



Kansas Advocates  
for  
Better Care

# **Preventing Malnutrition of Adult Care Home Residents**

*Funded by a 1998 grant from The Kansas Health Foundation*

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## INTRODUCTION

- ◆ Malnutrition, a common problem among nursing home residents, contributes to:
  - higher rates of infection
  - an impaired immune response, and
  - the development of pressure sores.
- ◆ Eating habits are highly individualized, and eating problems often occur due to ... interacting factors, such as poor oral health, medications, clinical conditions and lack of attention to individual food likes and dislikes.
- ◆ By educating nursing assistants on how to provide individualized care at mealtime, and ensuring that an adequate number of staff are available to assist those who need help, mealtime rather than being a task-oriented procedure will be an individualized, pleasant social event.

*J.K. Jones, "Mealtime in Nursing Homes - The Importance of Individualized Care." Journal of Gerontological Nursing, March 1996, p. 31.*

- ◆ Cognitively impaired residents sometimes exhibit challenging mealtime behaviors that require skillful nursing intervention.
- ◆ Commonly used strategies such as mixing the food together and totally feeding the resident or, conversely, labeling the person uncooperative and providing little supervision and assistance, will compromise the resident's dignity and nutritional intake. Strategies that promote independence, while at the same time providing adequate supervision and assistance within a pleasant social context, can enhance nutritional intake and enjoyment of meals.

*J.K. Jones & Ellen Schell - "The Mealtime Experience of a Cognitively Impaired Elder: Ineffective and Effective Strategies" Journal of Gerontological Nursing, July 1997, p. 39*

This publication is provided to update caregivers on techniques of observing and intervening in situations of poor nutrition. The section on the "preferred setting" describes the desired outcomes. The "nutritional risk factors" focus attention on residents prone to poor nutrition. The section on "interventions" provides general guidance for overcoming some difficult dining situations. The section on "accurate record of intake" emphasizes the need to give attention to actual intake. The accurate record helps caregivers track and anticipate changes in the health of residents.

## HOW MUCH DO YOU KNOW ABOUT MALNUTRITION IN ADULT CARE HOME RESIDENTS?

- 1) The definition of poor nutritional status includes:
  - A) Dehydration.
  - B) Obesity.
  - C) Alcohol abuse.
  - D) Vitamin deficiencies.
  - E) Involuntary weight loss.
  
- 2) Commonly used drugs with significant potential to adversely impact nutritional status include:
  - A) Diuretics.
  - B) Aspirin.
  - C) Laxatives.
  - D) Cardiac glycosides (i.e. digoxin).
  - E) Theophylline.
  
- 3) Eating difficulties experienced by nursing home residents
  - A) Are best treated by the placement of a feeding tube.
  - B) May be manifest as an inability to recognize that food is present and should be eaten.
  - C) May be caused by upper extremity dysfunction.
  - D) Are minor problems affecting few residents.
  - E) May be associated with difficulty with one or more phases of swallowing.
  
- 4) Depression
  - A) Is frequently unrecognized in elderly patients.
  - B) Is a leading cause of significant weight loss in the elderly.
  - C) May be correlated with deficiencies of Vitamin B12, Folate or Thiamin.
  - D) Is often treated with drugs which affect appetite, and salivary gland function.
  - E) Has minimal impact on nutritional status.

- 5) Signs of difficult swallowing include
- A) Coughing.
  - B) Clearing throat.
  - C) Leaning into the table.
  - D) Frequent swallowing.
- 6) One approach to decrease a resident's combative behavior at mealtime is to turn on the TV to distract him/her. **TRUE** **FALSE**
- 7) A resident who eats too slowly should be served before residents who eat at a normal rate. **TRUE** **FALSE**
- 8) To increase independence in eating, the *hand-over-hand* approach benefits the resident by providing:
- A) Reassurance and comfort.
  - B) Assistance when needed.
  - C) Allowing independence when appropriate.
  - D) Protection from self-harming behavior.
- 9) A dining room chair is better than a wheelchair for eating because it
- A) Stabilizes the resident's hips.
  - B) Can be pushed closer to the table.
  - C) Normalizes dining.
  - D) A & B.
  - E) B & C.
  - F) A, B & C.

