

Not eating one's meal can be caused by a number of issues such as: the food is room temperature when it should be hot (or warm when it should be cold) and no longer palatable to the resident due to the length of time it took for the tray to be delivered from the cart to the resident; the food is not palatable to the resident because s/he does not receive adequate tray set-up such as adding salt, pepper, and sugar to food and beverages, or cutting up hard-to-eat items; the resident does not like the food that is being served, but is not offered a substitute meal; the resident is a very slow eater but is not given adequate time to finish the meal; the resident is bored and lonely and lacks the motivation to eat; or the resident requires some level of physical assistance, but does not receive it because on occasion this resident can self-feed.

- ❖ Sources of information from which to determine the prevalence of residents with poor meal consumption include:
  - ✓ Interviews with dietary staff to determine whether or not trays are coming back to the kitchen with uneaten food.
  - ✓ CNA documentation of food and fluid intake.
  - ✓ Interviews with CNAs to determine if there have been complaints about the food.
  - ✓ Facility dietary policy regarding when dietary supplements are routinely administered.
  - ✓ Dining room observations.
  - ✓ MDS items K4a, K4b, and K4c for complaints about the food, complaints of hunger, and leaving more than 25 percent of food uneaten at most meals, respectively.

*How a Dining Assistant Program can help:* Unintentional weight loss and poor meal consumption can be improved with the implementation of a DA Program. First, the DA Program places more designated staff in the dining room during meals to help facilitate tray delivery and set-up. As a result, the food is more likely to be served at the temperature it was intended. In addition, increased staff availability during mealtimes makes it more likely that residents' preferences will be accommodated. Second, DAs have designated time in the dining room so they are more likely to identify residents who are not eating and are available to offer and obtain substitute food items or provide verbal cueing to encourage meal consumption. Also, keeping in mind standard infection control

procedures, DAs can be seated at a table with one or two residents who require full physical assistance or physical guidance as they eat. Finally, DAs can help to deliver between-meal foods and fluids and dietary supplements as a way to improve residents' caloric intake.

## **Problem: Quality of Life**

The clinical impact of residents' quality of life cannot be underestimated. Poor quality of life including the perception of loneliness and isolation can lead to depression and poor nutritional intake. Research has demonstrated that social stimulation during meals can improve the overall quality of life for nursing home residents as well as improve their oral intake and nutritional status.<sup>3</sup>

<sup>4</sup> A positive dining experience that includes social interactions results in more food eaten, fewer digestive disturbances, better absorption of nutrients, and more positive resident attitudes.<sup>5</sup>

Competing demands for CNA time both limit the amount of physical assistance residents receive during meals, as well as the CNA's time for social conversations with residents. Further, restricted CNA time often impedes their ability to dress and transport all appropriate residents under their care to the dining room. This leaves many residents to eat alone and isolated in their rooms who might have benefited from the social environment of the dining room.

- ❖ Sources of information from which to determine quality of life problems include:
  - ✓ Social Services notes and interviews with social service staff to identify residents with potential problems.
  - ✓ Activities notes and interviews with activities staff to identify residents with potential problems.
  - ✓ MDS Section E1 for indicators of depression, anxiety, and sad mood.
  - ✓ Resident observations.

*How a Dining Assistant Program can help:* Fundamentally, implementing a DA Program will increase the number of staff available in the dining room and circulating in and out of resident rooms during mealtimes to communicate with residents. As mentioned previously, a component of the DA training includes a

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<sup>3</sup> De Castro JM. Age-related changes in the social, psychological, and temporal influences on food intake in free-living, healthy, adult humans. *J Gerontol: MED SCI* 2002,57A(6):M368-M377.

<sup>4</sup> Simmons SF & Schnelle JF. (2004). Individualized feeding assistance care for nursing home residents: Staffing requirements to implement two interventions. *Journal of Gerontology: Medical Sciences*, 59A(9):966-973.

<sup>5</sup> Morton K. (Ed.). (2003). *Eating Matters: A Training Manual for Feeding Assistants*. West Hartford, CT: Consultant Dietitians in Health Care Facilities. A Dietetic Practice Group of American Dietetic Association.



module on resident communication. Staff who participate in a DA Training Program are taught the significance of engaging residents in social interactions as well as the nuances of communicating with them. They learn how to approach residents, how to listen to residents, and how to read resident cues. With the addition of DAs to a nursing home's staff, CNAs will also have more time available to provide care and interact with residents during mealtimes. They will also have more time to groom and dress residents and to encourage them to eat all three meals in the congregate setting of the dining room.

## Nursing Home Staffing Issues

### Availability and Appropriateness of Staff

Several issues related to nursing home staff can be motivating factors for implementing a DA Program. These factors include the interest of entry-level staff to gain more direct resident contact, and the use of the program as a stepping-stone toward CNA and eventual LPN or RN licensure. On the other hand, there are also some NH factors that might impede the implementation of a viable program. These factors include entry-level staff who are not interested in direct resident contact, entry-level staff who are subcontracted and therefore not available to perform tasks beyond those for which they were hired, and lack of interest in the program from nursing staff.

#### ***From the Field:***

At this facility, staff cannot work more than 40 hours per week and it is difficult for them to complete their work in 40 hours. They are not going to be willing to give up their lunch time or work overtime without compensation so that they can assist at mealtimes (Staff Developer, Massachusetts, 2008).

❖ Information to be gathered to determine staff interest and availability to participate in a DA Program:

- ✓ Determine whether or not contracted non-nursing staff are available to participate in the program.
- ✓ Interview non-nursing staff (e.g., laundry, housekeeping, dietary) to determine if they are interested in more resident contact.
- ✓ Interview non-nursing staff (e.g., laundry, housekeeping, dietary) to determine their interest in moving toward becoming a CNA and possibly an LPN or RN.
- ✓ Post a sign-up sheet with a flyer announcing the program and emphasizing that this may be an opportunity for advancement to becoming a CNA.
- ✓ Interview nurses to determine their availability to be trained on the program and to supervise the DAs.

*How a Dining Assistant Program can help:* The Abt Associates and Vanderbilt research teams received positive feedback during interviews with non-nursing staff (e.g., housekeeping and laundry) who had been trained and were serving as DAs. The majority of

these staff felt proud to have earned the certification necessary and to be providing direct resident care. Often the DA Program has the indirect effect of boosting the self-esteem of entry-level workers who believe, correctly, that they are fulfilling an important aspect of resident care. As a result, these workers tend to spend more one-on-one time with residents and engage in more positive social interactions with them than CNAs. One caveat to the use of entry-level staff as DAs is the manner in which staff are approached to participate. For example, during our study, negative feedback about the program was received from a DA who worked under a mandatory rather than voluntary DA Program. The issue of mandatory versus voluntary recruitment of DAs is discussed further in Chapter 5, *Recruiting Dining Assistants*.

Feedback obtained by the research team during interviews with charge nurses and directors of nursing about the DA Program was generally positive. However, taking on another responsibility – that of supervising DAs – is not always welcome. Our field experience indicates that once NH management endorse the program and nursing staff are able to observe the ease of implementation as well as the positive results that the program has for residents and staff, nursing staff are more interested in assuming the responsibility of program supervision. The topic of program supervision will be covered in detail in Chapter 7, *Implementing a Dining Assistant Program*.



### Whether the Nursing Home is Suited to a Dining Assistant Program

The appropriateness and/or model of the DA Program hinges on several factors related to the NH's physical plant and/or policies. Appendix A contains a series of six worksheets designed to assist NHs in designing and implementing a DA program. Worksheet # 2, "Assessing Nursing Home Resources," may be useful in evaluating the resources needed to implement a DA program.

❖ Information to be gathered to determine whether the NH is appropriately suited to a DA Program includes:

- ✓ Is there corporate support?
- ✓ Is there space in the NH to conduct the DA training?
- ✓ Is there currently an active volunteer program, or an initiative to begin one?
- ✓ Does the NH have a quality improvement initiative for nutritional status/outcomes?
- ✓ What is the dining room environment like; is there space to implement a full DA Program?

#### **From the Field:**

Dining space is a challenge for full Program implementation in our facility due to State regulations that prohibit feeding physically dependent residents in the presence of independent residents (Staff Developer, Tennessee, 2008).

*How a Dining Assistant Program can help:* Without corporate support, subsidiary NHs are restricted in their ability to implement a program. However, more and more corporate offices are embracing the DA Program and encouraging their affiliates to implement the program. If corporate management has not yet endorsed the program, but the NH administrator is committed to implementing the DA Program, the administrator and NH staff developer can use this Implementation Manual and other supporting materials mentioned here to try to obtain corporate interest and approval.

Space restrictions should not entirely rule out the possibility of implementing a DA Program; creative training locations and/or an abbreviated model of the program can be considered. First, program training can take place in an office or in any space where other onsite training takes place. The number of trainees per session should be based on the size of the space available for training. If the NH is part of a corporation, it is possible that training can take place at corporate headquarters with or without trainees from other corporate locations.

If space restrictions are such that the dining room cannot accommodate a DA to sit and help residents eat, a family room or a resident's room could be a possible setting. Finally, a DA who helps deliver and set up trays, interacts with residents, and retrieves substitutions from the kitchen plays a very valuable role that can be beneficial to residents and staff regardless of the size of the NH.

# Creating Dining Assistant Program Goals

Upper-level nursing home staff may have a number of different goals in mind when considering the implementation of a DA Program. These may reflect both immediate and long-term program goals.

The two most common immediate goals of a DA Program include:

- ❖ Improving care during dining, and
- ❖ Improving the overall quality of the dining experience for all residents.

Some longer-term program goals include:

- ❖ Fostering a team approach to care among both nursing and non-nursing staff.
- ❖ Supporting community involvement in the daily lives of residents.
- ❖ Promoting career advancement.
- ❖ Reducing the prevalence of unintentional weight loss among residents throughout the NH or residents on a particular unit (e.g., Dementia Care).
- ❖ Reducing the prevalence of pressure ulcers.

Regardless of the specific goal(s) selected, a well-coordinated DA Program has the potential to help a NH achieve one or all of these aforementioned goals. Incorporating the knowledge gained in the field during our CMS- and AHRQ-funded project, we offer insight and helpful guidelines for achieving seven common program goals.

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# Immediate Program Goals



## Goal: To Improve Provision of Dining Assistance Care

*What you need to know:* Improvement in providing dining assistance care should be among the primary goals of a DA Program, because it represents a key daily care process that affects residents' body weight and nutritional status over time (see long-term goals, below). Two main aspects of dining assistance care provision should be the focus of a DA Program: (1) amount of assistance, and (2) quality of assistance.

*Amount of assistance:* Most residents in need of assistance require at least 20 to 30 minutes (per resident per meal) during meals to promote adequate food and fluid intake. Federal guidelines define "adequate" food and fluid intake as consuming 75 percent or more of served food and fluid items during meals, although some residents may be able to maintain a healthy body weight by consuming slightly less than this amount (e.g., 60 to 70 percent). Staff should evaluate a resident's oral intake, weight loss history, and current nutrition and hydration status to determine if s/he is eating enough to maintain nutritional health.

*Quality of assistance:* The enhancement of independence in eating defines the second important aspect of dining assistance care. Residents should be encouraged and allowed to be as independent as possible while eating. Studies have shown that staff often provide unnecessary or excessive physical assistance (spoon to mouth feeding assistance) to residents capable of eating on their own with verbal cueing (e.g., "Try a bite of eggs"), encouragement (e.g., "What are you having for breakfast this morning?"), or physical guidance (e.g., staff member guides resident's hand to utensil, helps resident hold utensil or cup). Residents in need of these types of assistance, however, require just as much staff time (20 to 30 minutes, on average) as residents who are totally dependent on staff for eating.

*How a Dining Assistant Program can help:* Residents in need of staff attention during meals can be grouped together such that one DA can be seated at a table with three residents, one or two of whom might require physical help to eat while the remaining resident(s) might need only verbal cueing and encouragement. This seating arrangement is time-efficient for staff and allows up to three residents to be assisted simultaneously in a manner that promotes adequate food and fluid intake and independence in eating during approximately 45 minutes per meal per group of three. Beyond the quality of dining assistance care provision, there are other aspects of the overall dining experience that can be improved for all residents, regardless of their individual dining assistance care needs.



## Goal: To Improve the Overall Quality of the Dining Experience

### **From the Field:**

My goals for the Program are to create a calm ambiance in the dining room and to increase the efficiency of tray delivery (Director of Nursing, Massachusetts, 2008).

This goal applies to all residents within the NH, regardless of their dining assistance care needs, and represents a goal directly related to residents' daily quality of life. This goal can be defined in a number of different ways, depending upon the dining service within a NH.

A summary is provided below of just a few aspects of the quality of dining service salient to all residents, including ensuring timely meal delivery, offering alternatives and additional food helpings, encouraging more residents to eat in the dining room, and enhancing social interactions.

## Timely Meal Delivery Service

*What you need to know:* Studies have shown that a common complaint among residents is that they have to wait a long time for meal service and food items are often served at inappropriate temperatures (i.e. hot items are served cold). This goal requires communication and coordination with the dietary and kitchen staff responsible for meal preparation along with the staff responsible for meal delivery, if different from dietary (e.g., CNA or DA). The lack of coordination between the kitchen and floor staff related to meal delivery time(s) can pose a significant barrier to program implementation (see Chapter 7, *Implementing a Dining Assistant Program*).

*How a Dining Assistant Program can help:* The availability of extra staff during mealtimes can improve the timeliness of the meal delivery service for all residents because DAs can help with tray delivery and set-up (e.g., opening containers, cutting up meat, buttering bread) for their assigned residents or a larger group of residents. In addition, to the extent that DAs take responsibility for providing dining assistance to individual residents, this alleviates some of the care responsibility of the CNA who, in turn, has more time available to ensure timely meal tray delivery and set up for all residents to whom the aide is assigned. Meal tray "set-up" is included with delivery because it is time-efficient to deliver and set up simultaneously, and can greatly enhance a resident's independence in eating. Meal tray set-up consists of simple preparations that make it easier for the resident to eat independently, orient the resident to the meal, and engage the resident. ("Good morning, Betty. It's time for breakfast. Are you hungry this morning? Would you like salt or pepper on your eggs? How about cream or sugar in your coffee? May I butter your toast for you?" Let me open your carton of milk for you for your cereal.")

### **From the Field:**

Having a focused person assures that residents receive their food quickly when it is palatable (Administrator, Massachusetts, 2008).

## Offer Alternatives to the Served Meal and Allow Second Servings of Preferred Items

*What you need to know:* The availability of choices during mealtime enhances a resident's quality of life, and federal care regulations require that meal alternatives be available to the resident. In practice, there are often barriers to offering residents choices during mealtimes, such as direct care staff being unaware that other options are available to the resident, or the additional staff time required to go to the kitchen and get something else for the resident.

*How a Dining Assistant Program can help:* Similar to improving the meal delivery and set-up service for all residents, the availability of additional staff during mealtime allows for more staff time to be spent ensuring that residents actually have food and fluid items served that are appealing to them. In addition to offering alternatives to the served meal, making second servings available for preferred foods and fluids (as requested by residents or as evidenced by residents consuming 100 percent of one item and 0 percent of something else) is an effective way to increase the amount residents eat. Another strategy beyond increasing overall staffing during mealtimes through a DA Program is to coordinate with the dietary and kitchen staff such that an extra smaller cart is sent to the unit with "alternatives" to the main dish and/or second servings of popular items. This creates "easy access" for staff, thus increasing the likelihood that residents will be offered alternatives and second servings.

## Allow More Residents to Eat More Meals in the Dining Room

*What you need to know:* This goal appears simple, but in daily nursing home practice it is quite complex. Studies have shown that it is common for many residents to eat their morning and evening meals in their own rooms, and often while in bed, and only be served their mid-day meal in a dining room. There are many different reasons for this common care practice. First and foremost, many NHs do not have enough dining room space to accommodate all, or even most, of their resident population. The availability of two seatings per meal (early/late service for each meal) and the creative use of other space (activities room, family meeting rooms) can help address space limitations within a NH while also accommodating resident preferences and the potential need to feed some residents in different locations. For example, if meal service in the main dining room is reserved for higher-functioning residents, smaller spaces (activities room, family meeting rooms) can be used to provide dining assistance to residents with higher care needs. A second reason commonly given for this practice is that residents prefer to eat most meals in their own rooms, but research evidence suggests that it is

more often the staff care routine – not residents’ preferences – that determine a resident’s dining location for meals.<sup>6</sup>

*Why does it matter where residents dine?* Research studies have shown that residents who eat their meals in a common area, such as a dining room, receive more staff assistance to eat and more social interaction with staff and other residents during meals, resulting in higher food and fluid intake.<sup>7</sup> In addition, these residents also have more accurate medical record documentation (e.g., percent eaten estimates) compared to residents who eat in their rooms.

