State of Wyoming
Office of Healthcare Licensing and Surveys

Nutrition Support Assistant Program And Training Manual

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October 2018

NUTRITION SUPPORT ASSISTANT TRAINING MANUAL
TABLE OF CONTENTS

Introduction

The purpose of this Nutrition Support Assistant Program is to implement the use of paid feeding assistants in nursing homes as specified by the Federal Centers for Medicare and Medicaid Services (CMS) in 42 CFR 483.60(h), 42 CFR 483.60(h)(1), 42 CFR 483.60(h)(2), and 42 CFR 483.60(h)(3). A Nutrition Support Assistant is an individual who meets the requirements for paid feeding assistants as outlined in 42 CFR 483.60(h) and who is paid to feed residents by a facility, or who is used under an arrangement with another agency or organization. The intent of this program is to enhance the nutrition and hydration services provided to nursing home residents and reduce the incidence of unplanned weight loss and dehydration.

The Wyoming Department of Health, Office of Healthcare Licensing and Surveys, has approved these program requirements and training course. Successful completion of this Nutrition Support Assistant training course will meet the federal requirements for paid feeding assistants and the state minimum training course requirements. This program and training course shall be the only state-approved program and training course in Wyoming.

This is not a mandatory program. CMS has given each state the flexibility to decide whether or not to implement the program. Once the state opts to implement the program, each nursing home can decide whether or not to participate. Nursing homes are encouraged to offer the training course to volunteers and families.

The Wyoming Department of Health, Office of Healthcare Licensing and Surveys would like to acknowledge the Minnesota Department of Health, Paid Feeding Assistant Training Program; the Alzheimer's Association, Great Plains Chapter; and, the Wyoming Department of Health, Wyoming State Training School, for the use of their training materials included in this manual.

Background

CMS adopted regulations effective October 27, 2003, which allow the use of paid feeding assistants in nursing homes provided:

(1) States approve training programs and use federal requirements as minimum standards; and,

(2) Nursing Homes must use paid feeding assistants consistent with all other applicable guidelines under 42 CFR 483.60(h), 42 CFR 483.60(h)(1), 42 CFR 483.60(h)(2), and 42 CFR 483.60(h)(3).

Program and Training Requirements

I. Minimum Training/Competency

A. According to CMS, a state-approved training course must include, at a minimum, 8 hours of training/competency in the following areas:

- Residents' rights
- Communication and interpersonal skills

- Appropriate responses to resident behavior
- Recognizing changes in residents that are inconsistent with their normal behavior, and the importance of reporting those changes to the supervisory nurse
- Safety and emergency procedures, including the Heimlich maneuver
- Infection control
- Assistance with feeding and hydration
- Feeding techniques

II. Pre-employment Screening

A. Nutrition Support Assistants shall be subjected to the same background checks and screening processes as any other nursing home employee.

III. Program Reciprocity

A. Feeding Assistants transferring from other states must complete the Wyoming Nutrition Support Assistant training course, as there will be no reciprocity.

B. If an individual has passed the approved Nutrition Support Assistant training course offered in Wyoming, that competency is considered portable from one Wyoming nursing home to another.

IV. Facility Orientation Program

A. The Nutrition Support Assistant training course is intended to be in addition to the new employee orientation offered by the nursing home.

V. Coordination/Instructors

A. A Registered Nurse shall be responsible for coordinating the training course.

B. To enhance further instruction, other professionals may be utilized (i.e., social worker, registered dietitian, occupational therapist, physical therapist, licensed practical nurse, etc.)

VI. Licensed Nurse Supervision

A. Nutrition Support Assistants shall work under the supervision of a licensed nurse as specified in 42 CFR 483.60(h)(2).

B. The licensed nurse may delegate to the Nutrition Support Assistant and shall follow the delegation model according to the Wyoming State Board of Nursing, Nursing Practice Act and Administrative Rules and Regulations.

C. In an emergency, a Nutrition Support Assistant must call a supervisory nurse for help (42 CFR 483.60(h)(2).

VII. Competency

A. This training course includes a written exam and competency skills test. The written exam shall be passed with a score of at least 80%.

B. Documentation of successful completion of the approved Nutrition Support Assistant training course is required and must be retained by the nursing home in the employee's personnel file.

C. A nursing home must maintain a record of all individuals, used by the nursing home as Nutrition Support Assistants, who have successfully completed the training course.

D. A Registered Nurse shall conduct a yearly competency skills test and document successful completion. Documentation shall be retained in the Nutrition Support Assistant's personnel file.

VIII. Continuing Education

A. A Nutrition Support Assistant shall attain a minimum of six (6) hours of position-related continuing education per calendar year.

B. Documentation of training shall be maintained in the employee's personnel file.

C. An individual who has not practiced as a Nutrition Support Assistant within the last two (2) years shall be required to retake and successfully complete the state-approved training course.

VIIII. Criteria for Resident Selection/Ongoing Assessment

A. A Nutrition Support Assistant shall only assist a resident who does not have a complicated feeding problem. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or intravenous feedings 42 CFR 483.60(h)(3).

B. Resident selection for the program shall be based on the interdisciplinary team's current assessment and the resident's latest assessment and plan of care (42 CFR 483.160). At a minimum, the assessment shall include an evaluation of:

- cognitive status
- chewing and swallowing ability
- history of, or risk of, choking or aspiration
- motor control
- vision patterns
- strength and endurance
- hand dexterity
- food allergies

C. The assessment shall also include a nurse's summary statement of assessment data to reflect the clinical judgment/justification of the resident to be included or excluded from the program.

D. Each resident who has been selected for the program shall be reassessed at least quarterly or more frequently if there is a significant change in the resident's status.

Program Questions and Answers

Question: Is a Nutrition Support Assistant different from a CNA, LPN, or RN?

Answer: Yes. Nutrition Support Assistants are NOT certified or licensed as described by the following Wyoming State Board of Nursing definitions:

Certified Nursing Assistant (CNA) - means the performance of delegated nursing related tasks and services by a person, regardless of title or care setting, who has completed a specific course of study, and has met minimum competency requirements and is certified by the Wyoming State Board of Nursing.

Licensed Practical Nurse (LPN) - means a person who has graduated from a board-approved nursing education program preparing them as a practical nurse, has taken and passed the National Council Licensure Examination for Practical Nursing, and is licensed as a licensed practical nurse by the Wyoming State Board of Nursing. A licensed practical nurse performs practical nursing services according to the "Wyoming Nurse Practice Act" and the "Board Administrative Rules and Regulations" under the direction of a licensed physician or dentist, or registered professional nurse.

Registered Professional Nurse (RN) - means a person who has graduated from a board-approved nursing education program preparing them as a registered professional nurse, has taken and passed the National Council Licensure Examination for Registered Nursing, and is licensed as a Registered Nurse by the Wyoming State Board of Nursing. A registered professional nurse performs according to the standards of nursing practice as identified in the "Wyoming Nurse Practice Act" and Board Administrative Rules and Regulations".

An individual who is licensed or certified shall feed residents who have complicated feeding problems and provide all other types of nursing care. Nutrition Support Assistants shall not perform or be assigned tasks that constitute the practice of a CNA, LPN, or an RN.

Question: What is the role of a Nutrition Support Assistant?

Answer: Nutrition Support Assistants are individuals who have successfully completed a state-approved training course to assist nursing home residents with their nutrition and hydration needs. Nutrition Support Assistants must work under the supervision of a licensed nurse and shall not assist residents who have complicated feeding problems. Tasks appropriate for a Nutrition Support Assistant include:

- Serving food and fluids either during or between meals
- Providing encouragement and conversation
- Opening cartons and packets (milk, sugar, ketchup, etc.)
- Preparing food, such as buttering bread or cutting meat, to help the resident self-feed
- Offering snacks, nutritional supplements and fluids
- Assisting a resident as s/he drinks fluids
- Feeding the resident, if appropriate
- Recording food and fluid intake in accordance with facility policy

Question: Who can be a Nutrition Support Assistant?

Answer: Nutrition Support Assistants can be part-time workers, or students or retired individuals who only want to work a few hours a day. Some facilities may want to train their current part-time or full-time non-medical staff so they can assist residents during mealtimes.

Question: Which residents are potential candidates for the Nutrition Support Assistant Program?

Answer: The selected residents may have one or more of the following conditions:

- Cognitive impairment
- Visual impairment
- Poor motor control of their arms or hands
- Decreased strength or endurance
- Lack of appetite

Resident selection will be based on the interdisciplinary team's current assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the care plan.

Upon determination by the interdisciplinary team that it is safe to do so, a Nutrition Support Assistant may assist a resident in his/her room if the resident is unable or unwilling to dine in a congregate dining area.

Question: Are there residents who must be excluded from the Nutrition Support Assistant Program?

Answer: Yes. A Nutrition Support Assistant shall not assist a resident who has complicated feeding problems or medical conditions that, for safety purposes, require the skills of a CNA or licensed nurse. Examples of these conditions are:

- Recurrent lung aspirations
- Difficulty swallowing
- A tube feeding or intravenous feeding

Question: Can a Nutrition Support Assistant give a resident their medications?

Answer: No. A Nutrition Support Assistant shall not perform any nursing related tasks such as giving medications, bathing, transferring, toileting, etc.

Question: Will this program change the requirements for nurse staffing?

Answer: No. Nutrition Support Assistant's shall not be counted toward meeting the minimum state or federal nurse staffing requirements. Nutrition Support Assistants are intended to supplement CNAs, not take the place of CNAs, LPNs, or RNs.

COURSE MATERIALS

Residents' Rights

Key Terms

Confidentiality - Keeping personal and medical information private; not sharing the information with those who are not directly involved with the care of the resident.

Abuse – the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.

Physical Abuse – includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.

Verbal Abuse – the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.

Sexual Abuse – includes, but is not limited to sexual harassment, sexual coercion, or sexual assault.

Mental Abuse – includes, but is not limited to humiliation, harassment, threats of punishment, or deprivation.

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

Misappropriation of Resident Property – the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.

Vulnerable Adult – any person eighteen (18) years of age or older who is unable to manage and take care of himself or his property without assistance as a result of advanced age or physical or mental disability.

Ombudsman – a person responsible for investigating and resolving complaints from consumers or other members of the public against a company, institution, or other organization. Acts as a resident or patient advocate.

I. Describe the Nursing Home Residents' Rights

Purpose: This federal law provides all nursing home residents with the same rights as to all citizens.

A. Each resident has the right to a dignified existence, self-determination, and communication with and access to persons inside and outside the facility.

B. All staff members must promote and respect residents' rights. Remember, you work in the resident's home.

C. All staff members must maintain the confidentiality of the resident's personal and medical information.

D. Residents' rights are preserved when staff use skills which maintain and protect the resident's dignity and basic human rights.

E. A copy of the residents' rights must be given to each resident, or the resident's representative, upon admission.

Handout #1 – Residents' Rights

F. Describe ways to assist in resolving grievances

1. Realize the residents' rights give the resident the right to voice grievances without fear of reprisal.

2. When conflicts between residents occur, maintaining the safety of each resident must be the primary consideration.

3. Report information regarding resident conflicts accurately and immediately to the charge nurse. Skilled and caring staff can often work out resolutions for conflicts.

4. State ombudsman services assist residents and their families to resolve conflicts with facilities.

II. Define Abuse, Neglect and Misappropriation of Resident Property

A. Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.

1. Physical abuse – includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.

2. Verbal abuse – the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.

3. Sexual abuse – includes, but is not limited to sexual harassment, sexual coercion, or sexual assault.

4. Neglect – failure to provide the vulnerable adult with the necessary food, clothing, shelter, health care or supervision.

5. Misappropriation of resident property - the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent.

III. Describe Reporting of Abuse

A. Follow facility policy that must be consistent with state statutes and federal regulations. All long-term care staff are mandated reporters, as are all professionals and professional delegates.

B. Federal regulations require that all allegations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, be reported immediately to the Administrator and the Wyoming State Survey Agency.

C. A Wyoming Statute, the Adult Protective Services Act, requires any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, exploited or abandoned or is committing self neglect shall report the information immediately to a law enforcement agency or the Department of Family Services. Anyone who in good faith makes a report is immune from civil liability.

1. Confidentiality of reporter protected.

2. No reprisal or retaliation to reporter if done in good faith.

3. The law requires anyone having knowledge of abuse of a vulnerable adult to report.

4. Failure to report could result in a misdemeanor.

Handout #2 – Excerpts from the "Adult Protective Services Act" (Wyoming Statute Title 35, Chapter 20)

IV. Describe the Facility's Responsibility to Prevent the Occurrence of Abuse

A. Developing and implementing policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property.

B. Reporting all allegations of abuse, and results of investigations, to the proper authorities within the established time frames.

C. Performing thorough investigations of alleged abuse and prevent further potential abuse while the investigation is in progress.

D. Taking appropriate corrective action based on the results of the investigation.

E. Keeping records of incidents to monitor for trends or repeated incidents.

V. Discuss Scenarios of Abuse and Neglect During Nutrition Support

Handout #3 – Examples of Abuse and Neglect Related to Nutrition Support

Communication and Interpersonal Skills

Key Terms

Communication - The exchange of thoughts, messages, or information, by speech, signals, writing, or behavior.

Nonverbal Communication - Messages conveyed by methods other than spoken or written word such as facial expressions, body posture and gestures.

Body Language - gestures, movements, and mannerisms by which a person communicates with others. The person may or may not be aware of the message sent.

Aphasia – inability to speak or comprehend due to a brain injury.

Dysphasia – difficulty speaking or comprehending due to a brain injury.

Cognition - Awareness or alertness to be able to think, reason, make decisions and have memory or recall.

Cognitive Impairment - Mental decline that reduces awareness. Thinking tasks become difficult.

Confusion - Inability to distinguish or separate differences between things. There is an inability to follow directions.

Disorientation - Decreased awareness to time, place and person.

Dementia - The loss of intellectual functions (such as thinking, remembering and reasoning) of sufficient severity to interfere with a person's daily functioning.

Depression - Altered mood, loss of interest, feelings of hopelessness.