Answers: (1) A, B, C, D, E; (2) A, B, C, D, E; (3) B, C, D; (4) A, B, C, D; (5) A, B, D; (6) F; (7) T; (8) B, C; (9) F

## I. DINING ATMOSPHERE: The Preferred Setting

AREA OF CONSIDERATION	RECOMMENDATIONS
<i>PHYSICAL DINING ENVIRONMENT</i>	<ol style="list-style-type: none"><li>1) Provide an attractive, functional, home-like setting.</li><li>2) Use solid furniture:<ul style="list-style-type: none"><li>- Chairs with arm rest.</li><li>- Tables high enough for wheelchair.</li></ul></li><li>3) Provide good lighting - no glare, no shadows.</li><li>4) Avoid clutter.</li><li>5) Limit distractions.</li></ol>
<i>SOCIAL DINING ENVIRONMENT</i>	<ol style="list-style-type: none"><li>1) Promote independence in feeding.</li><li>2) Allow choice in menu and seating companions.</li><li>3) Arrange seating to promote conversation</li><li>4) Provide separate dining area for:<ul style="list-style-type: none"><li>- Independent residents</li><li>- Disruptive residents</li><li>- Restorative dining program residents</li></ul></li><li>5) Have resident wear dentures, glasses, hearing aids.</li><li>6) Have resident properly dressed for meals.</li><li>7) Avoid nursing measures during mealtime.</li></ol>
<i>ATTITUDES TOWARD DINING</i>	<ol style="list-style-type: none"><li>1) Promote independence rather than “doing for.”</li><li>2) Encourage independence and self-esteem.</li><li>3) Use respectful, kind approach.</li><li>4) Focus on the resident. Listen well. Anticipate needs.</li><li>5) Avoid long waiting times in dining area.</li><li>6) Proceed in unhurried manner.</li><li>7) Interact with the diners.</li></ol>
<i>CLINICAL CONCERNS</i>	<ol style="list-style-type: none"><li>1) Refer residents with eating problems for evaluation.</li><li>2) Train staff in methods that foster independence.</li><li>3) Carry out professional recommendations at all meals:<ul style="list-style-type: none"><li>- Positioning</li><li>- Adaptive equipment</li><li>- Behavioral approaches.</li></ul></li></ol>

ADA, “Dining Skills,” p. 202.

## II. NUTRITIONAL RISK FACTORS

(For Residents Prone to Malnutrition)

- ◆ Undesirable weight loss of five pounds or 5% in one month.
- ◆ Refusal to eat / drink, or marked change in intake.
- ◆ Development or deterioration of pressure ulcers.
- ◆ Chewing and/or swallowing difficulty.
- ◆ Impaired mental status.
- ◆ Conditions that require tube feeding.
- ◆ Abnormal laboratory values, such as:
  - Serum albumin < 3.5 g/dL
  - Total lymphocyte count < 1500 mm<sup>3</sup>.
- ◆ Diagnoses that may alter nutritional status, i.e., cancer, renal failure, alcoholism, liver disease, CVA, muscular or neurologic degeneration (M.S., Parkinson's), DM, HTN.
- ◆ Deterioration in ADL (activities of daily living) function.
- ◆ Grossly underweight.
- ◆ Increased metabolic needs caused by such problems as:
  - Severe trauma, burns, infection,
  - Recent fractures or surgery,
  - Protracted fever.
- ◆ Protracted nutrient losses caused by such problems as:
  - Malabsorption syndromes,
  - Short-gut syndromes/fistulas,
  - Renal dialysis.



*Wixted, D., "Clinical Nutrition Management," 1991.*

## Sample Nutrition Risk Screen from “Clinical Nutrition Management”

INSTRUCTION: Upon admission, assess the resident status in the clinical condition parameters listed below by assigning the corresponding score which best describes the resident in the appropriate column. Add the column of numbers to obtain the Total Score. If the total score is 8 or greater, the resident should be considered at risk for malnutrition. A prevention protocol should be initiated immediately and documented in the care plan.