*How a Dining Assistant Program can help:* Minimally, residents who require staff assistance to eat should be encouraged to eat most of their meals in the dining room to allow CNA or DA staff to provide assistance in a time-efficient manner (grouping residents together for care delivery, as described above). This also allows for easier supervision and management of a DA Program. The impact of a DA Program on residents’ dining location is that additional staff are available to assist with other mealtime tasks that might include transporting residents to and from the dining room. This extra help allows CNA staff more time to provide other aspects of care (transfer out of bed, dressing assistance) to prepare the resident for mealtime in the dining room.

## Enhancement of Social Interaction Among Residents and Staff

*What you need to know:* Social interaction among residents and staff during mealtime enhances residents’ food and fluid intake and quality of life. Thus, it is beneficial to all residents, and almost anyone on the staff (nursing and non-nursing) can provide social interaction without any required training. As mentioned above, the dining room is more conducive to the enhancement of social interaction because residents and staff are all in the same location.

*How a Dining Assistant Program can help:* Studies have shown that residents allowed to dine in their rooms are usually capable of eating independently, but if they have a problem with low intake, it tends to go unnoticed by staff until weight loss occurs. Thus, an extremely valuable role for a DA might be to visit residents who are dining in their own rooms to socially interact with them, see if they are happy with the served meal or if they would like something else, and offer to provide simple tray set-up. A designated staff member to periodically check on residents allowed to eat most meals in their own rooms would help identify residents who are eating poorly on their own and may be socially isolated during mealtime.

<sup>6</sup> Simmons SF & Levy-Storms L. (2006). The effect of staff care practices on nursing home residents’ preferences: Implications for individualizing care. *Journal of Nutrition, Health & Aging*, 10(3): 216-221.

<sup>7</sup> Simmons SF & Levy-Storms L. (2006). The effect of dining location on nutritional care quality in nursing homes. *Journal of Nutrition, Health & Aging*, 9(6): 434-439.



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# Long-Term Program Goals

## **Goal: To Promote a “Team” Approach to Care**

*What you need to know:* As part of an earlier study, this research team visited a number of NHs with active DA Programs. Several of these NHs reported they already had been using non-nursing staff from a variety of departments (e.g., activities, housekeeping, administrative) to assist during mealtimes prior to the federal regulation. The federal regulation simply made this arrangement more structured and formal. Many NHs might be similar in that they already are aware of non-nursing staff in other departments who desire to play a role in resident care provision.

*How a Dining Assistant Program can help:* A DA Program offers a constructive, meaningful avenue to offer non-nursing staff additional training that will directly benefit the residents as well as nursing staff. A DA Program can facilitate a “team” approach to care provision wherein every member of the staff (nursing and non-nursing) can play a vital role in the daily lives of the residents. The involvement of upper-level staff in the program further supports this effort. Finally, NHs should consider that a dining program offers a way to reward and advance exemplary CNA staff through involvement in the training and ongoing monitoring of the program.

## **Goal: To Increase Community Involvement**

*What you need to know:* The involvement of various community groups in a DA Program, in whatever capacity, requires additional staff time, resources (e.g., advertisement, interview and screening) and coordination (e.g., scheduling) but can be as effective as using non-nursing staff within the NH.

*How a Dining Assistant Program can help:* A DA Program offers an avenue through which to increase the involvement of the surrounding community in the daily lives of residents. An active volunteer program as well as family members and friends who visit often during mealtime might be an excellent resource for improving the mealtime experience of all residents. Volunteers, family, and friends represent groups who might be interested in receiving formal training to become a DA. Other potential outreach groups include community service programs through local high schools and senior centers.



## Goal: To Promote Career Advancement

### **From the Field:**

I think that the Dining Assistant Program can promote growth to a new level. For example, we have a CNA career program that takes CNAs through steps that eventually lead to nursing. Using the Dining Assistant Program as an incentive, we can train non-nursing staff as Dining Assistants and eventually step them up to the CNA program if appropriate (Staff Developer, Massachusetts, 2008).

*What you need to know:* Many nursing homes provide career building programs that facilitate the process through which CNAs become licensed nurses. A successful DA Program can serve as a first step in this process by providing advancement opportunities to non-nursing staff.

*How a Dining Assistant Program can help:* A DA Program offers an excellent opportunity for non-nursing staff to gain experience and exposure to providing direct care to residents. The positive experience gained by being trained as a DA as well as the satisfaction of providing hands-on care to residents may inspire some DAs to pursue nurse aide certification. A DA Program is a viable option as a first step in a series of skilled certifications.



## Goal: To Decrease the Prevalence of Unintentional Weight Loss

*What you need to know:* It is likely that decreasing the overall “prevalence of unintentional weight loss” in a NH represents a goal most salient to nursing homes because it is an MDS quality measure. However, the key daily care process that affects residents’ weight status is the amount and quality of dining assistance care, so improvements in dining assistance care represent the most effective solutions to reducing weight loss among nursing home residents. It should be noted that according to the literature, a small percentage of residents (~10 percent) will continue to lose weight, despite quality dining assistance care.

*How a Dining Assistant Program can help:* A DA Program can provide additional staff to help residents to eat and ensure that optimal dining assistance is provided consistently (i.e. daily), thus reducing weight loss over time among most residents.



## Goal: To Decrease the Prevalence of Pressure Ulcers

*What you need to know:* Similar to weight loss, the “prevalence of pressure sores” is an MDS quality measure. While adequate nutrition and hydration are vital to prevention and treatment efforts for pressure ulcers, a decrease in pressure ulcer prevalence represents a long-term program goal and one that requires a multi-faceted approach to care (e.g., nutrition and hydration, routine skin health assessments, repositioning programs).

*How a Dining Assistant Program can help:* A resident who has a low body mass index indicative of under-nutrition and/or a history of unintentional weight loss is likely to be at higher risk for pressure ulcer development, and inadequate nutrition and hydration can delay wound healing. A DA Program can improve the daily food and fluid intake of at-risk residents through dining assistance care and other

improvements to the overall dining experience of the resident, as discussed above. Trained DAs also can be used to promote hydration for residents throughout the day (between regularly scheduled meals) by being responsible for offering fluids multiple times per day between meals to residents. Thus, a DA Program need not be limited to scheduled mealtime periods to improve nutrition, hydration, weight loss, and skin health among residents.

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## Measuring Goal Progress

Strategies for measuring progress toward a goal depends on the goal itself. However, most of the goals described in this section can be measured with an observational tool that was designed for nursing home staff to use to monitor program implementation. This tool will be described in greater detail in Chapter 7, *Implementing a Dining Assistant Program*. The observational tool is easy to use and can be modified to reflect the specific goals of a given NH (e.g., increase the proportion of residents who eat most of their meals in the dining room). Worksheet # 3 in Appendix A may be used to record and track DA program goals.



# Recruiting Dining Assistants

Trainee recruitment can be one of the most challenging aspects of implementing a successful DA Program. This chapter helps prepare management for recruitment of potential DAs by presenting some of the hurdles that NHs may face during this process, and offering some suggestions to facilitate a successful recruitment process. Appendix A, Worksheet # 4, “Designing the DA Program” and Worksheet # 5, “Implementing the DA Program” may be useful tools for evaluating various recruitment strategies.

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# Targeting Recruits

Once the decision to implement a DA Program has been made, the administration needs to determine the most appropriate population to target for trainee recruitment. Trainees can be recruited from non-nursing staff or residents' families or other volunteers within the NH, or from the outside community.

A first step in the recruitment process is to determine or review the DA Program goals (see Chapter 4, *Creating Dining Assistant Program Goals*) so that the population that will best facilitate the achievement of these goals can be targeted. For example, if the NH management has a goal of creating an active volunteer program by increasing community involvement, then the target population should be volunteers from the community. If, on the other hand, the goal is supporting non-nursing staff in their advancement to direct care work such as nursing, then the recruitment target should be existing non-nursing staff.

## Family and Community Volunteers

### **Federal Register Notice (68 FR 55528):**

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 (2003).

Although DAs can be family or community volunteers or they can be drawn from existing non-nursing staff, only non-nursing staff are required by the federal regulation to participate in a Training Program. According to the federal rule, training volunteers is left to the discretion of the individual NH, as the NH is ultimately responsible for the care and safety of its residents. Specific states may have requirements regarding the training of non-staff volunteers. Nursing homes are encouraged to check the approval process and requirements for their specific state (see Appendix C for state contact information).

As noted, the federal rule does not require training for family or community volunteers; however, the lessons regarding the quality of resident care that are included in basic training modules provide invaluable education to non-medically trained individuals. Formal training teaches individuals about the importance of residents' independence, nutritional needs, safety, and communication styles with the outcome of improved overall quality of life for the residents (see Chapter 6, *Training Dining Assistants*).

## Recruiting Family Volunteers

Targeting potential family volunteers to participate in the DA Program is relatively straightforward. Family volunteers, especially those who already assist relatives in the dining room, demonstrate an

unsolicited interest in improving the quality of their loved ones' lives and are therefore, likely candidates.

- ❖ Following are a few suggestions that might be useful when recruiting family volunteers for participation in the DA Program:
  - ✓ Approach individuals who already provide regular dining assistance.
  - ✓ Post flyers in the lobby and hallways announcing the program and asking for volunteers.
  - ✓ Post a notice in the monthly newsletter.
  - ✓ Discuss the program at facility gatherings to which residents' families are invited, e.g., family council meetings.

## Recruiting Community Volunteers

Experience in the field has shown us that recruiting community volunteers is not an easy task. Our research team posted flyers announcing the program and soliciting volunteers in four senior centers local to the target nursing home; we received no responses. However, if the NH has an active volunteer program and/or outreach staff, recruiting community volunteers is a viable option for the DA Program.

- ❖ Following are some suggestions to help facilitate community volunteer recruitment:
  - ✓ Post flyers in area Senior Centers.
  - ✓ Attend area Senior Center meetings to make a brief presentation about the program.
  - ✓ Contact local colleges that offer a certificate or degree in a related discipline (e.g., Home Health Aide, Gerontology) to discuss the possibility of setting up an internship program.
  - ✓ Contact local high schools that may have internship or community volunteer requirements.
  - ✓ Advertise the program in community newspapers.
  - ✓ Post announcements in local church newsletters.

## Recruiting Non-Nursing Staff

To recruit trainees from existing non-nursing staff from within a facility, many different departments can be targeted.

- ❖ Following is a list of staff who may be the best fit for the program:
  - ✓ **Activity aides and social services staff** as they already do an excellent job of providing social stimulation and verbal

### ***From the Field:***

It makes me feel good to help people  
(Dining Assistant, Wisconsin, 2005).



encouragement to residents. Providing these aspects of care in the context of feeding seems like a natural extension of their current job tasks.

- ✓ **Speech and occupational therapy departments** take some responsibility for feeding residents as part of assessments and “Restorative Dining Programs” to teach residents self-feeding skills.
- ✓ **Dietary staff** may not be the best choice for training due to competing kitchen responsibilities that might prevent them from having adequate time available to feed residents. However, dietary staff could take responsibility for meal tray delivery, set up (opening containers, buttering bread, cutting up meat), pick-up, and providing an extra cart with available meal alternatives and/or second servings of popular items to make it easier for both CNAs and DAs to provide optimal care quality.
- ✓ **Housekeeping and laundry staff** usually can assist only during the mid-day (lunch) meal due to their work schedules that typically have them starting their work day after the morning meal and ending their work day prior to the evening meal.
- ✓ **Staff from any department** who are interested in becoming CNAs.
- ✓ **Any staff** interested in obtaining personal satisfaction by helping residents in a greater capacity than their daily work tasks require.

## Mandatory Versus Voluntary Participation of Non-Nursing Staff

In-house trainees can participate on a voluntary or mandatory basis. The Abt Associates and Vanderbilt research teams observed that some nursing home administrators require that all non-nursing staff complete the DA training. Most of those who institute this requirement do so to preempt a potential crisis situation where the NH is drastically short-handed and residents are left without adequate assistance during meals. By training all non-nursing staff in dining assistance, the NH can rely on an “all-hands-on-deck” model to fill this need during an emergency. One New Hampshire nursing home adopted this model because of the harsh winter weather and rural nature of the area. During the winter months, it is not unheard of for many staff members to have difficulty getting to work due to blizzards or ice storms. The “all-hands-on-deck” model works well in this situation.

### ***From the Field:***

To have everyone do it – during snow times it’s a big help (Dining Assistant, New Hampshire, 2005).

Often trainees who participate in a mandatory program are employed as DAs on an as-needed basis. Further, their assistance is used

only for resident transport, tray delivery, and tray set-up. However, observations the research team made during visits to nursing homes where DA Programs had been implemented revealed that in some instances hands-on dining assistance is mandatory. Unless the NH is instituting “all-hands-on-deck” policy, this is not a recommended model to ensure optimal Program implementation or sustainability. Placing a mandatory requirement on dining assistance will likely cause workers to become disgruntled and could lead to poorer quality care to residents. In interviews with Trained DAs, our research team learned that when staff are required to help feed residents, they are often dissatisfied.

***From the Field:***

Dining Assistants who perceived that they had no choice when management proposed Dining Assistant training were less satisfied than those whose participation was voluntary: When I took the job in laundry, no one said that I would have to feed residents, and I don't like it ( Dining Assistant, Colorado, 2005).

Recruitment of volunteers from among existing staff may be difficult if they perceive that becoming a DA will force them to give up their own time, lengthen their day, or in other ways create more work for them. When using non-nursing staff, it is important to ensure that staff have reasonable daily work schedules that allow their existing job tasks to be completed along with adequate breaks, and their new responsibilities as a DA. In other words, staff should not have to sacrifice their own lunch break or work overtime to complete their other job tasks to fulfill their responsibilities as a DA, as this will decrease interest in the program (see Chapter 8, *Sustaining the Dining Assistant Program*).

***From the Field:***

When they graduate from Dining Assistant Training, they get a raise and get more hours because they are part-time employees (Administrator, Colorado 2005).

Volunteerism can be encouraged with incentives. For some non-nursing staff, stressing the fact that they will obtain a Trained DA Certificate upon completion of the Training Program is an incentive. For others, an enticement is knowing that once they have successfully passed the Training Program, they will be able to provide direct care to residents and personally help to improve the quality of their lives. Both of these concepts should be stressed during recruitment, especially with non-nursing staff.

Other non-nursing staff may need more tangible incentives such as a monetary award. For example, one NH with which the team has worked in Tennessee offers a 50-cent per hour raise to all staff that successfully complete the training program and commit to a routine of regular dining assistance.



# Training Dining Assistants

At a minimum, a DA Training Program must meet the federal requirements for training. However, as described in Chapter 2, *Federal and State Requirements for a Dining Assistant Program*, DAs must complete a state-approved training course.

- ❖ At a minimum, a DA Training Program must include:
  - ✓ A minimum of eight hours of training.
  - ✓ Specific Training Topics, including:
    - ✓ 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.
  - ✓ State-specific training requirements.
- ❖ Instructor Qualifications
 

The federal rule restricts DAs from training other DAs, but does not specify instructor qualifications.
- ❖ Many states permit the following professionals to train DAs:
  - ✓ Registered Nurses (RNs)
  - ✓ Licensed Practical Nurses (LPNs)
  - ✓ Registered Dietitians (RDs)
  - ✓ Speech Language Pathologists (SLPs)
  - ✓ Registered Occupational Therapists (OTs)

## ***From the Field:***

A multidisciplinary teaching team can be effective because Dining Assistant trainees may respond better to training with multiple teachers, each with their own area of expertise. For example, an RN could be the principal trainer, with an OT responsible for teaching positioning of residents, a SLP teaching a section on identifying swallowing problems, and a SW explaining resident quality of life (Staff Developer, Massachusetts, 2008).

