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Feeding and Oral Care Guidelines for Certified Nursing Assistants Working with Patients with
Head and Neck Cancer

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Abstract

This project was developed after participating in a clinical experience that required graduate speech-language pathology students to assist with feeding elderly patients in a skilled nursing facility. These patients are typically fed by certified nursing assistants (CNA) with reduced training during their educational course on proper feeding for patients with specific swallowing-related disorders. This guided the purpose of the project which was to research the current licensure requirements in the state of Illinois for programs that train CNA's, obtain CNA perceptions for providing feeding and administering oral care to subpopulations at a higher risk of a medical diagnosis of dysphagia, and develop a resource based on a deficit observed in the survey. For this project, an online survey was created and distributed through social media platforms that asked CNA's to indicate how long they have worked as a CNA, the state they work in, a text box to list what they currently know about best feeding practices, a yes/no response to identification of 3-4 signs and symptoms of dysphagia, and six yes/no responses regarding perceptions that their CNA program adequately prepared them to feed and provide oral care to the following subpopulations: stroke, dementia, and individuals with head and neck cancer. The survey yielded responses from 73 participants across the United States representing 26 states and 2 participants from Canada. Based upon results of the survey, 77% of CNA's that participated felt that their education program for obtaining a CNA license did not adequately prepare them to provide oral care to patients with head and neck cancer. Similarly, 79% of participants did not feel adequately prepared to feed individuals with head and neck cancer. Full survey questions and results can be found in the appendix. As a result of the survey responses, this project will consist of a brochure that will inform CNAs proper feeding guidelines and oral care considerations for providing care to patients with head and neck cancer.

This brochure is intended to be a resource for certified nursing assistants to recognize clinical signs and symptoms of aspiration during meal times and provide proper feeding and oral care based on considerations of this pathology. This brochure will be beneficial in educating CNA's on feeding and oral care guidelines based upon the current available research in this field that may result in an increase in patient nutrition, reduce the risk of aspiration and severity of associated medical diagnoses, improve oral health care, and improve overall quality of life for patients with head and neck cancer.

Background

A certified nursing assistant (CNA) certification is regulated by the state in which a person resides and must follow guidelines set by federal government. For the state of Illinois, CNA licensure is regulated by the Illinois Department of Public Health under CFR Title 42 section 483.152. "Under this regulation, programs that train CNAs must require a minimum of 75 hours of clock training and only a minimum of 16 hours of training before contact with a resident in the areas of communication and interpersonal skills, infection control, safety/emergency procedures, promoting residents' independence, and respecting residents rights" (42 CFR 483.152 n.d., n.p.). CNA curriculums encompass six core areas and require demonstration of competency in each of the areas as part of the minimum 75 hours of clock training. These areas are basic nursing skills, personal care skills, mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents rights. Basic nursing skills includes five subcomponents with proper obtainment of vitals as an example of a subcomponent. Personal care skills is most important for patient health as it includes eight subcomponents such as bathing, grooming, oral care, proper feeding, and

transferring/positioning of a patient, and toileting. Mental health and social service cover five subcomponents and aim to teach CNAs how understand patient behaviors and modify their behaviors in response. Care of cognitively impaired residents also includes five subcomponents that all focus on teaching CNAs how to competently work with patients with cognitive deficits. Basic restorative services encompasses six subcomponents, such as care and use of prosthetic and orthotic devices like a dental prostheses. Basic restorative services also teach CNAs how to promote patient self-care. The last area is residents rights that educate CNAs on the rights of the patients that they serve on a daily basis (42 CFR 483.152 n.d.). CNA certifications require competency of skills that are required in clinical professions such as, occupational therapy, physical therapy, and speech-language pathology. In these professions, a master's or doctoral degree is required to treat patients. CNA's are asked to demonstrate the above mentioned competencies in an extremely limited timeframe. Under the CNA requirements, they are not given an appropriate time frame to learn and develop proper techniques of skills related to their scope of practice. This includes providing feeding and oral care to specialized subpopulations that often present with dysphagia in at least one or more stages of swallowing.

The first step to support proper feeding for patients is for CNAs to understand what a non-disordered swallow consists of. The stages of swallowing all work together and if one component is disordered, it may result in a disordered aspect of another part of the swallow. Swallowing is broken down into four stages with the first stage being the oral preparatory stage. During this stage food enters the mouth, is chewed, and mixed with saliva to form a bolus. Most of these actions are performed in the oral cavity voluntarily. The next stage is the oral phase in which the bolus moves backward in the mouth toward the pharynx. The tongue rises to make

contact with the hard palate behind the front top teeth and the soft palate rises to allow the bolus to pass the faucial pillars in the posterior portion of the oral cavity. Additionally, the hyoid bone moderately elevates in preparation for the next stage of swallowing. The pharyngeal stage occurs next in which the bolus moves through the pharynx and into the esophagus. During this stage, the hyoid and larynx move up and forward to close off the airway to prevent aspiration, or food material from entering the airway and open up the upper esophageal sphincter (UES). With the up and forward movement, the epiglottis, a leaf shaped cartilage at the root of the tongue, moves downward to cover the opening of the airway as the bolus moves through the UES and into the esophagus. The vocal folds close to add an additional layer of airway protection and the nasopharynx is closed off to prevent nasal regurgitation of food materials. In the final stage of swallowing, the bolus moves down the esophagus and into the stomach to complete the esophageal stage (Leonard & Kendall, 2014). With the exception of the oral preparatory stage, the stages of the swallow are involuntary and the bolus is moved downward through highly coordinated muscle movements and valving actions. With knowledge of typical swallowing in each phase, it is possible for CNAs to have a better understanding of what atypical swallowing during meal times looks like.