Agitation – Excessive restlessness and increased mental and physical activity.

Anxiety – A state of uneasiness, apprehension, and distress.

Fear - Sense of dread from feelings of danger.

I. Describe Communication

Effective communication occurs when the receiver gets the message in the way the sender intended.

Handout #4 - Communication: The Exchange of Information

A. Effective communication is essential to:

1. Reporting observations and progress of the resident.

2. Implementing the resident's care plan.

3. Relating to the resident, families and other staff members.

II. Identify Verbal Communication

A. Getting the message across through the use of voice or written words.

B. Used to give and receive information, facts and sharing of experiences.

C. Be alert to the resident's ability to understand the words used and read written information.

D. Be aware of verbal communication in:

1. Choice of words

2. Tone of voice

3. Speed of voice

III. Identify Nonverbal Communication

A. Getting a message across without the use of words.

1. Examples of nonverbal communication include:

Facial expressions	Posture
Gestures	Touch
Dress	Arm movement
Pacing	Raising of eyebrows
Smiling	Silence

2. Remember actions may speak louder than words. Be aware of your nonverbal behavior and body language when interacting with residents and their families.

Handout #5: Nonverbal Communication

IV. Describe Effective Communication

A. Effective communication requires time, patience and skill.

B. Guidelines for effective communication

1. The following techniques will encourage residents to verbalize their needs:

- Allow time for talking
- Refer to the resident by the name s/he prefers
- Keep the conversation resident-centered
- Maintain eye contact
- Reduce background noise
- Make sure your body language says you are listening
- Speak at the pace the resident understands
- Verbalize an interest in what the resident says
- Speak clearly and loud enough so the resident can hear

Handout #6: Principles for Good Listening/Effective Communication

2. The following can be barriers to effective communication:

- Not listening
- Avoiding eye contact
- Background noise
- Belittling a person
- Talking to a resident as if s/he were a child
- Appearing too busy or rushed
- Making judgments
- Not responding to the resident
- Giving false or inappropriate reassurances
- Speaking in a language other than the resident's primary language
- Dominating the conversation

C. Describe communication techniques to use when caring for the resident with vision impairments.

Handout #7: Techniques Used for Assisting Residents Who Are Visually Impaired

D. Describe methods to use when communicating with the hearing impaired resident.

Handout #8: Guidelines for Communicating with Residents with Hearing Impairments

E. Describe techniques for communicating with the resident who is language - speech impaired.

Handout #9: Communicating With Adults Who Have Brain Injuries

1. Residents who have suffered strokes may not be able to speak (aphasia) or have difficulty speaking (dysphasia). It is important to realize:

a. The resident usually understands, but cannot communicate verbally.

b. The resident may express frustration or anger because the words s/he says do not "make sense."

V. Discuss Cognitive Impairment

A. Define cognitive impairment

1. Cognition is an awareness or alertness to be able to think, reason, make decisions and have memory or recall.

2. Cognitive impairment means that something has happened in the brain, which reduces awareness. Problems with thinking tasks occur.

B. Discuss aging changes in the brain

The brain, like other parts of the body, may not always work as well as a person becomes older.

1. Decreased blood flow slows the thinking and responding process.

2. Some diseases interfere with brain function.

3. Some medications interfere with brain function.

C. Discuss signs of cognitive impairment

1. Confusion- inability to distinguish or separate difference between things. There is an inability to follow directions.

2. Memory loss - especially with recent events. Names of people and places are not recalled. Person is not necessarily confused.

3. Loss of problem solving ability. Making choices, especially with multiple options, becomes difficult.

4. Disorientation - decreased awareness to time, place and person.

D. Discuss dementia

1. Define dementia: The loss of intellectual functions (such as thinking, remembering and reasoning) of sufficient severity to interfere with a person's daily functioning. It may be either reversible or irreversible.

2. Identify some types of dementia illnesses; e.g. Alzheimer's Disease, Lewy Body Dementia, Vascular Dementia, Parkinson's Disease, Huntington's Disease, Creutzfeldt-Jakob Disease, Picks Disease.

a. Alzheimer's Disease - the most frequent cause of dementia. A progressive, regressive, degenerative disease that attacks the brain and results in impaired memory, thinking and behavior.

b. Lewy Body Dementia - the second most frequent cause of dementia in elderly adults. A neurodegenerative disorder associated with abnormal structures (Lewy bodies) found in certain areas of the brain.

c. Vascular Dementia - a deterioration of mental capabilities caused by multiple strokes (infarcts) in the brain.

d. Parkinson's Disease - a progressive disorder of the central nervous system.

e. Huntington's Disease - an inherited, degenerative brain disease that affects the mind and body. The disease begins in mid-life and is characterized by intellectual decline, and irregular and involuntary movements of the limbs and facial muscles.

f. Creutzfeld-Jakob Disease - a rare, fatal brain disorder caused by a transmissible infectious organism.

g. Picks Disease - a rare brain disorder that causes disturbances in personality, behavior and orientation.

E. Describe behaviors observed in residents with dementia

1. Depression - loss of interest, altered mood, feeling of hopelessness.

2. Agitation - restlessness, increased physical activity such as wandering or pacing.

3. Personality changes - behavior can change daily.

4. Anxiety - feeling uneasy, apprehensive, worried.

5. Fear - sense of dread from feelings of danger or threat of danger.

6. Difficulty performing familiar tasks.

7. Disorientation.

8. Poor judgment.

9. Loss of recent memory.

F. Discuss the stages of Alzheimer's Disease

Handout #10: Stages of Alzheimer's Disease

VI. Assisting the Cognitively Impaired Resident

A. Strategies to Implement When Assisting Residents with Dementia

1. Environment

a. Provide a structured, safe environment.

b. Avoid changes. Place the resident in same seat for all meals.

c. Avoid excessive stimulation. Too much activity and noise often adds to confusion and anxiety. Remove distraction if possible and refocus the resident.

2. Oral Communication

a. Call the resident by his/her preferred name; obtain eye contact.

b. Use a calm voice; speak softly, slowly, clearly and face the resident.

c. NEVER argue with the resident.

d. Keep communication simple by using short instructions such as: "Pick up your fork." "Put food on your fork." "Put the fork in your mouth." Use objects or hand movements to assist with communication.

e. Allow time for the resident to respond.

f. Acknowledge emotional feelings that are evident, "I can see you are frightened."

g. Promote independence by encouraging the resident to do as much as possible for him/herself.

h. Be flexible to accommodate the resident's needs at the time.

i. Show interest in the resident; avoid interrupting if the resident is speaking.

j. Talk about the resident's past or current interests such as golfing,

fishing, gardening, baking, etc. Don’t expect the resident to learn new things.

3. Body Language

a. Slowly approach the resident from the front as many persons with Alzheimer's disease have a decreased ability to see side views (peripheral vision).

b. Remain calm and reassuring.

c. Use calm body language and position yourself at the same level of the resident rather than "standing over" the resident.

d. Avoid jerky, rapid body movements.

e. Touch may be reassuring.

f. Be an attentive listener.

4. History of Resident

a. The resident's memory may not be reliable. Listen to the family; they may be able to give suggestions to assist in nutrition support. Many families have been caring for the resident with cognitive decline for a long time at home. Draw upon their familiarity.

b. Knowing the resident's history will assist in providing nutrition support for the resident with dementia; ask the nurse or social worker for information.

c. All information regarding the resident shall be held in confidence.

B. Discuss techniques for good communication with residents who have dementia

Handout #11: The Importance of Good Communication Skills

Appropriate Response to Resident Behavior

I. Behavior Problems

A. These behaviors usually result from fears and unmet needs. Be patient, understanding and respectful when assisting the resident.

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

C. Strategies to use to increase the resident's sense of control

1. Respond to appropriate behavior by genuine compliments, praise and positive comments.

2. Demonstrate your response of resident's appropriate behavior by non-verbal communication such as smiles and touch.

3. Help resident focus on the task of eating.

4. Do not respond negatively to inappropriate behavior.

5. Never laugh at or ridicule a resident's behavior.

II. Describe Methods of Responding to Resident's Behavior Problems

A. Resident to resident problems

1. Interrupt or separate residents quickly if harm to either one is probable.

2. Remove triggering stimulus.

3. Use a calm, gentle touch.

4. Call for help if needed.

5. Separate individuals. Respect individual's "territorial" rights.

6. Use facts, not guilt or shame when explaining reason for separation.

B. Inappropriate or Harmful Activity. You can frequently anticipate an inappropriate behavior that begins to escalate. This is the most appropriate time to redirect or distract the resident.

1. Attempt to redirect interest or distract the resident.

2. Attempt to remove the resident from the situation.

3. If the resident is not cooperative. Do not force redirection. Forcing usually increases the behavior.

a. Ask another staff member to work with the resident.

b. Remember, residents with dementia usually have rapid changes in emotion. They may be cooperative in a few minutes.

c. Do not "storm" a violent resident with a group of nursing staff. This is frightening and contributes to combative behavior.

4. Wait to resume assistance until the resident is calm.

C. Nutrition Support Assistant actions to implement when assisting a resident to eat

1. Approach facing the resident.

2. Identify yourself and explain what you are doing and why.

3. Use a calm voice and calm, steady, smooth body movements.

III. Review General Guidelines for Interacting with Residents Having Cognitive Impairment

A. Become aware of your own responses and reactions to the resident's behavior and modify your behavior if needed.

B. Develop appropriate attitudes for care givers

1. Respectful

2. Patient

3. Kind

4. Helpful

5. Pleasant

6. Gentle

7. Knowledgeable

C. Reinforce feelings of belonging and safety; "You're safe here."

D. Call the resident by the name s/he prefers.

E. Always treat the resident with dignity and respect.

F. Remember, the resident has the right to refuse to eat.

G. Maintain calmness in verbal and non-verbal communication.

H. Avoid changes in environment; maintain structure.

I. Maintain consistency in nutrition support by reporting to nursing staff all successes and failures at attempts to modify resident behaviors.

J. Acknowledge the resident's feelings, "I can see you are afraid; I can see you are feeling sad."

K. Behavior problems are decreased when feelings of positive self-esteem are maintained. Allowing residents to do as much as possible for themselves increases feelings of self worth.

L. Support the family members and listen to their suggestions; family involvement is encouraged.

M. Show understanding; think how you would like to be treated if you or your parent were the resident.

Recognizing and Reporting Changes in Resident Behavior

Key Terms

Continuity of Care - Providing 24-hour resident-centered care without interruption in resources or services.

Care Plan - A written guideline outlining the resident's individualized needs and what interventions will be implemented to meet those needs.

Signs - Signals that there may be illness or the body is not working normally. May be observed by seeing, listening, touching or smelling.

Symptoms - Signals that there may be illness or the body is not working normally. They are recognized by the resident and communicated to the nursing team.

Incident - An event that is not a usual routine and has or could result in injury.

I. Discuss Recognizing Changes in Resident Behavior

A. Nutrition support assistants have frequent and close contact with the resident; therefore, the nutrition support assistant has the opportunity to observe the resident closely during the meal.

B. Effective communication is necessary for continuity of care.

C. The care plan is an essential tool in communicating regarding resident care.

1. Care plans are developed for each resident and identify areas of observation and care.

2. Nutrition support assistants contribute to the resident care plan by making careful observations and reporting their observations and actions to the charge nurse.

D. Report physical, mental and emotional observations of residents such as:

1. Resident's reactions and behavior.

2. Resident's statements regarding his/her physical symptoms (pain, numbness, dizziness).

3. Care that seems to work best for the resident.

4. Care that does not work well.

E. The nutrition support assistant should be as specific as possible when reporting observations. Accuracy of reporting impacts resident care, the care plan and unit staffing.

F. Respect each resident's right to privacy and confidentiality when reporting.

G. Recognize and immediately report abnormal signs and symptoms such as:

- shortness of breath
- rapid respirations
- fever
- cough
- blue color to lips
- vomiting
- drowsiness
- sweating
- breaks or tears in the skin
- bruises
- sudden increase in confusion
- chills
- pains in chest
- pain in abdomen
- nausea
- excessive thirst
- pain on moving
- change in appetite
- difficulty swallowing or chewing
- any pain
- any unusual signs or symptoms

II. Reporting Unusual or Difficult Behaviors

Since Nutrition Support Assistants interact frequently with residents, it is important to note and report to the charge nurse any difficulties encountered while assisting with nutrition support. Facility protocols for documentation and reporting must be followed. Nutrition Support Assistants need to be alert for the following types of details when reporting to nursing staff:

A. Descriptions of the resident's response to feeding/nutrition support.

B. Specific descriptions of unusual behavior and examples.

C. Note what happened prior to the unusual behavior.

D. Use familiar descriptive language.

E. Describe any effective approach.

F. Include failures of recommended approaches.

III. Describe Incidents

A. Any event that does not fit the routine care of the resident or operation of the facility.

B. Any time an accident/incident occurs, a written report is made out according to facility protocol.

C. Examples of incidents:

Observed or alleged abuse, neglect, mistreatment, or lost/stolen items
An injury of unknown origin
Lost dentures, glasses, broken teeth
Resident, staff or visitor accidents
Theft from residents, staff or visitors
Resident or staff injury

D. Remember; report any incident immediately to the charge nurse.

IV. Recognizing and Reporting Changes in Residents

A. Objective information is factual - it is obtained by looking, touching, hearing and smelling.

1. The resident cannot raise their left hand.

2. The resident ate 50% of his breakfast.

B. Subjective information may or may not be factual - it is opinion, interpretation of a situation, or what a resident tells you.

1. The staff member reports that Mrs. Jones seems different than usual today.

2. Mrs. Doe says, “I don’t feel like eating breakfast because my stomach hurts.”

C. Report any information that seems important. It is always better to over report than under report.

Handout #12: Changes in Residents that Need to be Reported

V. Identify the Nutrition Support Assistant’s Responsibility in Record Keeping

A. The Nutrition Support Assistant may be responsible for some important record keeping regarding the resident’s appetite and intake.

1. Patterns of resident behavior or changes are identified through the Nutrition Support Assistant’s reporting and recording.

