Volunteer Participation in Feeding Residents: Training and Supervision in a Long-Term Care Facility

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Abstract. The increasing number of residents in long-term care facilities who require full and partial assistance during meals has created a need for volunteer support to enhance the quality of life for residents. The correlation between dependence in eating and the existence of swallowing disorders and the risk of aspiration in persons with swallowing disorders suggests that training must be given to volunteers who feed residents. A formalized program for volunteer training and supervision was implemented at Coler Memorial Hospital, a long-term care facility. The program’s development and benefits are outlined. Implementation of this program resulted in better training of volunteers, increased socialization, communication, and safety for patients during meals.

Key words: Long-term care facility - Volunteers, supervision - Volunteers, training - Deglutition - Deglutition disorders.

Ensuring adequate patient nutrition and hydration are major concerns in a long-term care institution. Failure to meet these basic needs in the most expeditious manner has an impact on every hospital service. A major obstacle in the provision of nourishment is the increasing number of residents who require partial or total assistance with eating. Residents may need to be fed due to gross and/or fine motor impairment, dysphagia, disorientation and confusion, emotional and/or psychiatric disturbance, anorexia, or any of these disorders in combination. Residents’ needs determine the level of assistance to be provided. Assistance may be given in the form of tray preparation (e.g., opening milk cartons, buttering bread), providing verbal encouragement, providing physical support to residents capable of assisted self-feeding, feeding residents with upper extremity disability or utilizing specialized therapeutic techniques, compensatory strategies, and adaptive feeding equipment.

Research has shown that the incidence of swallowing disorders increases during the normal aging process [1–3]. It is found at significant levels in the acute care population of those with neurogenic impairments, and in the chronically ill residing in skilled nursing facilities [4–6]. In the study conducted by Siebens et al. [6], it was found that 47% of a nursing home population was dependent upon staff assistance, ranging from verbal prompting to total physical assistance during eating. Dependent eaters also exhibited a higher prevalence of abnormal oral and pharyngeal stage swallowing behaviors. In this group, behavioral indicators of dysfunction included “spitting, drooling, choking, inability to chew, nasal regurgitation, squirreling of food, delayed swallow, overstuffing of the mouth, coughing while eating, and/or drinking and a wet sounding voice quality perceived during or following a meal” [6]. The number of residents who require assistance to eat places inordinate demands on staff at mealtime. This problem has led to the need to introduce volunteer participation during mealtimes in support of the medical staff in hospital-based and nursing home facilities. The correlation between dependence in eating and the existence of swallowing disorders [6], and the risk of aspiration in the swallowing disordered population [7] suggests that training must be given to volunteers who feed residents. In this context the volunteer feeding training program at Coler Memorial Hospital was developed.
Background

Policy guidelines for the utilization of volunteers in nursing homes are determined by individual state departments of health. The New York State Department of Social Welfare Memorandum issued in 1964 expressly prohibited volunteers from feeding residents [8]. Policy revision in 1969 omitted assistance with feeding from an approved list of examples of appropriate volunteer activities [9]. Concerns motivating this revision included a primary need to ensure that unpaid volunteers would not replace trained health care workers, in violation of the Federal Fair Labor Standards Act. This policy was modified in 1982 to allow volunteers to provide feeding assistance in voluntary and public nursing homes, but continued the exclusion of volunteer feeding assistants in proprietary facilities [10]. Included in this modified policy were strict requirements governing the implementation of the volunteer feeding program, including designation of a licensed professional with experience in feeding residents as the person responsible for establishing training, supervising, and administering the program. In addition, the policy states, “the volunteer feeding program, which shall be documented for each volunteer, shall include, but not be limited to orientation to physiological and behavioral characteristics of persons who need assistance with eating, demonstration of feeding techniques and supervised practical application by the volunteer” [10]. Part of the New York State Department of Health Bureau of Long-Term Care Services survey procedures for residential health care facilities (Article 28/NYQAS) includes mealtime observations and review to ensure compliance with policy.