With education of typical swallowing, an important next step is educating CNA's about the clinical characteristics of a person with dysphagia. By presenting CNA's with this knowledge, they will be more aware of the profile of a patient that may be dysphagic; therefore, they can look for clinical signs and symptoms of aspiration. A study conducted on 878 individuals from across 42 aged care facilities in Hong Kong explored common characteristics of dysphagic individuals after obtaining qualitative and quantitative measures (Pu, Murry, Wong,

Yiu, & Chan, 2017). The results of the study revealed from qualitative measures that patient medical histories with pneumonia, reduced mobility in activities of daily living, and the male sex were commonalities among the 51% of the sample diagnosed with dysphagia. The second model that obtained data from hands-on assessments concluded that the oral motor assessment rating for the participants in this study was a highly predictive variable of dysphagia, indicating that elderly individuals with poor strength and coordination of oral structures were associated with having dysphagia. This study also found statistical significance with results from the cognitive assessment that individuals with cognitive decline were likely to have dysphagia, in addition to individuals that lacked teeth (Pu et al., 2017). The characteristics of the dysphagic individuals found in the study conducted by Pu and colleagues were relatively unsurprising and are compatible with previous research of signs and symptoms related to dysphagia. This study gave general characteristics of the profile of dysphagic individuals, but many clinical symptoms are observed in dysphagia. Examples of clinical symptoms of dysphagia include difficulty chewing that can be characterized by anterior oral spillage, excessive chewing time of soft food, and/or weakness in the oral cavity; difficulty initiating the swallow; drooling due to possible lip or tongue weakness and infrequent swallows; nasal regurgitation; food sticking indicated by residue observed in instrumental assessments; coughing and choking during meal time and coughing when not eating; regurgitation of food materials; and weight loss (Crary & Groher, 2003). CNAs can look for these signs and symptoms during meal time feedings. Additionally, they may also note observations that include a wet vocal quality when eating, wet gurgling sounds with breathing, increased time needed to complete meals that may indicate fatigue of oral structures, increase frequency of eating attempts with decreasing volumes, compensatory posturing such as,

chin tucking or head turning during meals, and avoidance or preference of particular foods (Leonard & Kendall, 2014). As stated prior, the survey obtaining CNA perceptions asked a yes/no question as to whether CNAs felt that they could identify 3-4 of these clinical signs and symptoms of dysphagia during meal time. Based upon data obtained from 72 participant responses, 84.72% of CNAs felt that they could identify 3-4 signs with 15.28 % indicating that they could not. These findings highlight the importance of teaching clinical signs and symptoms of dysphagia to CNAs so that appropriate referrals may be made to SLPs regarding patients. If CNAs are unable to identify these signs and symptoms, patients may go untreated.

Upon providing CNAs education on what dysphagia is and the clinical symptoms associated, it is important to provide them knowledge on how to properly feed cognitively intact aged individuals before working with sub-populations with special considerations. Best practice guidelines for feeding indicate that patients should be free or have environmental distractions such as a television, or talking during eating reduced. It is important to observe for coughing, choking, throat clearing, and struggle during meal times (Leonard & Kendall, 2014). Before feeding a patient, CNA's should begin meal times by verifying the patient's identity and his/her diet order so that it is ensured that the patient is receiving the appropriate diet for his/her individual health needs. After determining that patients identity and diet considerations, CNAs need to obtain the proper equipment that may include assistive feeding devices such as spouted cups, swivel spoons, and long handled utensils. To adhere to infection control, CNAs must perform proper hand washing hygiene measures prior to feeding a patient. It is also strongly encourage that patients wash their hands as well. CNAs should assess the patient's dentition and cognitive and functional status to see if oral feeding is appropriate at that time. Body positioning

is another important aspect to proper feeding. Patients should be positioned in optimally safe upper body position as recommended or 90 degrees in a chair with head/neck flexion, if possible. Head stability should also be addressed during feeding. It is important that the patient is alert and oriented as much as functionally possible during feeding and that dentures or any oral prosthesis is securely placed before eating. Before any type of care is administered to a patient including feeding, it is important to give the patient information about what will happen and what to expect. This may be beneficial in decreasing uncertainty and confusion with a patient and increase compliance with feeding (“Feeding”, 2018). CNAs should set up patients food trays and cut food into appropriate bite sizes and add seasonings as patients ask. Residents rights should be maintained during mealtimes; Therefore, CNAs should allow residents to decide what foods they want to eat and in what order. For individuals with poor vision, CNAs can explain to them the food on their plate by describing the location of items in relation to a clock. For example, a CNA may say, “at 3:00 you have mashed potatoes and gravy and below it at about 5:00 is french style green beans, and your dinner roll is positioned at about 9:00”. Facing the patient during mealtimes allows CNAs to make eye contact with the patient that helps indicate readiness for each bite and pauses when needed by the patient. For cognitively intact adults, it is recommended that CNAs encourage any self-feeding. CNAs may also provide verbal prompts to patients to chew or swallow food in their mouth. It is out of dignity that CNAs should wipe food away from the patient's mouth and chin with napkins as needed. Depending on the medical needs of the patient, some patients should remain upright for a set period of time after meal completion. In the distributed survey, 28 CNAs indicated at least one of these guidelines when asked what they currently knew about best feeding practices. For example, one participants response stated

“First you make sure the patient is sitting in an upright position, it is easier for someone to choke if they are at an angle. Always make sure the patient has a drink. Fluid intake is important in general, but is very important when feeding, because food can be dry, or their mouths might be dry. This would prevent food from forming into the proper bolus needed to be swallowed. Food needs to be cut up properly along with making sure you are not giving patients too big of bites. Also, making sure the food is warm is important, of course!”. This participant also indicated that he/she has been a CNA for a duration of 5-10 years. On the other hand, another participant responded, “Slowly. That’s all the instruction I got.” and indicated that they had been a CNA less than a year. The participant responses reveal that experience is an important aspect of proper feeding and also reveals a stronger need for more emphasis on proper feeding in CNA coursework. Upon completion of the meal, CNAs should always provide proper oral care to the patient to prevent adverse effects from mealtime feeding (“Feeding”, 2018). Although none of the CNAs specifically mentioned performance of oral care after eating in the survey, eight responses indicated to check for pocketing as an aspect of oral care in best feeding practices. This final step leads to the next area of education for CNAs.