2. Depending on facility policy, the Nutrition Support Assistant may be responsible for documenting the resident’s appetite/meal record.

B. Describe the facility’s protocol for documenting intake and the importance of accurate documentation.

C. Explain to the Nutrition Support Assistant their responsibility, if any, in meal intake documentation.

1. Information must be accurate.

2. Resident information is confidential.

Safety and Emergency Procedures

Key Terms

Scald - Burn to the skin.

Entrapment - To catch in; as in a trap.

RACE - Acronym for actions to take in the event of a fire: Rescue, Activate, Confine, and Extinguish.

Heimlich maneuver - an emergency procedure used to dislodge food or an object from the windpipe of a choking person.

PASS - Acronym used to describe the technique used to operate a fire extinguisher: Pull, Aim, Squeeze, and Sweep.

Choking - Upper airway obstruction due to a foreign body in the windpipe, i.e., food.

Seizure - Sudden, involuntary movement of muscles. Person may be partially conscious or become unconscious.

I. Describe Safety of the Resident

A. It is necessary for all staff to be alert to safety concerns for the resident.

B. Adjustments to environment are necessary for individual needs, such as light, noise, air temperature and type of furniture.

C. Identify potential hazards to resident safety such as:

1. Falls are the greatest threat to residents. Be alert to all situations and report unsafe equipment such as electrical cords and slippery floors.

2. Lack of proper lighting. Glare is especially hazardous to the older person.

3. Serving the wrong diet.

4. Spilling hot food or beverages resulting in a scald.

5. Bedrails and physical restraints (can be life threatening due to falls and/or entrapment).

6. Improperly placed or non-working call light.

7. Improper use of smoking materials; smoking near oxygen.

8. Cluttered hallways.

9. Unsafe or non-working equipment.

Be alert to these potential safety risks and immediately report any potential hazard to licensed nursing staff.

D. Identify ways the Nutrition Support Assistant can prevent accidents and injuries to themselves and residents.

1. Follow the care plan at all times.

2. Know the policies and procedures for the Nutrition Support Assistant program.

a. Perform tasks accurately as learned.

b. Ask questions if unsure.

c. Do not perform tasks you have not been taught.

3. Know fire safety policy of facility.

a. Be alert to fire safety violations (smoking rules, oxygen safety, electrical equipment, unsafe wires).

b. Extension cords are not allowed.

E. Describe safety in the resident's room and common areas

1. This is the resident's personal area, the resident's "home."

a. The resident has a right to expect his personal area to be treated with respect and dignity. This includes knocking prior to entering the resident's room and handling personal items with respect. Furniture and personal items should not be moved without prior knowledge of the resident. This is important for all residents, but particularly for the safety of residents who are visually impaired.

F. Resident call light system

1. In the event of an emergency, a Nutrition Support Assistant must call a supervisory nurse for help on the resident call system.

a. Describe locations of call lights.

b. Discuss how to use the system.

II. Identify Situations that Call for Emergency Action

A. Fire

1. Major causes of fire:

a. Electrical malfunction,

b. Improper use of smoking materials.

c. Defects in heating systems.

d. Improper trash disposal.

e. Spontaneous combustion.

2. Actions to take when fire is discovered (RACE):

R -- remove residents in immediate danger

A – activate alarm and alert other staff

C -- confine fire

E -- evacuate and extinguish fire if possible

3. Follow procedures of facility.

Handout #13: RACE Against Fire

4. Use of fire extinguisher

a. The majority of fire extinguishers are the dry chemical type suitable for most types of fires.

b. Remember PASS

Pull - safety pin (usually twist and pull)

Aim - nozzle at base of fire

Squeeze - trigger handle

Sweep - side to side at base of fire

c. Discuss the location of facility fire extinguishers.

B. Describe methods to remove an immobile resident

1. Follow facility policy for evacuating immobile residents; this may include placing residents on a blanket on the floor and pulling them out from danger or moving the entire bed.

C. Finding a resident on the floor

1. Stay with resident.

2. Call for help immediately.

3. Do not attempt to move resident until nurse has assessed the resident.

D. Choking

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

2. Clutching the neck with one or both hands is the universal distress signal or sign for choking. Keep in mind, the resident may not be able to perform the universe distress signal.

a. Ask the resident, "Are you choking?"

b. If the resident can't speak or breathe and needs your help immediately, give abdominal thrusts if you have been trained in this procedure. Immediately call the nearest staff member who is trained in this procedure.

Handout #14: Universal Distress Signal for Choking and the Heimlich Maneuver for Choking

E. Finding an unresponsive resident

1. Call resident by name to determine unresponsiveness.

2. Call for nurse immediately and stay with the resident.

3. Assist the nurse as directed.

F. Seizures

1. Stay with the resident; move obstacles out of the way to avoid injury.

2. Immediately call for the nurse.

3. Ease the resident to the floor.

4. Roll the resident on his/her side.

5. Do not restrain the resident's movements.

G. Wandering or lost residents

1. Report to nurse immediately upon discovering a resident missing.

2. Follow instructions.

H. Severe Weather

1. Follow facility policy for tornado watches or warnings or other severe weather situations.

a. Close windows and drapes,

b. Move residents away from windows,

c. Protect and reassure residents.

I. Power outage

1. Follow facility policy.

Infection Control

Key Terms

Infection Control - Practices used to control and prevent the spread of disease.

Contaminated - Items or areas considered to have disease-causing organisms.

Microorganism - Tiny living bodies that cannot be seen with the naked eye; can only be seen with a microscope.

Pathogen - Disease-causing microorganism; germ.

Infection - Condition or disease where the body or part of it is invaded by pathogens that multiply and result in disease or harmful effects.

Chain of infection - A model used to understand the infection process.

Standard precautions - Use of protective equipment (e.g., gloves, gowns, masks), hand washing, and other measures to prevent the spread of infection.

Communicable disease - A disease that can be transmitted directly or indirectly from one individual to another.

I. Describe Principles of Infection Control

A. Define Infection Control: Practices used to control and prevent the spread of disease producing microorganisms called pathogens or germs

B. Identify ways microorganisms enter the body.

1. Body openings such as nose, mouth, eyes, urinary tract.

2. Body cuts (anytime the skin is broken).

3. Introduction of contaminated material through tubing such as indwelling catheter, intravenous (IV) or tube feeding tubes.

C. Describe the chain of infection.

Handout #15: Chain of Infection

The route pathogens travel to spread disease. There are six (6) parts of the chain of infection.

1. Pathogen or infectious agent- the cause of infection

2. Reservoir - where the pathogen can survive

3. Exit point - such as body secretions or infected wounds

4. Method of transmission - such as on hands or on contaminated supplies

5. Entry point - such as broken skin

6. Susceptible host - person receives pathogen and harbors it. Disease will occur more often in persons at risk such as those who are ill.

D. Describe Modes of Transmission

Handout #16: Ways Infections Spread

1. Direct Contact

2. Indirect Contact

3. Droplets

4. Airborne

5. Common Vehicle

6. Vectorborne

E. Describe conditions that affect the growth of pathogens.

1. Food for pathogen (can be found on the body, body fluids, equipment or trash)

2. Moisture

3. Air (necessary for growth)

4. Temperature (most microorganisms grow and thrive best at temperatures between 40 to 110 degrees Fahrenheit)

5. Darkness (direct sunlight kills some germs; most pathogens live best in darker areas)

II. Describe Standard Precautions

A. Guidelines recommended by the Centers for Disease Control and Prevention (CDC). The practices are called Standard Precautions and are designed to reduce the risk of transmission of disease producing microorganisms.

B. Standard Precautions practices include:

1. Hand washing. Wash hands frequently.

2. Gloves. Wear when touching body fluids or items contaminated with body fluids. Change gloves between tasks and remove before touching clean items. Wash hands before putting on gloves, and after the gloves are removed.

C. Importance of hand washing

1. Hand washing is the most effective way to prevent the spread of disease.

2. Demonstrate proper hand washing procedure.

Handout #17 Wash Your Hands!

3. Hand washing should be done:

a. When beginning and ending work.

b. Before and after contact with each resident.

c. Before handling food.

d. After using the bathroom, combing your hair, blowing your nose, eating, drinking or smoking.

e. After contact with blood or bodily fluids.

f. After handling a resident's belongings.

g. After working with anything soiled.

h. Before putting on gloves, and after the gloves are removed.

4. Discuss alcohol-based hand rubs

a. Appropriate use

b. Limitations

D. Describe measures which help to reduce or prevent the spread of infection

1. Hand washing - single most important measure in preventing the spread of infection.

2. Separation of clean and dirty items.

3. Correct serving of food.

4. Correct handling of clothing protectors and cloth napkins.

a. Do not allow clothing protectors or napkins to touch your personal clothing.

b. When clothing protector or napkin falls to floor, place in soiled linen hamper.

5. Maintain your own good health

a. Eat a well-balanced diet.

b. Get adequate sleep.

c. Engage in physical activity.

E. Describe facility policy for work restriction guidelines

1. If feeling ill, or diagnosed with a communicable disease by a physician, immediately report to your supervisor.

2. When ill, visitors should be encouraged to stay away from the facility.

Assistance with Feeding and Hydration

Key Terms

Nutrition - All of the processes involved in the taking in and utilization of food for body functioning.

Essential nutrients - Necessary nutrients in food needed by the body to supply heat and energy, build or repair tissue and regulate body functions: Proteins, carbohydrates, fats, vitamins, minerals and water.

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

Intake - All liquids or food consumed.

Therapeutic diet - A diet ordered by physician as part of a treatment for a disease or clinical condition, or to eliminate or decrease specific nutrients in the diet, (e.g., sodium) or to increase specific nutrients in the diet (e.g., potassium).

Mechanically altered diet - the texture of the food is altered (e.g., ground or pureed) to enable the resident to eat.

Dehydration -The lack of sufficient fluid in body and tissues. Can be life threatening.

Edema - Retaining fluid in the body; swelling.

NPO - Abbreviation for nothing by mouth.

I. Discuss Nutrition

A. Define nutrition

1. All of the processes involved in the taking in and utilization of food for body functioning.

2. In general, older people need fewer calories because they are less active; however, nutrient needs stay the same or even increase.

3. Adequate nutrition is a key factor in maintaining physical and cognitive function, and sustaining health and quality of life.

B. Identify essential nutrients

Handout #19: Six Essential Nutrient Groups

1. Necessary nutrients in food needed by the body to supply heat and energy, build or repair tissue and regulate body functions: Proteins, carbohydrates, fats, vitamins, minerals and water.

a. Proteins - Build and repair body tissues. Found primarily in meat, poultry, and dairy products.

b. Carbohydrates - Produce heat and energy. Found in fruits, vegetables and foods made from grains.

c. Fats - Produce heat and energy. Found in animal and plant foods: fat marbled meat, butter, cheese, nuts, and oils.

d. Vitamins - Regulate body processes and functioning. Found in a variety of foods.

e. Minerals - Build body tissues such as bones and teeth. Found in a variety of foods.

f. Water - Essential to life and all body system functioning. Normal adult intake is 2 quarts, or about 64 ounces, per day

II. Normal Aging Process in the Digestive System

A. Digestive System (stomach-intestines)

Major function is to provide the body with essential nutrients

1. Common changes with aging:

a. Gradual slowing down of entire system.

b. Decrease in taste: sweet, sour, bitter, and salt.

c. Reduced saliva and other secretions .

d. Missing teeth and poor fitting dentures.

B. Discuss Food Guide Pyramid for Older Adults

Handout #20: Tufts Food Guide Pyramid for Older Adults

1. The Food Guide Pyramid stresses more water and fiber and fewer calories.

a. The base of the pyramid is eight, 8-ounce glasses of fluid a day to prevent dehydration and constipation.

b. The pyramid is narrower than the traditional food guide pyramid because older individuals are less active and require less food to maintain the same weight.

c. To ensure adequate fiber intake the pyramid recommends whole grain products.

d. It also emphasizes nutrient dense foods like darker-colored fruits and vegetables that contain more vitamins.

e. Suggests using fats, oils and sweets sparingly.

f. A flag tops the pyramid as a reminder that older individuals may not absorb enough of the vitamins they need for healthy aging. They may need supplements of calcium, vitamin D and vitamin B12.

III. Describe Factors that Affect the Nutritional Status of the Resident

The nutritional needs of the older person are the same as other adults. However, meeting these needs can be more difficult for the elderly person. Some factors include:

A. Nutritional

1. Decreased appetite.

2. Drug-nutrient interactions.

3. Overly restrictive dietary prescriptions.

B. Physical

1. Fatigue level will influence energy to eat.

2. Level of alertness to focus on mealtime and eating.

3. Sensory loss.

a. Some loss of sensory ability is part of the normal aging process, especially taste, smell and sight. Meals may need to be enhanced with seasonings, unless contraindicated by the diet order or the resident's preferences.

b. Appetite is affected by sight, smell, taste and even the sound of food preparation.

4. Physical Comfort

a. Assure comfort for mealtime with proper positioning.

b. Correct positioning is also important to prevent aspiration of foods.

5. Teeth/Dentures

a. Missing, broken or loose teeth affect ability to eat.

b. Improperly fitting dentures impair the resident's ability to chew and swallow and enjoy mealtime.

c. Inability or difficulty in chewing or swallowing may require a mechanically altered diet.

d. Individuals who have difficulty swallowing have an especially difficult time with thin liquids. Products are available that thicken hot and cold liquids without changing the taste. Licensed nursing staff is responsible for assuring liquids are served at the appropriate consistency.

C. Psychological/Social

1. Emotional concerns affect appetite and nutritional status:

a. Loneliness, depression

b. Anger, frustration

2. Cultural influences

a. Religious practices

b. Traditions

c. Family customs

3. Dining Atmosphere

a. Mealtime is more than eating; it is also a time for socialization.

b. Each staff member needs to help to make the mealtime experience a pleasant one for each resident.

c. Pleasant tablemates and conversation at mealtime are important considerations. Remember, the focus of attention and conversations are on the resident.

d. Distractions should be kept at a minimum. Avoid loud noises, cell phones, clanging of dishes and unnecessary traffic.

