Methods for managing residents with dysphagia

Joanna Rudakiewicz explores the role nurses have in ensuring safe, effective and efficient care for people who have difficulty swallowing.

**Abstract**

Nurses working in nursing homes will care for residents who have dysphagia, or difficulty swallowing, on a regular basis. Clear, evidence-based guidelines are necessary for all staff to be able to meet the needs of these residents safely and efficiently. A multidisciplinary approach is important to ensure accurate assessment, devise appropriate care and achieve specific goals. Equipment such as valved beakers, rimmed plates and non-slip mats will help maintain safety during mealtimes. Prescription items, such as fluid thickeners and anticholinergic medication, help to manage the condition and provide comfort during mealtimes and in between. Robust education and training should be in place for all nursing and care staff who care for residents with the condition.

**Keywords**

Dysphagia, nursing homes, nutrition, oral hygiene, patient safety

**Symptoms**

Signs and symptoms of dysphagia vary, depending on which part of the upper GI tract is affected (WGO 2014). Nurses should be able to identify the signs and symptoms, especially as some of them may not be obvious. They should take action as soon as possible to establish the problem and prevent complications (Groher and Crary 2010).

If a speech and language therapist (SALT) is not available, nurses can carry out a simple bedside screening for dysphagia to establish if residents can swallow safely by giving them a small amount of fluid and food with different textures and observing for the symptoms listed below.
Table 1 | Physiological mechanisms involved in the stages of swallowing

<table>
<thead>
<tr>
<th>Swallowing stage</th>
<th>Physiological mechanism</th>
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<tbody>
<tr>
<td>1. Oral</td>
<td>Food enters oral cavity, Mastication and bolus (ball-like pellet of food) formation</td>
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<tr>
<td>2. Oropharyngeal</td>
<td>Soft palate elevates to seal nasopharynx, Larynx and hyoid bones move anterior and upward, Epiglottis moves posteriorly and downwards to close, Upper oesophageal sphincter relaxes and opens, Tongue propels bolus into oesophagus, Pharynx contracts clearing pharynx and closing upper sphincter, Larynx reopens</td>
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<tr>
<td>3. Oesophageal</td>
<td>Oesophagus contracts sequentially, Lower oesophageal sphincter relaxes, Bolus reaches stomach</td>
</tr>
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(World Gastroenterology Organisation 2014)

(Perry et al 2014). If nurses think that a resident is at risk of aspiration (food and/or fluid entering the lungs), oral nutrition should be stopped and immediate advice sought from a SALT or GP (Perry et al 2014).

Robbins and Banaszynski (2014) listed the most common signs and symptoms of oropharyngeal dysphagia as:
- Dribbling saliva or food from the mouth.
- Coughing or choking when eating or drinking.
- Keeping food in the mouth for prolonged periods.
- Food or fluid spilling through the nose (nasal regurgitation).
- Food sticking in the mouth or throat.
- Cutting food into small pieces.
- Leaving food on the plate or avoiding some foods.
- Using extra fluids to moisten food or wash it down.
- Weight loss.

People with oesophageal dysphagia may present with (Robbins and Banaszynski 2014):
- Hoarse voice or sore throat.
- Belching more than usual.
- Clearing the throat after meals or when lying down.
- Coughing.
- Difficulties swallowing tablets, bread or meat.
- Bitter taste in the mouth.
- A feeling of something sticky in the chest.

When any of these signs and symptoms are noticed and persist for a period of time, multidisciplinary team input should be sought (Robbins and Banaszynski 2014). SALTs will be able to carry out a detailed swallowing assessment and recommend further treatment. A multidisciplinary approach can minimise risks as a result of dysphagia such as aspiration, malnutrition and dehydration.

Dysphagia increases the risk of aspirating food and fluid into the respiratory tract, which can lead to bronchopneumonia and airway obstruction (McLaren 2006). Oropharyngeal aspiration is one of the most important factors leading to pneumonia in older people. Pneumonia is the leading cause of death among nursing home residents (Marik and Kaplan 2003). SALTs will carry out a detailed assessment and advise on appropriate food and fluid consistency to reduce or prevent the risk of aspiration (British Association for Parenteral and Enteral Nutrition (BAPEN) 2012). SALTs will also be able to recommend swallowing and eating techniques, positioning and oral and sensory exercises taking into account residents’ preferences and beliefs (Royal College of Speech and Language Therapists 2009).

