EDUCATIONAL CONFERENCE CALL #5 IN OUR SERIES:
"<u>Eating with Dignity: Nutrition and Hydration</u>"
WEDNESDAY, OCTOBER 11, 2006 – 3PM (ET) [2PM CT / 1PM MT / 12PM PT]

<u>EDUCATIONAL CONFERENCE CALL MINUTES</u>

1. **Welcome & Project Overview**
   - This call series on issues of quality in nursing homes, has been funded by the Retirement Research Foundation. The project began centered around the concept that while staff and professionals have access to information about nursing home quality care issues, family and residents often do not.
   - This project will help educate people by tapping into a national pool of experts. It will help inform families and residents on how to improve the quality of life and care in nursing homes they (or their family members) are in.
   - The calls have been successful. For example, we have seen people make connections across the country with people that have similar questions and issues. People are beginning to understand that they are not alone, and what type of progress is possible and is being made on related issues.
   - If you are participating in this series for the first time, and have not received a packet of materials for this call, please call NCCNHR at: 202-332-2275
2. **Introduction of Robyn Grant, Conference Call Special Facilitator**
3. **Conference Call Overview**
   - We welcome you, and are excited that so many folks have been able to join us.
   - This call is "Eating with Dignity: Nutrition and Hydration."
   - I would like to outline the agenda at this point and talk about logistics. There will be two speakers on the call. During the speaker presentations the other lines are muted. After each speaker there will be an opportunity to ask questions, and the operator will open the lines one by one. If there is not enough time – remember the follow-up call on November 1st, where you can ask more questions and we will provide technical assistance.
   - We only have 75 minutes, so if folks can be brief in their questions, that's best.
   - Web site: <u>www.nccnhr.org/consumervoice</u> - all information resources for this call series are available at this website.
4. **Speaker Introduction (Dr. Jeanie Kayser-Jones, Professor, Gerontological Nursing and Medical Anthropology, University of California, San Francisco)**
5. **Expert Speaker Presentation PART I: Dr. Jeanie Kayser-Jones**
   - Thank you, Robyn, and thank you for inviting me to participate in this important educational conference call. I am going to talk about nutrition and hydration simultaneously today because both are essential to health, and you really can't talk about one without talking about the other.
   - **<u>Causes of Malnutrition:</u>**

Clinical: There are many reasons why nursing home (NH) residents do not eat well, become malnourished, lose weight, and sometimes die.

- **Functional and Cognitive Impairment:** First, as we all know, some NH residents have had a stroke, PD, or other conditions that make it difficult for them to feed themselves. Also, many residents have some memory loss or they may have Alzheimer's disease so they need assistance with their meals.
- **Dysphagie (Swallowing problems)** are very common among NH residents. In one of our studies, we found that 45 out of 82 residents had swallowing disorders, but only 10 residents had been referred to a speech pathologist for an evaluation. A swallowing disorder is potentially a very dangerous condition, and it can lead to malnutrition and dehydration because when residents have difficulty swallowing they need to be fed slowly because it takes them longer to swallow a bite of food, and if the staff have a lot of residents to feed or assist at mealtime, they may not take the time that is needed to feed the residents adequately.

  If the staff feed residents too quickly, they will aspirate. That is, the food or liquid, instead of going into their esophagus and into their stomach, goes into their trachea and into their lungs. This is very, very dangerous. When this happens, some people develop what is known as "**aspiration pneumonia**" and some people die.

  Also, if a large amount of food accidentally goes into the resident's trachea (or what we commonly call our windpipe) it can partially or completely block the windpipe, and when this happens people cannot get enough oxygen, and they will die.

  Signs and Symptoms: It is very important for the staff and for families to recognize the signs and symptoms of a swallowing disorder. I will mention just a few symptoms and then refer you to an article that we have published that will be on the NCCNHR website for those of you who want more information.

  1) The resident may say that it is difficult to swallow;
  2) You may notice that food and liquids leak out of the mouth;
  3) Coughing before, during or after swallowing is a very common symptom;
  4) Choking while eating or drinking will occur, especially when drinking liquids like water, tea, and coffee;
  5) They may retain food in their mouths;
  6) They may try to push the NA away or refuse to open their mouth because they still have food in their mouth; they haven't had time to swallow it;
  7) Lastly, they may have repeated upper respiratory infections and pneumonia.

