NHD
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MANAGING DYSPHAGIA IN CARE HOMES

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Between 50 and 75% of care home residents are thought to have dysphagia, which means that catering to residents with chewing and swallowing difficulties is a challenge that most homes face on a daily basis.

The clinical term for difficulty swallow-ing and chewing food, dysphagia, occurs as a result of either nerve or structural damage which interferes with the safe movement of food and fluid from the mouth to the stomach. Signs of dysphagia include difficult, painful chewing or swallowing, dribbling or food spillage from lips and a sensation that food is stuck in the throat or chest, as well as a dry mouth, heartburn and changes in eating habits.

Caused by a wide range of con-ditions, from strokes to degenerative illnesses such as dementia, dysphagia can have serious consequences. For example, if a resident suffering with chewing and swallowing difficulties is served food with an inappropriate texture for their particular stage of dysphagia, there is a risk of aspiration - where food or fluid is accidentally 'breathed in', potentially leading to aspiration pneumonia - and choking. There is also the emotional and psychological impact of not being able to eat normally.

RISK OF MALNUTRITION

More than one million people over the aged of 65 are either malnourished or at risk of malnutrition.[1] In fact, 41% of new residents are malnourished when entering a care home[2] and, for those with dysphagia, ensuring that they get the nutritional intake they need to improve and maintain their health and wellbeing, can be particularly challenging.

Not only can eating become a very tiring process, the threat of the serious consequences described above can make mealtimes a fearful experience. Furthermore, for residents with dys-phagia as a complication of dementia, the confusion and memory problems that arise can have a significant impact on appetite levels and their overall dining experience.

Traditionally, dysphagia sufferers have been offered liquidised food, which can be unappetising and lacking in distinctive flavours. As water is usually added as part of the liquidising process, this dilutes both taste and nutrients, without contributing calories, vitamins or minerals.

Each of these factors can contribute to an increased risk of becoming undernourished, which is why it is especially important to screen residents with dysphagia for malnutrition - both on admission to a home and on an ongoing basis. There are a number of screening tools available, but BAPEN's 'MUST' tool is well recognised by the industry and is simple to use.

As well as screening all residents for malnutrition, the first step in catering to residents with dysphagia is for them to be assessed by a speech and language therapist, who can diagnose which stage of the condition they have reached.

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Table 1: Category E - 'Fork Mashable Dysphagia Diet'

Food must be soft, tender and moist
Requires some chewing
Pieces of soft tender meat must be served no bigger than 15mms
No skin, bone or gristle
No sticky foods, e.g. cheese chunks, marshmallows
Check before serving that no hard pieces, crust or skin have formed during cooking/heating/standing

Table 2: Category D - 'Pre-Mashed Dysphagia Diet'

Requires little chewing
Has been mashed up with a fork before serving
Usually requires a very thick, smooth (non-pouring) sauce, gravy or custard
Should have no hard, tough, chewy, fibrous, stringy, dry, crispy, crunchy or crumbly bits
Should have no skin, bone or gristle
Meat must be finely minced - pieces approximately 2.0mms.

GUIDELINES FOR TEXTURE-MODIFIED DIETS

Residents with chewing and swallowing difficulties who require a texture-modified diet, must be served food that is safe for them to eat, which is determined by the stage of dysphagia they are experiencing.

Recognising the difficulties faced in preparing texture-modified food, the National Patient Safety Agency created the Dysphagia Diet Food Texture Descriptors. These were published in 2011 and replace previous versions that were developed by the British Dietetic Association and the Royal College of Speech and Language Therapists.

Each Descriptor includes examples of how particular types of food should be prepared in order to be suitable for a resident at that stage of a texture-modified diet. This ranges from Category B, which can be described as a thin purée and is for those with more severe forms of dysphagia, to Category E. Described as 'fork mashable', food within Category E is for those in the early stages of dysphagia or in the final stages of returning to a 'normal' diet.