*Wixted, D., “Clinical Nutrition Management,” 1991.*

	PARAMETER	SCORE	RESIDENT STATUS/CONDITION
A.	LEVEL OF CONSCIOUSNESS/ MENTAL STATUS	0 1 2 3	Alert-oriented x3. Responds readily, would voice discomfort Slow to respond - disoriented x 1 Lethargic - disoriented x 2 Comatose, depressed, constant wanderer - disoriented x 3 (circle appropriate response)
B.	SELF-FEEDING ABILITY	0 1 2 3	Feeds self Feeds self with verbal cues Assisted by staff Fed by staff or tube fed
C.	WEIGHT STATUS	0 1 2 3 4	Stabile within last 3 months Explained weight changes (i.e., edema, diet, surgery, etc.) < 5% weight loss in 1 month or < 10% in past 6 months > 5% weight loss in 1 month or > 10% in past 6 months Weighs less than 85 lbs.
D.	ORAL HEALTH STATUS	0 1 2 3	Teeth/dentures - good condition Lost dentures/several missing teeth/sore gums (circle appropriate response) Edentulous Difficulty swallowing/frequency choking or difficulty chewing
E.	PHYSICAL ACTIVITY	0 1 2	Goes out Able to get of of bed/chair, but does not go out Bed or chair bound
F.	BODY MASS INDEX (BMI)	0 1 2 3	Body Mass Index (BMI) (weight in kg) / (height in M) 2 BMI greater than or = 23 BMI 21 to < 23 BMI 19 to < 21 BMI < 19
G.	MEDICATIONS	0 1 2 3	Respond below based on the following types of medications: Chemotherapy, Steroids, Glycosides, Cardiac, Psychoactives, Diuretics, Antibiotics, Overuse of Antacids or Laxatives. None currently taken Takes 1 of these drugs Takes 2 of these drugs Takes 3 or more of these drugs
H.	TREATMENTS	2	Receives 2 or more of the following treatments: Radiation Therapy, Dialysis, HOB elevated majority of the day due to medical necessity, O2 Therapy.
I.	MISCELLANEOUS	1 2 1 3	History of pressure ulcers in last 180 days. Conditions that would place resident at higher risk, i.e., peripheral vascular disease, COPD, dementia, diabetes, edema, hip fracture, chronic renal failure, terminal cancer, sepsis. Exhibits signs of malnutrition, i.e., pale skin, poor skin turgor, dull eyes, cracked lips. Currently has a pressure ulcer.
J.	PREDISPOSING CONDITIONS	1 2 3	Respond below based on the following list of diseases: Osteoporosis, Diabetes, COPD, Anemia, Arthritis, Cancer, Kidney disease, Malabsorption syndrome, Alcohol Abuse, GI Surgery, Prolonged Nausea, Diarrhea, Vomiting, Depression. 1 present 2 - 3 present 4 or more present
	<b>TOTAL SCORE</b>		Total score above 8 represents significant or potential risk.

### III. PRACTICAL INTERVENTIONS

#### *EATING-DISABLED ADULTS*

- ◆ Have the resident sit in an upright position up to the table. Make sure the hips are at a 90-degree angle with feet supported on the floor.

The caregiver can assist by putting a hand over the resident's hand using a *hand-over-hand* approach. The *hand-over-hand* approach begins with assisting the resident through the entire process of scooping food onto the utensil and directing the utensil to the mouth. As progress towards independence is made, steps are omitted.

- ◆ Retraining the hand-to-mouth eating pattern is done by helping the resident in the following ways:
  - Step 1: Put spoon in the resident's hand.
  - Step 2: Place hand over the resident's hand to help hold the spoon.
  - Step 3: Direct the spoon to the plate, fill the spoon.
  - Step 4: Direct the filled spoon to the lips.
  - Step 5: Touch the lips to cue the resident to open mouth.
  - Step 6: Repeat steps 2 through 5, omitting - "direct the filled spoon to lips."
  - Step 7: Help the resident fill the spoon again, using *hand-over-hand* assistance. This time, expect the resident to carry the filled spoon to the mouth with the caregiver holding onto the resident's wrist or forearm for assistance in lifting.
- ◆ Gradually reduce the amount of physical assistance while using only verbal cues to direct the resident's eating. Do not rush the resident.
- ◆ If the resident stops and needs help to restart eating, use the *hand-over-hand* approach and then allow the resident to eat independently. For residents with memory problems, brain injury or strokes, it is common to forget the individual steps of eating. Help the resident remember the steps - DO NOT DO IT FOR THEM. Providing too much assistance will actually make them less able to help themselves. Fade or gradually remove prompting so that the task can occur spontaneously. Often when the *hand-over-hand* approach is used to help the resident start to eat, the resident can continue parts of the eating process independently.
- ◆ Use popsicles, cookies and snacks between meals to maintain the hand-to-mouth pattern. Repetition is necessary and may take several weeks or months to grasp.
- ◆ Train and allow the resident to brush teeth, wash face, comb hair and shave. These activities use motions that are similar to eating.