  So this is a condition that needs careful attention because if the residents

cannot swallow, they will lose weight. We have published an article in Geriatric Nursing in which we discuss the "signs and symptoms" of swallowing disorders and what can be done to help residents eat safely.

- **Oral Health Problems** When doing research in nursing homes, we have also found that many of the residents have poor oral health care. Often, residents lose their dentures. Sometimes when they finish eating, they put their dentures on the tray, and the staff do not see them, and they are thrown out with the garbage.
  Also, if residents have lost weight, their dentures may not fit. We have also found that some residents had sores or lesions in their mouths that made it painful for them to eat, and sometimes residents have a very dry mouth, which can be caused by medications such as antihistamines (medication that people take for allergies) and antidepressants.
- **Depression:** Some residents don't eat because they are lonely or depressed, and depression is often not treated in nursing homes.

Sociocultural Factors: I would like to say a few words now about sociocultural factors that contribute to malnutrition and dehydration. By sociocultural factors, I mean, for example, whether or not residents have family or friends who visit regularly, inability of the resident to speak English, and lack of attention to individual food preferences.

We have found that residents who have family or friends who come to the NH and feed them are not as likely to become malnourished and dehydrated. Residents who do not have visitors, who do not speak English, and who are cognitively impaired, are the most at risk. Often, these residents eat only a small amount of their food, they begin to lose weight, the staff order a commercial supplement for them – which many dislike, and they continue to lose weight and die.

Institutional Factors:

There are many other factors, that I call **Institutional Factors,** that can cause malnutrition and dehydration. One of the biggest problems in nursing homes is inadequate staffing and lack of supervision of the nursing assistants at mealtime.

In our research, we have found that NHs are often understaffed. The NAs may have 6-8 people or even more to feed and assist at mealtime.

Sometimes, in their rush to get the trays out and then back on the cart before it goes back to the kitchen, they rush the residents through their meals and feed them too quickly.

Sometimes we have found that residents who need assistance with their meals do not receive help, and they may get little or no food.
The staff feed residents hurriedly, and I emphasized earlier how dangerous this is for residents who have swallowing disorders. Even some residents who do not

have swallowing problems may eat slowly. If the staff feed them too quickly, they may refuse to eat – again, they may push the nurse aide away, and she may take this as an indication that the resident doesn't want to eat, but it may mean that they just can't eat so quickly.

Because the staff have so much work to do, they want to get the trays out and then get them back on the cart. If they don't get the trays onto the cart before it goes back to the kitchen, they have to carry the trays all the way to the kitchen, which adds to their workload. So their priority is to get the trays out and back onto the cart.

We have seen that on some occasions residents were not fed at all. The staff took the tray into the room, but they did not feed the resident, and sometimes, they didn't even take the tray into the room.

Another reason why residents lose weight is because they don't like the food. It is interesting to me that in hospitals, where people stay for only a few days, the patients have a selective menu, but in most NHs where residents live months and years, often they do not have a selective menu; they have little choice of food. If we could not choose what we eat, we would probably not eat very well.

The lack of a choice of food is especially difficult for ethnic residents, such as Chinese and Japanese residents who are not accustomed to eating Western food. These residents often become malnourished.

Lastly, I want to say a few words about pureed food. When residents have poor oral health and/or a swallowing disorder, the staff often order a pureed diet for them. Pureed food is often unappealing, and many residents do not like it. They refuse to eat and continue to lose weight. When they lose weight, the staff call the physician and get an order for a commercial supplement. Many of the residents do not like the commercial supplements, and the supplements destroy their appetite for regular food.

It is important to know that just because a supplement has been ordered, this does not mean that the resident is drinking the supplement. In our research, we found that only 2 out of 40 residents in our study actually drank the full amount of supplement that was ordered by their physician.