IV. Identify Types of Diets

A. Define Diet

1. Foods and fluids regularly consumed by a person as a part of normal living.

B. List types of standard diets

1. General or regular

a. No food or fluid restrictions.

b. Provides essential nutrients for a balanced diet.

2. Clear liquid

a. In nursing homes, used for stomach or intestinal distress as the liquids are easy to digest.

b. Clear liquids such as fat-free broth, tea, gelatin (Jello) and popsicles.

c. Inadequate in all nutrients; short-term use.

3. Mechanically altered: Chopped, ground, or pureed

a. Used for a person having difficulty in chewing or swallowing.

b. Same food items as a regular diet; food has been mechanically altered.

c. The Nutrition Support Assistant shall not alter the consistency of food or fluids. Seek guidance from licensed nursing staff.

C. List types of therapeutic or special diets. Therapeutic diets are ordered by physicians to help in the treatment of a disease. Some foods may be increased in amount, some foods may be omitted (such as in allergy related diets) or some foods may be restricted to measured amounts. Dietitians plan and manage therapeutic diets.

1. Diabetic diet

a. Ordered for the person who has diabetes. Sometimes used for a person for weight reduction.

b. The amount of carbohydrates is usually controlled.

i. No sugar on tray.

ii. Limits foods with high sugar content such as honey, syrup, regular soda, jelly, jams, and candy.

iii. May have special sugar-free substitutes if indicated on diet plan.

2. No added sodium (salt)

a. Na – abbreviation for sodium.

b. No salt on tray.

c. Ordered for persons with heart, blood vessel or kidney disease.

3. Low sodium diet

a. No salt on tray.

b. Limit foods high in salt:

bacon
ham
luncheon meats
some cheeses and canned soups
processed foods

c. Ordered for persons with heart, blood vessel or kidney disease.

4. Low Fat/Low Cholesterol Diet

a. Ordered for persons with blood vessel, heart, liver or gallbladder disease.

b. No fried foods, limit saturated fats

c. Foods limited or omitted

margarine, butter, salad oils
meats marbled with fat, skin on poultry
whole milk and whole milk products

d. There are many fat free or low fat substitutes available.

5. Other therapeutic or special diets

a. Kidney related diseases – may be very restrictive.

b. Roman Catholic - may have meat restrictions on Fridays and some religious holidays.

c. Conservative Jewish Faith - laws related to food preparation and non-Kosher meats.

6. No food or fluid (NPO) - Due to medical reasons, the physician may order no food or fluid for a limited amount of time.

a. NPO – the abbreviation for nothing by mouth.

b. Get direction from nursing staff.

V. Discuss Importance of Fluid Balance

A. Define fluid balance

1. Balance of fluid or liquids taken into body with amount eliminated through output of urine, stool, perspiration and respiration.

2. Necessary for proper blood flow.

3. Necessary for removal of body waste (urine & stool).

4. Aids in cell protection to keep skin, mouth and throat moist, and eyeballs lubricated.

5. Regulates body functions.

temperature control	digestion
movement of secretions out of lungs	keeps urine diluted, stool soft

B. Identify signs of dehydration (lack of sufficient water or fluid within the body)

Older adults show signs of dehydration quicker than younger adults.

1. Lips and mouth become dry, may have difficulty in swallowing, and loss of appetite.

2. Tongue becomes thickened and coated.

3. Skin becomes dry, itchy and cracks.

4. Decrease in urine output because there is not enough fluid.

5. Urine is concentrated: darker in color, strong odor.

6. Fatigue, weakness different from usual.

7. Confusion in persons not usually confused.

8. Weak pulse, pulse rate is faster.

C. Identify signs of edema (too much fluid in the tissues)

1. Swelling or puffiness

a. Often seen in feet, ankles and hands.

b. Some residents have swelling in feet and ankles due to circulation problems from heart disease.

2. Congestion or wheezing.

3. Weight increase.

4. Decrease in urine output because the body is retaining fluid.

D. Identify ways to ensure adequate fluid intake

1. Consult care plan regarding fluids restricted, fluids encouraged, or nourishments ordered.

2. Offer fluid frequently, especially in hot weather or when the resident has a fever.

3. Offer fluids the resident likes, offer at correct temperature.

4. Keep water fresh and in a location easy for the resident to reach.

5. Position the resident properly to drink (hold glass and straw).

6. Some residents cannot manage a straw. (They have not used them in the past or do not have muscle strength to suck on the straw).

7. Encourage the resident to help self (use hand on hand technique).

8. Record intake accurately.

Handout # 21: Measuring in cc's

E. Describe Reporting Intake According to Facility Procedure

1. Fluids

a. All items liquid at room temperature.

b. Record accurately.

c. Identify amounts according to facility procedure.

2. Foods/Appetite

a. Record amount consumed according to facility procedure

Feeding Techniques

Key Terms

Dysphagia - Inability or difficulty in swallowing.

Aspirate - To breathe fluid or a foreign body into the lungs.

I. Describe Facility-Specific Procedures for Meal Times

A. Meal schedule

B. Tray procedures

C. Location of posted menu

II. Atmosphere

A. Pleasant Environment

1. Most residents eat in the dining room.

2. Seating arrangements are usually agreed upon by the interdisciplinary team and the resident/family.

3. Some facilities may have “open dining” where the resident comes to the dining room during a specified block of time. In this situation there may not be assigned seating.

4. If the resident is to eat in their room, make the area pleasant by removing clutter and assuring adequate lighting.

B. Social concerns

1. Ask the resident where and with whom he/she wishes to eat, if consistent with care plan.

C. Comfort of the resident

1. Verify with nursing staff that the resident’s toileting needs have been met.

2. Assure the resident is properly dressed.

3. Check for proper positioning.

4. Assure the resident has a clothing protector and/or napkin.

5. Verify the resident has dentures, eyeglasses and hearing aid, if needed.

D. Be sure the resident is served the correct tray.

1. Safety concern with therapeutic diets and appropriate food consistency.

E. Adaptive equipment should be available to residents to encourage self-feeding and independence.

Handout #22: Adaptive Equipment

1. Lap tray for wheelchair or geriatric chairs.

2. Cut-out (or nosey) cup.

3. Angled, built-up or weighted flatware.

4. Scoop dish or plate guard.

5. Dycem mats or rubber netting.

F. Describe methods used to assist the resident with eating

1. Positioning at table

a. Ask nursing staff to transfer the resident from wheelchair to dining room chair.

b. Hips are back in chair.

c. Hips, knees, and ankles form 90 degree angles.

d. Feet flat on floor, footstool, or on wheelchair footrests.

e. Verify table is correct height and chair is facing the table.

f. Head in an upright position with chin tucked slightly. Head is not tilted backwards for swallowing (to prevent aspiration).

2. Positioning in bed

a. Head of bed is elevated 45 degrees or more.

b. Pillows are used to support positioning.

c. Head in an upright position with chin tucked slightly (to prevent aspiration).

d. Bedside table is close to the resident.

3. Prepare food according to the resident's needs

a. Cut meat, open cartons, and butter bread.

4. Encourage self-feeding and independence

a. Tell residents where items are such as coffee and bread.

b. Use clock description for residents who are visually impaired.

c. Feed the resident only if s/he is unable to do so.

d. Remember, the resident has the right to refuse to eat.

G. Describe feeding the resident

1. Focus of attention and conversation is on the resident.

2. Use hand on hand to assist resident.

3. Check temperatures of foods before feeding. Feel container and observe for steam.

4. Place food items within the resident's visual field.

5. Explain what foods are on tray and ask resident what he/she would like to eat first.

6. Observe to make certain food is swallowed before giving additional food or fluids. May need to remind resident to chew and swallow.

7. Offer liquids at intervals with solid foods.

8. Use a straw for liquids if resident can manage.

9. Do not rush the resident.

10. Sitting next to resident at eye level conveys a non-rushed feeling; do not stand while feeding.

H. Describe symptoms of dysphagia (difficulty swallowing)

1. A common problem with residents who have had a stroke or are very confused.

a. Coughing before, during, or after swallowing.

b. Swallowing multiple times with each bite.

c. Frequent throat clearing.

d. Feeling of something caught in throat.

2. Aspiration (breathing fluid or food into the lungs) is the most serious health risk associated with dysphagia. Can be life threatening.

3. Notify nursing staff immediately if a resident exhibits any of these symptoms.

I. After the Meal

1. Remove napkin or clothing protector.

2. Assist the resident to wipe mouth and wash hands.

3. Communicate to nursing staff the resident is finished.

Wyoming Nutrition Support Assistant
Competency Checklist

Name _____ **Date** _____

A. Resident Preparation/Dining Atmosphere	YES	NO	NA
1. Verifies resident has been assisted with toileting			
2. Resident is properly dressed			
3. Resident has dentures, hearing aid and glasses			
4. Table and surrounding area is clean and uncluttered			
5. Lighting is adequate/no glare			
6. Loud noises and distractions are minimized (television/radio/cell phone/unnecessary traffic)			

Comments:

B. Dining Procedures/Safety	YES	NO	NA
1. Is familiar with facility dining procedures			
2. Verifies resident receives correct diet			
3. Is familiar with menu items and substitutes			
4. Determines if hot food temperatures (including beverages) are safe for resident			
5. Notifies licensed nursing staff immediately of any unusual resident behaviors, signs or symptoms			

Comments:

C. Positioning at Table	YES	NO	NA
1. Asks nursing staff to transfer from wheelchair to dining room chair			
2. Hips are in the back of the chair			
3. Hips, knees, ankles form 90 degree angles			
4. Feet flat on floor, footstool, or on wheelchair footrests			
5. Verifies table is correct height and chair pushed close facing table			
6. Head is in an upright position with chin tucked slightly			
7. Head is not tilted backwards for swallowing			
8. Seeks guidance for residents with poor sitting balance			

Comments:

D. Positioning in Bed	YES	NO	NA
1. Head of bed is elevated 45 degrees or more			
2. Pillows are used to support positioning			
3. Head is in upright position with chin tucked slightly			
4. Bedside table is close to resident			

Comments:

E. Resident Interaction/Assistance	YES	NO	NA
1. Resident is focus of attention/conversation			
2. Seating is arranged to promote conversation with the resident; no standing while feeding			
3. Clothing protector or napkin is used			
4. Cuts meat, opens cartons, butters bread, if appropriate			
5. Food items are placed in visual field and described			
6. Asks resident about adding seasonings			
7. Resident is asked what order they would like the food			
8. Solid food is given from the point of the spoon			
9. Solid foods and fluids are alternated			
10. Foods are not mixed to maintain flavor and appearance			
11. Encourages resident to feed self if capable			
12. Resident is not hurried			
13. Positive feedback is provided to the resident			
14. Seeks guidance if problems arise			

Comments:

F. Proper Use of Assistive Devices	YES	NO	NA
1. Lap tray for wheelchair or geriatric chair			
2. Cut-out (or nosey) cup			
3. Angled, built-up, or weighted flatware			
4. Scoop dish or plate guard			
5. Dycem mats or rubber netting			

Comments:

G. Infection Control	YES	NO	NA
1. Washes hands prior to assisting resident with meal			
2. Helps resident to wash hands			
3. Food remains covered until resident is ready to eat			
4. Uses hands not teeth to open condiments			
5. Cartons are opened without touching spout			
6. Flatware is touched by handles and avoids touching the rim of cups/glasses			
7. Dropped flatware is immediately replaced			
8. Avoids touching own hair, face, and body after hand washing and while assisting resident			
9. Follows proper hand hygiene procedures during the meal			

Comments:

H. After the meal	YES	NO	NA
1. Removes the napkin or clothing protector			
2. Assists resident to wipe mouth and wash hands			
3. Communicates to the nursing staff the resident is finished			
4. Documents intake according to facility policy			

Comments:

RN Evaluator _____ **Date** _____
(Name and Title)

Wyoming Nutrition Support Assistant
Written Exam

Name _____ **Date** _____

Select the best answer for each question then circle your answer on the Answer Sheet. A score of 80% is required to successfully pass this exam.

1. Which activity should be immediately followed by hand washing?
a. Using the restroom
b. Blowing your nose
c. After contact with blood or bodily fluids
d. All of the above

2. Residents have the right to refuse to eat.
a. True
b. False

3. What is the name of the emergency technique used for dislodging food or an object from the windpipe of a choking person?
a. First Aid
b. The Heimlich maneuver
c. CPR
d. None of the above

4. Which of the following resident conditions should be immediately reported to licensed nursing staff?
a. Bruises
b. Bleeding
c. Unusual behavior
d. All of the above

5. If you observe abuse or suspect a resident is being abused, what should you do?
a. Keep the information to yourself and not tell anyone
b. Immediately report the situation according to facility policy
c. Tell one of the certified nurse aides
d. Within one week, report the situation to your supervisor

6. Nutrition Support Assistants are NOT allowed to:
a. Open a milk carton for a resident
b. Transfer a resident from a wheelchair to a dining room chair
c. Serve meal trays
d. Provide verbal cues during a meal to residents with cognitive impairment

7. An alcohol-based hand rub can always be used in place of hand washing.
a. True
b. False

8. You woke up this morning with a cough and you have a sore throat and fever. You are scheduled to be at work in one hour to assist with breakfast. What is the appropriate action you should take?
a. Call the facility, ask for your supervisor, and report your symptoms
b. Go to work because you have no sick leave
c. Go back to bed and see how you feel in a couple of hours
d. Take Tylenol or Aspirin, then when your fever goes down, report to work

9. A resident starts to cough and states she is choking. What should you do?
a. Slap the resident between the shoulder blades
b. Leave the room to find help
c. Immediately perform the Heimlich maneuver
d. Stay with the resident and summon help from nursing staff

10. What should you do if a resident asks you to take them to the toilet?
a. Assist the resident to the nearest toilet room
b. Tell the resident you will get someone to help them, then immediately report the request to nursing staff
c. Ignore the request
d. Take the resident to their room

11. A non-verbal resident you are assisting readily accepts spoonfuls of meat and potato; however, the resident clamps his/her mouth closed when you offer a bite of vegetable. What should you do?
a. Mix the vegetable with the meat and potato
b. Stop offering the resident the vegetable
c. Ask for a substitute for the vegetable
d. Ask for another dessert

