Step 3: Implement New Staffing Strategies

Analyze your options for reorganizing staff to efficiently deliver feeding assistance both during and between meals and maximize benefits for residents.

STAFFING CHALLENGES AWAIT NURSING HOMES AT MEALTIMES

Having assessed residents' risk for weight loss (*Step 1*) and determined who among the at-risk residents is best served by which intervention (mealtime or snack—*Step 2*), you are now in a position to make informed decisions about how to efficiently use what may be your facility's most valuable resource: staff time.

The staffing challenges facing nursing homes at mealtimes are daunting. Consider, for example, that experts recommend a ratio of five residents to one nurse aide during mealtimes to ensure proper feeding assistance, but the ratio in most nursing homes is 8 to 10 residents to one nurse aide during the morning (breakfast) and mid-day (lunch) meal periods and 12 to 15 residents per aide during evening meal (dinner) (1). A recent report to Congress noted that 9 out of 10 nursing homes did not have sufficient staff to adequately care for residents (2).

With such severely restricted staff resources, nursing homes must work smarter in order to wring the most out of what they have. The information you gathered in the *Step 1* and *2 assessments* empowers you to do that. In this next step, you translate the knowledge gained from the resident assessments into a staffing scheme that is as effective as it is cost-efficient.

START WITH WHAT YOU KNOW, THEN CONSIDER YOUR OPTIONS

Start with a recap of what you know at this point:

- the number of nutritionally at-risk residents (those who eat less than 75% of most meals, about 50% to 80% of all residents)
- The percentage of at-risk residents responsive to the mealtime intervention (about 50%)
- The percentage of at-risk residents responsive to the snack intervention (about 40% of those unresponsive to mealtime assistance)
- the amount of time it takes to provide feeding assistance during meals and snack periods

Our research shows that the amount of time needed to provide each intervention exceeds the usual amount of time nurse aides spend on providing feeding assistance (though the interventions result in significantly higher intake levels):
Our research also shows that it takes 1-10 minutes, or an average of 2.5 minutes per resident, to transport a resident to/from the dining room or other common area for meals or snacks, not counting the time needed to

	Usual Mealtime Care	Mealtime Intervention	Snack Intervention*
Time providing Assistance (in mins)	9/resident	42/group of 3 OR 14/resident	15-20/group of 4 residents
Mealtime Intake: Total % (food and fluid)	47%	60-70%	Remains comparable 300-400 calorie gain from snacks
*Usual snack-time care is negligible in most nursing homes. (Simmons, & Schnelle, 2003; Simmons, Osterweil & Schnelle, 2001)			

get the resident out of bed, dressed, and groomed, if necessary, prior to transport. Taking all this information into account leads us to the following recommendations for staffing. Keep in mind that not every recommendation will work well in every facility. You should decide which to implement based on your residents' needs and your facility's staff resources. Please note: We've started our list with the least restrictive recommendations. You should consider implementing these first.

USE OUR NUTRITION SOFTWARE PROGRAM

Our nutrition software program automates many of the tasks associated with our weight loss prevention intervention, thereby saving your staff time. It can be used to organize assessment information, generate summary reports of residents with low intake levels, calculate resident responsiveness to our mealtime and snack interventions, and project staffing needs for providing daily feeding assistance. It also allows staffing needs to be determined based on individual tasks (e.g., transport of residents to and from the dining room, tray delivery and pick up), which informs decisions about which types of staff—nurse aides vs. feeding assistants or volunteers—might help with each task. And oh, yes, did we mention that it's free?

ENCOURAGE ALL RESIDENTS TO EAT IN THE DINING ROOM

All residents should be encouraged to eat most, if not all, of their meals in the dining room for several reasons. First, most residents say they prefer to eat their meals in the dining room. The fact that many remain in their rooms for the morning and evening meals may reflect the routine established by the staff more so than the residents' preferences (3). Second, presence in the dining room allows the staff to provide time-efficient feeding assistance to small groups of residents, rather than one-on-one assistance, which is the only option if residents eat in their rooms. In fact, it has been shown that residents who eat their meals in the dining room receive more assistance from staff compared to those who eat in their rooms and these residents also have more accurate documentation of their percent eaten during meals (4). Finally, dining in a common room promotes social interaction among residents and staff, which in turn stimulates food and fluid intake, according to several studies (1, 5-9).

Recent research shows that facilities with a policy that all residents should eat all meals in the dining room have a lower prevalence of weight loss and significantly better performance on multiple measures of nutritional care quality, including the provision of feeding assistance. In these facilities, nurse aides on the 11pm to 7am shift typically begin helping residents out of bed and providing morning care in preparation for the breakfast meal.

Facilities with limited space in dining areas can schedule multiple servings per meal. Minimally, all residents who require mealtime feeding assistance should be taken to the dining room, or other common location, for meals.

USE OTHER STAFF MEMBERS AND VOLUNTEERS TO HELP AT MEAL- AND SNACK-TIMES

If your facility is short-staffed at mealtimes, consider using non-nursing staff for some tasks. Volunteers, social activities, dietary personnel, licensed nurses, even administrative personnel can help with a variety of time-consuming tasks, all of them

typically the responsibility of the nurse aide such as: transport of residents to/from the dining room, meal tray delivery and set-up, retrieval of substitutions from the kitchen of the resident does not like the served meal, provision of social stimulation and encouragement to residents, provision of between meal snacks to residents. The performance of these tasks by staff other than nurse aides greatly increases the time nurse aides have available to provide quality feeding assistance to residents in need.