- **Dehydration**

  I want to focus now for a few minutes on dehydration – or lack of adequate fluids. We can live for quite a while without food, but most people, especially older people, cannot live too long without water. When we are younger, if we do not drink much water during the day, our kidneys will conserve the water that we have in our bodies, but as we get older, our kidneys lose some of this ability to conserve water, and that is partly why quite often we hear about nursing home residents dying from dehydration.

<u>So how much fluid do residents need each day and why do nursing home residents become dehydrated?</u>

Except in cases where residents have to limit their fluid intake for a medical reason such as in CHF, older people need about 5 to 6 eight ounce glasses of water daily, or about 1,200 to 1,500 cc a day – just to put this in perspective, there are 500 cc in a pint so that would be about 3 pints a day.

There are several reasons why residents do not get enough fluids. In our research, we found, for example, that often fluids were not offered or taken at mealtime, and 50% of the time no fluids were taken at designated nourishment hours, such as in the morning, afternoon, and at bedtime. Some residents went for 15-20 hours without any liquids.

If residents take little or no liquids at mealtime and then do not get something to drink in between meals, they are at great risk of becoming dehydrated. Also, if the staff do not offer fluids when they are feeding the residents, the residents may not eat well. When we take food into our mouths, it causes dryness. Liquids facilitate the chewing and swallowing of food.

6. Participant Question and Answers

Q My Mother was in a nursing home in MD. There is a lack of training for agencies or GNAs in handling my Mom's eating needs. I direct everything to the administration and Director of Nursing. Other residents are having trouble because of the shortage of staff (my Mother is in a skilled nursing section). How do we in-service those involved to the importance of small bites and pureed or liquefied food? Under time constraints, how can people be reached?

A Often, the bites that are given to residents are too big and they can't handle it. Residents can aspirate and die; this happened to my Mom. There should be regular in-service education on this problem. Many older people have problems swallowing. There are 4 phases to the swallowing process, and staff need to be educated as to how swallowing occurs, and how they can help people to eat safely and regularly. Find out if there is a speech pathologist in the facility. There needs to be frequent trainings because of staff turnover. You should go to administrator and ask if the speech pathologist can give an in-service education to staff and families who help the resident eat.

Q This would be helpful to family members who can help feed people.

A This can be taught by a speech pathologist; how to position the person correctly and check the residents' mouth after eating to make sure there isn't food pocketed in the side from bites that are too big – this can cause the resident to aspirate and die.

Q If a resident is dehydrated, medication can end up as an overdose.

A Too many times, water is available but the resident can't reach it, and can't call out for help because his/her lips and throat are so parched.

A One thing we can do is when we know there are residents who can't ask for, but need water, is have nurse aides give them a little bit of water every time they go into the room. You can put a sign at the top of the residents' bed asking nurses who enter the room to please give the resident a little water.

Q My Mom has been in a nursing home for 4.5 years, and has had some of the same problems. My Mom has dementia, is diabetic, and can't speak or walk. I don't know what to do anymore. The Doctor gives orders for her to have snacks between meals, but later, the snacks are still sitting there. I am worried about the times when I am not there to feed her. When people get asked if they want more food and they don't know, the food gets taken away. I have talked to the Director of Nursing over and over. The state doesn't require them to have more than 2 aides on at night to feed. Some nights there is one aide, and she might have to leave the dining room because there is an emergency. Since the last complaint, the Ombudsman has helped us to form a Family Council, and have someone in the dining room all the time while the residents are eating. There needs to be a lot of in-service on how to feed people. The Family Council has been going to the administration about this with the Ombudsman. There has been some improvement, but the improvement might not last, as has happened in the past. Is there a published or in-service video that the nursing home could use?

A Veterans Hospital in MA made a video tape that is very good. This information will be on the NCCNHR website. Keep going to the Director of Nursing and the administration and keep addressing the concerns.

Q I find water sitting on my Mother's bureau at night – she hasn't gotten a sip all day.

A Some facilities don't have enough water pitchers for every resident to have one. Some pitchers are too heavy, and the residents can't hold them.

Q A sign on a bed might help in some situations with the good aides who will notice the sign and follow the directions.