Oral care is important in reducing the risk of infection for patients and maintaining the integrity of current dentition. When CNAs provide oral care, they are removing plaque build up, preventing halitosis, and providing a measure of comfort for the patient (“Oral Care”, 2018). CNAs need to provide oral care to patients especially after feeding to ensure that food material is not left in the mouth to become an aspiration risk. For CNAs to properly provide oral care, they must collect the necessary materials, complete the proper procedure for hand washing, and obtain a pair of gloves to protect themselves from the patient’s bodily fluids. The procedure for

oral care is going to be different depending on the neurological and functional ability of the patient and whether the patient uses dentures or any other type of oral prosthesis. CNAs should position the patient as necessary to allow for comfort. During this time, it is important for CNAs to note and report to nursing staff any abnormalities of the oral cavity. This may include poor condition of the lips such as dry, cracked or chapped and oral secretions from the oral cavity with information regarding the amount, color, and viscosity of those secretions. It is important for CNAs to remember that self care is always encouraged to promote dignity and patient independence. For independent patients that CNAs will encounter more often in acute hospital settings or independent living, the CNAs role is to provide support and supervision until the patient has completed their typical oral care. When it comes to oral care for patients who wear dentures, special instruction is needed so that the dentures do not become damaged. Many patients are able to remove dentures for CNAs; however, in the case that a patient is unable to, a CNA may remove upper dentures by grabbing the front and the hard palate roof of the denture with one hand and use the other to break the seal between the denture and the roof of the mouth. Dentures can be slippery upon removal, so special care needs to be maintained so that the dentures do not fall and break. When removing the lower denture, CNAs can pinch the front and lingual surfaces with the thumb and index finger and carefully pull up (“Oral Care”, 2018). CNAs should be very careful not to drop the dentures to avoid breaking them and may use paper towels to line a basin as a form of protection in the instance that they were to slip and fall (“Oral Care”, 2018). Like a CNA would brush a patient’s teeth, a soft bristled toothbrush is used to gently brush the dentures to remove any food debris. It is important that specialized creams intended for dentures are used to brush them, as typical toothpaste can scratch and ruin the surface of dentures. Upon removal

of the dentures, they should be placed in a denture cup marked with the patient's name. The cup should be filled with warm water and a denture cleaner applied to it. Warm water is recommended to clean dentures to prevent distortion. A sponge tip swab dipped in mouthwash should be used to clean the oral cavity upon removal of the dentures. Again CNAs should note any abnormalities of the oral cavity. If sores are noted in the oral cavity especially along the gum line, it could be an indication that the patient's dentures were not fitted properly. Knowledge in previously discussed areas provide CNAs a foundation so that when they are presented with atypical pathology, such as head and neck cancer, they will better understand the importance of proper feeding and oral hygiene as it is related to swallowing, dysphagia, health status, and overall quality of life for the patient.

Head and Neck Cancer

Cancer is uncontrolled, abnormal cell growth that results in unwanted and potentially dangerous tissue with the ability to destroy other body tissues. It can be genetic in nature or result from environmental causes (Crary & Groher, 2003). Cancer afflicts millions of individuals with new cases every year. In the United States, it is estimated that head and neck cancer account for 3% or about 65,000 of those new cases and globally about half a million individuals are diagnosed (“Head and Neck Cancer”, n.d.). The American Cancer Society estimates that head and neck cancer will claim the lives of 10,030 persons as of this year. This cancer occurs most often in adults with an average diagnosis around the age of 62. It is estimated that the occurrence in patients in their mid fifties and younger is at a little over 25% of the time (“Key Statistics”, 2018). Head and neck cancers have been linked to occur more for males with no distinguishment of higher rates between ethnic groups and are often classified into five subtypes based on

anatomy with the oral cavity and pharynx being the more prevalent of the locations cancer is found. Additional locations for head and neck cancer include the larynx, nasopharynx, hypopharynx, and the nasal cavity (“Head and Neck Cancer”, n.d.). The primary risk factors currently identified to be associated with head and neck cancer include smokeless and smoked tobacco, heavy alcohol use, poor oral hygiene, and mechanical irritation (Crary & Groher, 2003 p. 69). Due to generational differences, the incidence of head and neck cancers seem to be on the decline with less individuals smoking cigarettes; However, the incidence of cancer testing positive for human papillomavirus associated oropharyngeal cancer is statistically rising(“Head and Neck Cancer”, n.d.). Additionally, alternative methods to cigarettes, such as vaping and e-cigarettes, are relatively new with little research on the potential effect for head and neck cancer.

Head and neck cancer complicates feeding for individuals. When it comes to feeding individuals with head and neck cancer, feeding will be dependent on a multitude of factors, such as the specific anatomical structures affected, types of medical interventions the patient has or will undergo, whether they are pre or post treatment, and the length of time they have been. These will impact the types of symptoms that can be observed in the patient, voice and communication, and cognitive functioning that all relate to mealtime feeding.

Symptoms of Cancer and Cancer Treatments

To begin, it is important to discuss the different types of symptoms and side effects observed in patients with head and neck cancer, as these symptoms will complicate oral feeding and provide insight to proper feeding strategies. Cancer is dependent on the type and the structures impacted. “There are general signs of cancer that can be observed such as fatigue,

pain, and unexplained weight loss and specific signs related to head and neck cancer such as, sores that do not heal, indigestion or difficulty swallowing, nagging cough or hoarseness (Crary & Groher, 2003 p.70).” Other symptoms that have been reported in head and neck cancer include halitosis not explained by poor oral hygiene, loosening of teeth, unusual nasal discharge or frequent nose bleeds, trismus (lockjaw), globus sensation, red or white patches in the mouth, and referred pain in the ear or jaw (“Head and Neck Cancer”, n.d.). “Many individuals with cancer experience pain and fatigue that compounds to create less than ideal outcomes for patients with head and neck cancer. Together this can lead to malnutrition that results in further issues. Malnutrition affects many body systems and can have consequences such as respiratory failure, poor wound healing, skin breakdown, increased susceptibility to infections, and a weakened immune system that may ultimately result in death for a patient. Furthermore, it is estimated that between about a quarter to half of patients with head and neck cancer experience some degree of malnutrition” (Crary & Groher, 2003 p. 71).

