ACE
Advancements in Clinical Excellence
Adaptive Dining Program

Purpose:
The purpose of this program is to create an interdisciplinary approach to managing the geriatric client in a skilled nursing facility who may have deficits in positioning their body for eating, gripping utensils, cups or food, scooping, bringing food to mouth and managing to swallow within the scope of practice for occupational therapy, speech language pathology, and physical therapy services.

Self feeding is an integral part of a resident's daily life and is a right under OBRA regulations. The skills of a therapist can address the physical or cognitive impairments that are affecting the resident's ability to feed themselves, make recommendations for adaptive equipment and educate the caregivers on compensatory techniques.

Patient Identification
There are several ways to identify residents who may benefit from therapy services to address deficits in rehab dining.

> ***Observation*:** Observe residents in the facility. Do you see residents who are having difficulty feeding themselves? Are there residents who eat in their rooms who previously ate in the dining room? Are certain residents taking longer to eat or leaving a lot of food on their plate? Is there excess spillage?
>
> ***Interview of Staff*:** Talk with facility staff to see if they can identify anyone having increased problems feeding themselves. Do they need more cues or more physical assist? Is their eating messier than usual or are they eating less? Have they had a recent weight loss? Does it take them more time to eat than in the past? Are they having difficulty in swallowing? Are there residents leaning in their chairs? Ensure that nurses, nursing assistants, activity staff, and dietary staff are all interviewed.
>
> ***Educational Opportunities*:** Don't miss an opportunity to educate! If there is a small group of nursing assistants, talk with them and briefly explain the criteria you are looking for to identify a decline in rehab dining skills. If the assistants know what therapy can do to help a resident, they may be more likely to generate referrals.

Criteria for Patient Identification
The following are potential criterion that may indicate therapy services are indicated:

- Decreased ability to chew food, drink liquids or swallow
- Decreased attention to the activity of eating
- Excessive chewing during meals
- Pocketing food (food remains in mouth after the swallow)
- Improper positioning at the table
- Leaving food on the plate (especially same colored food as the plate to indicate visual deficit)
- Speak with a "wet" voice during and shortly after drinking
- Excessive spillage on the floor or table following meal
- Taking excessive time to finish a meal (more than one hour)
- Drooling or spilling food our of mouth while eating
- Decreased ability to feed self: includes placing food on the utensil and successfully bringing it to the mouth
- Change in oral health or dentition affecting eating ability
- Change in mental state, increased confusion, depression, or other behavior related problems
- Poor posture at table or change of sitting device (from dining room chair to wheelchair)
- Change in sitting posture resulting in the decreased ability to feed self (leaning, slouching, etc.)
- Ignoring or neglect of food or drink on one side of the plate/tray
- Recent unplanned weight loss
- Unable to locate or pick up utensils
- Using utensil incorrectly

Documented Sources of Support for Therapy Intervention
MDS
When providing therapy services to long term residents of a skilled nursing facility, one should refer to the MDS to identify changes in status. The presence of a change in score or a difference in current status to previous status will signify a change in the condition of the resident and help support the intervention of therapy services.

- Section B 2, 3, 4, 5, 6 (Cognitive Patterns)
- Section D 1,2 (Vision Patterns)
- Section G 1 h, (Eating)
- Section G 4 a, b, c (Range of Motion)
- Section G 7 (Task Segmentation)
- Section G 8 (ADL Functional Rehabilitation)
- Section G 9 (Change in ADL Function)

- Section J 1a, c, d (Health Conditions)
- Section K 1a, b, c, K 3a, K 4b, c, K 6a (Oral/Nutritional Status)
- Section L 1a (Oral/Dental Status)

Quality Indicators
Review the following qualify indicators:
- Prevalence of symptoms of depression
- Prevalence of weight loss
- Prevalence of tube feeding
- Prevalence of dehydration
- Incidence of decline in ROM
- Incidence of cognitive impairment

Nursing Notes
Review the nursing notes to identify documentation related to the resident needing additional assistance with feeding, recent weight loss, or other signs of decline in rehab dining skills.

If nursing has not included any supportive documentation, it is OK to request they document because it will support the need for therapy services. Documentation from nursing that identifies the problem will support therapy intervention.

Incident Reports
Look for reports of coughing during meals.

Potential Interventions and Plan of Care
The plan of care for each resident is individualized to their own deficits and impairments. The following are possible interventions that could be utilized when addressing deficits in rehab dining.
- Assess upper extremity and grip strength, coordination, and ROM of neck and upper extremities
- Assess gross motor coordination and fine motor coordination
- Determine if proximal stability or distal function is a causative factor
- Identify components of hand-to-mouth mechanics
- Determine appropriate adaptive equipment or assistive devices to improve grasp and coordination
- Assess seated posture to improve ability to feed self and swallow
- Assess functional activity tolerance for sufficient frequency up, time up and awake time to eat
- Assess chair and table height for maximum feeding independence
- Assess and address any visual-perceptual deficits including field cuts, low vision, spatial relations, apraxia, agnosia, perseveration, body image/body scheme disorders
- Assess for swallowing impairments including oral motor and pharyngeal skills, phases of swallow and food/liquid consistencies for a safe swallow

- Assess cognitive status and distractibility during meals
- Assess psychological dysfunction preventing meals as a social interaction
- Assess activity tolerance and fatigue when eating a meal. Are they short of breath? Do they need to take rest breaks?