A In one home, residents at risk for pressure ulcers had a certain color tag at the head of the bed. I.e.: blue tag means be sure to offer this person water because she is going to get dehydrated. This makes it easier for the busy staff to remember to offer the resident water during the day. Signs can be institutional, but it might be preferable to dehydration.

7. Expert Speaker Presentation PART II: Dr. Jeanie Kayser-Jones

- **<u>Consequences of Malnutrition and Dehydration</u>**

The consequences of malnutrition and dehydration are severe. Good nutrition and adequate liquids are very important for NH residents. If NH residents do not eat and drink adequately they lose weight, their muscles become weak, they may fall, and they are susceptible to infections such as urinary tract and upper respiratory infections. A urinary tract infection can lead to what is called septicemia (which is blood poisoning from the infection) and this can be fatal.

An upper respiratory infection is also dangerous for an older person. We often hear in the wintertime that some older people die from flu or pneumonia.

Weight loss contributes to pressure ulcers, and if someone is malnourished, it is very difficult to heal a pressure ulcer, which can be very painful.

When residents do not drink an adequate amount of fluid, and if they become severely dehydrated, their electrolytes (especially their NA and potassium levels)

increase, and if these levels become too high, they may die. When someone does not drink an adequate amount of liquids, their kidneys try to conserve the amount of fluid that is in their bodies. Their urine becomes very concentrated – they urinate very little, and their urine is a dark yellow in color. So if the staff or family see that the urine is very dark and has a strong smell, this is a warning signal that the resident is not getting enough to drink.

Without adequate fluids, their kidneys will stop functioning; they go into what is called kidney failure. They will become drowsy, confused, their muscles become very weak, and if they do not receive fluids quickly, they will certainly die, and they can die very quickly. Older people are very fragile.

My Mother became very dehydrated when she was in a nursing facility, and the only reason the staff recognized the problem was because when they tried to take her for a walk in the evening, her legs simply collapsed beneath her; they were literally like rubber. She was so dehydrated that her kidneys had completely shut down.

- **Warning Signs: Malnutrition:**
  1) Weight loss – is the most common sign of malnutrition. Residents should be weighed monthly, and if they are losing weight, they should be weighed weekly. They should be weighed at the same time of day and with the same type of clothing each month. I once observed a nurse aide weighing a resident early in the morning. The resident was incontinent and had on an "Attend pad," that had been on all night long. The NA was weighing the resident without removing the Attend. Ask the staff about the resident's weight, ask to see the monthly weight record.
  2) If the resident is eating less than 50% for 2-3 days, this is an indication of a problem.
     a. Weight loss of 5 pounds in 1 month for those weighing 100 pounds or more and a 2 pound weight loss for residents who weigh less than 100 pounds - is a significant weight loss;
     b. Loss of 7.5% of body weight in 3 months.
     c. If they lose 10% of their body weight in 6 months – this is significant.
  3) You may see a loss of subcutaneous fat (i.e., the skin hangs on the arm; there is no fat underneath the skin).
  4) If you think your relative is malnourished, you can ask the doctor to do some laboratory tests such as serum albumin, hemoglobin and hematocrit, and potassium. You shouldn't have to memorize these tests. Just tell the doctor that you think your relative has been losing weight, and could he/she order some tests to see if your relative is malnourished?
- **Warning signals for dehydration:**
  1. Dry, cracked lips and a dry mouth. I have seen residents whose mouths were so dry that it was difficult for them to talk.
  2. They may complain of thirst – when we are doing research in NHs, residents often ask us for water.

3. Their skin may feel dry and warm to the touch;
4. Urine will be dark, yellow, and have a strong smell.

- **SOLUTIONS- What can families and advocates do?**
  1. Some facilities have "juice carts" with a variety of juices in the corridors – at wheelchair height, so that residents can go to the juice cart and get something, of their choice, to drink. But residents who are cognitively impaired would probably not be able to do this. However, if juices are readily available, the staff and families can offer fluids to the residents more often.
  2. When you visit a facility, make sure that water pitchers, straws and cups are at the bedside and within reach of the resident. Some facilities use heavy water jugs that are difficult for residents to handle. Talk to the staff about this, and see what can be done.
  3. Encourage families to bring in special items of food and liquids. The husband of one resident that I knew came every day and brought his wife a can of fruit juice, and he gave it to her. She drank it all.
  4. If the resident is on a pureed diet, and if they are not eating well, see if you can get it changed to a very soft diet. Pureed diets are unappetizing because they puree whatever is on the regular menu. Residents cannot identify what it is that they are eating. I don't think that I would eat something if I didn't know what it was. There are many soft foods that residents, even without teeth, can eat - such as milkshakes (not commercial ones- a real milkshake), malts, thick cream soups, ice cream, custards, puddings, yogurt, eggnog, frozen popsicles, etc. All of these foods are nutritious and appetizing.