Symptoms for patients are not limited to cancer type specifically and can also depend based on the type of intervention route they have elected to treat their cancer. Surgery is a common form of treatment to remove identified cancerous tissue, but it often needs to be combined with other forms of treatment. During surgery, it is possible that a patient will require a tracheostomy if the airway becomes compromised. Common surgeries for head and neck cancer include surgeries to remove a piece of the mandible or split the mandible, removal of a portion or all of the hard palate, partial or total larynx removal, surgeries to remove the larynx and pharynx, and reconstructive surgeries that move tissue from other parts of the body to help fill gaps created by the cancer resections (Crary & Groher, 2003). The tongue is a structure that

often requires tissues from other parts of the body and the portion of the tongue that is removed can have consequences on the oral stage and pharyngeal stages of swallowing (Leonard & Kendall, 2014). Surgery is invasive and comes with negative side effects that can include impaired speech or voice, swelling of oral structures that create dyspnea, difficulty chewing and swallowing, numbness in structures needed for eating, reduced mobility in the neck and shoulders, and hypothyroidism all which affect oral feeding (Crary & Groher, 2003) . As a result, patients are often dependent on tube feeding for a period of time post surgery to allow for healing. “ For these patients, percutaneous endoscopic gastrostomy (PEG) tubes are usually preferred over nasogastric (NG) tubes if possible to promote comfort of the patient, as treatment may last for months” (Leonard & Kendall, 2014 p.35). Multidisciplinary guidelines for nutrition management in head and neck cancer patients recommend PEG feeding if the placement is longer than four weeks (Talwar, Donnelly, Skelly, & Donaldson, 2016).

Radiation is another form of treatment and can be used pre and post operatively to shrink cancerous tumors prior to surgery and remove residual cancer cells. Side effects of radiation are common during and after treatment and at times some occur many years post radiation therapy. Side effects of radiation include changes to the salivary glands that are important in the oral phase of swallowing. These changes slow the production of saliva that can result in persistent dry mouth or make the saliva thick. Radiation side effects also include reduced sense of taste, loss of appetite, fatigue, nausea and vomiting, dental problems, mouth sores and/or sore throat, and painful swallowing that can all complicate oral feeding among others (Crary & Groher, 2003).

Chemotherapy is the one of the last treatments for cancer that also has side effects similar to radiation such as fatigue, nausea, appetite loss, and dry mouth. Chemotherapy also weakens

the immune system, can cause diarrhea and or constipation, and hair loss. Among the interventions, some patients may receive a combination of radiation and chemotherapy in attempt to remove the cancer without removing anatomical structures that may help preserve feeding (Crary & Groher, 2003).

Oral Feeding

Based on multidisciplinary guidelines, there are many recommendations for best practice for nutritional outcomes for head and neck cancer patients. “Good nutritional status is known to enhance therapy completion rates, oncologic survival, and post-treatment quality of life (QOL) for all types of cancer therapy” (Schoeff, Barrett, Gress, & Jameson, 2013 p.46). Current guidelines for head and neck cancer suggest best practice measures include screenings throughout treatment, assessments of nutritional status of the patient, inclusion of dieticians on a multidisciplinary team, diet modification to increase energy and protein intake during treatment to name a few (Talwar et al., 2016). These guidelines are beneficial for professionals including dieticians and SLPs. These guidelines help SLPs and dieticians develop treatment plans that will give guidance to CNAs about how to best provide feeding to these patients. SLPs who regularly assess swallowing function for these patients can determine the appropriate modified diet for the patient and compensatory and rehabilitative strategies that will also inform proper feeding for CNA’s. Because of the variability in head and neck cancer in regards to location of cancerous tissue and treatment course, every patient will present differently that makes it hard to provide CNAs with concrete instruction of how to properly feed. Additionally, there is a lack of current literature for CNAs specifically to provide feeding to these patients. This could explain why 79.17% of the CNAs that participated in the survey reported being inadequately prepared to feed

patients with head and neck cancers. However, it is important that there is an emphasis on oral intake, as studies indicate that it promotes greater quality of life for patients long term. As discussed prior, many patients undergoing treatment may require a PEG tube. Due to symptoms such as loss of appetite and pain, many patients have been found to avoid oral feeding, with preference to tube feeding. Research reviews have shown that the patients who have a partial or complete oral diet received better scores associated with the functioning of their swallowing one year post treatment compared to patients who did not (Schoeff et al., 2013). This shows the importances of proper oral feeding procedures so that mealtimes can be observed as successful for patients with head and neck cancer.

By understanding the symptoms head and neck cancer patients experience, feeding practices or guidelines can be developed for CNAs. It is known that many patients experience xerostomia (dry mouth) due to decreased saliva production from radiation treatment. Decreased saliva will make bolus formation more difficult and harder to clear residue. As a result, it would be recommended for CNAs to provide liquid washes much more frequently during meal time for these patients compared to other populations and especially at the start of the meal to prepare the oral cavity to receive food. Because these individuals are at risk for malnutrition, following multidisciplinary guidelines, a higher caloric diet would be beneficial to patients with head and neck cancer (Talwar et al., 2016). Additionally, the fatigue that many individuals with head and neck cancer experience would support cause for these patients to have more frequent smaller meals provided to them throughout the day to reduce the effects of the fatigue they experience. CNAs should also allow more for time during the oral preparatory phase due to the poor coordination and pain that a patient may experience when trying to eat. If a patient has had a

glossectomy, as stated prior, this could impact different stages of the swallow depending on the portion removed. Removal of the tongue can make bolus formation more difficult, as well as moving the bolus posteriorly in the mouth. For some patients, a glossectomy spoon may be needed to place food more posteriorly in the mouth so that it is easier for the patient to initiate the swallow and allows for less fatigue when eating.

Lastly, it is always important to follow proper feeding techniques that should be employed in every population regardless of afflicting pathologies. As stated prior, CNAs should use proper body-positioning during meal times, allow for patient readiness to eat, and support patients rights by offering them control of what order they would like to eat in. The last strategy of allowing patients to be incharge of decision making during meal times can help provide a sense of patient empowerment. Patient empowerment can also be seen as allowing the patient to have a say in their treatment when it comes to feeding. This actively involves the patient in their treatment plan and can increase patient compliance during treatment which in turn can increase oral feeding and promote better outcomes for patients with head and neck cancer (Leonard & Kendall, 2014). A meta ethnography of ten qualitative studies that focused on feeding of dependent individuals in nursing facilities looked at the attitudes of nursing professional in regards to feeding as a task or feeding as a relationship. “Researchers who observed the relationship perspective in action indicate that it results in many positive person outcomes for both the patient and the practitioner” (Martinsen, Paterson, Harder, & Biering-Sørensen, 2007 p. 214). This would also suggest that it would be beneficial to patients well being for CNAs to view feeding times with individuals with head and neck cancer as a time to connect so that patients would be more willing to be cooperative during mealtimes as they develop a bond with their