12. You walk into a resident's room and see a fire in the trash can. What is the first thing you should do?
a. Leave the room and look for a fire extinguisher
b. Remove any residents who are in immediate danger
c. Call 911
d. Report the fire to the residents in the near-by rooms

13. Dehydration can be life threatening.
a. True
b. False

14. You enter a resident's room and find the resident on the floor. What should you do?
a. Stay with the resident and immediately call for help
b. Assist the resident to a sitting position
c. Assist the resident into bed
d. None of the above

15. How do you prevent the spread of infection?
a. Don't come to work if you are ill
b. Treat all bodily fluids as potentially infectious
c. Practice proper hand hygiene
d. All of the above

16. RACE is an acronym for:
a. Run, Aim, Control, Evacuate
b. Rush, Assess, Control, Exterminate
c. Rescue, Activate, Confine, Evacuate
d. Repair, Activate, Contain, Exterminate

17. You are assisting a resident who is blind. What is the name of the method in which you inform the resident of the location of food items on the plate?
a. The top to bottom method
b. The left to right method
c. The clock method
d. None of the above

18. When speaking to a resident who is hard of hearing you should:
a. Get the resident's attention and make sure they can see you
b. Face the resident so they can see your lips
c. Reduce any background noise
d. All of the above

19. A technique that can be used to effective communicate with a resident who is visually impaired is:
a. Verbally identify yourself when approaching the resident
b. Speak loudly
c. Use sign language
d. All of the above

20. While assisting a resident at lunch, the resident asks you what is wrong with her roommate. You should:
a. Tell her what you know about her roommate's illness
b. Share what you overhead the nurse telling the doctor
c. Tell her what the roommate's daughter told you about her mother's medical condition
d. Respect the roommate's confidentiality and not share any information

21. Thirty minutes is ample time for all residents to complete their meal.
a. True
b. False

22. What is the role of an ombudsman?
a. Plans and performs fire drills
b. Acts as a resident's advocate
c. Approves the nutrient content of the menus
d. None of the above

23. A nurse leaves a small cup of pills on the table and asks you to make sure the resident takes them. What should you do?
a. Hand the pills to the resident
b. Ask a certified nurse assistant to give the pills to the resident
c. Ask the nurse what the pills are so you can tell the resident when you give the pills
d. None of the above

24. What is the most common type of dementia?
a. Cardiovascular Disease
b. Rheumatoid Arthritis
c. Alzheimer's Disease
d. Parkinson's Disease

25. A resident you are assisting has a preference of drinking several ounces of fluid during mealtime, and eats very little food. You would:
a. Refuse to give the resident fluids until at least half of the meal is eaten
b. Offer 2 ounces of fluid at the beginning of meal; refuse to offer additional fluids until the resident finishes the meal
c. Allow the fluids of choice and encourage the resident to eat solid foods
d. Allow the fluids of choice and not offer any of the solid foods

Wyoming Nutrition Support Assistant
Written Exam
ANSWER SHEET

Name: _____ **Date:** _____

1.	a	b	c	d
2.	True		False	
3.	a	b	c	d
4.	a	b	c	d
5.	a	b	c	d
6.	a	b	c	d
7.	True		False	
8.	a	b	c	d
9.	a	b	c	d
10.	a	b	c	d
11.	a	b	c	d
12.	a	b	c	d
13.	True		False	
14.	a	b	c	d
15.	a	b	c	d
16.	a	b	c	d
17.	a	b	c	d
18.	a	b	c	d
19.	a	b	c	d
20.	a	b	c	d
21.	True		False	
22.	a	b	c	d
23.	a	b	c	d
24.	a	b	c	d
25.	a	b	c	d

Score = _____

Handouts

Residents' Rights

The resident has a right to a dignified existence, self-determination, communication with and access to persons and services inside and outside the facility. A facility must promote and protect the rights of each resident.

* The resident has a right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the Resident are exercised by the person appointed under State law to act on the Resident's behalf. In the case of a resident who has not been adjudged incompetent by the State court any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.

* The resident has a right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising his or her rights.

* The resident has the right to be fully informed in a language he or she can understand of his or her total health status, including, but not limited to, his or her medical condition.

* The resident has the right to refuse treatment and to refuse to participate in experimental research and to formulate an advance directive.

* The resident has the right to exercise his or her legal rights, including filing a grievance with the state survey and certification agency concerning resident abuse, neglect, misappropriation of resident property in the facility, and noncompliance with the advance directive requirement.

* The resident has the right to manage his or her financial affairs.

* The resident has a right to choose an attending physician.

* The resident has a right to be fully informed in advance about care and treatment and any changes in that care or treatment that may affect the resident's well-being.

* The resident has a right to participate in planning his or her care and treatment or changes in care and treatment unless adjudged incompetent or otherwise found to be incapacitated under

laws of the State.

* The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

* The resident or legal representative has the right, upon oral or written request, to access all records pertaining to himself or herself, including clinical records within twenty-four hours. After receipt of his or her records, the resident or legal representative has the right to purchase (at a cost not to exceed the community standard) photocopies of the records or any portions of them upon request and with two day's advance notice to the facility.

* The resident may approve or refuse the release of personal and clinical records to any individual outside the facility except when:

The resident is transferred to another healthcare institution.
Record release is required by law or third party payment contract.

* The resident has a right to voice grievances with respect to treatment or care that fails to be furnished, without discrimination or reprisal for voicing grievances.

* The resident has a right to prompt efforts by the facility to resolve grievances, including those with respect to the behavior of other residents.

* The resident has a right to examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility.

* The resident has a right to receive information from agencies acting as client advocates and be afforded the opportunity to contact the agencies.

* The resident has a right to refuse to perform services for the facility.

* The resident has a right to agree to perform voluntary or paid services for the facility if he or she desires, if the facility has documented the need or desire for work in the plan of care, the plan specifies the nature of the services performed and whether the services are voluntary or paid, and if compensation for paid services is at or above prevailing rates.

* The resident has the right to privacy in written communications, including the right to send and receive mail promptly that is unopened. The resident has a right of access to stationary, postage, and written implements at the resident's own expense.

* The resident has the right to immediate access to any of the following:

- Any representative of the Secretary of the U.S. Department of Health and Human Services.

- Any representative of the State.
- The resident's individual physician.
- The State's long-term care ombudsman.
- The agency responsible for the protection of and advocacy system for mentally ill or developmentally disabled individuals.
- Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident or others who are visiting with the consent of the resident.

* The Facility must provide reasonable access to any resident by an entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

* The resident has a right to have reasonable access to the private use of a telephone.

* The resident has a right to retain and use personal possessions, including some furnishings and appropriate clothing, as space permits, unless to do so would infringe on the rights or health and safety of other residents.

* The resident has a right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

* Each resident has a right to self-administer drugs unless the facility interdisciplinary team has determined for a particular resident that this practice is unsafe.

* The resident has a right to be free from any physical restraints imposed or psychoactive drugs administered for the purpose of discipline or convenience and not required to treat the resident's medical symptoms.

* The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.

* The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

* The resident has a right to choose activities, schedules and health care consistent with his or her interests, assessments, and plans of care.

* The resident has a right to receive advance notice of transfers or discharges of the resident as required by law. The Resident has a right to receive notice before the resident's room or roommate is changed. The resident has the right to refuse a room transfer if the purpose of the transfer is to move the resident between a Medicare certified bed and a non-Medicare certified bed for purposes of Medicare eligibility.

* The resident has a right to organize and participate in resident groups in the facility and the resident's family has the right to meet with families of other residents.

* The resident has a right to participate (or refuse to participate) in social, religious, and community activities that do not interfere with the rights of other residents.

* The resident has a right to reasonable accommodation of individual needs and preferences except where the health or safety of the resident or other residents would be endangered.

* The resident has a right to freedom of choice of providers in accordance with applicable law and subject to the provider's compliance with all applicable laws and reasonable rules and regulations of the facility.

Wyoming's Adult Protective Services Act

Wyoming's Adult Protective Services Act (35-20-101 through 35-20-116) can be found on the State of Wyoming Legislative website (http://legisweb.state.wy.us) under the link to "state statutes and constitution." The following selected statutes are included in this training manual as they have the greatest significance for individuals involved in the Nutrition Support Assistant Program.

Who is a vulnerable adult?
In Wyoming a vulnerable adult is defined as: "any person eighteen (18) years of age or older who is unable to manage and take care of himself or his property without assistance as a result of advanced age or physical or mental disability." This definition includes individuals residing in nursing homes and other residential care facilities.

What is abuse/neglect of a vulnerable adult?
The most relevant definitions of abuse/neglect for long term care facilities include, but are not limited to:

Abandonment: leaving a vulnerable adult without financial support or the means or ability to obtain food, clothing, shelter or health care.

Abuse: intentionally or recklessly inflicting physical or mental injury, unreasonable confinement, intimidation, cruel punishment, and may include sexual offenses.

Exploitation: the reckless or intentional act taken to obtain control through deception, harassment, intimidation or undue influence over the vulnerable adult's money, assets or property with the intention of depriving the vulnerable adult of those assets.

Injury: any harm, including disfigurement, impairment of any bodily organ, skin bruising, laceration, bleeding, burn, fracture or dislocation of any bone, subdural hematoma, malnutrition, dehydration or pressure sores.

Neglect: depriving a vulnerable adult of the minimum food, shelter, clothing, supervision, physical and mental health care, and other care necessary to maintain life or health, or which may result in a life-threatening situation.

Reporting concerns of abuse/neglect?
The Wyoming legislature addresses the issue of reporting vulnerable abuse/neglect in several statutes. 35-20-103 states that "Any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, exploited or abandoned or is committing self neglect shall report the information immediately to a law enforcement agency or the department" of Family Services.

The statute outlines that the report may be made orally or in writing and shall include the following information to the extent available:

- The name, age and address of the vulnerable adult;
- The name and address of any person responsible for the vulnerable adult's care;
- The nature and extent of the vulnerable adult's condition;
- The basis of the reporter's knowledge;
- The names and conditions of the other residents, if the vulnerable adult resides in a facility with other vulnerable adults;
- An evaluation of the persons responsible for the care of the residents, if the vulnerable adult resides in a facility with other vulnerable adults;

The adequacy of the facility environment;

- Any evidence of previous injuries;
- Any collaborative information; and
- Any other relevant information.

Failure to Report

The Wyoming statutes are clear that every person or agency has a duty to report as stated in 35-20-111. "The duty to report imposed by W.S. 35-20-103 applies without exception to a person or agency who knows, or has sufficient knowledge which a prudent and cautious man in similar circumstances would have to believe, that a vulnerable adult has been or is being abused, neglected, exploited or abandoned, or is committing self neglect."

Failure to report could result in a misdemeanor charge as stated in 35-20-111. "Any person or agency who knows or has sufficient knowledge which a prudent and cautious man in similar circumstances would have to believe that a vulnerable adult is being or has been abused, neglected, exploited or abandoned, or is committing self neglect, and knowingly fails to report in accordance with this act is guilty of a misdemeanor punishable by imprisonment for not more than one (1) year, a fine of not more than one thousand dollars ($1,000.00), or both.

Immunity is given to health care workers in 35-20-114 by the following statute language. "A person or agency filing a report under this act or testifying or otherwise participating in any judicial proceeding arising from a petition, report, or investigation is immune from civil or criminal liability on account of the person's petition, report, testimony or participation, unless the person knowingly or negligently reports information that is false or lacks factual foundation.

Reporting to ones supervisor does not necessarily relieve an individual of making a report to law enforcement or to the Department of Family Services.

Penalty for making a false report 35-20-113.

Reporting false or misleading information can be penalized as stated in 35-20-113."A person commits a misdemeanor punishable by imprisonment for not more than one (1) year, a fine of not more than one thousand dollars ($1,000.00), or both, if he reports information pursuant to this act and knows or has reason to know the information is false or lacks factual foundation."

Examples of Abuse and Neglect Related to Nutrition Support

► A resident spits at a caregiver as she assists the resident with breakfast. In retaliation, the caregiver spits in the resident's face and yells, "Don't you ever spit at me again."

► A resident hits a caregiver as he assists the resident with lunch. In retaliation the caregiver removes the resident's meal from the table and says, "If you are going to act like that then you don't need to finish your food."

► You observe a caregiver take food away from a resident who has not yet finished his meal because it is time for the caregiver's break.