  4a. Visit at mealtime and observe how residents are being fed. Are they in an upright position? The article in *Geriatric Nursing* published in 1999 gives specific instructions as to how residents with swallowing disorders should be positioned when eating.

  5. Provide encouragement to the staff and show appreciation when they do a good job. Many of them work very hard with little pay, and it is difficult for them to feed some of the residents who eat very slowly.
  6. You might suggest that the NH have an in-service education program regularly on nutrition and hydration. One study showed that staff did not have adequate knowledge of the signs and symptoms of dehydration (see Morley, Thomas, & Kamel).
  7. In one facility where we conducted our research, after hearing our findings, the staff met and decided that non-nursing staff (business office, social work, etc.) could assist at mealtime by helping to pass trays, open cartons of milk, and cut the residents' meat, etc. This gave the NAs more time to feed residents.

Many of these suggestions are in the *American Journal of Nursing* article and other articles that are on the NCCNHR website.

I hope these ideas have been helpful, and I am happy to answer any questions that anyone may have, and thank you for listening.

8. **Participant Question and Answers**

Q What if the physician isn't responding when you know you have a resident that is malnourished?

A Go to the medical director. You can always change physicians. Keep pressuring the physician and tell him/her that it is urgent. Call the ombudsman, report it.

A Contact the Licensing Agency.

A Contact the Ombudsman.

Q My friend and my Mom are in nursing homes. Each time I went in, I found something that was wrong, wrote it down, the time of day - everything to describe the situation when I talked with Director of Nursing or the Administrator. After a couple of times of this documentation and meeting with these people, some changes were made. You must DOCUMENT EVERYTHING so that you have a backup when you file a complaint.

A Excellent idea. Retaliation can be a concern, but it is important to document everything.

Q Residents' Rights – one has the right to participate in ones' own care. With regard to costs, what is considered legitimate? The resident is on Medicare.

A My understanding is that if there are drugs that are not covered, you can buy medication at a drugstore that is cheaper, rather than buying it at the Nursing Home drugstore where it is expensive. Find out about Medicare Part D – this is supposed to be available for people in nursing homes.

A With regard to Part A, prescriptions are included. Contact your ombudsman, clarify what is and isn't covered by Medicare. Talk to the shift-counselor – he/she is trained in Medicare and Medicaid and can help you.

9. **Speaker Introduction: (Connie McDonald, Administrator, MaineGeneral Rehabilitation and Nursing at Gray Birch, Augusta, Maine)**

10. **Best Practice Provider: Connie McDonald**

My goal in sharing with you is to set the stage for understanding the culture of nursing homes, to offer ideas on bringing about important changes and to encourage residents and their families to become partners with the nursing home team in achieving these goals.

The first thing I want to say is that my experience with positive changes in nursing facility culture over the years has been truly awesome! I am very proud of all the efforts of our MaineGeneral team and those great folks around the country are making to continually improve our service to our elderly. It has been a great journey and is picking up momentum. I think we all can proudly say that today's nursing home is not that old stereotypical nursing home.

During this journey over the years we have been continually trying to figure out how to take good care of our elderly and have always tried to do our best. As the saying goes, when we learned a better way, we have done a better job. I'm going to add that it is my opinion that we have not always received the best guidance from so-called experts and the regulatory environment over the years. I also want to say that never in all this time have I ever doubted the loving intentions of the majority of care-givers working in long term care. It is truly a gift and a passion for those who dedicate their careers to this

service.

