EXECUTIVE Summary

The View from the Other Side of the Table

NANCY COLLINS, PhD, RD, LD/N

"We would like your permission to insert a feeding tube for nutrition and hydration. Have you ever heard of something called a PEG tube, Mrs. Collins?" This must be a bad dream. I swallow very hard and try to focus. Everything is blurry and moving quickly and slowly at once. Usually this scene is much different. On most days, I say, "Hello, my name is Dr. Collins, and I would like to discuss the possibility of a feeding tube with you." But today the situation is reversed, and the nurse is handing me a permission slip and asking me to sign a consent form for my father's feeding tube. Suddenly, the tables have turned, and the view from the other side is very different.

In the past year, I have had 2 immediate family members die and a third nearly die. I have spent most of the last year as a visitor rather than a healthcare provider. In fact, I have been a visitor to 5 different acute care hospitals in 2 states, a long-term acute care hospital (LTAC), a skilled nursing facility (SNF), a hospice, and 2 rehabilitation units. Day after day, I have had the opportunity to observe as an anonymous bystander, carefully watching the staff members go about their daily activities. Some of the things I saw made me proud to be in healthcare, but others made me cringe. And many simply perplexed me and left me wondering if I had gotten mixed up in a bad episode of "The Twilight Zone."

THE STAFF THAT TALKED TOO MUCH

On average, I spent 12 hours each day in these various facilities and spoke to the staff at length on a range of topics. The conversations ran the gamut from mundane matters like the weather to life-and-death matters like life support and do-not-resuscitate (DNR) orders. What surprised me was how readily the staff told me all the problems they faced as employees of the facility. When I asked for something as simple as ice chips, I was told I would have to wait, because, as usual, they were understaffed. When I asked for an extra pillow, the nurse apologized and said she was merely an agency nurse and had no idea where the pillows were kept—or anything else for that matter. When I asked a nurse if she would be working tomorrow, she exclaimed she would be, because the pay was so low she had no other choice than to work extra shifts despite being exhausted. When I asked to speak to a supervisor, I was told the nasty supervisor was fired because she had a fight with a nurse. I have never heard so many complaints and excuses in my life. But the winner as the most common excuse for poor care, lack of follow-up, and general rudeness was, "We are extremely understaffed." Keep in mind that most of these healthcare workers told me this very apologetically, as if they were at their wit's end. They kindly expressed how very sorry they were but that they were doing their best in an extremely difficult working environment.

The consequences of this type of behavior cannot be underestimated. Hearing this many times over the course of each day does not instill confidence in the level of care rendered. Nursing homes are under siege from litigation alleging wrongful death, negligence, and other charges. Derogatory statements from the clinical staff add

Feeding assistance that can/should be provided by all facility staff, volunteers, and family[1]:

- Verbal prompting (eg, "pick up your spoon and take a bite," "swallow")
- Encouragement (eg, "how about trying a little of this meatloaf?")
- Tray setup/assist (eg, unwrapping food, opening containers, cutting food, rearranging food/fluid for easier access)
- Social interaction throughout the mealtime period
- Meal tray substitutions if preferred by resident
- Extended access to tray up to 1.5 hours per meal
- Compliance with resident preferences for dining location and type of assistance.

Feeding assistance that can/should be provided by nurses/nursing assistants, trained feeding assistants, and family[1]:

- Physical guidance (eg, aid puts food on spoon and guides resident's hand, but resident feeds self)
- Proper positioning for eating.

Feeding assistance that can/should be provided by nurses/nursing assistants[1]:

- Physical feeding (eg, aid feeds resident, only if necessary).

fuel to the fire. Attempting to develop rapport with patients and family members by apologizing for the problems of the facility is harmful. The facility staff must present a united front. There must be proper venues to express frustration and air grievances. In long-term care, the residents have resident council meetings to discuss issues; the staff should have similar staff council meetings. It is understandable and even expected that staff members are not going to agree with every management decision and may have ideas on how to run things better. Ideas, complaints, rants, and raves should be encouraged. Some facilities award prizes for the best new ideas from staff, while others have hotlines, support groups, or monthly meetings. There are many ways to integrate staff/management communication, but none of those ways ever involves complaining to the patients and their families. The family members do not feel badly for the staff and pity their poor work life; they worry about the detrimental effect the facility is having on their loved one.