caregivers. It is important to remember that head and neck cancer can also impact the anatomy required for speech. This can make communication between the patient and the CNA interacting with them during meal time more difficult. Individuals with laryngeal cancer may experience these effects greatly if the cancer affects the vocal folds. These patients will have difficulty with phonation and may require esophageal speech or an artificial larynx that will change vocal quality and can increase the risk of a communication breakdown between the patient and the CNA during mealtimes (“Head and Neck Cancer”, n.d.). As a result, it is suggested that an alternative form of communication can be used during mealtimes, like a communication board, that a patient can use to signal if they are ready for a bite, need a drink, want more food, or if they are all done eating. This lessens the burden of communication breakdowns and frustration for the patient. As stated previously, prior to and after feeding, patients with head and neck cancer should have proper oral care performed to prevent further complications.

Oral Conditions in Head and Neck Cancer

Oral care is especially important for patients with head and neck cancer due to their increased susceptibility to infection. Multidisciplinary guidelines recommend that patients who will undergo radiation should be evaluated by an oncological dentist and have any teeth extractions or dental surgeries complete two weeks prior to the start of treatment. This will allow opportunity for healing time in the oral cavity (Talwar et al., 2016). Allowing for healing time is important due to the many symptoms that patients with head and neck cancer can or will experience while undergoing treatment, like mucositis. Mucositis is a condition in which mucosa tissue becomes inflamed. Mucosa lines tissues of the respiratory and digestive tract. When patients undergo radiation and chemotherapy, the therapy breaks down epithelial cells in the

mucosa. Mucosa secretes mucus as part of its function as a protective bodily function and is exposed with the breakdown of the epithelial layer. This makes patients more susceptible to infection. Oral mucosa lines the oral cavity and is the most common location for mucositis (“Mucositis”. n.d.). Research has revealed that “oral mucositis occurs in almost all patients receiving treatment for head and neck cancer and has been found to peak (is at its highest severity) around treatment week five in patients receiving radiation (Cullen, Baumler, Farrington, Dawson, Folkmann, & Brenner, 2017 p.25)”. Oral mucositis can begin anywhere from less than a week to about a week and a half following treatment and although it peaks around week five, it can last six weeks or longer (“Mucositis”. n.d.). The prevalences for oral mucositis differs based on radiation versus chemotherapy. Studies report that conventional chemotherapy results in a 20-40% occurrence for oral mucositis and high dose chemotherapy results in an 80% occurrence. Almost all patients experience oral mucositis while undergoing radiation for head and neck cancer (Cullen et al., 2017). Mucositis is a very painful condition that further complicates feeding abilities for patients with head and neck cancer; However, reducing the effects of mucositis through proper oral hygiene can help improve oral intake and decrease malnutrition. A radiation oncology center in the midwest focused on implementing an evidenced based approach to oral care for patients with head and neck cancer and examined how oral hygiene measures influenced patient outcomes. The facility carried out this approach by following its usual oral care guidelines for all participants and a select group of participants were given additional oral care measures that included an oral care kit and targeted education for the kit and oral care in head and neck cancer. “ The kit items included a soft toothbrushes, biotene toothpaste, Lanolin lip care products, waxed floss, and prepackaged salt and baking soda packets

that could be mixed to create an oral rinse. The products were chosen to reduce negative effects on oral epithelium. A timer was also included to encourage timely oral care”(Cullen et al., 2017 p.29). The patients in the usual care group and the select participant group were administered surveys that collected participant responses using a likert scale to rate their symptoms. The study revealed that the select participant group reported better oral care hygiene measures than the usual group and reported less severity of symptoms including mouth and throat soreness, difficulty swallowing, difficulty feeding, and difficulty talking. The select participants also reported better outcomes with dry mouth one month post treatment that demonstrated the importance of proper oral care in patients with head and neck cancer (Cullen et al., 2017). Another study corroborates these finding, as an oncology unit at a university hospital in Turkey implemented an oral protocol for head and neck cancer patients to reduce adverse effects on quality of life. The findings reported by the intervention and control group revealed that the individuals in the control group developed mucositis at a quicker rate than the intervention group and progressed through severity levels quicker. The beginning of the study started with 18 participants in the intervention group without mucositis and 16 participants in the control group. By week seven of radiation treatment, one participant in the intervention group had mucositis and six participants in the control group had developed mucositis. The participants in the intervention group also rated their pain levels to a lesser degree compared to the control participants with one patient rating their pain level as “severe” in week seven and 13 of the control patients with a rating of “severe” and four control patients rating their pain as “very severe”. No patients in the intervention group had a perceived “very severe” pain level (Karin, Tasci, Soyuer, & Elmali, 2014). Both of these studies exemplify that CNAs need to emphasize

the importance and provide oral care to patients with head and neck cancer after every meal or assist patients in providing their own. Mucositis is just one of the many oral symptoms a patient with head and neck cancer may experience. Patients may also experience trismus (lockjaw) that may make oral care difficult due to reduced opening of the oral cavity and can become a possible risk for aspiration (“Mucositis”. n.d.). Additionally, CNAs should be aware that trismus may not allow for a patient to have their dentures placed for meal times. CNAs should report these incidents to proper staff so that accommodations can be arranged. Osteoradionecrosis is another condition that also occurs for patients with head and neck cancer. It is necrosis of the bone as a result of radiation, or bone death (“Mucositis”. n.d.). While osteoradionecrosis occurs in a small sample of head and neck cancer patients, it is impacted by poor nutrition and poor oral hygiene.