Method

Coler Memorial Hospital is a 1045 bed municipal long-term care facility encompassing a 775 bed skilled nursing facility including pediatrics (29 beds), 270 hospital beds including 60 rehabilitation beds, a 17 bed intensive care unit (ICU), 14 respiratory beds, and a 22 bed acquired immunodeficiency syndrome (AIDS) unit. The hospital is located at the northern end of Roosevelt Island, accessible by aerial tramway (cable car), municipal bus, or car. Most residents have minimal family support and few outside visitors. For this reason volunteer interaction with residents has always been strongly encouraged.

In 1984, an interdisciplinary committee was formed at Coler Memorial Hospital. Included were the departments of communicative disorders, nursing, dietary, occupational therapy, and volunteers. The purpose of this committee was to restructure the volunteer feeding program. Due to the perceived enormity of this task, it was necessary to hire a coordinating manager to develop and implement the utilization of volunteers at mealtimes. A first step for the new coordinator was to ensure that use of volunteers to provide assistance in feeding residents did not infringe on any contractual agreements with the union.

A speech-language pathologist was selected to coordinate the volunteer feeding training program, since it was determined that their education and professional expertise best suited the program’s needs. The initial step in program development was establishment of the policy and procedures under which the program would function. Concurrently, a training curriculum was developed. Volunteer recruitment procedures were already in place under the auspices of the Director of Volunteers’ and remained unchanged. The following policies and procedures were developed.

1. All interested volunteers were not assigned feeding responsibilities until they had met the inservice training criteria.
2. All names were submitted to the coordinating manager of the volunteer feeding training program who was responsible for:
   a. Providing formal inservice training (lecture and “hands on” experience) with emphasis on the safe feeding of neurologically impaired residents and explanation of the purpose/use of adapted diets and feeding equipment as outlined in New York State Department of Health Memoranda.
   b. Initial assessment, following inservice training, of the volunteer’s ability to utilize basic safety and therapeutic principles in direct resident feeding (see Appendix A).
   c. Completion of inservice training evaluation checklist for each volunteer during the initial assessment.
   d. Coordinate assignment of volunteer feeding assistants to residents with input from the volunteer, the primary care physician, professionals in speech pathology, nursing, occupational therapy, and recreation therapy, director of volunteers, dietary department, family members, and/or friends.
   e. Follow-up supervision on a monthly and as-needed basis (upon request of nurse, volunteer, or resident). After the program’s goals and objectives were developed, they were presented to the Department of Rehabilitation Medicine and Nursing for review.

A curriculum for one 90 min lecture was prepared to meet the training objectives (see Appendix B). A slide presentation was developed as a visual supplement to the formal feeding training inservice lecture. Volunteers were photographed feeding actual hospital residents for illustration of the do’s and don’ts of therapeutic feeding. Printed summaries of the lecture highlights were provided. Completed by the coordinating manager or designee (Chief of Communicative Disorders, staff speech-language pathologist, nursing instructor) during direct patient contact, the Inservice Training Evaluation Checklist (Appendix A) measured the volunteer’s ability to meet program standards for safe therapeutic feeding related to positioning, food/liquid presentation, use of adaptive feeding equipment, interpersonal interaction, infection control, safety issues, and after-eating care. A copy of the Evaluation Checklist is retained on file for each trained volunteer for quality assurance purposes and annual review. A 4 month period from initiation of the program was established for all interested volunteers to complete the training module. At the end of the 4 months, untrained volunteers were no longer allowed to continue feeding residents. A memorandum was distributed explaining the new policy. Notification was also made in the hospital newsletter. Volunteers who were unable to develop skills sufficient to meet evaluation criteria during the practicum experience were given the opportunity to repeat the practicum. Volunteers who failed to meet appropriate standards during a second practicum were counseled and offered the opportunity to be assigned indirect feeding responsibilities. Duties were limited to providing help with tray preparation such as opening milk cartons, buttering bread, and removing paper coverings from straws.

Interdisciplinary committee meetings including representatives from nursing, communicative disorders, dietary, volun-