Congress of the United States
Washington, DC 20515

September 26, 2003

The Honorable Tommy G. Thompson
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Dear Mr. Secretary:

We are writing to express our opposition to a regulation that the Centers for Medicare and Medicaid Services has published regarding the use of feeding assistants in nursing homes. This is a dangerous proposal that runs the risk of further endangering the health of the nation's 1.5 million nursing home residents.

We agree that malnutrition and dehydration are serious problems in nursing homes, but this problem cannot be solved by using poorly trained, poorly screened, and poorly supervised workers to handle feeding responsibilities. Feeding an elderly resident who may be uncommunicative and may have difficulty chewing or swallowing is a complicated task that should be performed only by skilled and properly trained and supervised personnel.

Contrary to the claims of the nursing home industry, the regulation does nothing to solve the problem of understaffing in nursing homes that the Department of Health and Human Services recognized in a recent study.[1] In fact, the feeding assistant regulation may actually worsen the staffing problem by encouraging nursing homes to hire low-wage feeding assistants, instead of certified nurse aides.

Several provisions of the final regulation are particularly troubling. First, the final regulation requires that a feeding assistant receive only 8 hours of training before being allowed to work in a nursing home, compared to the 75 hours of training required by nurse aides. Eight hours is too little time to master the difficulties of feeding a nursing home resident, as well as learning about safety and emergency procedures, infection control, and resident rights. Moreover, the final regulation requires that potential feeding assistants attend a "State-approved training course," but the regulation gives the federal government no role in overseeing whether these courses provide sufficient training.

Compounding the problem of inadequate training, the final regulation simply requires that feeding assistants work under the "supervision" of a registered or licensed nurse. In fact, all certified nurse aides already work under the supervision of licensed and registered nurses, and all nursing personnel are ultimately under the supervision of the director of nursing. To require "supervision" without any standards is a meaningless requirement.

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[1] HHS, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II Final Report*, 1-6 (Winter 2001) (noting that over 90% of nursing homes have staffing levels that are too low to provide adequate care).

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In contrast, the proposed regulation required "direct supervision" and stated that a supervisory nurse had to be in the unit or on the floor where the feeding assistance was occurring. This proposed language ensured that better-trained staff were nearby in order to provide guidance or in the event of a problem or emergency. The final regulation merely states that that "[i]n an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system."

This is not an adequate safeguard. A series of investigative reports prepared by the minority staff of the House Government Reform Committee has found that call lights and call bells are not answered promptly at many nursing homes, resulting in waits of as long as two hours.[2] Such delays in responding to an emergency call from a feeding assistant could have fatal consequences for a choking resident.

Furthermore, these investigative reports have found that even trained nurse aides make mistakes in feeding nursing homes residents. For example:

- At a New York nursing home, a resident who was only supposed to receive pureed food was given a danish. The resident was found "hanging over the side of his chair gasping for air" with "his face turned blue." The resident died less than an hour later.[3]

- At a Missouri nursing home, state inspectors observed the staff repeatedly giving inappropriately thick liquids to a resident who had difficulty swallowing and was at risk for aspiration. On one occasion, the liquids caused coughing so severe that his physician had to be contacted. At the same facility, inspectors observed the staff feeding sweetened foods and drinks to a diabetic resident, despite a physician's order that he not receive concentrated sweets.[4]

- At a California nursing home, residents with difficulty chewing and swallowing were fed roast beef. Other residents with no teeth or dentures were served ham sandwiches.[5]

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[2] House Committee on Government Reform, Minority Staff, Reports on Nursing Home Conditions in Chicago (Mar. 27, 2000); Central New Jersey (July 6, 2000); 22nd District of California (Jan. 5, 2001); 19th District of Florida (Jan. 30, 2001); 13th District of Pennsylvania (July 23, 2001); 14th District of New York (Apr. 25, 2003).

[3] House Committee on Government Reform, Minority Staff, Report on Nursing Home Conditions in 14th District of New York (Apr. 25, 2003).

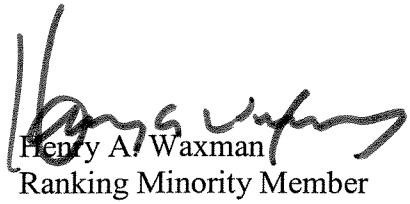
[4] House Committee on Government Reform, Minority Staff, Report on Nursing Home Conditions in 1st District of Missouri (Nov. 19, 2001).

[5] House Committee on Government Reform, Minority Staff, Report on Nursing Home Conditions in 22nd District of California (Jan. 5, 2001).

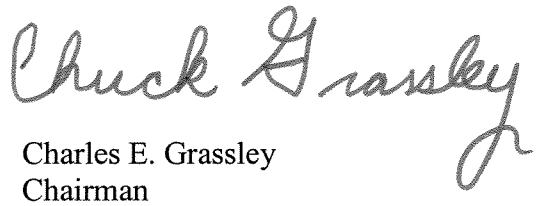
These mistakes will only be compounded by the use of inadequately trained feeding assistants.

In sum, this feeding assistant regulation is a step backwards in our efforts to improve the quality of care provided by nursing homes. We urge you to reconsider implementing this regulation.

Sincerely,



Henry A. Waxman
Ranking Minority Member
Committee on Government Reform
U.S. House of Representative



Charles E. Grassley
Chairman
Committee on Finance
U.S. Senate