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## Available Training Manuals

Multiple training manuals have been published and are available for staff developers/educators to use when conducting DA training. The manuals meet the federal requirements, but the NH may be required (due to state requirements) or may choose (due to facility culture and procedures) to supplement these materials with additional topics or activities. Following, we provide a list of training manuals that are readily available online to download or for purchase. Please note that this list is not exhaustive; there may be other training manuals developed by states or Associations that are not listed here.

- ❖ Available through Associations and other publishers:
  - ✓ American Health Care Association, *Assisted Dining: The Role And Skills Of Feeding Assistants*.
    - Available for Purchase on the AHCA website: [http://web1.pmds.com/AHCA\\_eBiz/Default.aspx?tabid=44&action=ShowProductDetails&args=248](http://web1.pmds.com/AHCA_eBiz/Default.aspx?tabid=44&action=ShowProductDetails&args=248)
  - ✓ The Consultant Dietitians in Health Care Facilities American Dietetic Association Practice Group, *Eating Matters – A Training Manual for Feeding Assistants*
    - Available for Purchase on the Consultant Dietitian in Health Care Facilities website: <http://www.cdhef.org/products/training/details.asp?id=5028>
  - ✓ Richardson, B. (Ed) The Consultant Dietitians in Health Care Facilities American Dietetic Association Practice Group Pocket Resource for Management, 2006 Revision
    - Available for Purchase on the Consultant Dietitian in Health Care Facilities website: <http://www.cdhef.org/products/training/details.asp?id=5028>
  - ✓ Hartman Publishing, *Assisting with Nutrition and Hydration in Long Term Care*
    - Available for Purchase on the Hartman Publishing website: <http://www.hartmanonline.com/fab/index.html>
- ❖ Available through state websites:
  - ✓ Colorado Department of Public Health and Environment, *Feeding Assistant Curriculum Specifications and Program Requirements*  
[http://www.cdphe.state.co.us/hf/download/FEEDING%20AST%20Curriculum%20\(Jan%2005\).pdf](http://www.cdphe.state.co.us/hf/download/FEEDING%20AST%20Curriculum%20(Jan%2005).pdf)

- ✓ Minnesota Department of Health, *Paid Feeding Assistant Training Program*  
[http://www.health.state.mn.us/divs/fpc/profinfo/lic/pfa/pfacourse1\\_4.pdf](http://www.health.state.mn.us/divs/fpc/profinfo/lic/pfa/pfacourse1_4.pdf)
- ✓ North Carolina Department of Health and Human Services, Division of Health Service Regulation, *North Carolina State-Approved Curriculum for Feeding Assistant*  
[http://www.dhhs.state.nc.us/dhsr/hcpr/pdf/approved\\_fed\\_cur.pdf](http://www.dhhs.state.nc.us/dhsr/hcpr/pdf/approved_fed_cur.pdf)
- ✓ Texas Department of Aging and Disability Services, *Feeding Assistant Training*  
<http://www.dads.state.tx.us/providers/NF/credentialing/NAT CEP/feedingassistant.pdf>

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# Training Enhancements

## ***From the Field:***

I liked the training materials, overall; however, in the future I will add more hands-on observations and training (Staff Developer, Massachusetts, 2008).

The federal regulations and some state's rules are specific about training topics that should be included in DA training. In addition, some instructors may want to enhance the training modules beyond the federal and state regulations and thereby fully engage the DA trainees in the overall DA Program. Ideas to incorporate in an enhanced training program include the following:

- ❖ Emphasize the importance of quality dining assistance and the DA's role.
- ❖ Incorporate hands-on dining room observations and training.
- ❖ Present the CMS-sponsored webcast, "How to Enhance the Quality of Dining Assistance in Nursing Homes."
- ❖ Conduct a DA skills evaluation.

## **Emphasize the Importance of the Dining Assistant's Role**

DA training can begin with an overview of the philosophy of the DA Program and the goals that the nursing home management have set for implementation of the DA Program. Instructors should emphasize that through this program, trainees can directly affect the quality of residents' lives. Introducing DA trainees to the importance of their role in improving the residents' quality of life can help promote the DAs' accountability, ownership, and investment in the program.

## **Incorporate Hands-On Dining Room Observations and Training**

Regular monitoring of meal-time activities can help to identify future quality improvement opportunities (see Chapter 7, *Implementing a Dining Assistant Program*). Used in training, instructors can model appropriate DA behavior and assistance through hands-on practice in the dining room.

## **CMS Webcast**

The CMS-sponsored webcast "How to Enhance the Quality of Dining Assistance in Nursing Homes" was developed based on research conducted by Dr. Sandra Simmons and Dr. John Schnelle of Vanderbilt University, and presents step-by-step instructions for conducting observations of staff behaviors that characterize optimal

dining assistance.<sup>8 9</sup> The goal of the webcast is to provide nursing homes with a tool to assess and identify areas for improvement in dining assistance.

- ❖ After viewing the program, participants will:
  - ✓ Be familiar with the federal DA regulation.
  - ✓ Understand the importance of direct observation in assessing dining assistance care quality.
  - ✓ Be able to use a standardized observational tool to assess dining assistance care quality.
  - ✓ Be able to use a standardized observational tool to identify areas for improvement.

### **From the Field:**

The CMS webcast on Dining Assistance was helpful. I will continue to use the whole video as part of the syllabus. It was useful in illustrating to the Dining Assistants why the Program is valuable (Tennessee NH Staff Developer, 2008).

I found the webcast very helpful – I want to show it to current CNAs. However, in the future, I will probably just show the vignettes and some of the history and philosophy that are important for trainees to understand (Staff Developer, Massachusetts, 2008).

This free webcast is available at <http://www.cms.internetstreaming.com>. The original webcast airdate was March 16, 2007. The entire webcast is about one hour, with about 10 minutes of vignettes of proper dining assistance care.

While the entire webcast is beneficial for DA training, time constraints may not allow instructors to air it in its entirety.

Interviews with staff developers suggest that the following are the most helpful sections of the webcast for training:

- ✓ The introduction to the regulations and study in the beginning of the webcast. This will help introduce trainees to the DA requirements and the importance of quality dining assistance.
- ✓ The vignettes of proper dining assistance care are half-way through the webcast. These vignettes can be used to provide trainees with examples of quality dining assistance techniques, including:
  - Social stimulation
  - Tray-set up
  - Verbal queuing
  - Offering a substitution or offering choices to residents
  - Physical assistance with verbal queuing
  - Allowing residents enough time for eating

The CMS Dining Assistant webcast is also useful to nursing home management as an introduction to the DA regulations, DA Programs, and quality dining assistance techniques. In addition, it can be used

<sup>8</sup> Simmons, SF, Babinou S, Garcia E, Schnelle JF. (2002). Quality assessment in nursing homes by systematic direct observations: Feeding assistance. *Journal of Gerontology: Medical Sciences*, 57A (10), M665-671.

<sup>9</sup> Simmons SF, Garcia EF, Cadogan MP, Al-Samarrai NR, Levy-Storms LF, Osterweil D, Schnelle JF (2003). The Minimum Data Set weight loss quality indicator: Does it reflect differences in care processes related to weight loss? *Journal of the American Geriatrics Society*, 51(10), 1410-1418.



as a tool for training DA supervisors on the observation tool (see Chapter 7, *Implementing a Dining Assistant Program*).

Additionally, Appendix A, Worksheets # 4 “Designing the DA Program” and # 5, “Implementing the DA Program” may be helpful for recording and tracking issues around training.

## Dining Assistant Skills Evaluation

Many states require evaluation of the DA through a skills demonstration, written examination, or combination of both. Even if a state does not require a skills demonstration or written examination, nursing homes may want to use these tools to ensure that the trained DAs have mastered the skills and concepts. States that do require competency testing may have specific requirements such as a standardized multiple-choice written exam and/or a skills demonstration test where DAs must successfully feed a resident in a clinical setting. Nursing homes in states without standardized exams can find written exams included in many of the available Training Manuals. Following is an example of a skills demonstration evaluation, “Assessing the Competency of the DA,” that the instructor can use to observe DA trainees while they assist residents. This example is a photo-ready version of the skills evaluation. This checklist should be added to the DA’s personnel file, as record of successful completion of the Dining Assistant Skills Evaluation.

## Dining Assistant Skills Evaluation

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Meal: \_\_\_\_ Breakfast \_\_\_\_ Lunch \_\_\_\_ Dinner

Observer: \_\_\_\_\_ Trainee observed: \_\_\_\_\_

Number of Residents Assisted \_\_\_\_\_

DID THE TRAINEE...	Yes	No	Not Applicable
1. Greet the resident(s) by name?			
2. Introduce self?			
3. Orient the resident(s) to the meal (breakfast, lunch, dinner)?			
4. Orient resident(s) to items on the tray (list what is being served)?			
5. Seat themselves either beside or across from the resident(s) to provide assistance?			
6. Ensure that the served meal is in accordance with resident's prescribed diet?			
7. Ensure that the resident(s) are sitting upright, to the greatest extent possible?			
8. Provide social stimulation intermittently throughout the meal period?			
9. Provide verbal instruction or orientation (includes prompts to eat for residents who eat independently and, if physically dependent, letting the resident know what food or fluid is being offered)?			
10. Offer alternative food/fluid items if the resident(s) are eating less than half of the meal or complains about the served items?			
11. Food and fluid items are kept separate (does not mix food/fluid items in an unappealing manner)? Note: mixing of foods with sauces is appropriate.			
12. Provide small, manageable bites of food for the resident(s)?			
13. Spend at least 20 minutes providing assistance?			
14. Orient the resident(s) that the meal is complete?			

**Comments:**

# Implementing a Dining Assistant Program

The purpose of this chapter is to review key steps in implementing an optimal DA Program in order to achieve both immediate (e.g., improvements in dining assistance care) and long-term (e.g., reducing unintentional weight loss) program goals (see Chapter 4, *Creating Dining Assistant Program Goals*). Appendix A, Worksheet # 5, "Implementing the DA Program" may be used as a tool to evaluate implementation options.

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# Identifying Residents Appropriate for the Program

The first step beyond training DA staff (see Chapter 6, *Training Dining Assistants*) is to identify residents appropriate for the program. Federal requirements state that DAs can feed only residents “without complicated feeding problems.”

- ❖ Complicated feeding problems are defined in the federal requirements as including, but not limited to, a resident who has:
  - ✓ Difficulty swallowing
  - ✓ Recurrent lung aspirations
  - ✓ Tube or parenteral/IV feedings

In addition, the federal requirements specify that resident selection should be based on a current assessment of the resident’s status by the charge nurse (RN or LPN, if allowed by state law) and the resident’s latest comprehensive assessment and care plan. The federal requirements also suggest that the charge nurse should consult with the interdisciplinary team members, such as a speech-language pathologist or other professionals, when identifying residents appropriate for a DA Program. The requirements do not deem residents inappropriate for a DA Program based only on their need for staff assistance to eat. Thus, even residents who are totally physically dependent on staff for eating may be appropriate for the Program as long as the resident does not have “complicated feeding needs,” as defined above.

- ❖ Although the federal requirements do not explicitly provide criteria for determining “difficulty swallowing,” the following criteria might be helpful in practice:
  - ✓ Diagnosis of dysphagia
  - ✓ Formal swallowing evaluation by a licensed professional (e.g., speech-language pathologist)
  - ✓ Prescribed diet requires pureed foods and/or thickened liquids

Beyond the federal requirements, there are other important aspects of identifying residents appropriate for a DA Program and assigning DA staff to help individual residents to eat: the dining assistance care needs of the resident, the experience level of the DA, and the language abilities of both.

Supervisory-level staff tend to assign DAs to residents who are totally dependent on staff to eat (spoon to mouth feeding) and/or

those who require a lot of staff time to feed (slow eating pace, frequent refusals). The rationale is that the assignment of these residents to a DA Program will increase the likelihood that they will get the amount of assistance they need during meals (typically 30-45 minutes of help to eat), and will greatly reduce the work load for CNA staff, who usually have several other residents for whom they are responsible during meals.

Residents who are independent in eating may not be included in a DA Program because they are perceived as not needing attention from staff during meals, yet many of these residents eat poorly on their own and respond well to simple verbal encouragement, social interaction, and the availability of alternatives to the served meal. All of these care tasks can be easily, effectively and comfortably provided by DAs (see Chapter 4, *Creating Dining Assistant Program Goals*). A good way to identify these residents is to observe residents who eat independently during meals (in the dining room or in their own rooms) and determine which of these residents eat less than half of the served meal. These residents should be considered for a DA Program.

Another important aspect of resident assignment is to ensure there are not significant language barriers between the resident and the DA. A resident who is verbally communicative usually will respond well to verbal encouragement and social interaction during the meal, even if the resident also has mild to moderate cognitive impairment. Thus, the DA will have the most success in encouraging a resident's food and fluid consumption if s/he is able to verbally communicate with the resident. DA staff who do not speak the language of the resident and/or are uncomfortable when they first start the program could be assigned to non-communicative residents for dining assistance care and/or be responsible for other mealtime tasks (e.g., transporting residents to/from the dining room for meals, tray delivery and set-up, retrieval of alternatives from the kitchen).

***From the Field:***

Dining Assistants new to the program could spend the first few meals working alongside a more experienced CNA who could provide the new Dining Assistant with guidance and helpful tips for successfully feeding challenging residents (Staff Developer, Massachusetts, 2008).

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## When to Implement the Program

A DA Program need not be implemented across all meals and days. In fact, it is best to start the program with only one meal per day and then expand the program to other meals. This approach allows staff to identify other barriers to program implementation early in the process (e.g., meal trays are not delivered on time to certain floors or units, residents need to be transported to the dining room for the program).

In practice, the mid-day meal (lunch) seems to be the easiest meal with which to start the program, because many residents are already out of bed and dressed by mid-day and eat their mid-day meal in the dining room. Morning (breakfast) and evening (dinner) meals tend to be more challenging for a DA Program in the beginning because, in some NHs, many residents eat their morning and/or evening meals in their own rooms, and often in bed. At the same time, studies have shown that a DA Program can be most helpful during the evening meal due to lower CNA staffing levels on the evening compared to the day shift.

Of course, DAs can provide help to residents, regardless of their dining location (in their own rooms or the dining room), and should be encouraged to do so. The federal requirements state that DAs should be under the direct supervision of a licensed nurse (RN or LPN), but the licensed nurse needs to be accessible to the DA only in case of an emergency (i.e. through the resident call system). However, it should be recognized that allowing residents to dine in their own rooms means that one DA will need to be assigned to that one resident for a given meal, resulting in less time-efficient care delivery and less ease in supervision.

The federal requirements specify that “facilities may use [Dining Assistants] to assist eligible residents to eat and drink at mealtimes, snack times, or during activities or social events as needed, whenever the NH can provide the necessary supervision.” Thus, a DA Program need not be limited to regularly scheduled meals, and can include a hydration program (offering residents fluids multiple times per day between meals), a snack program (offering residents snacks multiple times per day between meals), and even nutritional care during organized social group activities. A NH should start the program during days/times where the need is greatest and/or when it is most feasible for staff with the goal of expanding the program over time.

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## How to Monitor Dining Assistant Care Quality

One of the most important components of a successful DA Program is the involvement of one or more committed supervisors. The supervisor(s) will handle the scheduling as well as the supervision and monitoring of DAs. Regular, informal monitoring of meal-time activities can help to identify potential aspects of dining assistance that might need to be improved or discussed during staff meetings. The supervisor(s) will also monitor the behaviors of the residents who are being assisted for potential changes in feeding needs (e.g., resident is having difficulty swallowing), and be readily available to help the DA in the event of an emergency.

The *Federal Rule* does not require that the supervisor(s) be in the unit or on the floor at all times where assistance is furnished. Rather, the supervisor(s) are required to be available during an emergency on the resident call system (§483.35(h)(2); see Appendix B).

### Continuous Quality Improvement for Meals: An Observation Tool

To identify problems and successes in program implementation, supervisory-level staff can conduct more formal observations of the program on a regular basis. The observations do not have to be conducted during every meal or every day during which the program is active; observations during only one to three meals per week are sufficient to identify problems and successes. The observations should target residents who are part of the DA Program and also include residents who are not currently part of the program but maybe should be (e.g., residents who are eating poorly on their own). Beyond dining assistance care quality provided by DAs, the observations also can inform whether residents who are part of the program remain appropriate for the program or need additional help (e.g., assistive devices for eating, swallowing evaluation).