Federal regulations now allow nursing homes to hire single task workers or cross-train, existing non-nursing staff as "feeding assistants" so that additional staff is available to help during busy mealtime periods. States do vary in whether or not facilities within each state are allowed to use these types of workers. If allowed within the state, our research shows that staff trained as "feeding assistants" provide equally, if not better, feeding assistance care to residents as indigenous nurse aides within the same facilities (10). Thus, training non-nursing staff from other departments or volunteers to help during meals offers a promising way to augment your existing staffing resources for feeding assistance care provision. We have developed an implementation manual that you can use if you are interested in training other types of staff to provide feeding assistance care within your facility.

Our research shows that residents who are responsive to our *mealtime intervention* are more likely to need physical assistance to eat and to have difficulty with chewing and swallowing (5). Consequently, certified nurse aides or non-nursing staff formally trained as "feeding assistants", with supervision by licensed nurses, should be assigned to provide mealtime feeding assistances to these residents.

By contrast, residents responsive to our *snack intervention* were more capable of eating on their own (5). Given this, the delivery of snacks between meals might be a more suitable assignment for social activities personnel or volunteers, provided they are informed of residents' diet orders. Again, staff trained as "feeding assistants" also could provide snacks between meals. Otherwise, the snack intervention fits in well with most morning and afternoon social activities programs. Moreover, in our experience, social activities coordinators are willing to take on the extra responsibility because the intervention adds a new, pleasurable dimension to their programs.

TARGET FIRST THOSE RESIDENTS RESPONSIVE TO THE MEALTIME INTERVENTION

As noted earlier, most nursing homes do not have enough workers to provide adequate feeding assistance to all residents at risk of under-nutrition. The usual result is that all residents receive sub-standard care, so no one gets what they really need. If a facility is short-staffed, wouldn't it be ethically and clinically preferable to concentrate first on providing proper feeding assistance to those residents most likely to increase their food and fluid consumption as a result? Our *Step 2 trial of mealtime feeding assistance* enables nursing homes to accurately and reliably identify these "responsive" residents. Residents who do not eat more even when offered extra help during mealtime, need not receive such intensive feeding assistance during mealtimes. They should, however, be offered social stimulation and alternatives to the served meal in addition to our between-meal *snack intervention*

BEEF-UP YOUR BETWEEN-MEAL SNACK PROGRAM FIRST

With this approach, staff would focus first on identifying nutritionally at-risk residents who are responsive to the *snack intervention*, and then evaluate the *mealtime intervention*. This contrasts with our prior studies, where we concentrated first on targeting the mealtime intervention. However, we noticed that most of the 50% of at-risk residents who proved responsive to the mealtime intervention also responded to the snack intervention, increasing their daily intake level by 15% or more without any additional mealtime assistance. We also noticed that some residents were at such high risk for weight loss that they needed both interventions (mealtime assistance and between meal snacks).

The advantage of increasing intake levels through a snack program is that this intervention requires less staff time to implement per resident (about 20 minutes per group of 4) than a mealtime intervention (about 45 minutes per group of 3). Additionally, this between-meal intervention helps distribute feeding assistance throughout the day, so more workers, including the social activities staff, can help out. Residents who increase their daily food and fluid intake to adequate levels with the snack intervention may not need extra, more costly feeding assistance at mealtimes.

Time-Saving Tip:
If you cannot provide residents with three snacks daily, focus on providing snacks in the morning and afternoon time periods in conjunction with social activities. Our research shows that most residents eat significantly more during morning and afternoon snack periods than evening periods.

USE MORE RESTRICTIVE CRITERIA TO TARGET RESIDENTS FOR FEEDING ASSISTANCE

As a last resort, if your facility is severely under-staffed, you can use more restrictive criteria to target the mealtime or snack interventions to only those residents at highest risk for weight loss. Such residents either eat less than 50% of most meals or have a history of weight loss or both. Check results from the *Step 1 assessment* to identify residents with intake levels under 50% and then check medical records to see which residents show a history of weight loss. Our research and that of other investigators suggests that residents with low intake levels (i.e., who eat less than 75% of most meals) but who have a healthy Body Mass Index value (>21) and no recent weight loss may not, in fact, need intervention. These findings, however, are preliminary, and this targeting approach, unfortunately, means that some residents will likely receive sub-optimal feeding assistance. Many of them, however, may at least maintain their weight, even if they don't gain pounds. Despite its serious drawbacks, this targeting approach is preferable, ethically and clinically, to providing sub-optimal assistance to all residents.

Cost-Saving Tip:
Because nursing homes offer few additional foods and fluids between meals, including nutrition supplements (5,6,11) it may cost facilities more to buy these items for the snack intervention. Our recent work shows, however, that the cost of the snack intervention might be off-set by offering snacks instead of supplements (12). Both residents and family members seem to prefer having a choice of snack foods and fluids instead of supplements (12,13). Moreover, residents consumed more calories from between-meal snacks than

from supplements and have a lower refusal rate of snacks (5,12). These findings suggest that snacks are more palatable to residents.

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