ADA, "Dining Skills," p. 25 - 26.

- ◆ Help the resident build social confidence and reinforce self-esteem. Use the meal as a topic of conversation. Involve the resident in mealtime conversation.
  - a) Identify the food and discuss the flavor.
  - b) Talk about the client's interests, such as gardening, cooking or handiwork.
  - c) Avoid watching TV or ignoring resident while having private conversations with other caregivers or visitors.
  - d) Talk about favorite foods.

### ***DECREASED DESIRE FOR FOOD***

- 1) Determine food preferences.
- 2) Evaluate possibility of visual or auditory over-stimulation with residents who have dementia.
- 3) Praise resident for eating well.
- 4) Encourage the resident to just take a bite of each food.
- 5) Offer small snacks or nutrition supplement. (**NOTE:** if a snack or a supplement is given too close to the mealtime, the resident's appetite will be reduced for the meal.)
- 6) Provide opportunities for increasing physical activity level, including chair exercises, prior to meals.
- 7) Offer foods one at a time.
- 8) Discourage the drinking of large quantities of liquids just prior to, or during the meal.
- 9) Evaluate medications; digoxin often causes decreased appetite.
- 10) Depression can be a cause of decreased appetite.

## ***CONSTIPATION***

- ◆ Encourage adequate fluid intake. The best sources of fluid are water and fruit juices. Provide 6 to 8 (eight ounce) glasses, 2 quarts, or 1200-2000 cc of fluid each day. Additional fluids are recommended when fiber supplements are used.
- ◆ Identify if adequate fluid is being consumed by recording the amount of fluid that is consumed, and by observing that urine is pale yellow in color.
- ◆ Increase fiber in diet.
- ◆ Add prune juice or prunes to diet.
- ◆ Provide opportunities for exercise.
- ◆ Establish routine schedule for toileting and encourage prompt response to the urge to defecate.
- ◆ Identify potential food and medication interactions when using laxatives.

## ***SKIN SUSCEPTIBLE TO INJURY***

**NOTE:** Residents who are immobile, confused, thin and incontinent are susceptible to the development of pressure sores.

- ◆ Encourage resident to consume all food and supplements.
- ◆ Handle with care to prevent skin tears, especially when dressing and bathing. Choose soft, stretchy clothing.
- ◆ Avoid using tape on skin.
- ◆ Position properly for mealtime.
- ◆ Reposition resident to relieve pressure every two hours, or even more frequently.
- ◆ Pad pressure points, such as elbows, coccyx and heels.
- ◆ Apply lotion to skin. Do not rub or massage a reddened area, as rubbing may actually promote the development of a pressure sore.
- ◆ There may be need for additional protein, vitamin C and zinc.

*ADA, "Dining Skills," pp. 33, 37.*

## ***DEHYDRATION***

**NOTE:** Research indicates only 75% of fluids are consumed at meals and with medication. Most people do not make up the other necessary 25% during the day.

Fluid intake is adequate when the urine is pale yellow in color.

The thirst response is frequently impaired in the elderly, especially with central nervous system disorders, such as stroke, head trauma, Alzheimer's and Parkinson's. This impairment means that the resident will not seek out, ask for, or even readily accept liquids. The caregiver may wish to organize "tea time" or a "coffee club" when a neighbor, friend or pastor could stop by on a regular basis for something to drink and friendly conversation. Inadequate fluid intake can result in confusion.

The pinch test for skin turgor may be an unreliable indicator for dehydration in the elderly. If this test is used, use only the skin on the forehead or sternum. Pinch *gently*. If the resident is well hydrated, the skin should go back into place within two seconds.

- ◆ Encourage adequate fluid intake. The best sources of fluid are water and fruit juices. Other sources are popsicles, ice cream, gelatin, broth soup, fruit sauces and ice chips. Provide 6 to 8 (eight ounce) glasses, two quarts or 1200 - 2000 cc of fluid each day.
- ◆ Offer choice of liquids.
- ◆ Offer small amounts of fluid every hour.
- ◆ Record fluid consumed and urine output.
- ◆ Encourage adequate protein intake.



