NHD
THE DIETITIANS' MAGAZINE

eArticle with CPD
SPONSORED BY
NestléHealthScience
NOURISHING PERSONAL HEALTH
NHDmag.com Volume 4.01- January 16th 2014

COMPLIANCE WITH NPSA DYSPHAGIA DIET TEXTURE DESCRIPTORS

Are care homes complying with the new national standards for dysphagia diets?

Elizabeth Barnett
Speech and Language Therapy Team Lead, Community Older Adult Team, Sheffield Teaching Hospitals Foundation Trust

The Dysphagia Diet Food Texture Descriptors were launched in April 2011 by the National Patient Safety Agency (NPSA). They were developed in response to patient safety concerns and requests from the catering industry for clarity, replacing the previous 2002 guidance (1). Dysphagia carries with it significant associated health risks: choking; aspiration pneumonia; malnutrition and dehydration, as well as psychological effects such as fear of eating and loss of pleasure in eating.

Texture modification of food and drinks is a key element in reducing the risks associated with dysphagia and so accurate communication of information regarding texture recommendations, are of paramount importance. Under-modification of food texture has a risk of choking or aspiration; conversely, over-modification of food can reduce the nutritional content and be unappealing which can lead to a reduction in intake and pleasure in mealtimes.

Many residents with dysphagia live in care homes. Some estimates of people living in nursing homes with dysphagia are as high as 60 percent.

THE GUIDANCE

The Dysphagia Diet Food Texture Descriptors provide a standardised terminology and specific guidance as to the texture of each of the categories, which are E - fork mashable, D - pre mashed, C - thick puree and B - thin puree. The main changes from the previous guidance are that now a new category is included to describe a mashed diet and the soft diet category, which included items such soft sandwiches, has been removed from the dysphagia diet guidance.

The term 'Texture D', previously describing the Soft Fork Mashable category, now describes a pre-mashed consistency and the term Texture E, previously describing a Soft diet, now describes a Fork Mashable consistency. It was intended that this revised standardised terminology would be used by all health professionals and food providers, thereby ensuring that people with dysphagia would receive the correct texture of diet (which has been recommended by a professional trained in dysphagia management).

By June 2011, all the SLT services and hospital catering services had changed to the new descriptors, ensuring that diet texture recommendations for clients with dysphagia were standardised at all hospital sites and across the SLT service care pathway. Many residents with dysphagia live in care homes. Some estimates of people living in nursing homes with dysphagia are as high as 60 percent. We know that residents in care homes may be malnourished (2) and also that people who are having a texture modified diet are at greater risk of malnourishment (3).

For this high risk group of people, it is of upmost importance that all staff in care homes, both clinical and catering, understand the specific dietary requirements of residents with swallowing difficulties. Both hospital and community SLT services in Sheffield receive a high number of dysphagia referrals for people who live in care homes, predominantly nursing homes. In fact, the majority of referrals to the Community Older Adult Team involve contributing to the management of dysphagia in nursing home residents.

Elizabeth has extensive clinical experience in adult neuro and older people in both hospital and community settings. Her current clinical role is with older people in their own homes and in care homes and includes a training role with care home staff. Elizabeth teaches on the Sheffield Dysphagia Course (Sheffield Hallam University) regarding managing dysphagia in a community context.

Questionnaire results

Numbers of people on Texture Modified Diets (TMD):

- 587 people in care homes across Sheffield were being provided with a TMD, 239 having their meals modified to a pureed consistency.
- Residential homes typically had up to five residents needing TMD with relatively few residents having pureed diets (19 in total); 15 homes provided between one and three pureed meals.
- Nursing homes accounted for the vast majority (85 percent) of the number of people needing a TMD, most having between nine to 14 residents on a TMD.
- 90 percent of nursing homes had residents who they provided pureed meals for. Most were providing five to six pureed meals, but a significant number of homes were providing over 10 pureed meals, the highest number being 22.