HELP ME TO HELP YOU

Since I was spending so much time in these facilities and the staff took every opportunity to express how understaffed they were, it seemed obvious that I could be of use in matters like getting ice chips, refilling the water pitcher, preparing the wash basin, and assisting with feeding. I was more than happy to do what I could, and, frankly, I was relieved every time I could do something without having to infringe upon an already frazzled staff member. In some facilities, my assistance was encouraged and appreciated. But in 1 particular facility, the ice machine and water dispenser were behind locked doors along with every other supply one might need. It was like Fort Knox in this place. I wondered about the home-like environment when I could not even have access to a cup of water without a nursing escort. This begs the question, what is expected of visitors?

The feeding of residents is 1 of the most time-consuming tasks for long-term care staff. Almost as soon as breakfast is completed, it is time for morning snacks, quickly followed by lunch, more snacks, dinner, and, finally, evening snacks. Six meal occasions each day can strain any staff, particularly as the acuity level of residents increases and more residents require various degrees of assistance. The role of visitors in feeding residents is an issue that is not often addressed.

The key to understanding this issue is to recognize that the catch-all term "feeding residents" encompasses a range of activities, including social interaction, verbal prompting, and appropriate levels of physical assistance with eating. The value of socialization during mealtime has been well studied. People tend to eat more when engaged in conversation and having an enjoyable time. Isolation and loneliness may contribute to poor meal consumption. It is for this reason that residents are encouraged to eat meals in the dining room rather than alone in their rooms. Encouraging visitation during mealtime is 1 strategy that can help visitors play a role in care and may even help combat poor intake.

Verbal prompts and cues are another strategy that family members and visitors can be taught. Saying things like, "You're doing great—take a few more bites" can help residents focus on the meal. Verbal cues are especially helpful for residents with loss of cognitive function who may have trouble staying with the task of eating. The visitor may find this role rewarding if his or her loved one does increase meal intake as a result of this action. Cues to keep a chin tucked in or take a drink between a certain number of bites can also be useful. Each resident has special mealtime requirements, and by communicating these needs to visitors and encouraging their engagement during meals, intake may improve.

Even physical assistance with eating can span a gamut of activities. Visitors can set up the tray, open containers and packets, and cut food into bite-sized pieces. In addition, they can be taught

Circle Reader Service Card No. 11

techniques like mirroring. Mirroring involves making an eating motion and encouraging the resident to copy this motion. The highest level of assistance is actually spoon-feeding residents. While this task is best left to trained staff members, there are still many areas in which family can participate.

STAFF AND VISITORS AS 1 UNIT

With some thought and planning, polices and procedures can be put in place to allow visitors to play an active and useful role during mealtime. The alliance of visitors and staff is a win-win situation. Visitors can have a more productive and fulfilling experience by partaking in some level of care, while staff can get a few more hands on deck during busy meal periods. Expectations must be communicated to visitors in order for this team approach to work. It is far more beneficial to explain to a visitor that he or she can help with the healing process by visiting during meals rather than apologizing that the facility is understaffed. As the saying goes, it is not what you say but how you say it. So the next time you speak with a visitor, remember that eventually you will be on the other side of the (dinner) table as the visitor. Remember to say the type of things that would make you feel comforted and reassured if your parent was the patient. ■

Reference

1. Castellanos VH. Food and nutrition in nursing homes. *Generations*. 2004;27(3):65–71.

Resources

1. Simmons SF, Osterweil D, Schnelle JF. Improving food intake in nursing home residents with feeding assistance: a staffing analysis. *J Gerontol A Biol Sci Med Sci*. 2001;56(12):M790–M794.
2. Simmons SF, Alessi C, Schnelle JF. An intervention to increase fluid intake in nursing home residents: prompting and preference compliance. *J Am Geriatr Soc*. 2001;49(7):926–933.
3. Simmons SF, Babineau S, Garcia E, Schnelle JF. Quality assessment in nursing homes by systematic direct observations: feeding assistance. *J Gerontol A Biol Sci Med Sci*. 2002;57(10):M665–M671.

Author's note: I would like to thank the many healthcare professionals I met who were wonderful to me and my family during very trying times. Your extra effort will always be remembered. And special thanks to my friend and colleague Dr. Victoria Castellanos for always sharing her information and progressive ideas on long-term care nutrition care.

Nancy Collins, PhD, RD, LD/N, is a registered and licensed dietitian in private practice in Pembroke Pines, Fla. For the past 15 years, she has served as a consultant to healthcare institutions on issues regarding regulatory compliance, clinical nutrition, and food service management and as a medico-legal expert to law firms involved in healthcare litigation. Correspondence may be sent to Dr. Collins at NCtheRD@aol.com.