*ADA, "Dining Skills," p. 38.*

## ***POSITIONING***

Providing good positioning at mealtimes is essential. Positioning provides the framework on which other interventions may be added to promote independence in eating as well as to make the resident more comfortable during mealtime.

It is extremely important that the resident be positioned properly for eating and drinking. The resident who is not positioned may choke or aspirate (inhale food or fluid into lungs).

The trunk should be in an upright position, hips bent as closely to a 90-degree angle as possible, the head held forward with chin down slightly. The knees and ankles also need to be at 90-degree angles, with the feet supported squarely on the floor to maintain this position.

Many problems that residents have with eating or drinking result from illness or weakness that cause poor sitting balance. A stroke is one example of an illness that often requires the caregiver to pay special attention to the resident's position.

## ***MOUTH***

The mouth is the beginning of the gastrointestinal tract which is used for digestion and absorption of food and nutrients. In the mouth, glands produce saliva. Saliva contains enzymes that begin the digestion process by moistening the food. Chewing also breaks up solid food into smaller pieces. Loss of teeth, common among the elderly, limits dietary intake. The tongue contains taste buds. A variety of diseases and drugs can alter the sense of taste. The health of the mouth has a significant impact on the ability to eat.

Indications of mouth problems: bites utensils, tongue, cheek; dry mouth/cracked lips; food/liquid comes out of nose; sores in mouth; coated tongue; missing teeth; tongue thrust; others.

**NOTE:** Tissue repair proceeds more slowly in the elderly, and healing can be delayed when vitamin C deficiency and protein deficiency are present, and when a source of infection is allowed to remain in the oral cavity.

**NOTE:** Many people without teeth are able to eat a wide range of foods, including tender meats, canned fruits and vegetables, and bread.  
Raw fruits and vegetables may be difficult to chew.

## ***SWALLOWING***

Dysphagia is any problem encountered in chewing or swallowing foods, beverages or medications. The incidence of dysphagia appears to be on the rise as the population of the United States ages. Dysphagia affects 40 to 65% of residents in extended care facilities. Dysphagia is not a disease; instead, it is a symptom of an underlying condition that affects the swallowing process. Dysphagia is best assessed and treated under the direction of a speech-language pathologist.

### **THE SWALLOW**

Swallowing is a complex process that involves more than 30 muscles, and 5 of 12 cranial nerves. The swallowing process is divided into four stages.

- 1) *Anticipatory stage:* During this stage, decisions are made regarding the type, rate and size of bite. This stage is voluntarily controlled.
- 2) *Oral stage:* This stage consists of two phases which are voluntarily controlled.
  - a. *Preparatory phase* results in the food being chewed up and formed into a ball or bolus.
  - b. *Lingual phase* results in the tongue moving the bolus to the back of the mouth.
- 3) *Pharyngeal stage:* In this involuntary stage of swallowing, the airway is protected as the bolus moves past the pharynx and into the esophagus.
- 4) *Esophageal stage:* The bolus passes through the esophagus and into the stomach in the involuntary stage. Liquids usually descend in three to five seconds, and solids in eight to twenty seconds. As this stage ends, the *oral preparatory stage* may begin again.

General warning signs indicating swallowing problems include:

- ◆ Coughing before, during or after swallowing food, liquids or medications.
- ◆ Need to swallow three or four times with each bolus.
- ◆ Frequent throat clearing.
- ◆ Hoarse, breathy voice or gargly breathing.
- ◆ Feeling of something caught or sticking in throat.
- ◆ Drooling.
- ◆ Pocketing of food in mouth.
- ◆ Repetitive rocking of tongue in mouth.

General warning signs of aspiration pneumonia include elevated temperature and fatigue. It is possible for an older person to have pneumonia *without* the elevated temperature.

Aspiration, which refers to foreign materials taken into the lungs, is the most serious health risk from dysphagia. Residents can aspirate foods without any external signs.

*ADA, "Dining Skills," pp. 73-74.*

## ***SHAKES OR HAS TREMORS***

- ◆ Reduce the distance from the plate to the resident's mouth.
- ◆ Position so that the resident's elbows and forearms are supported on the table. Adjust table height to support elbows. The table height may need to be adjusted to allow the elbows to rest on the table.
- ◆ Provide foods that are easy to handle. Creamed peas and rice pudding are easier to scoop up onto silverware than are plain peas and rice.
- ◆ Encourage independence with the appropriate use of assistive devices.
- ◆ Evaluate benefit of using soft neck collar.
- ◆ Consider a seating arrangement that gives the resident some privacy if tremors cause embarrassment.