Oral Care

The oral cancer foundation provides many oral care recommendations that are applicable to CNAs providing care. For example, patients with head and neck cancer should use salt water mouth rinses to keep the oral cavity moist and help remove any debris (“Mucositis”. n.d.). CNA’s can help facilitate this by offering patients opportunities before and after and between meal times to use a salt water mouth rinse. Because of oral sores that can develop in patients with head and neck cancer, CNAs need to be aware of how dentures can play a role. Improperly fitting dentures can create more sores in the oral cavity when placed wrong by irritating the gum line. Dentures are also not recommended to not be worn if they are loose fitting or if severe oral sores are present. Additionally, CNAs should remove dentures whenever the patient is not eating to allow air exposure for the gums (“Mucositis”. n.d.). CNAs can assess the lips as part of the oral cavity and take measures to keep them moisturized. CNAs are also important in providing

water throughout the day for the patient. This helps the patient increase their fluid intake and CNAs should encourage fluid intake to patients to help with effects of dry mouth from decreased saliva production. Other recommendations can be made for CNAs depending on the environment they work in. For example, lemon or glycerin swabs are not recommended to be used in this population that can be more easily found in hospitals. Only toothbrushes with soft bristles should be used in these patients and no toothpastes with whitening agents are recommended. CNAs should continuously monitor the oral cavity for any changes that could indicate signs of infection, such as white patches or worsening sores. A fever is an additional sign of infection that a CNA may need to be checking for with patients with head and neck cancer, especially if the patient is undergoing radiation therapy at that time (“Mucositis”. n.d.). It is important that the appropriate healthcare providers are notified of any of these changes. As stated prior it is important that dentists assess these patients prior to treatment due to conditions such as loose teeth that can be a sign in patients with head and neck cancer. Following this assessment, CNA’s can carry out dental recommendations that may include the use and care of an oral prosthesis for meal times. Other oral care guidelines identified in research include patients implementing flossing when their platelet counts are in the appropriate range and avoiding the use of products that can irritate the gums, which include mouthwashes with drug ingredients that indicate alcohol and flavored toothpastes (“Mucositis”. n.d.) Patients also should not use chlorhexidine mouthwashes as a best practice in oral care when mucositis is present.

Conclusion

Overall, there is currently a lack of literature that discusses CNA roles as caregivers for patients with head and neck cancer. While it could be due to the circumstances that occur with head and neck cancer, more education is needed to teach caregiver roles how to properly implement oral care to help support oral feeding in this population. This is an area of health that while statistically is declining, will be present in the current generations as they age. Guidelines for head and neck cancer strongly recommended continued assessment by dietitians to decrease nutritional deficits and speech-language pathologists (SLP) regarding swallowing status for safety of oral feeding. It will be the interpretation of the SLP's findings that will give further direction to CNAs to provide proper feeding. It is especially important for CNAs to remember that the symptoms of head and neck cancer and the symptoms resulting from treatment combine to create poor outcomes for feeding; Therefore, oral care is integral to reduce the effects of these symptoms to support oral feeding that will in return support proper nutrition, reduce additional health complications, and increase the quality of life for these patients. When CNAs understand the side effects of cancer treatment and the symptoms of cancer, they can also make necessary mealtime modifications to make mealtime feeding a more positive experience.

The information obtained in the survey presents a need for more thorough education in feeding and oral care in CNA certification coursework based upon participant responses. However, the responses from the 75 participants may not be reflective of the entire certified nursing assistants community that works with populations at risk for dysphagia. More thorough research into CNA perceptions can help to confirm or deny the results obtained in the current survey.

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APPENDIX A

Question 1: How many years have you been a CNA?

Less than a year	24	32%
1-5 years	33	44%
5-10 years	14	18.67%
10+ years	4	5.33%

Question 2: What state do you work in?

ND	1	IN	5	TN	2	MN	1
IL	12	CA	9	FL	2	VA	2
WI	6	AL	2	CT	2	MT	1
PA	4	MI	2	NH	2	NC	2
TX	2	WA	2	OH	2	NY	4
ID	1	KS	1	MA	2	OR	2
NE	1	MD	1	Canada-Ontario	1	Canada-Quebec	1

Question 3: Do you feel your CNA course adequately prepared you to provide oral care to patients who have experienced a stroke?

Yes	40	55.56%
No	32	44.44%
No response	3	

Question 4: Do you feel your CNA course adequately prepared you to provide oral care to patients with dementia?

Yes	37	51.39%
No	35	48.61%
No response	3	

Question 5: Do you feel your CNA course adequately prepared you to provide oral to patients with head and/or neck cancer?

Yes	16	22.22%
No	56	77.78%
No response	3	

Question 6: Do you feel your CNA course adequately prepared you to properly feed patients with dementia?

Yes	48	66.67%
No	24	33.33%
No response	3	

Question 7: Do you feel your CNA course adequately prepared you to feed patients with head and/or neck cancer?

Yes	15	20.83%
No	57	79.17%
No response	3	

Question 8: Do you feel your CNA course adequately prepared you to feed patients that have experienced a stroke or stroke-related symptoms (e.g., facial paralysis)?

Yes	37	51.39%
No	35	48.61%

No response	3	
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Question 9: Do you feel you could identify 3-4 signs that a patient has dysphagia (difficulty swallowing) during mealtime feeding?

Yes	61	84.72%
No	11	15.28%
No response	3	

Question 10: Without using external resources, please briefly list what you currently know about best practice for feeding patients. If you do not know you may indicate so.

- NA
- N.a
- I'm still very new to this and work on night shift so I don't really deal with full meals. We mostly just give liquids. Some patients are on nectar-thick or honey-thick liquid to reduce risk of choking. Others require special cups (good luck finding them at night though!). There are some small snacks available if requested, but usually those patients are independent or require set-up help only.
- Small bites and make sure they swallowed. They can also have purée, Mechanical soft foods, also thickens drinks.
- We are always rushed to complete our jobs but this like everything else takes time and patience to do well.
- Feed on strong side Alternate solids and liquids
- Always take your time Never rush the patient Use adaptive equipment if resident needs Offer drinks in between bites Take a break or stop feeding when patient begins to cough or if you hear a gargling noise that indicates aspiration.
- Encourage as much independence as possible, communicate with patient, check diet orders and swallowing precautions, offer fluids after two bites of food, keep patient upright for 30 minutes after eating
- I did not learn much during the training, I just feed them in small bites and try to make sure they get a sip of drink after every few. I feed slowly and watch for any difficulty swallowing.
- A patient that has had an episode of dementia or tia, we try to feed soft foods, IE thickened soup, applesauce, ect. If they have an immediate problem I was taught to stroke the neck and if that didn't help, to suction out the food. From there we only introduce very small amounts (syringe) to the back of cheek to judge if they can swallow. Suction if necessary. Use mouth swabs next to keep mouth moist and help with sucking. Drops of water on the tongue next. Call Doctor, Hospice to inform.
- Patient must be awake with an appropriate diet. Sitting up in chair or at least 45 degrees in bed. Limit distractions. Offer different foods and alternate liquids with solids. Watch for signs of aspiration.
- Sitting next to the patient as opposed to standing over them is essential. Be knowledgeable about their diet. Don't eat while feeding someone. Do your best to discover a patient's likes and dislikes and tailor your feeding accordingly. Look for watery eyes or any signs of difficulty swallowing and report any to a superior.
- Pureed food, liquid thickeners