A standardized observational tool (see Appendix E) has been developed and used extensively in both research studies and care practice for this purpose.<sup>10</sup> It is recommended that observations be conducted more frequently early in program implementation (e.g., three meals per week during the first few weeks); and, this frequency can be reduced once the program is stable (no new staff or residents added to the program and care quality is considered “good” during all observed meals/days). The CMS-sponsored web-cast titled “How to

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<sup>10</sup> Simmons, SF, Babinou S, Garcia E, Schnelle JF. (2002). Quality assessment in nursing homes by systematic direct observations: Feeding assistance. *Journal of Gerontology: Medical Sciences*, 57A (10), M665-671.



Enhance the Quality of Dining Assistance in Nursing Homes” discussed earlier in this manual provides an overview of the Abt Associates Vanderbilt study and the observational tool for program monitoring activities (see Chapter 6, *Training Dining Assistants*).

The information generated by the observational tool can be reported as dining assistance care quality indicator scores and used for DA Program monitoring and/or ongoing 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 information into understandable quality categories for which dining assistance can be scored as either “passing” or “failing” for individual residents and mealtime periods. The rules and rationale that guide the scoring of eight dining assistance care QIs are also presented in Appendix E.

## Providing Feedback to Staff

The advantage of the mealtime observational tool and the QI scores generated by the tool is that this information can be used to provide feedback to staff about program successes and areas in need of improvement.

- ❖ Previous experience with quality improvement efforts showed that feedback was most beneficial if delivered in the following format:
  - ✓ **Weekly Group Staff Meetings** where all relevant staff are present.
  - ✓ **Brief Feedback Sessions** (< 15 minutes) that can be scheduled at convenient times for staff.
  - ✓ **Focus on the QI Summary Scores** generated by the observational tool. For example, “Last week during breakfast, we observed staff providing social interaction 80 percent of the time for residents who ate in the dining room. That is a big improvement from the week before when the rate was only 60 percent. Great job, everyone!”
  - ✓ **Video Vignettes** of desirable staff behavior are optional, but are an excellent way to acknowledge exemplary staff care practices and demonstrate desirable staff behavior by showing staff and residents within the NH. Such vignettes might include, for example, a video clip of a staff member interacting socially with a resident (or actor) during mealtime.<sup>11</sup> Other video examples of proper dining assistance care are contained in the CMS-sponsored web-

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<sup>11</sup> Note that appropriate resident and/or family consent must be obtained prior to any filming of residents.

cast titled “How to Enhance the Quality of Dining Assistance in Nursing Homes” discussed earlier in this manual.

## Who Can Be a Program Supervisor

While the federal regulation requires that DAs work under the supervision of a licensed nurse (RN or LPN), as stated previously, the licensed nurse needs to be accessible to the DA only in case of an emergency (i.e. through the resident call system). The supervisory-level person(s) responsible for monitoring DA Program implementation need not be a licensed nurse.

- ❖ The following types of staff have been effectively employed to monitor DA Program implementation:
  - ✓ Exemplary CNA
  - ✓ Licensed nursing staff (charge nurse, unit nurse manager)
  - ✓ Assistant to the staff developer
  - ✓ Social worker
  - ✓ Social activities coordinator
  - ✓ Registered Dietitian (RD)
  - ✓ Other dietary staff
  - ✓ Upper-level management (administrator and director of nursing)

Ideally, multiple staff should learn how to monitor care quality provided by DAs so that the responsibility is shared among staff. Moreover, the involvement of different levels of staff in program monitoring activities communicates to the DAs that the program is a valued part of the resident’s overall care plan, and that their contribution is significant in the daily life of the resident. Finally, the advantage of having multiple disciplines involved in the observations is that each person may notice unique aspects of the resident’s dining experience that could be improved. For example, dietary staff may notice residents’ food preferences while activities staff may notice how residents’ seating could be re-arranged to be more conducive to social interaction.

The staff developer and charge nurse are both in an excellent position to be the lead supervisors; however, their time is limited due to many other responsibilities. The program works best if there is at least one other staff member who can serve as an assistant to the staff developer and/or charge nurse in the supervisory capacity, such as an assistant director of nursing or an experienced CNA. The advantage of using an experienced CNA in this position is that s/he also can take responsibility for documenting percent eaten for residents in the program and feeding if the meal period requires

### ***From the Field:***

Co-ownership between the staff developer and director of nursing would be ideal, but also co-ownership with a senior CNA would probably allow for more hands-on supervising (Staff Developer, Massachusetts, 2008).

more time than the DA has available. S/he also can communicate effectively with the other CNA staff to ensure that residents who are part of the program are in the right location at the right time for meal service (e.g., dressed and transported to the dining room).

Appendix A, Worksheet # 6, “Monitoring and Sustaining the Dining Assistant Program”, may be useful as a tool for organizing and tracking activities associated with monitoring and sustaining the DA Program.

# Sustaining the Dining Assistant Program

Successful program implementation hinges on the nursing home's ability to sustain it. Following are several key components to sustaining a successful DA Program that we have either observed through our experience working with NHs that have implemented a Program, or that we have gathered from interviews with staff developers. Appendix A, Worksheet # 6, "Monitoring and Sustaining the Dining Assistant Program", is provided as a tool for organizing and tracking activities associated with monitoring and sustaining the DA Program.

## ***From the Field:***

Before entering into a Dining Assistant Program, make sure that the staff developer and director of nursing are on board because if the timing isn't right, they may feel overwhelmed and resist the program (Staff Developer, Massachusetts, 2008).

## ***From the Field:***

Let trainees know that they can make a change in peoples' lives; they can make a difference. Dining Assistants will be more invested and feel that "they [the residents] are depending on me" (Staff Developer, Massachusetts, 2008).

- ❖ **Obtain initial "buy-in" from administrator, director of nursing, and staff developer.** The NH administrator and/or the corporate office may decide to implement a DA Program. However, as soon as possible, the NH's staff developer and director of nursing should be included in discussions and the decision-making process to ensure their support. The staff developer will be in charge of training, and the director of nursing will have at least some level of involvement in DA supervision. The timing of the training sessions and Program implementation need to coordinate with their schedules. The support of the staff developer and director of nursing are essential to successful Program implementation, as is that of the Registered Dietitian (RD) and dietary manager.
- ❖ **Promote DA accountability and ownership.** Trainers should allow time at the beginning of the training session to go over the fundamental philosophy of the DA Program: making a positive impact on residents' lives. Enlightening trainees about their ability to effect a positive change in the quality of someone's life will promote a sense of responsibility, ownership, and accountability, not only for the residents under their care but also for the Program overall.
- ❖ **Provide ongoing support from administrator, director of nursing, staff developer.** This support can be demonstrated through involvement in the weekly observations and/or feedback sessions, financial incentives to trainees (e.g., modest raise),

and/or allocating time for other key personnel (e.g., assistant director of nursing, lead CNA) to conduct supervisory tasks.

- ❖ **Provide ongoing program monitoring.** Regular feedback to DAs about the Program (see above) should include individual and overall Program successes as well as areas that may be in need of improvement. Getting together as a group will reinforce the notion that the DA Program is important, and that the services that the Assistants are providing are valuable and have a direct impact on the residents.
- ❖ **Involvement of multiple supervisory-level staff** so that the program does not stop when one key person is not present (e.g., vacation, ill, or resigns from their position).
- ❖ **Consistently involve DAs.** If assisting with meals becomes a routine, DAs will be more likely to persist than if their help is provided in a more sporadic way. Helpful tools to ensure regular participation include a posted month-by-month calendar of assignments and a posted sign-in sheet.
- ❖ **Be sensitive to staffing difficulties.** Finding available staff to train as DAs is often the biggest challenge that NHs face once they have decided to implement a DA Program. The demands of their primary job often prohibit regular involvement in the Program. For example, some job descriptions require a 40-hour work week, leaving only the lunch break or overtime without compensation as options to make up for time spent assisting residents with meals. In this situation, the administrator might consider allocating a “free” 45 minutes to DAs on the day/s when they provide meal-time care. Another possibility is to offer a financial incentive in the form of a small raise.
- ❖ **Schedule repeat training sessions** one to two times per year to help retain an adequate number of trained DA staff. DAs, like CNAs, will be lost from the Program due to turnover.
- ❖ **Incorporate the program into monthly care plan meetings,** so that there is an up-to-date list of all residents deemed appropriate for the program.
- ❖ **Extend the program** to other meals or between-meal periods (through a snack or hydration program), so that the program has a larger impact on the nutritional status and quality of life of residents, and there are several available time periods throughout the day that are options for DAs to help residents.

### ***From the Field:***

At this facility, staff cannot work more than 40 hours per week and it is difficult to complete work in 40 hours. The administrator might consider allocating a “free” 45 minutes to Dining Assistants on the day that they assist with meals (Staff Developer, Massachusetts, 2008).

# Appendix



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**Appendix A     Dining Assistant Program  
Worksheets**





## Dining Assistant Program Worksheets

There are six worksheets designed to assist a nursing home in designing and implementing a Dining Assistant Program.

Worksheet # 1 Conducting the Nursing Home Dining Assessment

Worksheet # 2 Assessing Nursing Home Resources

Worksheet # 3 Setting Goals

Worksheet # 4 Designing the Dining Assistant Program

Worksheet # 5 Implementing the Dining Assistant Program

Worksheet # 6 Monitoring and Sustaining the Dining Assistant Program

***NOTE: Before beginning, make sure your State allows dining assistants***



## Worksheet # 1

### Conducting the Nursing Home Dining Assessment

Use this **Dining Score Card** to assess your nursing home's dining program. For each category, a variety of assessment techniques are suggested – document review, resident and staff observation, and staff discussion. Tasks are organized by category so that if time is limited, tasks can readily be split among several assessors or prioritized based on available time. A 'yes' response likely indicates some level of concern. No attempt has been made to quantify how many positive responses constitute a problem.

#### Dining Score Card

		Yes	No
<b>Document Review</b>	Review the most recent survey - are there any citations related to meal consumption or weight loss?	<input type="checkbox"/>	<input type="checkbox"/>
	Review results of resident or family satisfaction surveys – has food quality, temperature or level of assistance been an issue?	<input type="checkbox"/>	<input type="checkbox"/>
	Check the complaint logs – have families complained about food/meals in the past 30 days?	<input type="checkbox"/>	<input type="checkbox"/>
	Review the MDS Quality Measure for weight loss – is the nursing home above the state average?	<input type="checkbox"/>	<input type="checkbox"/>
	Review monthly weight documentation – are there residents who have significant weight loss (i.e., 5% or more in the past 30 days, 10% or more in the past 180 days)?	<input type="checkbox"/>	<input type="checkbox"/>
	Review meal consumption records in conjunction with dining room observations – are there instances where the meal consumed does not agree with the percent recorded?	<input type="checkbox"/>	<input type="checkbox"/>
	Review your dietary supplement policy - are there instances where staff are not following the supplements' policy?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Observation</b>	Are trays being returned to the kitchen at the end of the meal with more than 50% of the tray untouched?	<input type="checkbox"/>	<input type="checkbox"/>
	Are there residents eating in the dining room who are not eating and not receiving encouragement, cueing or offer of an alternate meal?	<input type="checkbox"/>	<input type="checkbox"/>
	Are there residents eating alone in their rooms who are not eating and not receiving encouragement, cueing or offer of an alternate meal?	<input type="checkbox"/>	<input type="checkbox"/>
	During the meal, are nurse aides talking to each other and not to the residents?	<input type="checkbox"/>	<input type="checkbox"/>
	Is the dining room environment pleasant (e.g., is the music appropriate, TV off, staff interacting with residents)?	<input type="checkbox"/>	<input type="checkbox"/>
	Are supplements served on meal trays?	<input type="checkbox"/>	<input type="checkbox"/>
	Are supplements returned to the kitchen untouched?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Discussion</b>	Talk with Nurse Aides regarding food complaints and the level of assistance needed at mealtimes.	<input type="checkbox"/>	<input type="checkbox"/>
	Talk with the Dietary staff about food complaints, or whether they notice trays returned to the kitchen untouched.	<input type="checkbox"/>	<input type="checkbox"/>
	Talk with charge nurses and medication nurses – are residents refusing supplements? Are Nurse Aides consistently offering between meal snacks and supplements?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Totals</b>			



## Worksheet # 2

### Assessing Nursing Home Resources

Use Worksheet # 2 to evaluate the resources likely needed to successfully implement a Dining Assistant program. Any “yes” responses on this tool indicates encouraging prospects for designing and implementing a Dining Assistant program. The nursing home’s decision-maker must determine if s/he thinks the necessary resources are available. Some components may not be considered as critical as others. In the event that adequate support is not present, the assessor may work on achieving a comfortable level of support before moving on to Worksheet # 3 – Setting Goals. A list of references follow that may provide more information in support of dining assistant programs.

#### Nursing Home Resource Assessment

		Yes	No
<b>Staff Support- Is there “buy-in” and support from:</b>	Administration	<input type="checkbox"/>	<input type="checkbox"/>
	Director Of Nursing	<input type="checkbox"/>	<input type="checkbox"/>
	Staff Development Coordinator	<input type="checkbox"/>	<input type="checkbox"/>
	Nursing Supervisors	<input type="checkbox"/>	<input type="checkbox"/>
	Dietitian	<input type="checkbox"/>	<input type="checkbox"/>
	Dietary Manager	<input type="checkbox"/>	<input type="checkbox"/>
	Other Department Heads potentially involved (e.g., Laundry, Housekeeping, Activities)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Corporate Support Finances</b>	If applicable, is there corporate support?	<input type="checkbox"/>	<input type="checkbox"/>
	Can the nursing home offer a financial incentive to dining assistants upon completion of the program?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Training</b>	Is there someone who can conduct the training?	<input type="checkbox"/>	<input type="checkbox"/>
	Is there adequate space to conduct the training?	<input type="checkbox"/>	<input type="checkbox"/>
	Is there adequate funding to purchase training materials?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Trainees</b>	Are there non-nursing staff interested in advancing their training to include direct care and perhaps eventual nurse aide certification?	<input type="checkbox"/>	<input type="checkbox"/>
	Are there non-nursing staff willing to be cross trained in an area outside their current employment area?	<input type="checkbox"/>	<input type="checkbox"/>
	Is there an active volunteer program to draw potential trainees from?	<input type="checkbox"/>	<input type="checkbox"/>
	If no active volunteer program, is there community/nursing home interest and support to develop this?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Space</b>	Is there adequate dining room space to accommodate extra residents/dining assistants?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Totals</b>			

## **Worksheet # 2 Continued**

### **References on Nutrition in the Elderly and Feeding Assistant/Dining Assistant Programs**

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## Worksheet # 4

### Designing the Dining Assistant Program

Using all of the information gathered to this point, consider the following questions in designing the Dining Assistant program. Evaluation of the following design options in conjunction with knowledge of nursing home resources and goals should help users plan an optimal program well suited to the home's unique needs.

#### Designing the Dining Assistant (DA) Program

Issues	Considerations	Notes
Identifying DAs	Volunteers from the community?	
	Paid workers from the community?	
	Non-nursing staff – voluntary recruitment?	
	Non-nursing staff – mandatory recruitment?	
DA Tasks	Transport residents to and from dining room?	
	Deliver and set up trays?	
	Circulate around the dining room to provide social stimulation?	
	Circulate around the dining room to identify residents in need of assistance?	
	Offer and retrieve alternate meal items?	
	Provide physical guidance to residents?	
	Provide encouragement/cueing to residents?	
	Offer between meal snacks and fluids?	
DA Assignments	Where are residents' meal time needs the heaviest?	
	When are residents' meal time needs the heaviest?	
Supervision & Training	What department will 'own' the program?	
	What department will do the scheduling and how will this be communicated to other departments?	
	Who will provide supervision?	
	Who will conduct the training?	
	Who will monitor the performance of the DAs and how will this be done?	
Administration	Who will develop the policy and procedure and write the job description?	
	Will there be any incentive (financial or other) offered to participating staff?	



## Worksheet # 5

### Implementing the Dining Assistant Program

At this point, there should be a fairly clear vision of how the Dining Assistant Program will be structured. Decisions should have been made on where and how Dining Assistant (DA) recruits will be found (volunteers or paid workers, in-house or from community); what tasks the DA will perform, who will provide the training and how ongoing supervision will be provided.