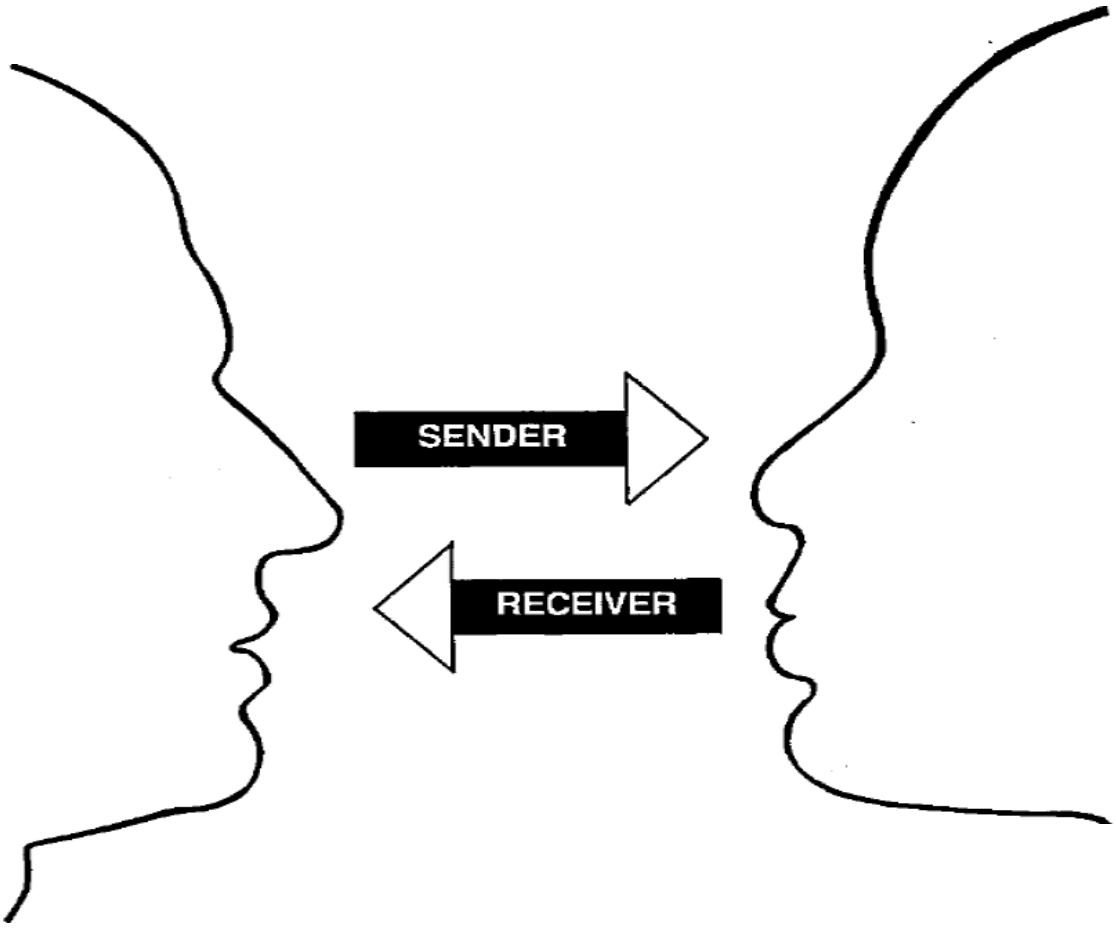
► A resident will not open their mouth to take a spoon of food, so the caregiver forces the spoon into the resident's mouth.

► A caregiver tells a resident they can't have dessert unless they eat the rest of the meal.

Handout #4

COMMUNICATION

The Exchange oflnformation



Effective Communication occurs when
the receiver gets the message
in the '\vay the sender intended

Non-Verbal Communication

SIGNAL		POSSIBLE MEANING
Folded arms	» » » » » » » » »	Defensive – no compromise
Hands covering/over mouth	» » » » » » » » »	Insecure – not sure what is being said
Tug at ear-nose-throat	» » » » » » » » »	Impatient – usually wants to interrupt
Fingers of both hands touching (open praying position)	» » » » » » » » »	Supreme confidence
Tightly clenched hands – wringing hands – excessive perspiration – tics – rocking, swaying	» » » » » » » » »	Nervousness – varying degrees
Feet and/or body pointing toward exit	» » » » » » » » »	Ready to leave
Hands supporting head when leaning back	» » » » » » » » »	Thinking, unsure of ground, stalling
Hand to face	» » » » » » » » »	Evaluating, listening
Index finger alongside nose	» » » » » » » » »	Very suspicious of what is being said
Crossing fingers while talking/listening	» » » » » » » » »	“I’m not sure”
Kicking at ground or imaginary object	» » » » » » » » »	Disgust
Shaking hands	» » » » » » » » »	Friendly, superior, equal inferior
Crossed legs with foot kicking	» » » » » » » » »	Hostile
Drumming on table	» » » » » » » » »	Not listening while expressing tension
Rubbing palms of hands together	» » » » » » » » »	Expectations
Fidgety in chair	» » » » » » » » »	Resentful of questions
Closing nostrils with fingers	» » » » » » » » »	Sign of contempt
Clenched hands, thumbs locked	» » » » » » » » »	Exercising extreme self-control
Placing hands to chest	» » » » » » » » »	Honest, sincere
Hands on hips, elbows bowed outwards	» » » » » » » » »	Openness, self-satisfaction

Principles for Good Listening/Effective Communication

Effective communication takes time, patience and skill. It also helps you to establish a good relationship with your resident. The following principles will help:

1. If you do all of the talking, you can't listen to what the resident has to say. Remember, the resident is the focus of your attention.

2. Put the resident at ease by showing him/her you want to listen. Look and act interested in what the resident is saying. Use appropriate body language.

3. Minimize loud noises and distractions. Reduce background noise, and turn off you cell phone.

4. Empathize (show understanding) with the resident's situation. Try to put yourself in his/her place. Never talk to the resident as if they were a child.

5. Be patient. Allow time for talking. Do not interrupt resident.

6. Hold your temper. An angry or upset person gets the wrong meaning from words.

7. Be careful with arguments and criticism. NEVER ARGUE OR CRITICIZE! This makes the resident defensive.

8. Ask open-ended questions. This demonstrates your interest and you gather more information.

9. Maintain good eye contact (except when culturally inappropriate). It tells the resident you have their attention.

REMEMBER!

- Recognize the feelings the resident expresses. Withhold judgment and remarks.
- Accept the resident as a person whether he/she is likeable, difficult to work with, or just plain objectionable.
- Demonstrate interest in the resident's interests. Become aware of dislikes.
- Always approach the resident's complaints and comments as worthy of consideration.
- Be consistent. The resident will learn and know what to expect from you.
- Avoid increasing the resident's anxiety. Do not call attention to shortcomings, mistakes, unusual habits. Do not be insincere, indifferent, and NEVER threaten the resident.
- Discuss the resident's needs, not yours. Use effective communication techniques.
- Remember, the resident who is the most difficult probably needs you the most.
- Only share personal experiences to show you understand. Remember, the resident is the focus of the conversation.

Techniques Used For Assisting Residents Who Are Visually Impaired

Verbally identify yourself when approaching the resident and let them know when you are leaving

When assisting the resident during mealtime, explain the position of the items by relating them to the position on a clock

Always talk directly to the resident

Knock before entering a resident's room (it is the resident's home)

Refer to the resident by the name s/he prefers

Assist the resident with use of eye glasses; clean glasses as needed

Maintain familiarity in the resident's environment by not moving personal items or furniture

Speak clearly and slowly, using moderate tone of voice

The person may not be hearing impaired; do not use a loud voice or shout

Guidelines for Communicating With Residents With Hearing Impairments

1. Reduce background noise.
2. Get the resident's attention – make sure they can see you.
3. Speak slowly and distinctly.
4. Form words carefully – keep your sentences short.
5. Keep your hands away from your mouth to allow for lip reading.
6. Rephrase words as needed.
7. Face the person as you speak.
8. Have the light source behind the resident, rather than shining in his/her face to avoid glare and to enable him/her to see you better.
9. Use facial expressions, body language, gestures to show the person what you mean.
10. Try to reduce other distractions to the resident so that he/she can concentrate upon only your communication.

Communicating with Adults with Brain Injuries

Keep in mind that what the resident says, and what they mean, may be very different.

Keep noise and distractions to a minimum.

Verbalize one task at a time and allow the resident time for completion.

Remember to give the resident time to search for words s/he wants. You may suggest words, but give the resident time to respond to each suggestion.

Keep sentences short and simple with prolonged pauses between your words and phrases.

If the resident is verbal, give simple directions and ask them to repeat back to you to assure understanding.

If the resident has an impaired memory, repeat instructions and write reminders.

The resident may not have a hearing problem. Using a raised voice may startle them.

About the Stages of Alzheimer's Disease

Experts have documented common patterns of symptom progression that occur in many individuals with Alzheimer's disease and developed several methods of "staging" based on these patterns. Progression of symptoms corresponds in a general way to the underlying nerve cell degeneration that takes place in Alzheimer's disease. Nerve cell damage typically begins with cells involved in learning and memory and gradually spreads to cells that control other aspects of thinking, judgment and behavior. The damage eventually affects cells that control and coordinate movement.

Staging systems provide useful frames of reference for understanding how the disease may unfold and for making future plans. But it is important to note that all stages are artificial benchmarks in a continuous process that can vary greatly from one person to another. Not everyone will experience every symptom and symptoms may occur at different times in different individuals. People with Alzheimer's live an average of 8 years after diagnosis, but may survive anywhere from 3 to 20 years.

The framework for this fact sheet is a system that outlines key symptoms characterizing seven stages ranging from unimpaired function to very severe cognitive decline. This framework is based on a system developed by Barry Reisberg, M.D., Clinical Director of the New York University School of Medicine's Silberstein Aging and Dementia Research Center.

Within this framework, we have noted which stages correspond to the widely used concepts of mild, moderate, moderately severe and severe Alzheimer's disease. We have also noted which stages fall within the more general divisions of early-stage, mid-stage, and late-stage categories.

Stage 1: No cognitive impairment
Unimpaired individuals experience no memory problems and none are evident to a health care professional during a medical interview.

Stage 2: Very mild decline
Individuals at this stage feel as if they have memory lapses, especially in forgetting familiar words or names or the location of keys, eyeglasses, or other everyday objects. But these problems are not evident during a medical examination or apparent to friends, family, or co-workers.

Stage 3: Mild cognitive decline
Early-stage Alzheimer's can be diagnosed in some, but not all, individuals with these symptoms

Friends, family or co-workers begin to notice deficiencies. Problems with memory or concentration may be measurable in clinical testing or discernible during a detailed medical interview. Common difficulties include:

- Word- or name-finding problems noticeable to family or close associates
- Decreased ability to remember names when introduced to new people
- Performance issues in social or work settings noticeable to family, friends or co-workers

- Reading a passage and retaining little material
- Losing or misplacing a valuable object
- Decline in ability to plan or organize

Stage 4: Moderate cognitive decline (Mild or early-stage Alzheimer's disease)
At this stage, a careful medical interview detects clear-cut deficiencies in the following areas:
- Decreased knowledge of recent events
- Impaired ability to perform challenging mental arithmetic—for example, to count backward from 100 by 7s
- Decreased capacity to perform complex tasks, such as marketing, planning dinner for guests, or paying bills and managing finances
- Reduced memory of personal history
- The affected individual may seem subdued and withdrawn, especially in socially or mentally challenging situations

Stage 5: Moderately severe cognitive decline (Moderate or mid-stage Alzheimer's disease)
Major gaps in memory and deficits in cognitive function emerge. Some assistance with day-to-day activities becomes essential. At this stage, individuals may:
- Be unable during a medical interview to recall such important details as their current address, their telephone number, or the name of the college or high school from which they graduated
- Become confused about where they are or about the date, day of the week or season
- Have trouble with less challenging mental arithmetic; for example, counting backward from 40 by 4s or from 20 by 2s
- Need help choosing proper clothing for the season or the occasion
- Usually retain substantial knowledge about themselves and know their own name and the names of their spouse or children
- Usually require no assistance with eating or using the toilet

Stage 6: Severe cognitive decline (Moderately severe or mid-stage Alzheimer's disease)
Memory difficulties continue to worsen, significant personality changes may emerge, and affected individuals need extensive help with daily activities. At this stage, individuals may:
- Lose most awareness of recent experiences and events as well as of their surroundings
- Recollect their personal history imperfectly, although they generally recall their own name
- Occasionally forget the name of their spouse or primary caregiver but generally can distinguish familiar from unfamiliar faces
- Need help getting dressed properly; without supervision, may make such errors as putting pajamas over daytime clothes or shoes on wrong feet
- Experience disruption of their normal sleep/waking cycle
- Need help with handling details of toileting (flushing toilet, wiping and disposing of tissue properly)
- Have increasing episodes of urinary or fecal incontinence
- Experience significant personality changes and behavioral symptoms, including suspiciousness and delusions (for example, believing that their caregiver is an impostor); hallucinations (seeing or hearing things that are not really there); or compulsive, repetitive behaviors such as hand-wringing or tissue shredding
- Tend to wander and become lost

Stage 7: Very severe cognitive decline (Severe or late-stage Alzheimer's disease)
This is the final stage of the disease when individuals lose the ability to respond to their environment, the ability to speak, and, ultimately, the ability to control movement.

- Frequently individuals lose their capacity for recognizable speech, although words or phrases may occasionally be uttered
- Individuals need help with eating and toileting and there is general incontinence of urine
- Individuals lose the ability to walk without assistance, then the ability to sit without support, the ability to smile, and the ability to hold their head up. Reflexes become abnormal and muscles grow rigid. Swallowing is impaired.

There is currently no cure or prevention for Alzheimer's disease, but the Alzheimer's Association is fighting on your behalf to give everyone a reason to hope. For more information about Alzheimer research, treatment and care, please contact the Alzheimer's Association.

Contact Center **1.800.272.3900**
TDD Access **1.312.335.8882**
Web site **www.alz.org**
e-mail info@alz.org

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The Importance of Good Communication Skills

Communicating with a person who has a dementing illness, such as Alzheimer's disease, can be a terribly difficult task. Often in the early stages of a dementing illness, people have trouble finding the words to express their thoughts, or may be unable to remember the meaning of simple words or phrases; but these problems are usually minor inconveniences or frustrations. The later stages may be much more difficult. Language skills are quite impaired, resulting in nonsensical, garbled statements, and great difficulty in understanding.

When people cannot comprehend what is being said, or cannot find the words to express their own thoughts, it can be painful, frustrating, and embarrassing for everyone. The following are some suggestions of things to think about when communication with an impaired person.

Your Approach – You Set the Tone

- **Think about how you are presenting yourself.** Are you tense? Frowning? Are you being bossy or controlling? People with dementia are often extremely aware of non- verbal signals such as facial expression, body tension and mood. If you are angry or tense, they are likely to become angry, anxious, or annoyed.

- **Try a calm, gentle, matter-of-fact approach.** You set the mood for the interaction. Your relaxed manner may be contagious.

- **Use a non-demanding approach – try humor, cajoling, or cheerfulness.** Humor or gentle teasing often helps caregivers through difficult moments. Convincing someone to get out of bed or go to the bathroom is usually easier if you can make a game or joke of it. Ordering or demanding may be much less successful with some people.

- **Try using touch to help convey your message.** Sometimes touch can show that you care, even when your words don't, or when you are not understood. Some people shy away from being touched, but most find gentle touch reassuring.

- **Begin your conversation socially**. Winning the person's trust first can often make a task much simpler. One way of doing this is to spend time chatting before approaching the task at hand. For example, you might spend ten minutes talking about the weather, family members, or some reassuring topic, to help get the person in a relaxed frame of mind and create a pleasant mood.