Terminology of TMD:

- 75 percent of nursing homes were aware of the new Dysphagia Diet Food Texture Descriptors, in comparison with only 19 percent of residential homes.
- Despite being aware of the guidance, only one care home was using this terminology consistently across the home.
- About a quarter of homes were using the now superseded national descriptors from 2002 (1). Other homes used a variety of terms to describe their modified diets. The term 'puree' could describe a food with texture in it; the 'liquidised' option was described as being smooth, but very runny. 'Soft' was used in several homes to describe a pureed diet.

Thickened Drinks:

- Most residential homes and a quarter of the nursing homes did not differentiate consistency.
- Some homes made some sort of distinction using terms such as 'thickened vs slightly thickened'; 'one scoop vs two scoops' (of thickener); 'spoon thickened vs thickened', or descriptive terms such as 'mousse- like', or 'custard'.
- Eight nursing homes used the nationally recognised terminology for grading of fluid thickness stages 1-3 (4).

The experiences of the community team working with care homes over many years is that there continues to be a muddle of terminology used to describe texture modified diets which varies between homes and even groups of staff within a home. The diets produced by the kitchen do not always relate to the standard descriptions, often being over modified.

SLT SURVEY

Nine months after the relatively high profile launch of the guidance, it did not appear as if the care homes in Sheffield were even aware of the new guidance. Apart from being a patient safety issue, the resulting errors that were made in implementing diet recommendations resulted in a waste of SLT resources, with therapists spending far more time than necessary in ensuring that diet recommendations were understood and complied with.

To get a clearer picture of the issues and scope of the problem, a survey was undertaken by the SLT working as part of the Care Home Support Team (CHST).

It was intended that that the findings would be able to direct us to provide beneficial training into the care homes. A questionnaire was sent out via email to the 71 care homes in Sheffield registered to provide care for older people, half being residential and half nursing, including EMI. Care homes ranged in size between 19 to 120 beds, residential homes being smaller having up to 40 beds and nursing homes between 40 and 120 beds.

Care home managers were asked to provide information about: the numbers of residents on texture modified diets; the terminology used to communicate information within the home regarding diet textures; their knowledge of the national descriptors, alongside any opinions they had regarding difficulties experienced in managing provision of texture modified diets (TMD) and any learning needs of their staff.

A picture emerged from the 79 percent of questionnaires returned of both the size and the distribution of the population of people in care homes with dysphagia and the variation in terminology used to describe texture modified diets.

When asked to comment about other issues, managers cited difficulties finding food choices for residents on TMD at tea time and for snacks and felt that training in the new terminology was needed.

The survey demonstrated that the nursing homes in particular had a significant number of residents on TMD and although managers were aware of the NPSA guidance, they had not implemented its use within their homes. Although the size and case mix of the different homes needed to be taken into account, it was felt that some homes that were providing a large numbers of pureed diets were perhaps doing so inappropriately.

RESOURCE® ThickenUp™ Clear - a taste free food and drink thickener for your patients with dysphagia

- Transparent and taste free
- Thickens rapidly[1]
- Amylase resistant[1]
- Does not continue to thicken over time[1]

Available on the App Store

FREE Resource ThickenUp Clear App

ANDROID APP ON Google play

Developed for patients and healthcare professionals this new app includes: Dosage calculator, Mixing instructions and Product information

For more information please call the Nestlé Health Science Careline on 00800 68874846 or 0800 000030 or visit nestlehealthscience.co.uk

References: 1. Data on file

Nestlé Health Science produces a range of foods for special medical purposes for use under medical supervision used with patients requiring either an oral nutritional supplement or a sole source of nutrition.
® Reg. Trademark of Société des Produits Nestlé S.A.

NestléHealthScience
NOURISHING PERSONAL HEALTH

My experiences this past year of working with nursing homes have made me aware of how difficult it is to effect change in organisations, without a fundamental driver.