So how did we get to where we are today? Nursing homes were modeled after hospitals and began to function in the same manner as hospitals, transferring nursing practice and other aspects that mimicked the medical model. This of course is very institutional, and certainly is more about tasks and procedures than personal choice and a homey environment. This practice continues in hospitals today. The regulations also mimicked those of the medical model and they also continue to do so today.

I could go on and on about all kinds of things that create conflict when we want a resident-centered culture, but today we are talking about dining with dignity and promoting good nutrition and hydration. You have heard about the risks of poor nutrition and hydration, so I will focus primarily on the dignity part, and share what we've done, as I believe that good intake will result from a good mealtime experience.

Therefore, I'm going to tell you about some of the things that we have been doing over the past few years that have improved the satisfaction of our residents.

- We involve our Dietary staff in the service of the meal, where they directly interact with the residents. As relationships develop between the resident and those preparing the meal, a more personalized service can be accomplished. Little things that residents have asked for can be taken care of ahead of time, adding to the pleasure of the meal service. I have had some former residents ask about Tom, one of our dietary staff, who is just wonderful with residents in the dining room.

- We plan how to meet the needs of those residents requiring hands-on assistance at meals. This means reviewing regularly the staff to resident ratios needed, and setting up several meal services if appropriate. Sometimes this requires a seating plan and assignments for staff to meet the needs of 2-3 residents at the same time. There should never be more residents dining at one time than the staff can adequately assist.

- We involve the residents in planning the menus. Regularly we ask for input both informally and at Resident Council meetings. We get the cooks involved in these discussions, as this relates to personalized service. We mix in special days like Fried Egg Fridays and other fun menu planning.

- We encourage family members to join residents for meals. I usually recommend that a nominal fee be charged because there are some families that will bring large numbers, eat everything in sight and leave without really accomplishing what the goal is: <u>a normal and positive family mealtime interaction</u>. However, we always provide free meals to those we know can't afford to come otherwise.

- We have a variety of frequent small dining activities such as men's

breakfasts, ladies' luncheons, big game pizza parties, and social hours. We include residents in events like staff baby showers. (They sometimes "spill the beans" and let the secret out, but it is great fun.) One of our discoveries was that the same menu can be served in a different location, perhaps on different china, and the meal gets rave reviews, way beyond what we would hear in the dining room. We just smile and say "thank you".

- We require "all hands on deck" for mealtimes. Now this is a key starting point: This means that no nursing employees are taking their breaks during resident mealtimes. And except for emergencies, all other nursing functions such as passing medications and charting are put aside as long as residents need assistance at meals.

  It is important to understand that in the beginning the staff doesn't "get" why this is so important. They see mealtime as an opportunity to accomplish things that they haven't been able to get to. This is the medical model, by the way, and you may have experienced it yourself while in the hospital when there isn't anyone around after trays are passed.

  To help staff think differently about this, we talk a lot about the importance of the mealtime experience in quality of life. We reflect on how important it is for us to have our mealtimes be the way we want them – maybe quiet & peaceful, maybe a social event with lots of others, often somewhere in between and maybe each of these things at different times. Most people come to understand that we want to make choices about our meals and how we have them.

  So as we come to acknowledge that our residents rely on us to help them reach the same mealtime goals that we have, we realize we need to have more flexibility in our practices around meals. So at our facilities we have implemented some changes in our practice as we continue on our journey.

  - We started with our approach to breakfast: we let residents know that breakfast is served in the dining room from 8 – 9:30 and they are free to come anytime. Residents are encouraged to come in their robes if they want to.
  - If residents do not want to get up early, we offer a continental breakfast in the neighborhood family room when they do get up.
  - We offer two main choices at each meal plus an assortment of side dishes like salads, soups and sandwiches. We also keep a personalized list of residents' requests and dislikes.
  - We serve restaurant style, asking residents what their choice is before serving.

We also have looked at our dining areas and had staff from dietary and nursing along with residents and families make suggestions about the décor. We can't afford an expensive make-over, but we have had very creative and homey touches added by these groups. We quite often have a dining room host that visits with residents during the meal, which is greatly appreciated and adds to the sociability of the dining experience. We play "age appropriate" background music. And we encourage staff to sit down with residents and engage in conversation. We have a number of housekeeping staff that enjoy this activity.