Things to Think About When You Speak

- **Talk to the person in a place that is free from distractions,** such as equipment noise, television, or other conversations. People with dementia often have very little ability to screen out distractions.

- **Begin conversations with orienting information**. Identify yourself, if necessary, and call the person by name. After creating a relaxed atmosphere, explain what it is you propose to do.

- **Look directly at the person and make sure you have his or her attention before you begin to speak.** If you cannot get the person's attention, wait a few minutes and try again. Move slowly. Gently touch an arm or hand to gain attention, while saying the person's name several times. Be careful not to startle him or her.

- **It is important to be at eye level with the person**, especially when talking to someone who is very impaired or who is hard of hearing.

- **Speak slowly and say individual words clearly**. This is particularly important for people with hearing problems or those who are in the later stages of dementia.

- **Use short, simple sentences.** People with dementia may not be able to remember more than a few words at a time. Pause between sentences and allow plenty of time for the information to be understood.

- **Ask simple questions that require a choice of a yes/no answer,** rather then open-ended questions. For example, instead of saying, "What would you like to wear today?" you might say, "Do you want to wear this green dress or this red one?" or "Is this the dress you would like to wear today?"

- **Use very concrete terms and familiar words**. As people become more impaired, they lose the ability to understand abstract concepts. You may need to say, "Here is your soup at this table," instead of "It's time for lunch." They may also revert to words from childhood or earlier in life, so that "Do you need to go to the bathroom?" may not be understood as easily as "Do you have to pee?"

- **Talk in a warm, easy-going, pleasant manner.** Try to use a tone of voice that you would like people to use with you.

- **Keep the pitch of your voice low.** Sometimes when people don't immediately understand us, we have a tendency to shout. This will simply upset the person with dementia and will make communication more difficult.

When Doing a Task Together

- **Try to focus on familiar skills or tasks.** People with dementing illnesses gradually lose the ability to learn new tasks, but may be able to do familiar work, hobby-related tasks or household chores even when very impaired.

- **Give choices, whenever possible.** For example, choosing whether to take a bath before or after dinner or choosing which of two shirts to wear, may help the person continue to feel some sense of control over life.

- **Allow plenty of time for the information to be absorbed**. People with dementia often need much more time to absorb simple statements or instructions. Allow a moment of silence before gently repeating an instruction. This requires a lot of patience on the part of caregivers.

- **Repeat instructions exactly the same way.** It may take a number of repetitions before the person responds. If, after allowing for plenty of time, the instructions are still not understood, try using different key words, or demonstrating what you want the person to do.

- **Break the task down into simple steps.** Most of our daily tasks are very complex activities. The concepts of "getting dressed" or "taking a bath" may be too overwhelming and abstract for a person with a dementing illness. Instead, the person may be able to respond better to small, concrete steps – one part of the task at a time. For example, the first step in getting dressed might be unbuttoning pajamas. The second step might be taking the right arm out of the sleeve. Find out which steps the person is able to do and encourage those. Gently help with steps that are most difficult. Although this technique takes time and practice, doing tasks together can become more successful and pleasant.

- **Modify the steps as the person becomes more impaired.** You may need to break the tasks into even smaller steps, or you may need to gradually begin doing some of the steps that the person was able to do previously. Again this takes time and patience on the part of the caregiver, but can be rewarding for both the person with dementia and the caregiver.

- **Praise sincerely for success.** We all need to hear that we are doing a good job, and for people who are losing their abilities it may be particularly important. Praise doesn't need to be long or "gushy," but may be a simple "Thank you" or "You did a nice job."

When You Are Having Trouble Being Understood

- **Listen actively and carefully to what the person is trying to say.** If you do not understand, apologize and ask the person to repeat it. Let him or her know when you do understand by repeating it or rephrasing it.

- **Try to focus on a word or phrase that makes sense**. Repeat it back to the person and try to help him or her clarify what is being said.

- **Respond to the emotional tone of the statement.** You may not understand what is being said, but you may recognize that it is being said angrily or sadly. Saying, "You sound very angry," at least acknowledges the feeling, even if you cannot decipher the words.

- **Try to stay calm and be patient.** Remember the person is not doing this on purpose and is probably even more frustrated than you. Your calmness and patience will help create a caring atmosphere that will encourage the person to keep trying.

- **Ask family members about possible meanings for words, names, or phrases that you do not understand.** Sometimes people with dementia talk in a kind of code that may make sense to people who have known them for a long time. A name called over and over may be a close friend or relative from the past whose memory is reassuring, "Let's go down that street to my house," may be a very logical way of referring to a long corridor and room, when the names of these places have disappeared from memory. Language from childhood, such as names for bathroom habits or pet names for things, may reappear in the person's vocabulary. While it is helpful to use their words (e.g., "pee" or "tinkle"), it is important to continue to treat them as adults, not children.

Things Not To Do

- **Don't argue with the person.** This always makes the situation worse. Furthermore, it is important to remember that a person with dementia no longer has the ability to be rational or logical to the extent you do.

- **Don't order the person around**. Few of us like to be bossed around and the person with dementia is no exception. Even when your words are not understood, your tone of voice will be.

- **Don't tell the person what he or she can't do.** State directions positively instead of negatively. Instead of "You can't go outside now" try "Let's sit down here and look at these pictures."

- **Don't be condescending.** It is hard not to use a condescending tome of voice when you are speaking slowly and in short sentences. However, a condescending tone is likely to provoke anger, even if the words are not understood.

- **Don't ask a lot of direct questions that rely on a good memory.** Often our attempts at being sociable involve asking people about themselves, Remember that people with dementia have memory loss and may feel humiliated or angry if you ask questions they can no longer answer. Try rephrasing. For example, instead of "Who is this in the picture?" say "This must be your daughter." This approach allows the person to reply gracefully and noncommittally if he or she is not sure.

- **Don't talk about people in front of them.** It is easy to fall into the habit of talking about people in front of them when they can no longer communicate well. It is impossible to know how much someone with dementia understands, and this may vary from moment to moment.

When Verbal Communication Fails

- **Try distracting the person.** Sometimes simply diverting the person's attention to other activities (e.g.; going for a walk, changing the subject, offering a snack, and turning on the television) may be enough to diffuse an angry or anxious mood. Try again later.

- **Ignore a verbal outburst if you can't think of any positive response.** It is much better to ignore angry or agitated statements than to become angry yourself. You might also try apologizing and letting the subject drop, or changing the emotional tone of the conversation. (e.g., making a positive, cheerful comment, instead of an angry reply)

- **Try other forms of communicating.** There are lots of ways of communicating that don't involve words. Familiar songs, gentle touching massage, favorite foods, or talking together can often demonstrate concern and affection more effectively than words. These modes of communication can also help soothe a troubled person and take the edge off difficult moments.

Source: Anne Robinson, Beth Spencer, and Laurie White, authors. Prepared at Eastern Michigan University in collaboration with the Alzeheimer's Association (ADRDA) – Greater Ann Arbor Chapter with a grant from the Department of Mental Health.

For further information about Alzheimer's disease or related disorders, contact the Alzheimer's Association at:

- Great Plains Chapter, 402-420-2540 or 1-800-487-2585 (Helpline)
- Omaha and Eastern Nebraska Chapter, 402-572-3059 or 1-800-309-2112 (Helpline)

Changes in Residents that Need to be Reported

- Refusing to eat or drink, or eats very little or eats only certain things.
- Complaints of pain, nausea, dizziness, etc.
- The resident becomes withdrawn or angry all the time.
- The resident becomes agitated, combative or restless.
- A resident's dentures don't fit and she is unable to chew her food.
- The resident coughs or chokes when they attempt to swallow.
- The resident is falling asleep during meals.
- The resident is holding the food in his mouth without swallowing.
- Any unusual behavior.
- Any bleeding or bruising.
- The resident is short of breath.
- The resident's lips appear blue in color.

Handout #13

RACE AGAINST FIRE

R

RESCUE

Remove resident(s) from immediate danger - close door behind you.

A

ACTIVATE ALARM

Follow facility policy for activating the fire alarm.

C

CONFINE

Close all other doors and windows in the area.

E

EVACUATE AND EXTINGUISH

Fight fire if feasible.

Universal Distress Signal for Choking

Heimlich Maneuver for Choking

A resident who is choking can't speak or breathe and needs your help immediately. Follow these steps:

1. Stand behind the resident, wrap your arms around the resident's waist.
2. Make a fist with one hand
3. Place the thumb side of your fist against the victim's upper abdomen, in the soft area below the ribcage and above the navel.
4. Grasp your fist with your other hand
5. Press your fist into the resident's upper abdomen with a quick upward thrust. Do not squeeze the ribcage; confine the force of the thrust to your hands.
6. Repeat until object is expelled.

If the resident becomes unconscious, gently lower to the floor.

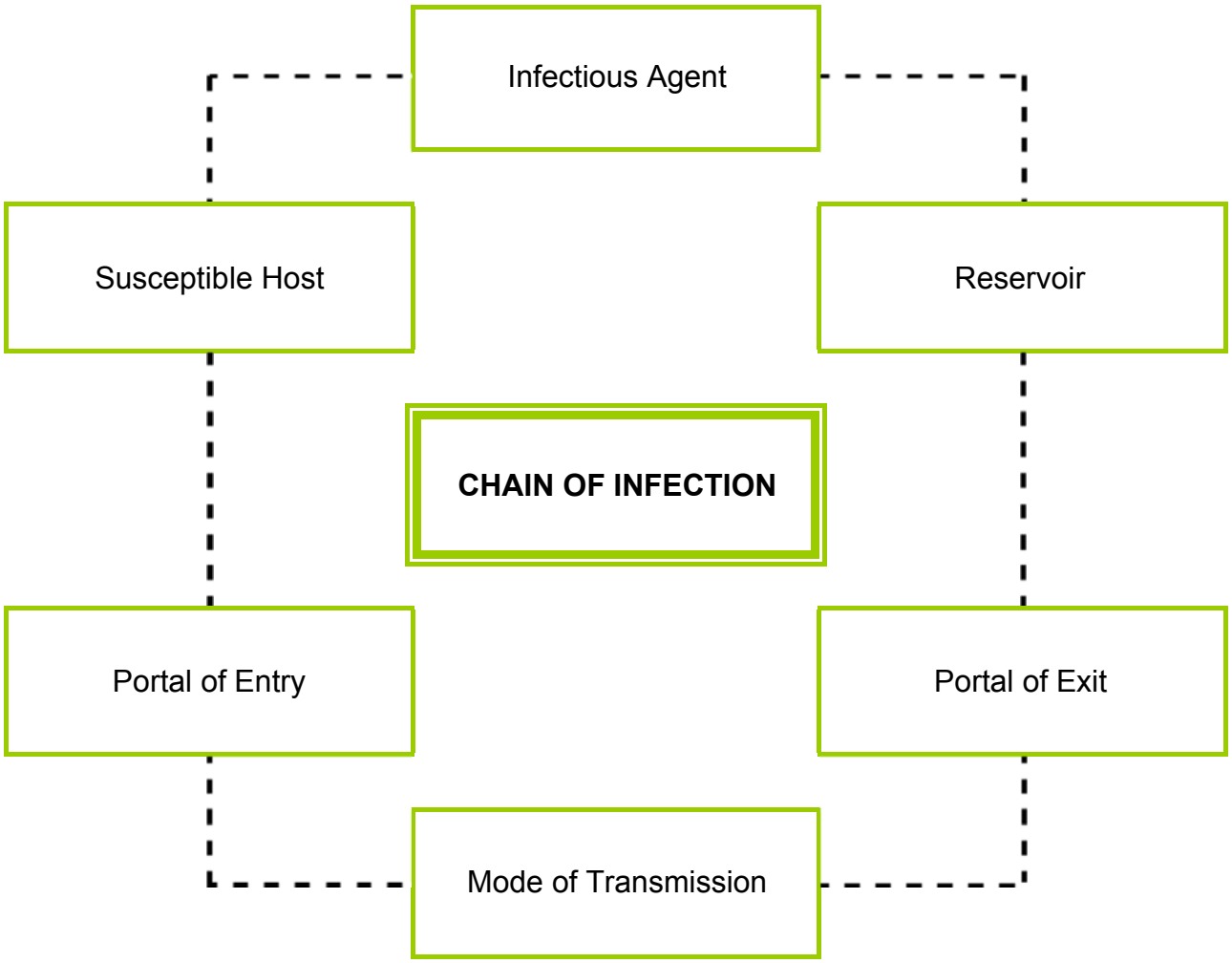
If the resident is already unconscious, or you are unable to reach around the resident:

1. Place the resident on their back.
2. Facing the resident, kneel astride the residents hips.
3. With one of your hands on top of the other, place the heel of your bottom hand on the upper abdomen below the rib cage and above the navel.
4. Use your body weight to press into the resident's upper abdomen with a quick upward thrust. Repeat until object is expelled.

NEVER SLAP THE VICTIM'S BACK. This could make the situation worse.

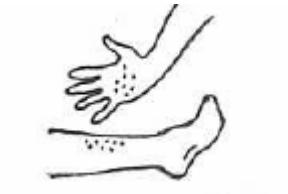
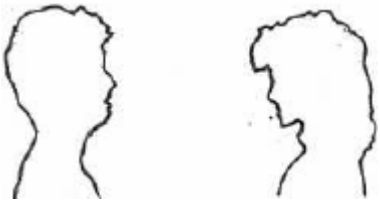
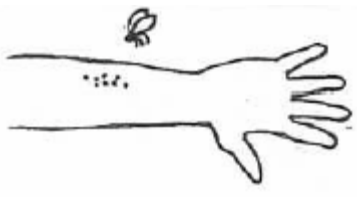
Handout #15

Chain of Infection



The “Chain of Infection” is a model used to understand the infection control process. Each of the links must be present and in sequential order for an infection to occur. An awareness of this cycle provides the caregivers with knowledge of how to prevent the spread of infection.