This worksheet provides more detail and guidance on the recruitment, training and supervision of the DA and the selection of appropriate residents for a DA Program.

<b>Program Implementation</b>		
<b>Issues</b>	<b>Consider</b>	<b>Notes</b>
Community Recruitment– Hiring/Screening Process	Who will schedule and conduct the interviews?	
	What are the selection criteria for hiring (e.g., appropriate appearance, cheerful, friendly attitude, comfortable with elderly) and how will these be communicated to interviewer(s)?	
	Will reference checks be done?	
	If this is a volunteer position, what is the facility/corporation policy on screening volunteers?	
	Will family members be considered for training, if requested?	
	Does the State require background checks?	
	Is there a minimum age requirement?	
	How many people are you aiming to recruit? How many people can you train and supervise?	
	Design a flyer to advertise your program – ask to post it in senior centers, local schools (colleges and high schools), churches, community buildings.	
	Design an ad to be placed in local newspaper or community bulletin board, college or high school publications, church newsletters.	
Spread the word about the program at staff and resident/family meetings. Encourage staff and families to promote the program to interested parties in their community.		

## Program Implementation

Issues	Consider	Notes
Nursing Home Staff Recruitment	Will this be a voluntary or mandatory recruitment? Make a list of pros and cons for each approach.	
	Involve key staff in the decision-making process to obtain buy-in.	
	If a monetary incentive is to be offered for in-house staff, determine how this will be structured (e.g., hourly pay increase for hours worked as DA, bonus upon training completion).	
	Communicate program details to potential candidates – be prepared to answer questions regarding a perceived increase in workload, scheduling, monetary incentives, opportunities for advancement and supervision.	
Training	Review your State's training requirements (e.g., hours, content). See Appendix C for state contacts.	
	Review training materials – some States have made training materials available for download. See Pages 34 - 35 for training resources.	
	If purchasing materials, preview materials and select the most appropriate for the group being trained.	
	Determine the training schedule that best suits trainees and trainer(s). Consider including 'practice' time in the dining room.	
	Recruit staff (e.g., administrator, dietitian, social worker, nursing director, nurse aides, occupational therapist) to assist with training.	
	Determine if you will offer recognition for DAs upon completion of training program (e.g., certificates, ceremony, bulletin board notice, photographs for marketing).	
	Determine how you will deal with students who miss training sessions.	
	Determine how you will deal with students who do not pass the program.	

### Program Implementation

Issues	Consider	Notes
Supervision & Scheduling	Will there be set schedules or will it vary week to week; how frequently will it be posted or otherwise communicated to DAs?	
	For community workers – paid and volunteers –Will DAs submit available time? How will this be communicated?	
	For in-house staff, how many meals will be assigned? How will schedule conflicts be resolved?	
	For in-house staff, how will DA and regular work load be managed so as not to create stress or resentment?	
	Who will be responsible for monitoring DAs' performance?	
	How will DA performance be monitored, and how frequently? See Appendix E for Observation Tool.	
	How will feedback be provided to DAs?	
Resident Identification	Review State and Federal requirements regarding appropriate residents (i.e., those without complicated feeding problems).	
	Conduct observations in dining areas using the Observation Tool to identify residents who eat less than 50%.	
	Prioritize residents/dining locations/meal times most in need of assistance.	
	Match resident needs with DA resources keeping in mind that the DA program may be introduced in phases depending on availability of resources.	



## Worksheet # 6

### Monitoring and Sustaining the Dining Assistant Program

It's important to monitor the status of the Dining Assistant program and provide ongoing feedback to all those involved. The Dining Assistant (DA) program has the potential to impact the quality of care delivered to the residents, the nursing home's standing in the community, family/resident satisfaction, and staff morale. Even the most successful program will hit occasional "rough" patches that will necessitate additional support to maintain and continue program activities. Ongoing monitoring will alert leadership to problems in time to put appropriate interventions in place to keep the program on track.

Worksheet # 6 provides some ideas for monitoring the various components of a Dining Assistant program.

<b>Monitoring and Sustaining the Dining Assistant (DA) Program</b>		
<b>Issues</b>	<b>Consider</b>	<b>Notes</b>
Monitoring DA program goals	Review progress toward goals (e.g., as part of Continuous Quality Improvement (CQI)).	
	Provide regular feedback to staff on progress toward goals.	
Monitoring residents	Conduct regular dining observations of residents – including those in the program and those not in the program.	
	Review findings from observations to ensure that DA program residents remain appropriate for the program.	
	Review findings from observations to identify other residents who might benefit from the DA program.	
Monitoring DAs	Conduct regular dining observations to ensure that DAs are performing appropriately.	
	Solicit feedback from DAs on concerns, job satisfaction, suggestions for program improvement, requests for additional training, etc.	
Monitoring Staff	Solicit feedback from Nursing, Dietary, Activities, Social Service staff on any concerns they may have regarding the program or suggestions for program improvement.	
Monitoring Families/Community	Look for opportunities to provide updated information on program progress/successes at Family Meetings, postings in nursing home, etc.	
	Solicit feedback on the DA program during care plan meetings/conferences.	



**Monitoring and Sustaining the Dining Assistant (DA) Program**

<b>Issues</b>	<b>Consider</b>	<b>Notes</b>
Sustaining the DA program	Meet regularly with program supervisors and trainers to monitor the participation of DAs (e.g., number of meals covered, number of DAs, number of residents served, training needs, scheduling issues).	
	Schedule training programs as needed to maintain a steady supply of trained DAs.	
	Seek opportunities to reward/recognize DAs' contribution to residents' QOL.	
	Periodically review the nursing home Dining Score Card (Worksheet # 1) to monitor the impact of the DA program.	

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## Appendix B Federal Register Notice



**2003 Federal Registry Notice**  
**Requirements for Paid Feeding Assistants in Long Term Care Facilities**

[Federal Register: September 26, 2003 (Volume 68, Number 187)]  
[Rules and Regulations]  
[Page 55528-55539]  
From the Federal Register Online via GPO Access [wais.access.gpo.gov]  
[DOCID:fr26se03-21]

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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.

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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>.

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## **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 Sec. 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<sup>1 2 3</sup>. 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

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<sup>1</sup> Stone, R.I. (2001) Frontline workers in long-term care: Research challenges and opportunities. *Generations*, 25(1), 49-57.

<sup>2</sup> 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.

<sup>3</sup> United States General Accounting Office. Nursing Workforce: Recruitment and Retention of Nurses and Nurses Aides Is a Growing Problem. (Washington, DC., May 2001)

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<sup>1</sup>. 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 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

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<sup>1</sup> Stone, R.I., Reinhard, S.C., Bowers, B., Zimmerman, D., Phillips, .D., Hawes, C., Fielding, J.A., and Jacobson, N. (2002). Evaluation of the Wellspring Model for Improving Nursing Home Quality.

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 1 ½ 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 Sec. 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 Sec. 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 (Sec. 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 Sec. 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 Sec. 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 (Sec. 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 Sec. 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 Sec. 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 Sec. 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 Sec. 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 Sec. 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 Sec. 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 Sec. 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 Sec. 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 Sec. 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 Sec. 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 60-70 percent of nursing home residents are cognitively impaired. Other suggestions included training in dementia, food and drug interactions, diet consistencies, how much and how to feed, resident preferences, difficulty swallowing, and emphasis on performing only feeding tasks for which training has been provided. A consistent concern of commenters was a need for a training emphasis on recognition and prevention of emergency situations associated with feeding, such as dysfunctional swallowing, tracheal aspiration, esophageal obstruction, and other potentially severe emergency situations.

Response: It is important to note that the training course requirements proposed in Sec. 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 Sec. 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 Sec. 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 Sec. 483.160(c) is inconsistent with Sec. 488.335, which requires a state to review all allegations of resident neglect, abuse, and misappropriation of property, and follow procedures in Sec. 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 Sec. 483.160(c). Paragraph (c) is unnecessary because it repeats certain provisions of existing Sec. 488.335. Since Sec. 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 Sec. 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:

[sbull] We are reorganizing and revising Sec. 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.

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

[sbull] In revised Sec. 483.35(h)(2), we are revising the supervision requirement to remove the word, ``direct,`` from the phrase, ``direct supervision.``

[sbull] Also, in revised Sec. 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.

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

[sbull] In Sec. 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.

[sbull] Also, in Sec. 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.

[sbull] In Sec. 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 Sec. 483.160(a).

[sbull] In Sec. 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 Sec. 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:

[sbull] The need for the information collection and its usefulness in carrying out the proper functions of our agency.

[sbull] The accuracy of our estimate of the information collection burden.

[sbull] The quality, utility, and clarity of the information to be collected.

[sbull] 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 6 hours/year, the total would be 20,400 hours for facilities. Using a clerical wage cost of \$10 per hour, the total facility burden is estimated to be \$204,000.

We are submitting a copy of regulation Sec. 483.160 to OMB for its review of the information collection requirements. The revision is not effective until OMB has approved it.

If you comment on these information collection and 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 C5-16-03, 7500 Security Boulevard, Baltimore, MD 21244-1850; and

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

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

## **VI. Regulatory Impact Statement**

### **A. Overall Impact**

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is



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

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

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

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of

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

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

For these reasons, we are not 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 Sec. 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.

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

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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

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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).

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2. In Sec. 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:

Sec. 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 Sec. 488.301n of this chapter, if--  
(i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of Sec. 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.

\* \* \* \* \*

Sec. 483.7 [Amended]

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3. Section 483.7 is amended as follows:

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a. In paragraph (e)

(1), the definition of ``Nurse aide'' is amended by adding a sentence to the end of the definition;

0

b. A new paragraph (q) is added.

The additions read as follows:

Sec. 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 Sec. 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 Sec. 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

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

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

Sec. 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.

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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

0

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).

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

Sec. 488.301 Definitions.

As used in this subpart--

\* \* \* \* \*

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

\* \* \* \* \*

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

Dated: May 22, 2003.

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

Approved: June 24, 2003.

Tommy G. Thompson,  
Secretary.

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

BILLING CODE 4120-03-U

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## Appendix C      State Contacts





State	Contact Agency	Information on State Websites	Description of Information
AK	Board of Nursing or Licensing	N/A	N/A
AL	Division of Licensure and Certification, Alabama Department of Public Health	<a href="http://www.alabamaadministrativecode.state.al.us/docs/hlth/index.html">http://www.alabamaadministrativecode.state.al.us/docs/hlth/index.html</a>	Alabama Administrative Code 420-5-10-.12
AR	Office of Long Term Care Licensing, Arkansas Department of Human Services	State does not participate in program.	
AZ	Office of Long-term Care Licensing, Division of Licensing Services, Arizona Department of Health Services	State does not yet participate in program, but has a statute allowing the development of rules allowing PFAs. The State is currently working on creating rules that would allow the use of PFAs.	
CA	Department of Health Care Services	N/A	N/A
CO	Health Facilities Division - Long Term Care, Department of Public Health and Environment	<a href="http://www.cdphe.state.co.us/hf/download/FEEDING%20ASST%20Curriculum%20(Jan%2005).pdf">http://www.cdphe.state.co.us/hf/download/FEEDING%20ASST%20Curriculum%20(Jan%2005).pdf</a> <a href="http://www.sos.state.co.us/CCR/Rule.do?deptID=16&amp;deptName=1000%20Public%20Health%20and%20Environment&amp;agencyID=144&amp;agencyName=1011_Health%20Facilities%20and%20Emergency%20Medical%20Services%20Division%20-%20Rules%20promulgated%20by%20the%20Colorado%20Board%20of%20Health&amp;ccrDocID=2477&amp;ccrDocName=6%20CCR%201011-1%20STANDARDS%20FOR%20HOSPITALS%20AND%20HEALTH%20FACILITIES&amp;subDocID=23522&amp;subDocName=CHAPTER%20V%20LONG%20TERM%20CARE%20FACILITIES&amp;version=13">http://www.sos.state.co.us/CCR/Rule.do?deptID=16&amp;deptName=1000%20Public%20Health%20and%20Environment&amp;agencyID=144&amp;agencyName=1011_Health%20Facilities%20and%20Emergency%20Medical%20Services%20Division%20-%20Rules%20promulgated%20by%20the%20Colorado%20Board%20of%20Health&amp;ccrDocID=2477&amp;ccrDocName=6%20CCR%201011-1%20STANDARDS%20FOR%20HOSPITALS%20AND%20HEALTH%20FACILITIES&amp;subDocID=23522&amp;subDocName=CHAPTER%20V%20LONG%20TERM%20CARE%20FACILITIES&amp;version=13</a>	Curriculum Specifications and Program Requirements  State Regulations: Department:1000 Public Health and Environment; Agency:1011 Health Facilities and Emergency Medical Services Division - Rules promulgated by the Colorado Board of Health; CCR 1011-1 Standards for Hospitals and Health Facilities; CHAPTER V Long Term Care Facilities; Part 11.001 - Feeding Assistants
CT	Connecticut Department of Public Health	<a href="http://www.dir.ct.gov/dph/PHC/phc.doc">http://www.dir.ct.gov/dph/PHC/phc.doc</a>	Public Health Code 19-13-D8t(l)(9). Chronic and convalescent nursing homes and rest homes with nursing supervision, Nurse's Aide and Feeding Assistant Training and Employment
DC	Health Regulation and Licensing, Department of Health	N/A	N/A
DE	Division of Long Term Care Residents Protection, Delaware Health and Social Services	<a href="http://regulations.delaware.gov/AdminCode/title16/3000/3215.shtml">http://regulations.delaware.gov/AdminCode/title16/3000/3215.shtml</a>	Delaware Administrative Code, Title 16 Health & Social Services, 3215 Training of Paid Feeding Assistants
FL	Bureau of Long Term Care Services, Agency of Health Care Administration	<a href="http://www.hpm.umn.edu/nhregsPlus/nursing_services/nursing_services_florida.htm">http://www.hpm.umn.edu/nhregsPlus/nursing_services/nursing_services_florida.htm</a>	Section 400.23(3)(b), Florida Statutes
GA	Office of Regulatory Services, LTC, Department of Human Resources	<a href="http://rules.sos.state.ga.us/docs/290/5/8/25.pdf">http://rules.sos.state.ga.us/docs/290/5/8/25.pdf</a>	Rules of Department of Human Resources, Office of Regulatory Services Chapter 290-5-8-.25 Dining Assistants
		<a href="http://rules.sos.state.ga.us/docs/290/5/8/01.pdf">http://rules.sos.state.ga.us/docs/290/5/8/01.pdf</a>	Rules of Department of Human Resources, Office of Regulatory Services Chapter 290-5-8-.01 Definitions
HI	Hawaii State Department of Health, Office of Health Care Assurance	N/A	N/A
IA	Division of Health Facilities, Department of Inspection and Appeals	<a href="http://www.legis.state.ia.us/ACO/IAChtml/481.htm#rule_481_58_24">http://www.legis.state.ia.us/ACO/IAChtml/481.htm#rule_481_58_24</a>	Iowa Administrative Code 481-58.24(9) Paid Nutrition Assistant
ID	Idaho Department of Health, Bureau of Facility Standards	The state allows the use of feeding assistants.	No rule.