- follow the swallow guidelines set by the SLP or OT
- Sit patient at 90 degrees Sit next to them. Do not stand if possible. Ask them what they want to eat
- HOB @ 90 deg Feed slowly allowing proper time for chewing Offer frequent sips of beverage Appropriate usage of thickeners for beverages
- Make sure you're at eye level with them while feeding, they're upright 90ish degrees and continue to stay upright 30 mins after feeding. Show/describe them their plate and give 2 options on what they want to eat. Encourage independence as much as safety possible. Make sure they have the correct diet/meal and that the texture is okay/approved
- *feed at their pace
- Feed slowly and with patience when someone cannot vocalize how they like to be fed. If they cannot use a side of their mouth, take care to put food in another side. Basically make it as easy as possible to eat. Use the right diet and make sure to give fluids so they can get some of the food particles that may have been stuck in a dry mouth.
- Slowly. That's all the instruction I got.
- Just a side note, the majority of everything I learned as a CNA has been through the work. My CNA course probably meant well, and taught best practices. It just didn't often translate into the real world very much, nor was its training always practical or realistic. In general, feeding patients depends on the patient. A big part of feeding someone "well" is knowing them well enough to pick up on their cues. So, ideally, I know when someone wants more. I give people time to respond when I ask, "Do you want cake? Do you want more? Do you need a drink?" I look for a grimace on their face if they're non-verbal to see if they like a food or not. I like to make sure my folks have sips every few bites, particularly the choking risks. In general, myself and co-workers follow the dietary guidelines expected such as chopped foods, thickened liquids, and so on. Whenever possible, I encourage people to feed themselves. By and far, even some of my advanced Alzheimer's residents instinctively know when a spoon is to their lips and will open their mouth. When they're not hungry, don't like the food, or don't want anymore they'll often keep their lips pressed or signal some other body language I'm looking for to tell me to stop or not. In a nutshell, even more simply... I don't overload the utensil. I watch that the person has swallowed. Once they have swallowed, I offer them more food and often verbally communicate what it is as in my situation, I serve a dementia population. At any signal of strain or discomfort, I stop. If choking and resident is unable to clear by coughing, of course we employ further assistance. Emergency protocols followed if necessary.
- - make sure they're not pocketing food - make sure they are swallowing at the same rate they're receiving food/drink - watch for evidence of cough reflex - avoid chewing fatigue, but ensure thorough chewing - keep hydrated - encourage independence
- I know to offer small bites at a slow pace and to ensure the patient has swallowed all of the first bite before offering another. A beverage should be offered every couple of bites.
- Always raise head to above 45 degrees Small slow bites with drinks in-between Don't be afraid to try different ways to serve drink, whether by straw or special cup If in doubt about current food preparation, talk to speech therapy about re-evaluating for thickened liquids, mechanical food, or pureed food
- Depending on their exact situation, I go based on the info I can gather looking at them. Can they swallow well? Do I have to position them into a position where they're less likely to aspirate? What kind of diet are they on? Is it a mechanical thickened? Etc etc. Most patients I work with are in the hospital setting so I don't come across too many dementia/cancerous patients on the floor I work on.
- Use a sweetener like pudding or ice cream to help a patient eat. Give fluids in between bites. Go at a pace comfortable for resident/patient Wash hands before moving on to next resident/ patient Don't force feed
- Always sit the pt up at 90 degrees. If they are on tube feeds, you must pause the machine if you are lowering the bed any lower than 30 degrees. Always check the diet order in the computer before giving a pt anything to eat or drink. If it's a dementia pt, it helps to put the spoon in their hand, and cup yours over theirs, so they feel like you aren't force feeding them.

- Explain what you're doing as you go. Ask what they want and go at their pace.
- I'm very young and just started my CNA job, so I'm very inexperienced. Each patient is different, and I've mostly only fed stroke victims. They have to have a drink of water after every two bites (to prevent choking) but most do not like to follow that rule. I most of the time engage in conversation, and kind of put the glass up so they will naturally just take a sip of water. Some do not like to talk though, and it can be difficult in the process. Sometimes it makes them uncomfortable for me to stare, so I look away and they just start eating on their own. It all depends on what they want or like.
- Allow the patient to do as much for himself/herself as possible. Sit the patient up in bed or in a chair. Thicken beverages as indicated. If tolerated, put the utensil in the pt's hand and move the hand with the patient. For stroke patients, place food in the mouth on the unaffected side. Go slowly and allow the patient to fully swallow the food. Encourage them to tuck the chin while swallowing. Check the mouth for squirreling of food in the cheeks.
- Have them sitting up comfortably in a chair. Use clothing protectors. Carry on a friendly conversation with the patient if they enjoy that. Tell the resident what you are feeding them. Offer frequent sips of their beverage. Make sure foods are the appropriate temperature. Always follow the care plan.
- Patients set the pace Offer small bites and a drink Watch for pocketing Watch for aspiration Sit with patient while feeding Cue to swallow/chew if necessary/appropriate
- Small amounts of pureed food. Sternum rub if they consistently fall asleep while eating (never had to do it myself, only saw it done). Have patience. Communicate a lot. Play music while they eat to get their interest up. Let them do as much as they can. Encourage them.
- I'm not sure anymore
- Don't give the next bite until they swallow the first one. Use small bites. Follow dietary recommendations for what foods to feed.
- Small bites, if the patient has a weak side place the food on their strong side.
- Just from experience: 1. Always ensure proper posture 2. Provide small, easily chewable bites 3. Make sure mouth is clear before a new bite 4. Ask if patient needs fluids, or provide fluids every 2-4 bites, depending on patient ability to chew/swallow.
- I don't really know anything besides offering them a drink every few bites.
- To have patients up in a chair as much as possible, if not then at (or as close to) 90 degrees in bed to avoid aspiration. Feed small bites and allow time to chew, while also giving fluids frequently. Keep them upright at least 30 minutes to avoid aspiration.
- Make sure there isn't too much food in each bite, offer drinks every 3-4 bites, make sure the pt is sitting upright, talk to them in between bites to make sure they've swallowed everything
- Always check their tray card in order to ensure that they have the correct type of food and drink. Feeding a resident with a swallowing disorder normal food when it should be pureed, or giving a resident regular water instead of thickened water can lead to aspiration or choking. You should fill their spoon no more than halfway with food or drink (if fudge thick). Watch for residents pocketing their food. If they get several bites in their mouth and they don't swallow them before taking another, this can lead to problems, such as choking. Always offer your resident their drink every two bites. This allows them to better swallow their food and can help them swallow thicker foods (like sandwiches, pudding, etc.) easier. Always keep a close eye on your residents while they are eating. Frequent coughing can be a sign of dysphagia and can lead to choking if your resident has an undiagnosed swallowing disorder, or they are just having problems masticating and swallowing. Just so you know, I took my CNA course over a period of 10 months. I was also taught a lot more than most aides are taught in their 30 hours of classroom and 70 hours of clinical time. If I remember correctly, our class had around 150-200 hours logged for each student. Thank you for creating this survey!
- Unknown