## ***RANGE OF MOTION***

Degree of reduction in manual dexterity is a good predictor of degree of dependency. About 60% of elderly in nursing homes are able to eat independently. The other 40% either require assistance, or are fed by vein or tube.

In general, the number of elderly who require help increases with age, both in and outside of nursing homes. Losing the ability to eat independently not only detracts from the quality of life, but also is associated with a higher death rate. Certain interventions and assistive devices can increase eating independence.

Difficulties include inability to move: elbow, wrist, hand, neck, shoulders.

## ***MENTAL STATUS***

Mental status has a significant impact on the ability to eat independently as well as on the desire to eat and, ultimately, on nutrition health. Several studies have identified 10% of elderly residents with malnutrition to have psychiatric problems as the main cause. As many as half of all nursing home residents have significant cognitive disabilities. Mental changes that occur with disease, such as Alzheimer's Disease, interfere with the ability to remember how to eat as well as affect the response to the sense of hunger and fullness.

The drugs that are used to treat psychiatric disorders often alter appetite. It is difficult to differentiate whether the change in appetite is due to the drug, or to an improvement in the psychiatric state of the resident.

Indications of altered mental status:

- combative
- throws food
- over-chews food
- eats non-edible things
- forgets to eat
- expresses inappropriate emotion
- paces
- shows paranoia
- spits
- will not go to dining room

## ***SENSORY***

The body's senses have an impact on the ability to eat independently as well as on the enjoyment received from eating. The sensory response to food is complex. In addition to smell and taste, the brain coordinates sensory signals for sight, temperature and texture, and interprets them as a single flavor. Sensitivity to taste and smell usually decreases with aging. About one-third to one-half of a person's taste buds die by age 70 years. Taste is also affected by denture wearing, smoking and zinc deficiency. Zinc supplements improve taste only when there is a zinc deficiency, which is uncommon in the United States.

Sensory problems include:

- sense of temperature
- sense of texture
- hearing loss
- vision loss
- sense of taste
- sense of touch (drops things)

*ADA, "Dining Skills," pp. 109, 123.*

## ***SANITATION AND SAFETY***

The greatest health risk from food is bacterial contamination. About one-third to one-half of all diarrhea cases in North America are due to food-borne organisms. The elderly can suffer greatly from illness caused by certain food-borne bacteria.

It is usually not possible to tell from taste, smell or sight that eating a particular food poses a risk. Therefore, sanitation and safety guidelines, as well as regulations for health care facilities, have been established.

Handwashing can reduce the spread of bacteria both in food handling and resident contact. Hands need to be washed before and after contact with residents. Wear gloves when anticipating contact with blood, body fluid, tissues, mucous membranes or contaminated surfaces, or when breaks in the skin are present. Bloodborne pathogens may enter the body through open cuts, nicks and skin abrasions, even dermatitis and acne, as well as the mucous membrane of the mouth, eyes or nose. Hands must be washed even when gloves have been used. If skin comes in contact with blood or body fluid contaminated with visible blood or human tissues, wash immediately with soap and water.

Safety concerns:

- food temperatures
- hoarding food
- mixing food
- taking food or utensils from others

## ***SYRINGE-FEEDING SAFETY***

The use of feeding syringes is appropriate only if the resident has had a comprehensive assessment which clearly indicates the cause for use of a feeding syringe. Using a feeding syringe should be a last resort.