Note: N/A - Information not Available

Source: Abt Associates Inc. September 2008

State	Contact Agency	Information on State Websites	Description of Information
IL	LTC Training and Education	<a href="http://www.ilga.gov/commission/jcar/admincode/077/077003000C06620R.html">http://www.ilga.gov/commission/jcar/admincode/077/077003000C06620R.html</a>	Illinois Administrative Code TITLE 77, CHAPTER I, SUBCHAPTER c, PART 300, SECTION 300.662 RESIDENT ATTENDANTS
IN	Indiana State Department of Health Department of Health, Division of Long Term Care	<a href="http://www.in.gov/isdh/files/DiningAssistantApp.pdf">http://www.in.gov/isdh/files/DiningAssistantApp.pdf</a>	Application for Approval of the Dining Assistant Program
		<a href="http://www.in.gov/legislative/iac/iac_title?iact=410">http://www.in.gov/legislative/iac/iac_title?iact=410</a>	Indiana Administrative Code 410 IAC 16.2-1.1-19.3, 410 IAC 16.2-3.1-14, 410 IAC 16.2-5-1.4, 410 IAC 16.2-5-13, 410 IAC 16.2-3.1-53 Dining Assistants
KS	Kansas Department of Health and Environment, Health Occupations Credentialing	<a href="http://www.kdheks.gov/hoc/downloads/QandA16.pdf">http://www.kdheks.gov/hoc/downloads/QandA16.pdf</a>	Frequently Asked Questions
		<a href="http://www.kdheks.gov/hoc/downloads/Guidelines_Nov_2005.pdf">http://www.kdheks.gov/hoc/downloads/Guidelines_Nov_2005.pdf</a>	Paid Nutrition Assistant Guidelines
		<a href="http://www.kslegislature.org/legsrv-statutes/getStatute.do">http://www.kslegislature.org/legsrv-statutes/getStatute.do</a>	Kansas Statute KSA 39-923 (27) Definition, Paid Nutrition Assistant
KY	Cabinet for Health and Family Services, Office of Inspector General	<a href="http://www.lrc.ky.gov/kar/902/020/390.htm">http://www.lrc.ky.gov/kar/902/020/390.htm</a>	Kentucky Administrative Rules 902 KAR 20:390. Paid feeding assistants
LA	Department of Health and Hospitals, Bureau of Health Ser	<a href="http://www.dhh.louisiana.gov/offices/publications/pubs-112/LTC%20MinLicStndrds_0606RUL.pdf">http://www.dhh.louisiana.gov/offices/publications/pubs-112/LTC%20MinLicStndrds_0606RUL.pdf</a>	regulations
MA	Department of Public Health, Division of Health Care Quality	<a href="http://www.mass.gov/Eeohhs2/docs/dph/quality/hcq_circular_letters/ltc_facilities_0312437.pdf">http://www.mass.gov/Eeohhs2/docs/dph/quality/hcq_circular_letters/ltc_facilities_0312437.pdf</a>	Letter to Administrators
MD	Department of Health and Mental Hygiene, Office of Health Care Quality	<a href="http://www.dsd.state.md.us/comar/10/10.07.02.41.htm">http://www.dsd.state.md.us/comar/10/10.07.02.41.htm</a>	Code of Maryland Regulations 10.07.02.41 Paid Feeding Assistant
ME	Maine Department of Health and Human Services, Division of Licensing and Regulatory Services	<a href="http://www.maine.gov/sos/cec/rules/10/ch110.htm">http://www.maine.gov/sos/cec/rules/10/ch110.htm</a>	Department of Health and Human Services, Chapter 110: Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities, Chapter 1: Definitions; Chapter 8: Personnel; Chapter 9: Resident Care Staffing
MI	Department of Community Health, Bureau of Health Professions	N/A	N/A
MN	Minnesota Department of Health, Compliance Monitoring Division, Licensing and Certification Program	<a href="http://www.health.state.mn.us/divs/fpc/profinfo/lic/pfa/pfaq.html">http://www.health.state.mn.us/divs/fpc/profinfo/lic/pfa/pfaq.html</a>	Q&A
		<a href="http://www.health.state.mn.us/divs/fpc/profinfo/ib04_1.html">http://www.health.state.mn.us/divs/fpc/profinfo/ib04_1.html</a>	Paid Feeding Assistant Nursing Home Bulletin
		<a href="http://www.health.state.mn.us/divs/fpc/profinfo/lic/pfa/pfacourse1_4.pdf">http://www.health.state.mn.us/divs/fpc/profinfo/lic/pfa/pfacourse1_4.pdf</a>	Minnesota Paid Feeding Assistant Training Program
		<a href="http://www.health.state.mn.us/divs/fpc/profinfo/lic/pfa/pfaapprove.html">http://www.health.state.mn.us/divs/fpc/profinfo/lic/pfa/pfaapprove.html</a>	State-approved training courses
		<a href="https://www.revisor.leg.state.mn.us/statutes/?id=144A.62">https://www.revisor.leg.state.mn.us/statutes/?id=144A.62</a>	Minnesota State Statutes 144A.62 Resident Attendants
		<a href="http://www.health.state.mn.us/divs/fpc/profinfo/lic/pfa/pfahome.html">http://www.health.state.mn.us/divs/fpc/profinfo/lic/pfa/pfahome.html</a>	Paid Feeding Assistant Webpage
MO	Department of Health and Senior Services, Certified Nursing Assistant Registry	<a href="http://www.dhss.mo.gov/CNARegistry/FeedAssistant.html">http://www.dhss.mo.gov/CNARegistry/FeedAssistant.html</a>	Paid Feeding Assistant Requirements

Note: N/A - Information not Available

Source: Abt Associates Inc. September 2008

State	Contact Agency	Information on State Websites	Description of Information
MS	State Department of Health, Division of Health Facilities, Licensure and Certification	<a href="http://www.msdh.state.ms.us/msdhsite/_static/resources/973.pdf">http://www.msdh.state.ms.us/msdhsite/_static/resources/973.pdf</a>	Sample Feeding Assistant Quiz
		<a href="http://www.msdh.state.ms.us/msdhsite/_static/resources/975.pdf">http://www.msdh.state.ms.us/msdhsite/_static/resources/975.pdf</a>	Application for Approval
		<a href="http://www.msdh.state.ms.us/msdhsite/_static/resources/974.pdf">http://www.msdh.state.ms.us/msdhsite/_static/resources/974.pdf</a>	Feeding Assistant Training Certificate
		<a href="http://www.msdh.state.ms.us/msdhsite/_static/resources/971.pdf">http://www.msdh.state.ms.us/msdhsite/_static/resources/971.pdf</a>	Feeding Assistant Policy Chart
		<a href="http://www.msdh.state.ms.us/msdhsite/_static/resources/972.pdf">http://www.msdh.state.ms.us/msdhsite/_static/resources/972.pdf</a>	Feeding Assistant Program Memo
MT	Department of Public Health and Human Services, Quality Assurance Division, Certification Bureau	<a href="http://www.dphhs.mt.gov/qad/feedingassistant/fatrainingoutline.pdf">http://www.dphhs.mt.gov/qad/feedingassistant/fatrainingoutline.pdf</a>	Feeding Assistant Training Outline
		<a href="http://www.dphhs.mt.gov/qad/feedingassistant/index.shtml">http://www.dphhs.mt.gov/qad/feedingassistant/index.shtml</a>	Feeding Assistant Program Introduction
		<a href="http://www.dphhs.mt.gov/qad/feedingassistant/feedassistantchecklist.pdf">http://www.dphhs.mt.gov/qad/feedingassistant/feedassistantchecklist.pdf</a>	Feeding Assistant Skills Competency Skills Checklist
		<a href="http://www.dphhs.mt.gov/qad/feedingassistant/checklistpp.pdf">http://www.dphhs.mt.gov/qad/feedingassistant/checklistpp.pdf</a>	Policy and Procedure for Completing Competency Checklist
		<a href="http://www.dphhs.mt.gov/qad/feedingassistant/feedingevalform.pdf">http://www.dphhs.mt.gov/qad/feedingassistant/feedingevalform.pdf</a>	Feeding Assistant Curriculum Evaluation Checklist
		<a href="http://virtual.state.mt.us/qad/feedingassistant/feedingassistantrequirements.pdf">http://virtual.state.mt.us/qad/feedingassistant/feedingassistantrequirements.pdf</a>	Feeding Assistant State Agency Requirements
NC	North Carolina Department of Health and Human Services, Division of Health Service Regulation	<a href="http://www.dhhs.state.nc.us/dhsr/hcpr/pdf/approved_fed_curr.pdf">http://www.dhhs.state.nc.us/dhsr/hcpr/pdf/approved_fed_curr.pdf</a>	State-Approved Curriculum for Feeding Assistants
ND	Department of Health, Division of Health Facilities	<a href="http://www.legis.nd.gov/information/acdata/pdf/33-07-03.2.pdf">http://www.legis.nd.gov/information/acdata/pdf/33-07-03.2.pdf</a>	North Dakota Century Code 33-07-03.2-16.1 Paid Feeding Assistant
NE	Nebraska Department of Health and Human Services, Licensing and Regulatory Affairs	<a href="http://www.hhs.state.ne.us/crl/nursing/dining/dining.htm">http://www.hhs.state.ne.us/crl/nursing/dining/dining.htm</a>	Paid Dining Assistant
		<a href="http://www.hhs.state.ne.us/crl/nursing/dining/apps.htm">http://www.hhs.state.ne.us/crl/nursing/dining/apps.htm</a>	Paid Dining Assistant Application
		<a href="http://www.hhs.state.ne.us/crl/nursing/dining/nhrequirements.htm">http://www.hhs.state.ne.us/crl/nursing/dining/nhrequirements.htm</a>	Nursing Home Requirements
		<a href="http://www.hhs.state.ne.us/crl/nursing/dining/course.htm">http://www.hhs.state.ne.us/crl/nursing/dining/course.htm</a>	Training Requirements
		<a href="http://www.hhs.state.ne.us/crl/nursing/dining/requirements.htm">http://www.hhs.state.ne.us/crl/nursing/dining/requirements.htm</a>	Requirements for Approval of Courses
		<a href="http://www.sos.state.ne.us/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-172/Chapter-105.pdf">http://www.sos.state.ne.us/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-172/Chapter-105.pdf</a>	Nebraska Administrative Code 172 NAC 105 Paid Dining Assistants
		<a href="http://www.hhs.state.ne.us/crl/statutes/napdastat.pdf">http://www.hhs.state.ne.us/crl/statutes/napdastat.pdf</a>	Statutes related to Dining Assistants
NH	New Hampshire Board of Nursing	<a href="http://www.nh.gov/nursing/practice/paid_feeding.htm">http://www.nh.gov/nursing/practice/paid_feeding.htm</a>	FAQs
NJ	Department of Health and Senior Services, Division of Health Facilities Evaluation and Licensing	State does not participate in program.	
NM	Department of Health, Division of Health Improvement, Health Facilities Licensure and Certification Bureau	N/A	N/A
NV	Department of Health and Human Services, Bureau of Licensure and Certification	<a href="http://health.nv.gov/docs/paidfeedingassistant.pdf">http://health.nv.gov/docs/paidfeedingassistant.pdf</a>	Paid Feeding Assistant Training Program Application

Note: N/A - Information not Available

Source: Abt Associates Inc. September 2008

State	Contact Agency	Information on State Websites	Description of Information
NY	Department of Health, Division of Residential Services, Bureau of Professional Credentialing	<a href="http://www.health.state.ny.us/professionals/nursing_home_administrator/docs/dal_07-11_paid_feeding_assistants_dear_administrator.pdf">http://www.health.state.ny.us/professionals/nursing_home_administrator/docs/dal_07-11_paid_feeding_assistants_dear_administrator.pdf</a>	Letter to Administrators
		<a href="http://w3.health.state.ny.us/dbspace/NYCRR10.nsf/0/8525652c00680c3e8525652c004980f8?OpenDocument">http://w3.health.state.ny.us/dbspace/NYCRR10.nsf/0/8525652c00680c3e8525652c004980f8?OpenDocument</a>	Department of Health Regulations 10NYCRR 415.13 (d) Feeding Assistant
OH	Ohio Department of Health, Nurse Aide Training Competency Evaluation Program	<a href="http://www.odh.ohio.gov/ASSETS/B04819C4871248EFA7C98717A3A69703/FR17_07.2.pdf">http://www.odh.ohio.gov/ASSETS/B04819C4871248EFA7C98717A3A69703/FR17_07.2.pdf</a>	Ohio Administrative Code 3701-17-07.2 Dining Assistants
OK	Oklahoma State Department of Health, Protective Health Services	<a href="http://www.ok.gov/health/documents/HRDS-NAR%20FeedAsstProfChcklst%20ODH%20507.pdf">http://www.ok.gov/health/documents/HRDS-NAR%20FeedAsstProfChcklst%20ODH%20507.pdf</a>	Feeding Assistant Proficiency checklist
		<a href="http://www.ok.gov/health/documents/HRDS_Chapt675.pdf">http://www.ok.gov/health/documents/HRDS_Chapt675.pdf</a>	Oklahoma Administrative Code 310: 675-19 (1-8) Oklahoma State Department of Health, Nursing and Specialized Facilities, Feeding Assistants
		<a href="http://www.ok.gov/health/documents/HRDS-NAR%20FeedAsstRegistrationApp%20ODH%20509.pdf">http://www.ok.gov/health/documents/HRDS-NAR%20FeedAsstRegistrationApp%20ODH%20509.pdf</a>	Feeding Assistant Registration Application
		<a href="http://www.ok.gov/health/documents/HRDS-NAR%20FeedAsstCertofCompletion%20ODH%20508.pdf">http://www.ok.gov/health/documents/HRDS-NAR%20FeedAsstCertofCompletion%20ODH%20508.pdf</a>	Feeding Assistant Certificate of Completion
OR	Department of Human Services, Seniors and People with Disabilities Division, Office of Licensing and Quality Care	<a href="http://www.dhs.state.or.us/policy/spd/rules/411_086.pdf">http://www.dhs.state.or.us/policy/spd/rules/411_086.pdf</a>	Oregon Administrative Rules 411-086-0250 (7) Dietary Services, Dining Assistant
PA	Department of Health, Division of Nursing Care Facilities	<a href="https://app2.health.state.pa.us/commonpoc/Login/Login.aspx">https://app2.health.state.pa.us/commonpoc/Login/Login.aspx</a>	Pennsylvania Department of Health, Facility Message Board; 10/14/2003 Long Term Care Directive - Feeding Assistants
RI	Department of Health, Office of Facilities Regulation	<a href="http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/4215.pdf">http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/4215.pdf</a>	Rules and Regulations for Licensing of Nursing Facilities 25.11-14 Assistance with Eating and Hydration
SC	Department of Health and Human Services, Bureau of Long Term Care Services	<a href="http://www.dhhs.state.sc.us/Internet/pdf/Attachmt%20B%20NursHomes%20Core%20Curriculum%20Outline.pdf">http://www.dhhs.state.sc.us/Internet/pdf/Attachmt%20B%20NursHomes%20Core%20Curriculum%20Outline.pdf</a>	Paid Feeding Assistant Core Curriculum Outline
		<a href="http://www.dhhs.state.sc.us/Internet/pdf/AQandA.pdf">http://www.dhhs.state.sc.us/Internet/pdf/AQandA.pdf</a>	Questions and Answers
		<a href="http://www.dhhs.state.sc.us/Internet/pdf/Attachmt%20A%20NursHomes%20Signature%20Sheet.pdf">http://www.dhhs.state.sc.us/Internet/pdf/Attachmt%20A%20NursHomes%20Signature%20Sheet.pdf</a>	Requirements for Paid Feeding Assistant Programs
SD	South Dakota Department of Health, Office of Health Facilities Licensure and Certification	<a href="http://legis.state.sd.us/rules/DisplayRule.aspx?Rule=44:04:07:17">http://legis.state.sd.us/rules/DisplayRule.aspx?Rule=44:04:07:17</a>	Administrative Rule 44:04:07:17. Nursing facility nutrition and hydration assistance program
TN	Tennessee Department of Health, Health Facilities	State does not participate; information not available online.	
TX	Texas Department of Aging and Disability Services	<a href="http://www.dads.state.tx.us/providers/NF/credentialing/NATCEP/feedingassistant.pdf">http://www.dads.state.tx.us/providers/NF/credentialing/NATCEP/feedingassistant.pdf</a>	Feeding Assistant Training (Manual)
		<a href="http://secure.sos.state.tx.us/pls/pub/readtac\$ext.TacPage?sl=R&amp;app=9&amp;p_dir=&amp;p_rloc=&amp;p_tloc=&amp;p_ploc=&amp;pg=1&amp;p_tac=&amp;ti=40&amp;pt=1&amp;ch=19&amp;rl=1113">http://secure.sos.state.tx.us/pls/pub/readtac\$ext.TacPage?sl=R&amp;app=9&amp;p_dir=&amp;p_rloc=&amp;p_tloc=&amp;p_ploc=&amp;pg=1&amp;p_tac=&amp;ti=40&amp;pt=1&amp;ch=19&amp;rl=1113</a>	Texas Administrative Code
UT	Department of Health, Bureau of Health Facility Licensing, Certification, and Resident Assessment	<a href="http://www.rules.utah.gov/publicat/code/r432/r432-150.htm">http://www.rules.utah.gov/publicat/code/r432/r432-150.htm</a>	Utah Administrative Code R432-150-24. Nursing Care Facility. Food Services. (10 - 17)
VA	Virginia Department of Health, Office of Licensure and Certification	<a href="http://www.vdh.state.va.us/OLC/Laws/documents/NursingHomes/feed%20hydration%20program.pdf">http://www.vdh.state.va.us/OLC/Laws/documents/NursingHomes/feed%20hydration%20program.pdf</a>	Feeding/Hydration Assistant Training Program
VT	Agency of Human Services, Department of Disabilities, Aging, & Independent Living, Division of Licensing & Protection	N/A	N/A
WA	Department of Social and Health Services, Aging and Disability Services Administration	<a href="http://www.aasa.dshs.wa.gov/professional/letters/nh/2004/04-004.htm">http://www.aasa.dshs.wa.gov/professional/letters/nh/2004/04-004.htm</a>	Dietary Aide Program Requirements

