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Feeding Difficult-To-Feed Patients

Recent research has suggested that the way a CNA feeds is a complex dynamic interaction among many factors.

"MRS. JONES WON'T OPEN HER mouth to eat." "Mr. Smith holds his food in his mouth and won't swallow." Feeding problems such as these are common in many medical facilities. Nearly 50 percent of the residents in one nursing home were reported to require assistance to eat (Dwyer *et al*., 1987). What are caregivers supposed to do when they are asked to feed these difficult-to-feed patients? What are "good" versus "bad" feeding practices? New research indicates that not only are there no easy answers to these questions, they are rarely even addressed in certified nurse assistant (CNA) textbooks or inservice training sessions (Pelletier, 2004).

Lack Of Adequate Information

In most medical settings, CNAs are the primary caregivers to feed patients, including those with dysphagia (swallowing disorder). A recent study by Pelletier (2004) reported that CNAs possessed limited accurate, up-to-date knowledge about dysphagia and feeding that may be related to their training.

For instance, the risk of aspiration in four CNA textbooks was associated with tube feedings only, with no mention of aspiration pneumonia related to dysphagia (Hegner, Caldwell, and Needham, 1999; Sorrentino, 1999; Sorrentino, 2000; Wolgin, 2000). None of the texts reviewed dysphagia diet terminology; only 2/4 CNA texts reviewed mentioned signs or symptoms of dysphagia at all.

Although all the CNAs in the Pelletier study showed rudimentary knowledge of the signs and symptoms of dysphagia (for example, coughing, choking, chewing, or oral problems), they did not appear aware of the more subtle but equally important signs such as a wet voice or throat clearing after a swallow.

Furthermore, discussion about how to manage difficult feeding behaviors was typically missing in CNA training sessions and texts. These include such common feeding problems such as holding food/liquid in the mouth, refusal to open the mouth, and oral pocketing of food.

Without any discussion of these issues in texts or inservice training, CNAs develop their own on-the-job strategies that may actually increase the risk of aspiration (for example, "plug the nose" to decrease holding in the mouth) (Pelletier, 2004) or lead to undignified feeding strategies (for example, play airplane to open the mouth).

The Role Of SLPs

CNAs might benefit from discussing these problems with speech-language pathologists (SLPs). SLPs are experts in swallowing disorders and can help improve CNAs' basic knowledge about dysphagia. They are the primary resource to help a medical team develop a feeding plan of treatment designed to reduce the risk of aspiration and improve swallowing skills.

The SLP will assess a patient's ability to eat safely and how to best communicate with him/her. While a dietitian will provide information regarding what nutrients and types of foods/liquids a patient should eat, the SLP will provide information regarding how the nutritional diet should be provided.

For example, the SLP may recommend a diet that is modified in texture and/or viscosity, such as pureed or ground food with thickened liquids. They may recommend what feeding techniques will increase safety such as a chin tuck or effortful swallow. The SLP may even recommend the patient should be NPO and receive an alternative mode of nutrition, such as tube feeding.

For more information about resources and how to find an SLP with expertise in dysphagia, contact the American Speech-Language-Hearing Association (*see box, page 51*).

New ideas about the content and format of inservice feeding training to CNAs may be helpful (*see sidebar, page 51*). It is also important to recognize that solely increasing a CNA's knowledge about feeding is not likely to change his/her feeding practices. The literature suggests that changing any clinical practice is a difficult thing to accomplish, even when people are confronted with evidence that suggests

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their current practice is ineffective or even harmful (Ashford, Eccles, Bond, Hall, and Bond, 1999; Oxman, Thomson, Davis, and Haynes, 1995). Recent research has suggested that the way a CNA feeds is a complex dynamic interaction among many factors such as resident characteristics (for example, communication skills, severity of dysphagia, etc.), institutional factors (e.g., facility is short staffed; food is cold or disliked, etc.) and beliefs (for example, a combination of feeding knowledge, previous feeding experience, and values) (Pelletier, 2005). Therefore, what feeding strategy is chosen depends on how a CNA responds to the feeding situation presented and his/her individual feeding beliefs.

Different Belief Systems

It appears that two different CNA feeding belief systems influence their feeding practices. Labeled by the CNAs themselves, technical feeders believe their most important goal in feeding is to get the patient to eat. Social feeders also believe it is important for patients to eat, but they also highly value meeting the psychosocial needs of the patient. Social feeders believe eating is a time to socialize and if a patient indicates they don't want anymore to eat, social feeders will stop feeding and talk to them.

These different feeding beliefs lead to different feeding practices and tension between CNAs. Social feeders can be viewed as just "chit-chatting" while technical feeders are "force feeding."

It is important to acknowledge that although different feeding approaches and outcomes may be observed by these two types of feeders, there is not one belief system that is better than another. Both feeders care deeply about their patients and feed them in a manner that reflects what they fervently believe is best for them. Given this context, judging what is "good" versus "bad" feeding technique is difficult because ethical and legal questions arise.

For example, how hard should one push to get a patient to eat? All patients have a right to refuse treatment. When do we "force" someone to eat for their "own good?" Or should we interpret their behavior as their legal right to refuse food? What does "force feeding" look like? How many times do we try to pry open a mouth to feed? The answers to these questions involve legal and ethical issues for which we have no good answers at this time.

CNAs need up-to-date information about how to best feed patients. For example, increasing the thickness of a liquid and using a chin tuck position during the swallow may dramatically increase safe swallowing in some individuals with dysphagia. But these strategies are not helpful for everyone. In fact, a chin tuck position or liquids that are too thick may actually increase the risk of aspiration in certain individuals.

The only way one can reliably assess whether someone is swallowing safely is to perform an instrumental examination of swallowing, such as a videofluoroscopic swallow study (VFSS) or fiberoptic endoscopic evaluation of swallowing (FEES). Given the results of an instrumental dysphagia exam, SLPs can then provide CNAs with reliable information regarding how to best feed their patients.

Unfortunately, CNAs feed individuals every day with little guidance. Typically they rely only on one another to tell them what "worked" best to feed a patient.

CNAs need reliable, accurate information about how to feed difficult-to-feed patients and dysphagia. By increasing collaboration with SLPs and reflecting on their feeding practices, CNAs can feed their patients with a high degree of safety, care, and dignity. ■

Ideas To Train CNAs In Feeding

■ Have CNAs submit a list of their patient feeding problems prior to the inservice. Use these real, current problems to brainstorm with them the best ways to solve the problems. In this manner, you are acknowledging their problems and opening communication with them to talk to you about them.

■ Involve your rehabilitation team as appropriate so CNAs are updated on current dysphagia and feeding strategy information. The opportunity to educate them as current problems are discussed is a more effective teaching style than a lecture presentation.

■ Follow up with the CNAs and their difficult patients on the unit so that appropriate modifications can be made when necessary and open communication continues.

■ Ask CNAs to learn at least three things about the patient they are feeding and report back to you. Research has shown that while feeding, CNAs rarely talk to patients about anything other than the food, if at all. Anecdotally, increased patient-initiated conversation and CNA positive feelings about feeding have been reported given this simple task.

■ Discuss the two feeding belief systems of feeders. Have CNAs reflect on their own feeding behaviors and those they have observed.

For More Information

■ The author can be contacted at capelletier@uams.edu.

■ For more information about resources for working with CNAs on feeding or locating speech-language pathologists, contact the American Speech-Language-Hearing