- ◆ After professional consultation, when the decision is made to use a syringe because the resident will not take food/liquid any other way, remember to:
  - Consider that residents have good and bad days with levels of eating ability.
  - Offer food with spoon before using syringe.
  - Obtain instructions on safe use of syringe before feeding a resident.
- ◆ Use the smallest syringe practical to avoid overfilling the mouth and to reduce the risk of aspiration.
- ◆ Begin meal with *COLD*, slightly thick liquid to stimulate muscles used in swallowing.
- ◆ A liquefied, pureed diet may be needed to ease use of syringe. When liquefied, pureed diet is used, larger volumes are required to provide the same nutrients.
- ◆ Keep resident's head from tilting back. Chin should be at a 90-degree angle or less.
  - Insert tip of syringe gently into mouth towards cheek on the dominant side of the mouth.
  - If feeding stroke resident, present food to unaffected side of mouth. It may be helpful to turn resident's head towards affected side.
- ◆ Squeeze bulb gently to force *small* amount of food from tip to allow resident to initiate sucking reflex. If using plunge-type syringe, offer no more than one teaspoon of food at a time.
- ◆ Check to make sure food is swallowed. Do not introduce more food until rising of larynx (Adam's apple) is observed.
- ◆ Keep resident's head elevated for 30 minutes after feeding.
- ◆ Disposable syringes used for feeding need to be discarded and not reused. Reusable feeding syringes must be sanitized following manufacturers guidelines, following each use.
- ◆ Keep the resident's dignity a priority.

*ADA, "Dining Skills," p. 144.*

## IV. ACCURATE RECORD of INTAKE

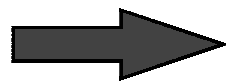
Directions to Certified Nurse Assistants and Caregivers:

1. Refer to diagrams. Add up points for food eaten.
2. Put a zero with the total points to get the percentage (%) eaten.
3. Record all meals in percentages (%).
4. Report to the charge nurse if a resident eats less than 75%, and offer the resident a substitute.

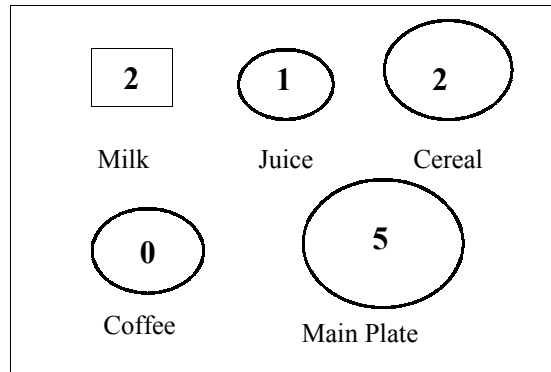
When totaling points, divide the main plate points as follows:

Breakfast: eggs = 3 points; toast = 2 points

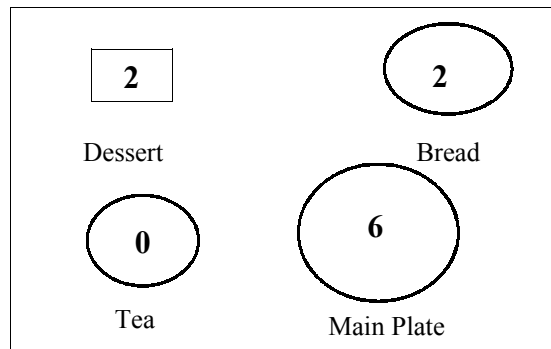
Lunch and dinner: meat = 2 points; vegetable = 2 points; starch = 2 points.



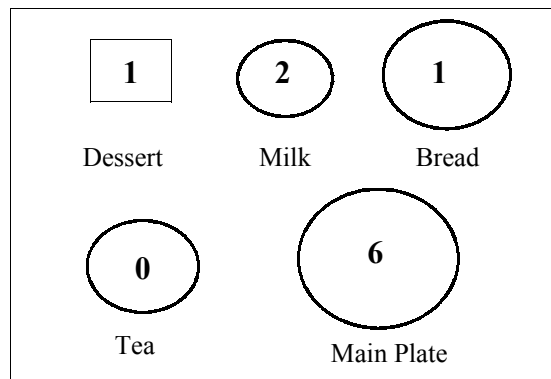
**Breakfast**



**P.M. Meal without Milk**



**P.M. Meal with Milk**





**KABC** is a statewide, non-profit organization  
founded in 1975 as **KINH**.

Our mission is advocating quality long-term care  
in Kansas' adult care homes.

Our volunteer Board of Directors includes consumers,  
health care professionals and business leaders  
from across Kansas.

**KABC** provides consumer information  
on each nursing home in Kansas.

Visit, call or write us at

**Kansas Advocates for Better Care**

913 Tennessee, Suite 2  
Lawrence, Kansas 66044

#### **PUBLICATION REFERENCES**

American Dietary Association, *"Dining Skills: Practical Interventions for the Caregivers of the Eating-Disabled Adult,"* 1994.

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