Note: N/A - Information not Available

Source: Abt Associates Inc. September 2008

State	Contact Agency	Information on State Websites	Description of Information
WI	Department of Health and Family Services, Office of Caregiver Quality	<a href="http://www.dhfs.state.wi.us/caregiver/FeedingAssistant/FAstandCurr.htm">http://www.dhfs.state.wi.us/caregiver/FeedingAssistant/FAstandCurr.htm</a>	Standardized Feeding Assistant Curriculum
		<a href="http://www.dhfs.state.wi.us/RL_DSL/Publications/04-008.htm">http://www.dhfs.state.wi.us/RL_DSL/Publications/04-008.htm</a>	Feeding Assistant Program Requirements
		<a href="https://www.dhfs.state.wi.us/caregiver/FeedingAssistant/FAprogApprvl.htm">https://www.dhfs.state.wi.us/caregiver/FeedingAssistant/FAprogApprvl.htm</a>	Training Approval Procedures
WV	West Virginia Department of Health and Human Resources, Office of Health Facility Licensure and Certification	<a href="http://www.wvdhhr.org/ohflac/NursingHome/Resources/Feeding%20assistant%20guidelines%20-%207May04.pdf">http://www.wvdhhr.org/ohflac/NursingHome/Resources/Feeding%20assistant%20guidelines%20-%207May04.pdf</a>	Guidelines for Feeding Assistants
WY	Wyoming Department of Health, Office of Healthcare Licensing and Surveys	<a href="http://wdh.state.wy.us/Media.aspx?mediaId=682">http://wdh.state.wy.us/Media.aspx?mediaId=682</a>	Nutrition Support Assistant Program and Training Manual

Note: N/A - Information not Available

Source: Abt Associates Inc. September 2008

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# Appendix D      CMS-Issued Guidance for State Surveyors





Center for Medicaid and State Operations/Survey and Certification Group

**Ref: S&C-07-30**  
**(revised)**

**DATE:** August 10, 2007

**TO:** State Survey Agency Directors

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** **Nursing Homes** - Issuance of New Tag F373 (Paid Feeding Assistants) as Part of Appendix PP, State Operations Manual, Including Training Materials

**\*\*\*The effective date of this guidance has been changed to coincide with the earlier than anticipated release of the official transmittal on August 17, 2007\*\*\***

**Memorandum Summary**

- New guidance for long-term care surveyors regarding the requirements for Paid Feeding Assistants will be published August 17, 2007.
- An advance copy of this guidance and training materials are attached.
- This training packet is to be used to train all surveyors who survey nursing homes by the implementation date.

The Centers for Medicare & Medicaid Services (CMS) published a final rule on September 26, 2003 (68 FR 55528) that allowed long-term care facilities to use paid feeding assistants 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 of this rule is to provide more residents with help in eating and drinking and reduce the incidence of unplanned weight loss and dehydration.

New surveyor guidance including interpretive guidelines and severity guidance has been developed for the implementation of this regulation through the new Tag F373 – Paid Feeding Assistants. This new guidance for surveying long-term care facilities will become effective August 17, 2007. At that time, a final copy of this new guidance will be available at <http://www.cms.hhs.gov/Transmittals/> and ultimately incorporated into Appendix PP of the State Operations Manual.

We are providing you with an advance copy of the new Paid Feeding Assistant guidance which contains the interpretive guidelines, investigative protocol, and deficiency categorization. The interpretive guidelines provide terminology and information regarding the use of paid feeding assistants that surveyors will need to apply the regulation. The investigative protocol explains the investigation's objectives and procedures surveyors will need for their investigation and determination of compliance. The deficiency categorization provides criteria for the determination of the correct level of the severity of outcome to any resident(s) from any deficient practice(s) found at Tag F373.

Also attached to this memo are training materials for the new Tag F373. These training materials are to be used to train all surveyors who survey nursing homes by the implementation date. We encourage training to be conducted in person with group discussion to optimize learning. However, if this is not feasible to meet the needs of your surveyors, it is acceptable to use other methods. The training materials may also be used to communicate with provider groups and other stakeholders.

Regional Office (RO) and State Survey Agency (SA) training coordinators must document the completion of training on this new guidance for all RO and State nursing home surveyors within their region utilizing the Learning Management System (LMS) – a course code will be provided through one of the Survey and Certification Regional Training Administrator (RTA) teleconferences.

Enclosed with this memorandum are the following files:

- Advance copy of Paid Feeding Assistants guidance (F373) – (PDF);
- Training Instructor Guide – (PDF); and
- PowerPoint presentation file – (PowerPoint file).

For questions on this memorandum, please contact Susan Joslin at 410-786-3516 or via email at [Susan.Joslin@cms.hhs.gov](mailto:Susan.Joslin@cms.hhs.gov).

**Effective Date:** This guidance is expected to be published in final on August 17, 2007.

**Training:** The materials should be distributed immediately to all State Agencies and training coordinators.

/s/  
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Enclosures: Advance copy of Paid Feeding Assistants guidance (F373)  
PowerPoint Presentation  
Training Instructor Guide

***State Operations Manual, Appendix P, Task 2, Entrance Conference – ADVANCE COPY***

*Ask the administrator if the facility utilizes paid feeding assistants. If yes, request further information about how and where the paid feeding assistants receive their training. Determine whether the training for the paid feeding assistant was provided through a State-approved training program by qualified professionals as defined by State law, with a minimum of eight hours of training.*

*Request the names of staff (including agency staff) who have successfully completed training for paid feeding assistants, and who are currently assisting selected residents with eating meals and/or snacks;*

*NOTE: Paid feeding assistants must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). Therefore, if a facility has a nursing waiver, that facility cannot use paid feeding assistants when a licensed nurse is not available.*

***State Operations Manual, Appendix P, Investigative Protocol: Dining and Food Service, Procedures Part 4:***

- *If you observe a resident who is being assisted by a staff member to eat or drink, and the resident is having problems with eating or drinking, inquire if the staff member who is assisting them is a paid feeding assistant. If so, follow the procedures at tag F373.*

## **F373**

### **§483.35(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.

*NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160:*

*(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.*

***Intent: §483.35(h)***

*The intent of this regulation is to ensure that employees who are used as paid feeding assistants are:*

- *Properly trained (in accordance with the requirements at §483.160, including maintenance of records);*
- *Adequately supervised;*
- *Assisting only those residents without complicated feeding problems and who have been selected as eligible to receive these services from a paid feeding assistant; and*
- *Providing assistance in accordance with the resident's needs, based on individualized assessment and care planning.*

***Definitions***

*“Paid feeding assistant” is defined in regulation at 42 C.F.R. § 488.301 as “an individual who meets the requirements specified in 42 C.F.R. § 483.35(h)(1)(i) 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.”*

***NOTE:*** *The regulation uses the term, “paid feeding assistant.” While we are not using any other term, facilities and States may use whatever term they prefer, such as dining assistant, meal assistant, resident assistant, nutritional aide, etc. in order to convey more respect for the resident. Facilities may identify this position with other titles; however, the facility must be able to identify those employees who meet the requirements under the paid feeding assistant regulation. These requirements do not apply to family and/or volunteers who may be providing the resident with assistance.*

*“Resident call system,” for the purposes of this requirement includes not only the standard hard-wired call system but other means in an emergency situation by which a paid feeding assistant can achieve timely notification of a supervisory nurse (when not present in the room).*

## **Overview**

*The intent behind the use of paid feeding assistants by nursing homes is to provide nutrition and hydration support to residents who may be at risk for unplanned weight loss and dehydration. These are residents with no complicated problems associated with eating or drinking, who cannot or do not eat independently due to physical or cognitive disabilities, or those who simply need cueing or encouragement to eat. The use of paid feeding assistants is intended to supplement certified nurse aides, not substitute for nurse aides or licensed nursing staff. Use of paid feeding assistants is an option for nursing homes if their State approves the use of paid feeding assistants and establishes a mechanism to approve training programs for paid feeding assistants.*

## **Interpretive Guidelines §483.35(h)**

*NOTE: The regulation at §483.30(a)(2) requires that "Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to service as a charge nurse on each tour of duty." In the paid feeding assistant regulation, the term charge nurse is used to identify who is responsible for assessing the eligibility of a resident to be assisted by a paid feeding assistant. The regulation also states that a paid feeding assistant must work under the supervision of an RN or LPN, and they must call the supervisory nurse in case of an emergency. Therefore, a facility that has received a waiver and does not have either an RN or LPN available in the building cannot use paid feeding assistants during those times.*

## **Charge Nurse Assessment of Resident Eligibility for Feeding Assistance**

*The facility must base resident selection on the charge nurse's (RN, or LPN if allowed by State law) current assessment of the resident's condition and the resident's latest comprehensive assessment and plan of care. Charge nurses may wish to consult with interdisciplinary team members, such as speech-language pathologists or other professionals, when making their decisions.*

*Paid feeding assistants are permitted to assist only those residents who have no complicated eating or drinking problems. This includes residents who are dependent in eating and/or those who have some degree of dependence, such as needing cueing or partial assistance, as long as they do not have complicated eating or drinking problems.*

*Paid feeding assistants are not permitted to assist residents who have complicated eating problems, such as (but not limited to) difficulty swallowing, recurrent lung aspirations, or who receive nutrition through parenteral or enteral means. Nurses or nurse aides must continue to assist residents to eat or drink who require the assistance of staff with more specialized training.*

*Facilities may use paid feeding assistants to assist eligible residents to eat and drink at meal times, snack times, or during activities or social events as needed, whenever the facility can provide the necessary supervision.*

### ***Supervision (by RN/LPN) of Paid Feeding Assistants***

*A paid feeding assistant must work under the supervision of an RN or LPN. While we are not prescribing the exact means by which facility RNs and LPNs assert their supervisory responsibilities, we expect that facilities will do so in a way that avoids negative outcomes for their residents. If a facility chooses to use paid feeding assistants, it is the facility's responsibility to ensure that adequate supervisory nursing staff are available to supervise these assistants.*

*The supervisory nurse should monitor the provision of the assistance provided by paid feeding assistants to evaluate on an ongoing basis:*

- *Their use of appropriate feeding techniques;*
- *Whether they are assisting assigned residents according to their identified eating and drinking needs;*
- *Whether they are providing assistance in recognition of the rights and dignity of the resident; and*
- *Whether they are adhering to safety and infection control practices.*

*Adequate supervision by a supervising nurse does not necessarily mean constant visual contact or being physically present during the meal/snack time, especially if a feeding assistant is assisting a resident to eat in his or her room. However, whatever the location, the feeding assistant must be aware of and know how to access the supervisory nurse immediately in the event that an emergency should occur. Should an emergency arise, a paid feeding assistant must immediately call a supervisory nurse for help on the resident call system.*

*The charge nurse and the supervisory nurse may or may not be the same individuals.*

### ***Resident Call System***

*The regulatory language at this Tag states that, "in an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system." Residents may be receiving assistance in eating or drinking in various locations throughout the facility, such as dining areas, activity rooms, or areas such as patios or porches in which a resident call system is not readily available. The resident call system requirement at §483.70(f), F463, only specifies that the call system be available in the residents rooms and bathrooms. Regardless of where a resident is being assisted to eat or drink, in the case of an emergency, the facility needs to have a means for a paid feeding assistant to obtain timely help of a supervisory nurse. Therefore, for the purposes of this requirement, a "resident call system" includes not only the standard hard-wired or*



wireless call system but other means in an emergency situation by which a paid feeding assistant can achieve timely notification of a supervisory nurse.

### ***Use of Existing Staff as Paid Feeding Assistants***

*Facilities may use their existing staff to assist eligible residents to eat and drink. These employees must have successfully completed a State-approved training course for paid feeding assistants, which has a minimum of 8 hours of training as required in 483.160. Staff may include, for example, administrative, clerical, housekeeping, dietary staff, or activity specialists. Employees used as paid feeding assistants, regardless of their position, are subject to the same training and supervisory requirements as any other paid feeding assistant.*

### ***Maintenance of Training Records***

*The facility must maintain a record of all employees used by the facility as paid feeding assistants. The record should include verification that they have successfully completed a State-approved training course for paid feeding assistants.*

### ***Investigative Protocol***

#### ***Use of Paid Feeding Assistants***

#### ***Objectives***

*The objectives of this protocol are to determine, for a facility that uses paid feeding assistants:*

- *If individuals used as paid feeding assistants successfully completed a State-approved training course;*
- *If sampled residents who were selected to receive assistance from paid feeding assistants were assessed by the charge nurse and determined to be eligible to receive these services based on the latest assessment and plan of care; and*
- *If the paid feeding assistants are supervised by an RN or LPN.*

#### ***Use***

*This protocol is used when a surveyor identifies concerns through observation; interview with residents, family, or staff; or record review, that the facility may not be following the requirements regarding paid feeding assistants, including proper training and supervision of feeding assistants, and proper selection of residents for feeding assistance.*

#### ***Procedures***

*Briefly review the comprehensive assessment and interdisciplinary care plan to guide observations to be made. The team coordinator assigns one surveyor to obtain the facility's*

*records of all employees used by the facility as paid feeding assistants, for review for completion of the training course for paid feeding assistants.*

### ***Observations***

*If the concern was discovered through resident or family interview, observe the resident while they are being assisted to eat and drink by a paid feeding assistant. Determine if the assistant is using proper feeding technique and is providing the type of assistance specified in the resident's care plan. Note the resident's condition and observe for the presence of complicated feeding problems.*

*If the concern was discovered through observations that were already made, only conduct additional observations if necessary to complete the investigation.*

### ***Interviews***

#### ***Resident and Family Interviews***

*If a resident is selected for this protocol through surveyor observation that they are having difficulties in eating or drinking and they are being assisted by a paid feeding assistant, interview the resident if the resident is interviewable. Ask questions to gain information about why the resident is receiving these services and the resident's experience with receiving assistance to eat and drink. If concerns are identified, inquire if they have reported these problems to a nurse. If the resident is not interviewable, ask these questions of a family member.*

*If the concern was discovered through resident or family interviews already conducted as part of Task 5D, focus any additional interview on questions specific to the investigation.*

#### ***Paid Feeding Assistant Interviews***

*Interview the paid feeding assistant who was assisting the selected resident. Determine whether there are concerns with the paid feeding assistant's training, supervision, or the selection of the resident such as:*

- *What training did you successfully complete in providing feeding assistance?*
- *What information did you receive about this resident's needs for assistance (type of assistance needed, any precautions)?*
- *In what manner and by whom are you supervised while assisting residents?*
- *What issues/problems do you report (such as coughing, choking, changes in the resident's usual responses, or level of alertness) and to whom do you report?*
- *What would you do if an emergency occurred while you were assisting a resident to eat or drink? Who would you contact and how would you contact them if you are not near the resident call system?*

### ***Charge Nurse Interview***

*Interview the charge nurse who is responsible for assessing this resident as eligible to receive assistance by a paid feeding assistant. Ask:*

- *How they determined that this resident has no complicated feeding problems and is eligible to be assisted by a paid feeding assistant;*
- *How they determine that each eligible resident remains free of emergent complicated feeding problems;*
- *Who supervises paid feeding assistants and how is the supervision accomplished;*
- *Describe the processes in place to handle emergencies when a supervisor is not present in the area where paid feeding assistants are assisting residents.*

### ***Supervisory Nurse Interview***

*Interview the nurse who is supervising the resident during the meal or other times when the paid feeding assistant is assisting the resident to eat or drink. Ask how they supervise paid feeding assistants.*