We have implemented some other practices that help improve the nutritional intake of our residents as well.

- We pass snacks every afternoon to everyone. A dietary employee does this and once again the relationship that develops is very important for the resident and for satisfaction.
- In our dementia neighborhoods we serve those who need the most assistance right from the kitchenette in their family room. They can see and smell what's being served and feel the familiarity of the smaller dining environment. This helps them relate to the experience of dining.
- We have a nutritional support program that includes
    - A fortified cereal each morning
    - A bran muffin morning snack to improve fiber intake
    - We set up resident-specific nutritional support plans
    - An activity that includes food almost every day, often with the residents preparing it
    - We stock our resident refrigerators with sandwich fillings, custards, milkshakes, peanut butter, lots of ice cream and other nutritious and calorie dense snacks. We encourage the night shift to snack with residents who are awake at night.
    - Some of our neighborhoods have bread-making machines and that is a great activity anytime.
    - During the summer we have extra drink wagons and popsicles for residents and staff to enjoy together.

We've set staff expectations:

- We have dedicated assignments for CNAs and because of this they have a personal relationship with their residents. They know what works best for them.
- We require staff to sit down with residents and to converse with them as they assist them with eating. We expect them to take as long as the resident needs.
- We do not force residents to eat. We offer alternatives, but if the resident refuses we let it go. We later offer nourishing snacks to those who don't eat their meal.
- We have a formal "Feeding Assistant" training program that teaches non-nursing personnel how to assist a resident with their meals. These folks can be a real bonus to a stretched CNA team.

We employ a licensed Diet Technician as our on-sight Food and Nutrition manager. Our consultant Dietitian is in the facility several times a month. We expect these professionals to lead the parade toward good nutrition and hydration. They also provide training to the nursing team at least annually.

To conclude my remarks, I want to encourage residents and families to partner with the nursing home management and staff to bring about desired change. Join the Family Council, ask for a meeting with management, talk about mutual purpose and goals and offer to help. Residents, family members and the terrific people that work in nursing homes all want the same things.

I can virtually guarantee that a collaborative approach of talking about the goals and desires will get you started in the right direction. Appreciating that change is hard and understanding that nursing home staff are often fearful of not meeting regulations or of not getting things done when they are asked to change the way they do things could be the reason they resist. Be supportive of them as they begin to try new ways. Don't expect that everything can change all at once. Often teams of CNAs, or nurses or dietary staff will have to make big adjustments in their normal routines to accomplish the goals. They will be as happy as you are when they see the positive results.

I hope I have been helpful in sharing my experiences and ideas with you today. I thank you for being caring consumers and wish you all much success as you continue your journeys.

Thank you.

11. Participant Question and Answers

Q Are there states with minimum training regulations for staff for feeding residents? In CA there is an 8 hour training required, but that may not be being enforced.

A That is a component of all CNA training. There is at least a minimum, there is no other uniform training as far as I know.

Q There is a series on public TV: "Remaking American medicine, healthcare for the 21st century." It addressed the case of two prominent hospitals where patients died due to the fault of the medical professionals. Relatives of those who die can come together to make positive changes.

A Don't put up with poor care in nursing homes. Find another home. It is important to look for quality. There are more good nursing homes than there are bad ones. Some times you need to look for not-for profit or faith-based.

12. Announcements

- Action Steps – We challenge call participants to get involved in your loved ones' or your own nutrition and hydration.
- The follow-up call is on November 1st; this will be another opportunity to ask questions, or talk about how you have used/shared the information you've heard today.
- We look forward to having you report back to us, so that we can celebrate successes and make additional suggestions as necessary.

13. Closing, Wrap up, Announcements

- Please fill out the evaluations you will receive via email or mail. Please make sure that if people joined you on the call, you are able to get them an evaluation and have it returned to NCCNHR.
- The next Educational Call is on November 8th on Incontinence & Quality Care. You need to register for that call if you are interested in participating.
- We ask that ombudsmen try to have at least one or two active family members or residents with them on these calls.
- Thank you for your time. Good afternoon.