To prevent malnutrition and dehydration caused by dysphagia, advice from a dietitian is needed. The resident’s weight should be monitored and the Malnutrition Universal Screening Tool (BAPEN 2011) should be used to assess nutritional status at least monthly. This tool helps to identify those at risk of obesity, malnutrition or malnourishment. It also provides guidelines for management and care planning when any of these states have been identified. A diary of daily food and fluid intake will be helpful in establishing how much and what kind of food and drink the resident can manage. If necessary, diet supplements can be offered to maintain nutritional intake and weight (BAPEN 2012).

Diet

The National Patient Safety Agency (NPSA) (2011) recommend that all care settings should have at least two textures of food and drink available for patients or residents with dysphagia:
- Thick purée dysphagia diet: puréed moist food that is not sticky in the mouth, has a fine texture without lumps and can be eaten with a fork.
- Fork mashable dysphagia diet: soft, tender and moist, requires some chewing but has no hard pieces.

In some care settings a further two textures may be required: a pre-mashed dysphagia diet, which is soft, tender and moist, with no hard, chewy pieces; and a thin purée dysphagia diet, which is runny and moist, cannot be eaten with a fork and is not sticky in the mouth.

Fluids for residents with dysphagia can be thickened to three stages, depending on severity of symptoms and individual needs. Nutrition and Diet Resources (2005) differentiated the following stages:
Stage 1 can be drunk from a straw or from a cup, it leaves a thin coat on the back of a spoon.
Stage 2 can be drunk from a cup but is too thick to be taken through a straw, leaves a thick coat on the back of a spoon.
Stage 3 is too thick to be drunk, must be taken with a spoon.

To control the size of fluid bolus and reduce the speed of oral intake the following equipment can be used: a teaspoon rather than a standard-sized spoon, small cups rather than the standard 250ml ones, one-way valved cups with lids. Straws of various diameters can also be used to help adapt the bolus size (Cichero and Murdoch 2006).

Kilworth (2003) stressed that the presentation of a texture-modified diet is important, as change of consistency may discourage people from eating. When the plate is well presented it makes the food look more attractive and appealing.

Nursing role
The role nurses have in ensuring residents are receiving appropriate treatment is vital. As soon as residents are admitted to the home an assessment of nutritional needs and possible nutritional issues should be carried out (Kilworth 2003). As soon as symptoms of dysphagia are noticed nurses are responsible for appropriate referrals to a SALT for detailed assessment and/or to a GP for initial advice if the nurse would like some input from a professional before the SALT assessment. After diagnosis and recommendations are made, nurses should devise appropriate care plans, taking into consideration individuals' needs, wishes and beliefs. Consent for treatment must be obtained if residents have mental capacity. If residents do not have mental capacity, the nurse, together with the multidisciplinary team, should make a decision in their best interests to maintain safety and wellbeing after completing the mental capacity assessment in line with the Mental Capacity Act (MCA) 2005 in England and Wales or the Adults with Incapacity (Scotland) Act 2000 in Scotland. Care plans must be person centred and include elements such as likes and dislikes; preferred time of meals; place of eating, for example, own room; any aids needed such as valved beaker cups, valved straws, rimmed plates or non-slip mats; and cultural needs. Care plans must identify risks and have appropriate assessments in place to reduce them, for example, choking risk. They should also include instructions for trained staff on how to manage choking incidents if required (NPSA 2007).

Communication Clear goals should be set and regularly evaluated and reviewed. Progress needs to be checked against the goals set and clearly documented. Nurses should ensure that communication between staff in the home is efficient and everyone involved in residents' care is aware of their needs. This includes kitchen staff, care assistants, nurse colleagues and family members. All staff must be aware of the consistency of food and fluid required for the person with dysphagia and if any specific aids or help with eating are needed. They should also have appropriate training on preparing thickened fluids to the right consistency. An information poster can be placed in the kitchen or dining room for staff to refer to.

Environment Staff should also make every effort to provide an appropriate environment for mealtimes. Comfort should be maintained. Residents’ posture during mealtimes is important: sitting upright with a stable base for legs and arms when eating at the

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**Figure 1** The three stages of swallowing

- **Stage 1** can be drunk from a straw or from a cup, it leaves a thin coat on the back of a spoon.
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**Environment** Staff should also make every effort to provide an appropriate environment for mealtimes. Comfort should be maintained. Residents’ posture during mealtimes is important: sitting upright with a stable base for legs and arms when eating at the
table or positioned upright with the head slightly flexed forward to protect the airway when eating in bed (McLaren 2006). Those eating in bed should remain in an upright position for 30 minutes after finishing their meal to prevent aspiration (McLaren 2006). Ideally, mealtimes should be protected, which means no medications should be given, no tests should be carried out and any distractions should be reduced to a minimum. Residents should be given enough time to consume food and any help required should be offered on an individual basis.