- Patients should be upright as much as tolerated. At least 45 degrees. Alternate food with liquid. Go slow. Use a spoon over a fork whenever possible. Always give appropriate textures of food eg. Mech. Soft, Nectar thick liquids, et cetera. Pt should remain upright for at least 30 minutes following eating.
- Small bites, offer drink every 3-4 bites. Let patient do as much as they're capable of
- Cut up the pieces small. If they have trouble eating a certain food, stop feeding it. Thicken liquids if needed without an order if they are choking on it.
- -Small sips/bites -no straws -sitting straight up in chair or bed -direct patients to double swallow -check for pocketing of food
- Small bites. Show and tell what you're feeding them. Wait for it to cool down.
- Half spoon bites, alternate with water, take tests, avoid talking/singing with good in mouth, posture, helpful appliances like altered silverware/cups/plates
- -Don't force feeding patients/residents -if feeding patients/residents in bed make sure to keep their head elevated
- Wash my hands and hands of the patient(pt); don't wear gloves if feeding the pt; make sure the food on the tray meets the pt's diet and check for food allergies; make sure pt is sitting up and awake; sit down beside the pt start with a sip of liquid to hydrate the mouth; talk to the pt and let them know what is on their plate; make sure food is an adequate temperature; offer the pt the options on their plate; give sips of liquid in between bites
- Sit upright (45-90 degrees) Alternate bites of food with sips of liquid Remind to take time chewing and swallowing Watch to make sure patient swallows before feeding more Look for signs of coughing/choking/distress
- Small amounts on spoon, verbal encouragement, waiting to swallow before new bite, offering drink every few bites, body at 90 degrees (also courses don't teach the things in the qs but you learn all on the job)
- 90 degree angle. Small bites, frequent drinks, watch for signs of dysphagia. I could write a book but it's late
- Easily swallowable food Sit the patient upright Give them small bites at a time Let them drink in between each bite
- Idk
- For patients with dysphagia the consistency of liquid is based on their ability to swallow. This can be anywhere from nectar thick to honey to pudding. Foods should be a certain consistency as well, depending on the ability of the patient to chew and swallow. Check if the patient is holding food in their cheek when feeding. And also monitor the patient closely for signs of aspiration such as coughing, gagging, or turning red.
- For patients that are having difficulty eating foods, sit them up completely strait. Sometimes it helps to have them tip their chin forward to swallow. Check for pocketing and loss of liquids from the mouth. Pay attention to coughing and any other unusual symptoms while feeding a patient.
- Go at the patients rhythm Use a smaller spoon Wait between bites
- Be aware of current health/issues eating Take small bites and sips between bites Check for food pocketing Have patient sit up right Talk to patient/ let them know what they're about to get
- Slow is best, take your time, watch carefully for swallowing and (with dementia patients) remind if necessary.
- Eat and drink slow. Head elevated above 80 degrees. Chew thoroughly and take small bites. Make sure no food pocketed or trouble swallowing or chewing.
- chin to chest swallowing, bits of lemon ice to facilitate a swallow reflex/quench thirst, watch for pocketing, watch for signs of aspiration
- Distraction helps, small bites helps, sometimes keeping the patient helps, going slow helps, finger food helps, etc
- Make sure patient is alert, ask them if they are ready for a bite. If they cough, encourage them to keep coughing

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- 1/4 to 1/2 spoon/ fork full, let them fully chew then swallow, then give small drink between bites
- First you make sure the patient is sitting in an upright position, it is easier for someone to choke if they are at an angle. Always make sure the patient has a drink. Fluid intake is important in general, but is very important when feeding, because food can be dry, or their mouths might be dry. This would prevent food from forming into the proper bolus needed to be swallowed. Food needs to be cut up properly along with making sure you are not giving patients too big of bites. Also, making sure the food is warm is important, of course!
- When feeding patients, they must be sitting upright, higher than 30 degrees. you must explain to them what food they are getting ready to eat and let them know when the food is coming. you must then make sure that they are chewing and swallowing their food, at times coaching
- Take your time
- Slow and steady, watching for signs of possible aspiration or difficulty chewing/swallowing
- 1)A swallow eval may need to be completed before a meal is prepared to determine the type of diet especially with patients who have suffered a stroke, have dysphasia, etc. 2) Feed them small bites to reduce the risk of choking. 3)Offer fluids between bites. 4)Do not rush, let patient go at their own pace.
- Small bites. Let them chew the bite fully.
- Add thickener as described on patient's chart or diet card.
- They should have the right food. They should be sitting up right Give them time to chew with out rushing. Make sure they are swallowing the food right. And not keeping it inside. Pouching? If they start chocking, let nurse know to refer them to speech. And let dietary know they might need to change food.