Handout #16

WAYS INFECTIONS SPREAD (Modes of Transmission)	
Direct Contact Touching Contaminated Material 	**Indirect Contact** Microorganisms Spread From One Person to Another by an Object 
Droplets Microorganisms Spread by Coughing, Sneezing, or Exhaling 	**Airborne** Microorganisms Traveling in the Air By Themselves or on dust Particles 
Common Vehicle Microorganisms Spread to Many People by One Source 	**Vectorborne** Microorganisms Spread by Insects 

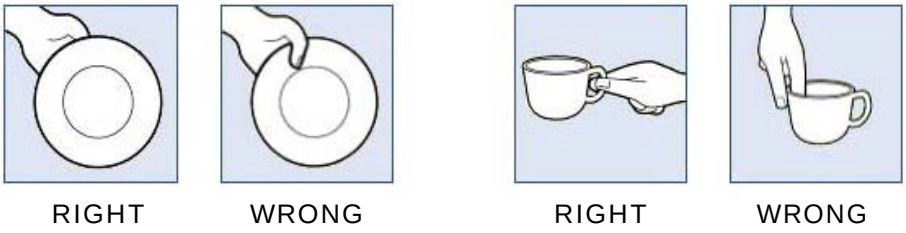
WASH YOUR HANDS!!!!

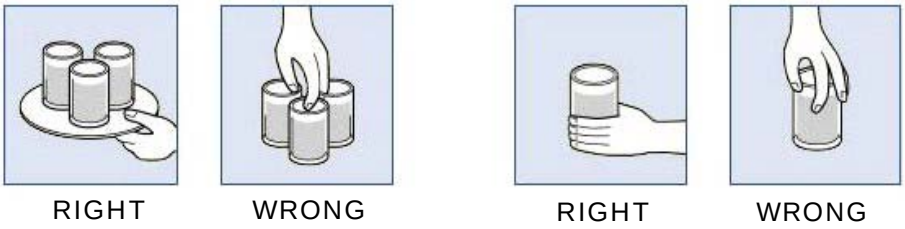
1. Wet hands
2. Apply soap
3. Wash hands by applying friction for 15 seconds
4. Rinse hands with water
5. Dry hands with paper towel
6. Turn off water with paper towel

REMEMBER, hand washing is the most effective way to prevent the spread of infection

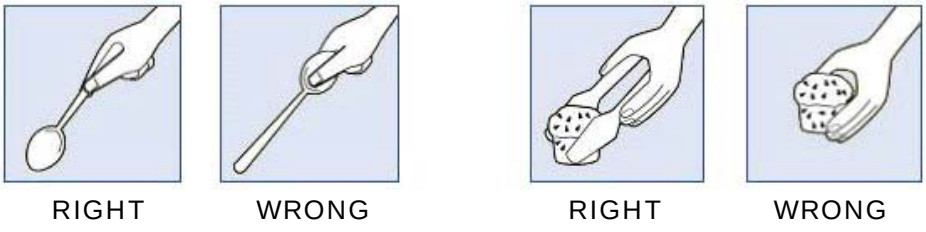
Handout #18

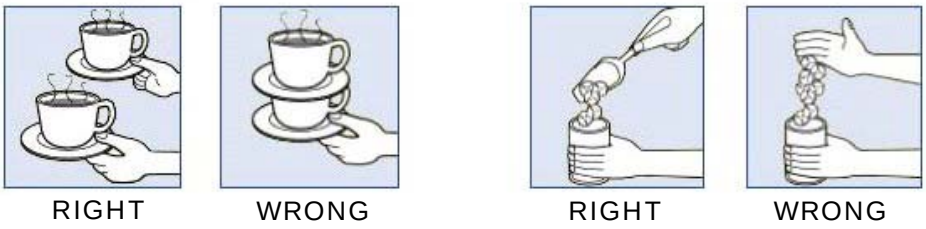
Minimizing Contamination during Service





Handling Food, Glassware, Dishes, and Utensils



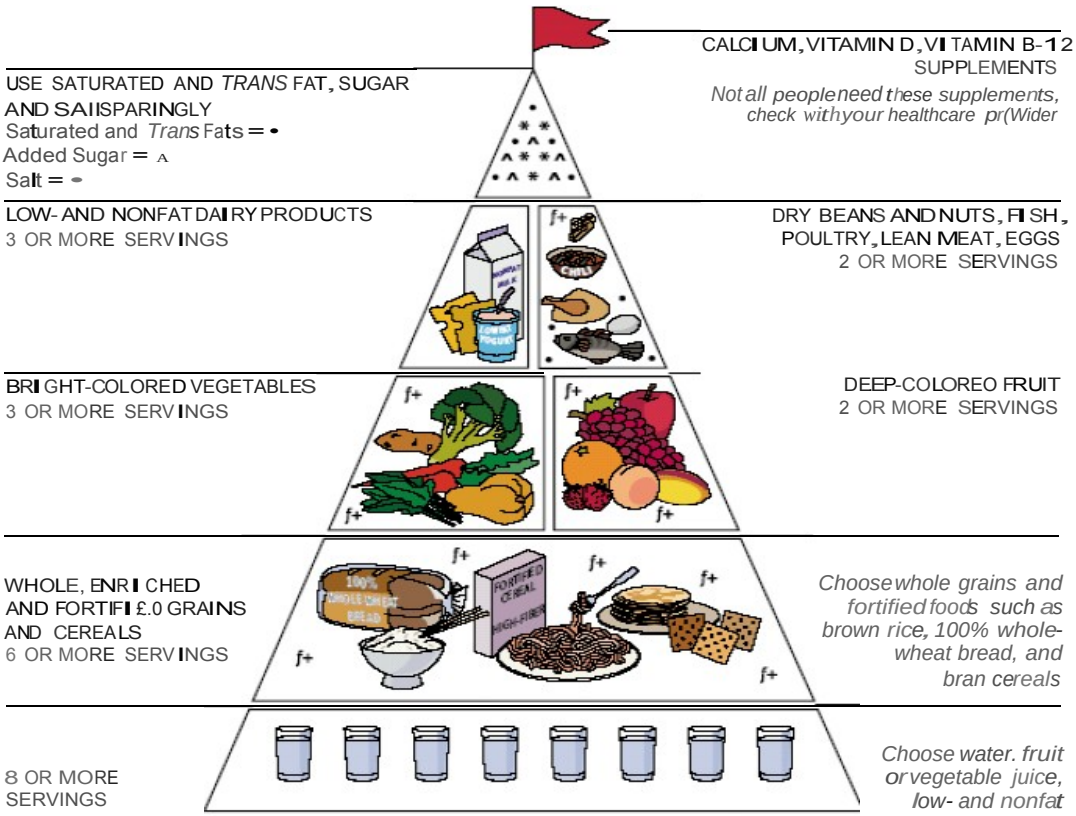


Six Essential Nutrient Groups

NUTRIENTS	FUNCTION
Vitamins And Minerals	Regulate body functions; Build and repair body tissue
Carbohydrates	Provide heat and energy
Fats	Provide fatty acids needed for growth & development; Provide heat and energy
Proteins	Build and repair body tissue; Provide heat and energy
Water	Carries nutrients and wastes to and from body cells; Regulate body functions

TUFTS

Food Guide Pyramid for Older Adults



For additional copies visit us on the web at http://nutrition.tufts.edu

Handout #21

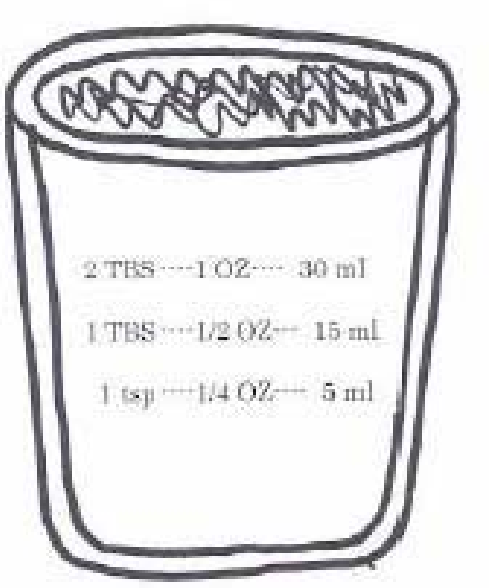
Measuring in CC's

Measuring Intake

Recording and reporting the patient's intake is important information in managing a patient's fluid balance, recovery from an infection, or preventing possible health problems.

Intake and output commonly referred to as I & O is the measurement of all liquids drank and all urine voided. Liquids are all beverages and foods that are liquid at room temperature. Ice cream, popsicles, and cream soups are foods included in intake measurement.

In health care, measurements are recorded in metric rather than apothecary or household measurements.



Apothecare/Household	Metric
1 oz. (ounce) = 2 Tbsp.	30 cc (cubic centimeters)
8 oz. = 1 cup	240 cc

Manufacturers list ounces on beverage containers. A single serving milk carton is 8 ounces and a standard pop can is 12 ounces. To determine the intake to record requires a little math:

8 oz. Milk	12 oz. Pop
X 30 cc per ounce	X 30 cc per ounce
240 cc Milk	360 cc Pop

Handout #22

Adaptive Equipment

Utensils: Tool to Increase Oral Control

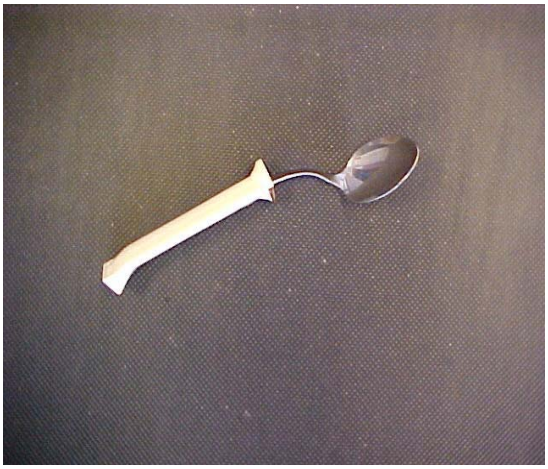
This equipment enhances mealtime independence. Special utensils encourage improved head and neck alignment for a safe swallow. Fluid loss due to spillage is decreased.

Cut Out Cup

- Cut out cups are designed for individuals who have difficulty coordinating head alignment with jaw and lip control.
- The cup rim is cut out on one side. The cut out edge is positioned toward the nose. This allows the cup to tilt up fully, without tipping the head back.
- It helps control the flow of liquids.
- It improves mealtime etiquette, and is less messy.

Utensils: Tool to Increase Hand Control

Adaptive equipment enhances mealtime independence. Special utensils encourage appropriate trunk and head alignment. Their use decreases the loss of calorie and hydration due to spillage.

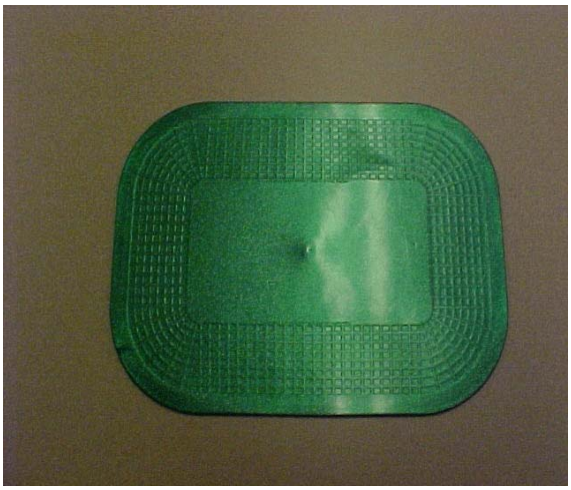


Angled Spoon

- Angled utensils are designed for persons with limited arm and wrist movement, who cannot demonstrate a complete scooping movement.
- The spoon angles toward the mouth.
- They help to prevent food spillage due to poor arm movement.
- Mealtime is less messy.
- They encourage appropriate body alignment.

Built Up Handle Spoon, Forks, Knives

- Built up handle utensils are for persons who grasp utensils with the palm of the hand and have limited strength.
- The built up handles are cylindrical and large.
- They help to prevent food spillage due to weak hand strength.
- They can be used with hand-over-hand physical assistance as a beginning step to independent eating.



Dycem Mat

- A dycem mat is used with persons who have poorly coordinated arm and hand control.
- It is a gelatin-like material which provides a non-skid surface for adaptive utensils.
- The utensils stay placed in front of the person. Tipping and spillage are decreased.
- It improves mealtime etiquette.
- Hand wash with soap and water. DO NOT BLEACH.

Scoop Dish

- Scoop dishes are used with individuals who have limited or exaggerated scooping movements.
- It features a raised side which is turned in the direction of the scoop motion.
- It helps to prevent frustration and anxiety in loading the utensil.
- It decreases spillage from the plate to the table.

Weighted Utensils

- Weighted utensils are used with individuals who have poorly coordinated hand and arm movement when it is away from the center of the body.
- The weight of the cup or the two hand grasp helps to stabilize.
- Weight helps to prevent spillage and encourage better oral control.

Photos courtesy of the Wyoming Department of Health, Wyoming State Training School.

Additional Resources:

Assisted Dining: The Role and Skills of Feeding Assistants, American Health Care Association, 2003.

Eating Matters: A Training Manual for Feeding Assistants, Consultant Dietitians in Health Care Facilities, 2003.

Eating Matters: Feeding Assistants Manual, Consultant Dietitians in Health Care Facilities, 2003.

How to Enhance the Quality of Dining Assistance in Nursing Homes. Centers for Medicare and Medicaid Services Webcast, March 16, 2007.

APPENDIX A

Wyoming Nutrition Support Assistant
Written Exam
ANSWER KEY

1. d
2. True
3. b
4. d
5. b
6. b
7. False
8. a
9. d
10. b
11. c
12. b
13. True
14. a
15. d
16. c
17. c
18. d
19. a
20. d
21. False
22. b
23. d
24. c
25. c

APPENDIX B

Certificate of Completion

is hereby granted to

_____

For successfully completing the
Wyoming Department of Health, Office of Healthcare Licensing and Surveys
course requirements to become a

Nutrition Support Assistant

_____
RN Coordinator

_____
Nursing Home

_____
Date Completed