**Taking medication** Residents with dysphagia may also be vulnerable at medication rounds. Nurses dispensing medications to dysphagic residents must be aware of the risk of aspiration or choking and that they may have difficulties swallowing solid medications. Robbins and Banaszynski (2014) recommended the following strategies to address so-called ‘pill dysphagia’:
- Moisten mouth with water before swallowing the tablet.
- Insert the tablet into a small piece of food or on a spoon of yoghurt. The resident must be aware this has been done; medications must not be given covertly without need.
- After swallowing the tablet take a spoon of yoghurt to help the tablet move through the digestive tract.
- Ask for an alternative to the tablet, for example, liquid or orally disintegrating tablets.

The Nursing and Midwifery Council (NMC) (2010) advised against tampering with solid medications by, for example, crushing them, without clear advice from a prescriber, because doing so might alter their therapeutic properties. Nurses are accountable for all decisions made about administration of medications, including administering against prescriber’s advice (NMC 2010).

**Hygiene** Residents with dysphagia must maintain oral hygiene. Mouth and lips should be kept moist, dentures or teeth brushed at least twice a day (morning and evening), and any debris or food remaining in the oral cavity removed after meals to avoid choking and prevent gum disease. Drooling must be managed appropriately to ensure dignity. Good strategies to address drooling are provided by Bavikatte et al (2012) and include managing eating and drinking techniques, oral motor training if the resident is able to co-operate, pharmacological therapy, for example, the anticholinergic drug hyoscine to control production of saliva, or simple measures such as providing a handkerchief or tissues and privacy. Taking regular sips of fluid and extra dry swallows may also be helpful (Cichero and Murdoch 2006).

**Artificial nutrition**
If dysphagia becomes severe and treatments such as modified diet or liquid medication are no longer appropriate and the risk of aspiration is high or aspiration has already occurred, decisions must be made about further care. This may raise difficult ethical questions since artificial nutrition can be seen as an aggressive form of treatment (Chernoff and Seres 2014). There are three options for artificial nutrition: nasogastric tube, percutaneous endoscopic gastrostomy and jejunostomy (Crary and Groher 2003). As there are medical and psychological risks and benefits to artificial nutrition, it is important that residents understand this and have a clear picture of what it will entail before making the decision (Crary and Groher 2003).

Such decisions are often made in advance, when residents have mental capacity and are able to understand the information relating to the decision, retain the information, weigh up the information in terms of risks and benefits and communicate a decision. If the resident has not made an advance care plan and there is no lasting power of attorney about their health and wellbeing, the multidisciplinary team will act in the resident’s best interest when taking decisions about further treatment. Where it is unclear if the person has capacity, a mental capacity assessment should be carried out in line with the MCA 2005 or the Adults with Incapacity (Scotland) Act 2000. When the person is deemed not to have capacity, best interest decisions can be made for them.

This may also mean that no further treatment will be given and palliative care will be advised if the resident is in the last stages of life and surgery is impossible or artificial nutrition would not bring any benefit (Chernoff and Seres 2014). The National Institute for Health and Care Excellence (2006) dementia guideline stated that if impaired swallowing and inability to take food and fluid by mouth are a consequence of advanced dementia, and the condition is not going to improve, artificial nutrition should not be implemented. Artificial nutrition in the last stages of dementia can be seen as resulting in more harm than benefit. Instead, taking small amounts of food and fluid by mouth could be advised to maintain comfort, as this will outweigh the risks of aspiration (Jones 2010). Quality of life and death, rather than prolonging life, should be the priority when caring for residents.
with advanced dementia during the last stages of the illness.

Conclusion
Nurses play an important part in caring for residents with dysphagia in nursing homes. They undertake initial assessment of swallowing difficulties and make appropriate referral for treatment to a SALT for detailed assessment and/or to a GP for initial advice if the nurse would like some input from another healthcare professional before the SALT assessment. After diagnosis and recommendations for treatment are made, nurses will devise person-centred care plans and implement management strategies. Nurses will also teach residents, their families and junior staff how to manage dysphagia safely, maintain residents’ dignity and ensure they are happy with treatment received. Therefore, it is essential that nurses gain and maintain appropriate knowledge about dysphagia and are confident in its management. This will ensure safe, effective and efficient care for residents living with the condition.

References