Documentation & Coding

Common Codes to Bill

97003	OT Evaluation
92610	SLP Swallow Eval
97001	PT Eval
92526	SLP Swallow Treatment
97110	Therapeutic Exercise
97112	Neuromuscular Reeducation
97530	Therapeutic Activities
97535	ADL Retraining
97532	Cognitive Retraining (for sequencing/planning)

Documentation Pointers

- Document all adaptive equipment trials, even if they were not successful to show progress and rationale for the final equipment.
- Document if the resident can be more independent with adaptive equipment but refuses to use it.
- Tie the rehab dining intervention to medical need based on the therapeutic skills provided.
- Document the time to complete a meal and amount or percentage of intake.
- Break the activity down into its component parts (food to fork, fork to mouth, etc.)
- Make short term goals based upon components of the task, not the entire task.
- Identify strategies used: hand over hand, cues provided by therapist, intervention level, change in grasp patter. (Make sure cues are skilled in nature and not routine cueing that a CNA could do)
- Document status of environment during meals – is it noisy and distracting, quiet and calm, etc, and its effect upon the resident. Does performance change when in different environments?
- Document progress and establish goals based on consistent performance or the task as measured by multiple trials.
- When assessing range of motion, record accurate measurements upon evaluation and assess on a regular basis to demonstrate progress (use a pinch meter, for example). If you are making a goal to increase range of

motion – do not use vague terms such as WFL or WNL as these terms do not clearly establish a baseline.

- Tie your skilled interventions to the goal. For example, if you are doing resistive strength training to improve grip strength, the documentation should note how strength is progressing and the patient is making progress towards goals.
- To ensure documentation reflects skill, state reasons why the goals are not fully met. For example, if the goal is only met 50% of the time, does not carry over to other shifts with the CNA – why is that?
- Document what is happening at other meals: report carryover, difficulties (less responsive at time of day and needs to be fed for evening meals, etc). This variance can support continuing on therapy treatment and should also trigger a change in treatment patterns. For example, treating during a meal at different times of the day prior to discharge, not always just with breakfast, etc. to ensure gains can be maintained throughout the day once discontinued from therapy services.
- **If recommending a program for nursing to carryover, clearly indicate the content of the program, who was trained (family member, CNA, nurse, feeding assistant, etc), their response to carryover, any skilled teaching or cueing you provided to ensure appropriate performance or application.** This is to note and support that you provided education, it does not comment on the consistency of the program being performed.

Goal Suggestions:

GOOD GOALS:

- ★ Pt. will feed self 2 of 3 trials of fork to mouth with no spillage for independent self feeding with a weighted fork in one week.
- ★ Pt. will complete 75% of meal in 30 minutes with minimum assist for utensil to mouth feeding in two weeks.
- ★ Pt. will independently utilize compensatory method of turning plate (clock method) to overcome neglect for full nutrition intake in two weeks.

BAD GOALS:

- ★ Pt. will use weighted spoon.
- ★ Pt. to complete 20 reps of gripper with 3 lbs. resistance.

Inservice Outline
Adaptive Dining Program

What are signs that a patient may be having problems with feeding themselves?

- Difficulty with eating and/or drinking
- Excessive chewing of food
- Pocketing food – food remains in mouth after the swallow
- Dropping utensils and knocking over items
- Using fingers instead of utensils
- Requesting more help
- Wet sounding voice during or shortly after drinking
- Difficulty seeing food
- Takes excessive time to finish a meal
- Drooling or spilling food or drink out of mouth
- Unusual amounts of food and drink spilled outside of eating area
- Problems getting food onto spoon or fork
- Difficulty getting food to mouth
- Change in seating position making self feeding difficult
- Weight loss or eating less
- Difficulty grasping or handling fork, spoon, or knife
- Seeming easily distracted and forgetful which affects their ability to focus on eating

What can you do if you think a resident may be having trouble with rehab dining?

- Tell the nurse the problems you observed and ask them to document it in medical record
- Tell a member of the therapy team or leave a note in their mailbox
- Write what you saw on the 24 hour report
- Bring it up for discussion at morning report or other patient related meeting

What can therapy do to help these residents?

- Evaluate the resident to see what they are able to do
- Provide treatment to increase the resident's strength and coordination to help them be as independent as they are able to
- Development recommendations that can be integrated into a restorative program
- Rehab can identify adaptive equipment including weighted silverware, plate guards, special drinking glasses, etc. to help the resident do as much for themselves as able
- Make recommendations for specific setup and assist strategies to help the resident do as much for themselves as they can
- Assess cognitive and visual deficits affecting rehab dining performance

- Make recommendations in seating and positioning to enable the resident to feed themselves.

What can be done everyday to help with rehab dining problems?

- Ensure the resident is sitting safely in the chair, safe and supported, not leaning to side, backwards or forwards
- Check to ensure the leg rests are on the wheelchair so the resident's legs are supported
- If adaptive equipment is recommended, ensure it is present at all meals
- Be observant during mealtimes to see if someone would benefit from therapy services
- Allow the resident adequate time to complete each meal
- It is helpful for the plate and placemat to contrast in color

Show examples of some common adaptive equipment used with rehab dining.

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Please answer the questions and return to therapy to be entered into our monthly drawing.

1. Which is a sign that a person may need therapy services to help them with eating?
    a. Leaning in chair
    b. Drooling or food falling out of mouth
    c. Taking longer to eat than usual
    d. Seeming very distracted during the meal
    e. All of the above

2. What should you do if you think a resident may benefit from therapy on the Rehab Dining Program?
    a. Nothing
    b. Tell the nurse to request a screen for therapy
    c. Tell the therapy department
    d. B and C

3. Which would <u>not</u> be a good idea to help a resident eat a successful meal?
    a. Make sure the residents are seating appropriately in their chairs and not leaning.
    b. Make sure their legs are supported on the leg rests of the wheelchair if they use one
    c. Make sure if they use adaptive equipment for eating that it is present
    d. Sing to them to get them to eat more

_____ _____
Name Shift