### ***Review of Assessment of Eligibility to Receive Assistance from a Paid Feeding Assistant***

*Determine whether the charge nurse based her/his assessment of the resident's ongoing eligibility to be assisted by a paid feeding assistant on identification of the current condition of the resident and any additional or new risk factors or condition changes that may impact on the resident's ability to eat or drink. This information may be contained in the RAI or in other supporting documents such as progress notes, etc. The assessment of eligibility to receive assistance from a paid feeding assistant is ongoing and should be in place from the day of admission.*

### ***Requirements for Training of Paid Feeding Assistants***

*Determine how the facility identifies that paid feeding assistants have successfully completed a State-approved training course that meets the requirements of 42 C.F.R. §483.160 before they are allowed to assist eligible residents with eating and drinking.*

*If the facility uses temporary (agency) staff as paid feeding assistants, request documentation that these staff have met the minimum training requirements specified by the State.*

### ***Determination of Compliance (Task 6, Appendix P)***

*The information below should be used by the survey team for their deficiency determination at Task 6 in Appendix P. The survey team must evaluate the evidence documented during the*

*survey to determine if a deficiency exists due to a failure to meet a requirement and if there are any negative resident outcomes or potential for negative outcomes due to the failure.*

### ***Synopsis of Regulation (42 C.F.R. 483.35)***

*The paid feeding assistant requirement has five aspects:*

- *Staff who are used as paid feeding assistants must have completed a State-approved training course;*
- *The facility must base resident selection to be fed by a paid feeding assistant on the charge nurse's assessment and resident's latest assessment and care plan;*
- *Paid feeding assistants must work under the supervision of an RN or LPN, and, in an emergency, must call a supervisory nurse for help on the resident call system;*
- *Paid feeding assistants assist only residents who have no complicated health problems related to eating or drinking that make them ineligible for these services; and*
- *The facility must maintain a record of all individuals used by the facility as paid feeding assistants, and must maintain documentation of successful completion of a State-approved training course by these individuals.*

### ***Criteria for Compliance***

*Compliance with 42 CFR 483.35(h), F373, Paid Feeding Assistants*

*The facility is in compliance with this requirement if all the following are met:*

- *The facility only employs paid feeding assistants who have successfully completed a State-approved training course before providing assistance;*
- *The facility selected qualified residents based on the charge nurse's ongoing assessment and the latest assessment and plan of care;*
- *The facility provides supervision by an RN or LPN;*
- *The facility provides, in cases of emergency, a working call system (and other means for areas without a call system) for the paid feeding assistant to summon help in an emergency;*
- *The facility ensures that the paid feeding assistant only assists residents who have no complicated health problems related to eating or drinking that make them ineligible for these services; and*

- *The facility maintains a record of all individuals used by the facility as paid feeding assistants, and maintains documentation of each paid feeding assistant's successful completion of a State-approved training course.*

*If not, cite F373.*

### ***Non-compliance for F373***

*After completing the investigative protocol, determine whether or not noncompliance with the regulation exists. Noncompliance for F373 may include, but is not limited to, one or more of the following:*

- *An employee of the facility (permanent or temporary) who has not successfully completed the State-approved training course is assisting a resident to eat/drink;*
- *The facility allowed an employee who has completed a course that is not State-approved to assist a resident to eat or drink;*
- *A paid feeding assistant was observed assisting a resident in a location without a call system available or other means of emergency notification;*
- *A resident who was assessed by the charge nurse as ineligible for services due to complicated eating/drinking problems, or a resident who has not been assessed for eligibility, is being assisted by a paid feeding assistant;*
- *A paid feeding assistant was not being supervised by a RN or LPN;*
- *RN or LPN staff members assigned to supervise paid feeding assistants were observed to be unavailable (e.g., not in reach of contact);*
- *The clinical record of a resident being assisted by a paid feeding assistant did not show evidence that the resident was eligible to receive assistance from a paid feeding assistant;*
- *The facility did not maintain records of paid feeding assistants working in the facility; or*
- *The facility did not maintain documentation of a paid feeding assistant's successful completion of a State-approved paid feeding training course.*

### ***Potential Tags for Additional Investigation***

*During the investigation of F373, the surveyor may have identified concerns with additional requirements related to outcome, process, and/or structure requirements. The surveyor is cautioned to investigate these related requirements before determining whether non-compliance may be present at these other tags. Examples of some of the related requirements that may be*

considered when non-compliance has been identified include the following (but are not limited to):

- 42 CFR 483.15(a), F241, *Dignity*
  - *Determine if staff are attentive and responsive to the resident's requests, and if they provide assistance to eat in a manner that respects the resident's dignity, meets needs in a timely manner, and minimizes potential feelings of embarrassment, humiliation, and/or isolation related to inability to assist themselves with food or fluid intake.*
- 42 CFR 483.20(b), F272, *Comprehensive Assessments*
  - *Review whether the facility initially and periodically conducted a comprehensive, accurate assessment of the resident's ability to eat and drink with or without assistance and/or identified a condition that makes the resident ineligible for this service.*
- 42 CFR 483.20(k)(1), F279, *Comprehensive Care Plans*
  - *Review whether the facility developed a comprehensive care plan that was based on the assessment of the resident's conditions, needs, and behaviors, and was consistent with the resident's goals in order to provide assistance with nutrition and hydration as necessary.*
- 42 CFR 483.20(k)(2)(iii), F280, *Comprehensive Care Plan Revision*
  - *Determine if the care plan was reviewed and revised periodically, as necessary, related to eligibility to eat and drink with assistance of a paid feeding assistant.*
- 42 CFR 483.25(i)(1), F325, *Nutritional Parameters*
  - *Review if the facility had identified, evaluated, and responded to a change in nutritional parameters, anorexia, or unplanned weight loss, dysphagia, and/or swallowing disorders in relation to the resident's ability to eat.*
- 42 CFR 483.25(i)(2), F327, *Hydration*
  - *Review if the facility had identified, evaluated, and responded to a change in the resident's ability to swallow liquids.*
- 42 CFR 483.25(a)(3), F312, *ADL Assistance for Dependent Residents*
  - *Determine if staff identified and implemented appropriate measures to provide food and fluids for the resident who cannot perform relevant activities of daily living.*

- 42 CFR 483.30(a), F353, *Sufficient Staff*
  - *Determine if the facility has qualified staff in sufficient numbers to provide assistance to eat or drink to those residents who require such assistance. For residents who are not eligible to receive assistance from paid feeding assistants, determine if there are sufficient CNAs to provide this assistance to these residents in a timely fashion.*
- 42 CFR 483.75(i)(2), F501, *Medical Director*
  - *Determine whether the medical director collaborates with the facility to help develop, implement, and evaluate resident care policies and procedures based on current standards of practice, e.g., the use of paid feeding assistants, their supervision, and the criteria for determining which residents are eligible to receive assistance to eat or drink from paid feeding assistants.*

#### *IV. DEFICIENCY CATEGORIZATION (Part IV, Appendix P)*

*Once the team has completed its investigation, analyzed the data, reviewed the regulatory requirement, and identified any deficient practice(s) that demonstrate that non-compliance with the regulation at F373 exists, the team must determine the severity of the deficient practice(s) and the resultant harm or potential for harm to the resident. The key elements for severity determination for F373 are as follows:*

1. *Presence of harm/negative outcome(s) or potential for negative outcomes because of lack of appropriate use of paid feeding assistants.*

*Non-compliance related to an actual or potential harm/negative outcome for F373 may include, but is not limited to:*

- *A resident who is not eligible to receive these services is assisted by a paid feeding assistant;*
- *A resident who is eligible to receive these services is assisted by a paid feeding assistant and develops coughing and/or choking episodes related to the paid feeding assistant using poor techniques indicating lack of appropriate supervision.*

2. *Degree of harm (actual or potential) related to the non-compliance:*

*Identify how the facility practices caused, resulted in, allowed, or contributed to the actual or potential for harm:*

- *If harm has occurred, determine if the harm is at the level of serious injury, impairment, death, compromise, or discomfort; or*

- *If harm has not yet occurred, determine how likely is the potential for serious injury, impairment, death, or compromise or discomfort to occur to the resident.*

3. *The immediacy of correction required:*

*Determine whether the non-compliance requires immediate correction in order to prevent serious injury, harm, impairment, or death to one or more residents.*

*The survey team must evaluate the harm or potential for harm based upon the following levels of severity for tag F373. First, the team must rule out whether Severity Level 4, Immediate Jeopardy to a resident's health or safety exists by evaluating the deficient practice in relation to immediacy, culpability, and severity. (Follow the guidance in Appendix Q.)*

**NOTE:** *The death or transfer of a resident who was harmed or injured as a result of facility non-compliance does not remove a finding of immediate jeopardy. The facility is required to implement specific actions to correct the non-compliance which allowed or caused the immediate jeopardy.*

***Severity Level 4 Considerations: Immediate Jeopardy to resident health or safety***

*Immediate Jeopardy is a situation in which the facility's non-compliance with one or more requirements of participation:*

- *Has allowed/caused/resulted in, or is likely to cause/allow/result in serious injury, harm, impairment, or death to a resident; and*
- *Requires immediate correction as the facility either created the situation or allowed the situation to continue by failing to implement preventative or corrective measures.*

*Examples of the facility's non-compliance that may cause or contribute to negative outcomes at severity level 4 include, but are not limited to:*

- *An eligible resident in an activity room who is being improperly assisted to eat by a paid feeding assistant, experiences choking, there was no call system readily available, and/or the supervising nurse was not available to assist, and the resident expired;*
- *A resident who is not eligible to receive these services due to complicated feeding problems is assisted by a paid feeding assistant, whether or not the resident has experienced negative outcomes.*

**NOTE:** *If immediate jeopardy has been ruled out based upon the evidence, then evaluate whether actual harm that is not immediate jeopardy exists at severity level 3.*



### ***Severity Level 3 Considerations: Actual Harm that is not Immediate Jeopardy***

*Level 3 indicates non-compliance that results in actual harm, and can include but may not be limited to clinical compromise, decline, or the failure to maintain and/or reach the resident's highest practicable well-being.*

*Examples of the facility's non-compliance that may cause or contribute to negative outcomes at severity level 3 include, but are not limited to:*

- *An eligible resident who was assessed to have the potential to improving their eating ability was assisted to eat by a paid feeding assistant. The assistant provided too much food too quickly and the resident was pocketing the food in her cheeks. The resident experienced choking and coughing and subsequently vomited. As a result, the resident became fearful, refused solid foods, and would only consume liquid dietary supplements.*

*NOTE: If severity level 3 (actual harm that is not immediate jeopardy) has been ruled out based upon the evidence, then evaluate as to whether level 2 (no actual harm with the potential for more than minimal harm) exists.*

### ***Severity Level 2 Considerations: No Actual Harm with potential for more than minimal harm that is Not Immediate Jeopardy***

*Level 2 indicates non-compliance that results in a resident outcome of no more than minimal discomfort and/or has the potential to compromise the resident's ability to maintain or reach his or her highest practicable level of well being. The potential exists for greater harm to occur if interventions are not provided.*

*Examples of the facility's non-compliance that may cause or contribute to negative outcomes at severity level 2 include, but are not limited to:*

- *Paid feeding assistants are assisting eligible residents to eat in an area with no call system, and the supervising nurses are not nearby, but there have been no resident outcomes; and*
- *Eligible residents are being assisted to eat by employees who have not successfully completed a State-approved paid feeding assistant training course and who otherwise by State law would not be allowed to feed residents (such as RNs, LPNs or CNAs), and there were no resident negative outcomes.*

### ***Severity Level 1: No actual harm with potential for minimal harm***

*Level 1 is a deficiency that has the potential for causing no more than a minor negative impact on the resident(s).*

*Examples of the facility's non-compliance that may cause or contribute to negative outcomes at severity level 1 include, but are not limited to:*

- *Facility did not maintain a record of employees who had completed a State approved paid feeding assistant training program and were used by the facility as paid feeding assistants.*

\*\*\*\*\*

*BELOW IS NEW TEXT WHICH WILL BE ADDED TO APPENDIX PP AT §483.75(e).*

*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.*

\*\*\*\*\*

*BELOW IS NEW REGULATORY TEXT WHICH WILL BE ADDED TO APPENDIX PP AT NEW SECTION §483.75(q).*

*§483.75(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.*

*BELOW IS NEW INTERPRETIVE GUIDANCE WHICH WILL BE ADDED TO §483.75(q).*

*Guidelines: §483.75(q)*

*Note: Refer to F373*

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**Appendix E      Dining Assistant Observation  
Tool and Scoring Rules**



## CONTINUOUS QUALITY IMPROVEMENT FOR MEALS: AN OBSERVATIONAL TOOL

Date: \_\_\_ / \_\_\_ / \_\_\_

Staff Observer: \_\_\_\_\_

Begin Time: \_\_\_:\_\_\_ am pm

End Time: \_\_\_:\_\_\_ am pm

Meal: \_\_\_ Breakfast \_\_\_ Lunch \_\_\_ Dinner

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.

Resident Name	1	2	3	4		5		6	7		8	Comments (resident complaints about meal or staff offers of substitutions?)
	Physical Assist	Verbal Instruction	Social Stimulation	Supplement		Assist Time		Total % Eaten	Medical Record			
				Yes	Consumed	>5 min	<5 min		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. What proportion of resident population is eating in the dining room? (total number in dining room(s) / total residents capable of oral intake) _____%	
2. Of those who received physical assistance (column 1), how many also received verbal instruction (column 2)? _____%	
3. Of the total number of observed residents, how many received at least one episode of social stimulation from staff (column 3)? _____%	
4. Of those who were given a supplement (column 4. yes), how many received more than 5 minutes of assistance (column 5. > 5)? _____%	
5. Of those who ate less than 50% (column 6), how many received more than 5 minutes of assistance (column 5: >5)? _____%	
6. Of those who ate less than 50% (column 6), how many had documentation equal to or less than 60% (column 7: total % eaten)? _____%	
7. Of those who ate less than 50% (column 6), how many were offered a substitution (see comments)? _____%	
8. Of those who had documentation assistance was provided (column 8), how many received more than 5 minutes of assistance (column 5: < 5)? _____%	
<b>Observational Definitions</b> Physical Assistance/Physical Guidance Verbal Instruction (cueing, reminders) Social Stimulation Supplement Assistance Total Percent Eaten Medical record Comments	Record 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. 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). 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"). 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"). Record any type of oral liquid nutritional supplement (e.g., Resource, High Protein Nourishment, Ensure) given with the meal and amount consumed by resident. Record estimated time spent by any type of staff (nurse aide, licensed nurse, feeding assistant) providing any type of assistance to encourage eating during the meal. Calculate on a 0% to 100% metric using the same measurement system required of nurse aides, or other designated staff, in the facility. Documentation of total percent eaten and assistance provided by nurse aide or other staff for the same day and meal as observation. Record resident complaints about meal service or appetite, staff offerings of substitutions for served meal or other relevant observations (e.g., refusal of food or help).

## 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 8 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 below reflects a liberal approach that maximizes the opportunity for staff to “pass”.

### *Feeding Assistance Care Quality Indicators for Meals*

#### *1. Staff ability to get residents out of bed and to the dining room for meals.*

**Scoring Rule:** Score as “fail” if less than half of the resident population, as defined by those residents capable of oral food and fluid intake (exclude residents who are bed-bound, tube-fed and/or on hospice) is eating the meal in the dining room, or other common location. Count all dining rooms and other common eating area(s).

**Rationale:** Residents eating in the dining room are more likely to receive help to eat from staff, social interaction during the meal, and accurate documentation of their percent eaten. Residents are often allowed to eat meals in their rooms in bed, not necessarily due to their own preference but because it is easier for staff. Moreover, residents who eat in their beds are often not positioned properly for eating (semi-reclined), which places them at greater risk for choking. Finally, social isolation during meals may contribute to low oral intake and depressive symptoms.

#### *2. 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., “Please try your beans.”).

**Rationale:** Graduated prompting protocols using verbal instruction increase 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 instruction. 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).

#### *3. 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.

#### *4. Staff ability to provide adequate feeding assistance to residents who receive an oral liquid nutritional supplement during mealtimes.*

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

**Rationale:** Oral liquid nutritional 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. 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.

*5. 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 direct 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 feeding assistance from staff, then the 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.

*6. 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 direct 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 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.

*7. 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 direct observation, and who is not offered a meal alternative (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).

*8. 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 need to be aware of the inaccuracy of this documentation to inform improvement efforts.



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