Team Name: Regional Home Care Leadership Team Team Lead: Regional Director - Home Care Approved by: Executive Director - East	Reference Number: CLI.5411.SG.010 Program Area: Home Care Policy Section: Service Delivery
Issue Date: September 28, 2018 Review Date: Revision Date:	Subject: Home Care Services: Oral Feeding without Swallowing Disorder

STANDARD GUIDELINE SUBJECT:
Home Care Services: Oral Feeding without Swallowing Disorder

PURPOSE:
To facilitate safety in meeting nutritional requirements, Home Care clients who meet eligibility requirements, assessed as unable to feed themselves and do not have a swallowing disorder may receive Home Care services to assist with feeding.

To outline the eligibility criteria for oral feeding assistance.

DEFINITIONS:
Swallowing Disorder – includes a number of diseases and conditions that cause difficulty in passing food or liquid from the mouth to the stomach that increase the risk of choking/aspiration e.g. stroke, neck tumor, Multiple Sclerosis.

IMPORTANT POINTS TO CONSIDER:

- Eligibility Requirements:
    - The person must be eligible for Home Care (Eligibility for Home Care CLI.5410.PL.004).
    - The environment has been assessed as safe for client and staff for this activity.
    - Clients who cannot safely or independently feed themselves.
    - Client has no family or caregiver who can assume responsibility for feeding the client.
    - Clients assessed as not having a swallowing disorder.

- <u>Guidelines for Frequency:</u>
  - The frequency of service required to meet the client's nutritional requirements shall be up to a maximum of 4 times per day.
- Wherever possible, in order to enhance and promote health and independence the client/family and/or caregiver(s) shall be taught new ways of feeding.
- The client/family/caregiver is responsible to provide and maintain equipment that is not provided by Home Care and is required to facilitate the provision of feeding/ nutritional needs/tasks e.g. customized cutlery, drinking cups and lipped plates as per Occupational Therapist assessment.

<u>PROCEDURE:</u>

1. The Case Coordinator is responsible to:
   - Complete a comprehensive assessment of client's ability to feed self, Case Coordinator Service Considerations: Oral Feeding without a Swallowing Disorder (CLI.5411.SG.010.SD.01).
   - Assess the availability and capability of family/caregiver supports to assist client with feeding.
   - Respond to requests for oral feeding assistance from Rehabilitation Services.
2. When feeding/nutritional services are provided to Home Care clients assessed as requiring services, the care plan will:
   - Be discussed/developed in collaboration with the client/family/caregiver.
   - Clearly identify the tasks, Home Care and client/family/caregiver responsibilities.
   - Include the frequency of service and supplies/equipment to be provided/required.
3. In instances where client specific training is required, the Case Coordinator will arrange for the training for direct service staff/caregiver prior to the provision of care. For example, this may include training of specialized feeding techniques by a Speech Language Pathologist.
4. Where a client is in the community, receiving care for feeding by a Home Care Attendant shows signs of difficulty with swallowing; the Home Care Attendant will report the change in function to the Home Care office immediately. The Case Coordinator will contact the client/family/caregiver to advise that care can no longer be provided by a Home Care Attendant for feeding. Alternate care will be arranged as per the Case Coordinator assessment that may include feeding by a Direct Service Nurse and/or refer client for swallowing assessment by completing the Community Based Rehabilitation Services Referral form (CLI.6310.SG.007.FORM.01).

5. When nutritional concerns unrelated to swallowing difficulties are identified through the Case Coordinator assessment, the Case Coordinator may refer to the appropriate allied health care professional as necessary to address related health issues e.g. Physician, Dietitian, Chronic Disease Prevention Team.
6. The Case Coordinator:
   - Registers client to Home Care Attendant Department in Procura.
   - Documents on the Manitoba Health, Seniors & Active *Living* - Care Plan Information MG-1840 form the information sheets reviewed and left with client/family/caregiver and the services provided.

SUPPORTING DOCUMENTS:

CLI.5411.SG.010.SD.01	Case Coordinator Service Considerations: Oral Feeding without a Swallowing Disorder

REFERENCES

Eligibility for Home Care (CLI.5410.PL.004)
Community Based Rehab Referral (CLI.6310.SG.007.FORM.01)
Manitoba Health, Seniors and Active Living - *Personal Care Services. HCS 207.14, October 2009*
Manitoba Health, Seniors & Active Living - *Care Plan Information MG-1840 form*
Home Care Direct Service Protocols (WRHA) based on *Manitoba Health Direct Service Protocols, September 2009*