As a very minimum, the Care Quality Commission requires all care settings to offer Category C and E meals to residents. As dysphagia is a journey that changes, it is very important that input from a speech and language therapist is sought on a regular basis to ensure that residents are given a diet that is fully appropriate for their stage. Tables 1, 2, 3 and 4 outline a few examples of what is required by each category.

It is also important to note that, as the texture of food may change during the cooking/cooling process, consistency should be checked just prior to serving to make sure the dish is still fully compliant with the descriptors. For full details of the Descriptors click here . . .

Fluids and medications may also need to be thickened for dysphagia sufferers, but it is vital to make sure care homes seek the advice of a speech and language therapist.

THE RIGHT APPEARANCE

Not only should texture-modified food meet the guidelines outlined by the Descriptors, the appearance of food is an important consideration, especially for residents with dementia who may become easily confused about what they are being served. Ideally, meals should be visually appealing and resemble the foods they are supposed to. While this can be difficult for care homes to achieve in-house, there are specialist food products available that include moulded options that look just like the food served to other residents.

SUPPORT AT MEALTIMES

Where needed, residents with dysphagia should

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Typical amount
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4 x 30ml shots = 400kcals & 8g protein
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Table 3: Category C - 'Thick Purée Dysphagia Diet'

Cannot be poured
Smooth throughout, requires no chewing
Is moist
Holds its shape on a plate or when scooped
Can be eaten with a fork because it does not drop through the prongs
No garnish

Table 4: Category B - 'Thin Purée Dysphagia Diet'

Can be poured
Does not hold its shape on a plate or when scooped
Requires no chewing
Cannot be eaten with a fork because it slowly drops through the prongs
The texture is not sticky in the mouth
There are no loose fluids that have separated off

be offered help to adopt the correct posture to encourage safe and comfortable digestion. Similarly, any help needed with eating and drinking should be available throughout the day.

Setting the scene for comfortable dining is of course important for all care home residents, but is particularly vital for those with dysphagia, so noise and interruptions should be kept to a minimum during mealtimes. Attractively set tables will help create a setting conducive to the enjoyment of food, but 'fussy' decorative touches can prove distracting - especially for residents prone to confusion, such as those with dementia - so presentation should be kept uncluttered.

To minimise any isolation, dysphagia sufferers may experience at mealtimes, texture-modified meals should complement the menu options available to all residents.

SUMMARY

As dysphagia is a common side effect of conditions that typically impact more greatly on elderly people (such as those who have suffered a stroke, have dementia and Parkinson's), catering to residents with chewing and swallowing difficulties is an ongoing challenge for care homes. Working with specialist providers of texture-modified meals is a useful means of serving residents options that closely resemble the dishes available to others, but regardless of whether dishes are prepared in-house or through an external supplier, adherence to the Descriptors means homes can be confident that residents with dysphagia are served meals that are safe for them to eat.

As well monitoring for signs of under-nourishment among all residents, dietitians should work closely with speech and language therapists, care home managers and caterers to ensure that residents with dysphagia continue to be served the most appropriate and safe texture suitable for their chewing and swallowing abilities, as well as food that is appealing and enjoyable to eat.

References
1 The Malnutrition Task Force www.malnutritiontaskforce.org.uk/about
2 BAPEN: Nutrition Screening Survey in the UK and Republic of Ireland in 2011

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Questions relating to: *Managing dysphagia in care homes*
Type your answers below and then **print for your records** or print and complete answers by hand.

Q.1	What factors can contribute to malnutrition in the elderly?
A	
Q.2	Describe the aetiology and symptoms of dysphagia.
A	
Q.3	What are the further risks of dysphagia?
A	
Q.4	Explain the challenges faced when managing dysphagia in elderly patients.
A	
Q.5	Describe the role of a speech and language therapist at the assessment stage.
A	
Q.6	Outline the four categories of the Dysphagia Diet Food Texture Descriptors.
A	
Q.7	Describe the categories that all care settings are required to offer their residents.
A	
Q.8	Why is food appearance an important consideration in providing meals to this patient group?
A	
Q.9	What support can be given at mealtimes to elderly patients?
A	

Please type additional notes here . . .

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