Chew on this

Dysphagia care gives all staff plenty to think about; only through highly co-ordinated efforts can residents be well served.

By Samantha Murray and Kelly Rodgers

What is dysphagia? It's a term that means 'swallowing problem'. It has numerous causes, including stroke, head and neck cancer, dementia and Parkinson's disease. It can also affect the otherwise healthy elderly.

About 67 per cent of residents within residential aged care have dysphagia. Take a moment to consider the enormity of this number. In a dining room that seats 30 residents, 20 of them will have dysphagia. The mismanagement of dysphagia can result in these residents facing potentially life-threatening consequences, as well as poor quality of life.

After falls, choking is said to be second-highest cause of preventable death within residential aged-care facilities. Did you know that someone on a soft diet cannot safely eat a meat pie or toast? And that jelly is not suitable for residents on thickened fluids?

So how do you know if someone has dysphagia? There are signs you can look and listen for that might lead you to believe someone has dysphagia; however, it should be diagnosed by a speech pathologist (SP). Some signs to look for include:

- Coughing during or after eating/drinking
- Not finishing meals or taking a long time to consume a meal
- Spitting out food
- Reports of feeling full quickly
- Wetness in vocal tones
- Temperature spikes and/or recurrent chest infections.

An SP will conduct an assessment to enable the least restrictive diet modification that can be offered. When a diagnosis has been made, it is essential to follow the texture modification and fluid thickness recommendations made by the speech pathologist. Of residents that do have dysphagia, 50 per cent may show no visual or audible signs that food or fluids have entered their airway (silent aspiration). Upgrading and downgrading diets and fluids without a recommendation from an SP can have negative consequences.

Texture-modified diets enable residents to consume adequate nutrients and fluids to maintain nutritional status, while reducing the risk of choking and aspiration. Once the SP has provided recommendations for texture modification of the diet and thickened fluids, an accredited practising dietitian (APD) can work with individual patients or an institution as a whole to ensure nutrition and hydration requirements are met, within guidelines set by the SP.

Residents with swallowing difficulties

are often at higher risk of malnutrition and therefore APD involvement is essential. Both food and fluids may be fortified or enhanced to achieve optimal nutritional intake. Menus should be carefully planned to ensure meals are high in protein and energy to maximise the nutritional value. Fortification of meals can also assist, particularly when intake is poor. Butter, cream, oil, cream cheese, cheese, and milk powders are all great examples of easy meal fortifiers. An APD can assist with individualised meal plans for residents who struggle to maintain weight.

AN SP or APD can also advise on the correct feeding strategies to assist residents at meal times, yet another important step to ensuring optimal nutritional intake.

In 2007, the Dietitians Association of Australia and Speech Pathology Australia joined forces to standardise terminology across the country in an effort to reduce confusion and improve the understanding of texture modified diets. The standards outline regular, unmodified routines, along with the following diets and fluids.

Texture-modified diets: soft diet (texture a), minced and moist diet (texture b), smooth puree diet (texture c)

Fluid consistencies: mildly thick fluids (level 150), moderately thick fluids (level 400) and extremely thick fluids (level 900).

Managing dysphagia in aged care is a little like walking a tightrope. Workers are balancing resident safety, nutrition and hydration, and quality of life. Without the appropriate management from all team members, it is easy to have a fall. An effective management plan requires an interdisciplinary approach, which includes the speech pathologist, APD, nursing staff and care staff, as well as food services – and of course the resident.

The idea behind an interdisciplinary approach to dysphagia management is that all parties are working together to achieve the ultimate goals. Many facilities like to adopt a multidisciplinary approach, where allied health professionals work within their own discipline to achieve separate goals for a resident. That is the wrong approach against dysphagia. When attempting effective management of this issue, working together to achieve a shared goal is fundamental.

All members of the team need to understand dysphagia and the risks of inappropriate meal provision. If a dietary change is made without consultation of the other team members, it can often result in negative outcomes for quality of life, nutrition, hydration and pulmonary status. In contrast, working within a team can help keep residents in balance and maintain and optimise nutrition, hydration, safety, and, ultimately, quality of life. ■

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