The information gained from the survey, along with referral data from the SLT team, helped identify which homes to approach as a training priority. This ensured that homes with the highest number of residents on TMD, particularly on puree diets, or where there were a high number of referrals to SLT, necessitating a lot of liaison, would be given training in the use of terminology for TMD. Training would focus on nursing homes, as the residential homes had relatively few residents needing TMD.

Training would be delivered 'in house 'as this method had been shown to be most effective for initiating change in practice across the staff group in a home. As this model of training is time-consuming, involving several meetings and training sessions, only 10 homes were initially identified. The other nursing homes and residential homes would be able to access advice: individual residents from the SLT team, or access the city-wide training sessions including information on TMD. The survey is to be repeated this year to see to what extent practice has changed overall and whether offering training into homes has been successful in effecting a sustained change in practice.

TRAINING IN PRACTICE

Over the past six months I have been working with the 10 identified nursing homes. Initially, I had hoped that we would not only get all staff using both the Dysphagia Diet Texture descriptors and Thickened Fluids descriptors correctly, but that the kitchens would consistently be able to provide correct E and C textures; Texture D to be mashed at the point of service by care staff.

In homes where a significant number of residents need a pre-mashed (D) diet, I had envisaged that the home would change the menu choices to routinely incorporate a fork mashable (E) option. By mashing the food at point of service rather than produced in the kitchen, this would increase the pleasure of the meal for residents who often are heard to complain: 'I just want what they've got,' or, 'I want real food!'

In the event, in general, I have had to revise these aspirations, now concentrating on implementing use of the new terminology across the staff group and ensuring that forms used in communication of information are revised, e.g. menu choice forms. Working with the kitchen on diet textures and changing menus are out of my scope of expertise and, despite having given lots of ideas for options for menu choices, it has become clear that the catering staff need a significant amount of one-to-one support in menu planning, which is not available.

My experiences this past year of working with nursing homes have made me aware of how difficult it is to effect change in organisations, without a fundamental driver. All the guidance and good practice guides will make little difference to practice within care homes unless there is a 'must-do' driver attached to it. Without a contractual requirement to implement specific standards, in the avalanche of other 'must-do' legislation; guidance will remain just that, sitting on a shelf gathering dust.

The key person in effecting change is the care home manager. However, within the context that they have to operate in, without the support of the company management (both moral and financial), any significant change is extremely difficult to implement. Any change needs an investment in time and up- skilling, which all has a financial cost attached. When new tools are developed, aimed at enhancing patient care, staff will need hands-on training in how to use them. When care home cooks may not have had any training in catering, let alone in specialist diets and no training is available, the task we are asking of them to design menus and make appetising and nutritious foods for residents with significant health problems on a shoestring budget, is enormous.

References
1 National Descriptors for Texture Modification in Adults (2002). BDA, RC
2 Nutrition screening survey, BAPEN 2008
3 L Wright et al, Journal of Human Nutrition and Dietetics, Vol 18, issue 3, 213-219, June 2005
4 Fluid Thickening Guide SNDRi

THE DIETITIANS' MAGAZINE

eArticle with CPD

Volume 4.01- January 16th 2014

Questions relating to: *Compliance with NPSA dysphagia diet texture descriptors.*
Type your answers below and then **print for your records.** Alternatively print and complete answers by hand.

Q.1	Describe four health risks associated with dysphagia.
A	
Q.2	What are the psychological effects of dysphagia?
A	
Q.3	What was the rationale which resulted in the dysphagia diet food texture descriptors (DDFTD) being launched in April 2011?
A	
Q.4	What are the four DDFTD?
A	
Q.5	What are the differences between the 2002 and the 2011 guidance?
A	
Q.6	Describe the problems related to a) under modification of a food texture and b) over modification of a food texture.
A	
Q.7	Describe the reasons why the SLT undertook a survey with the Sheffield Care Homes.
A	
Q.8	Describe at least four of the findings of the Sheffield SLT survey.
Q.9	What limitations have been encountered by the Sheffield Team with the 'in house' training of care home staff?
Q.10	What has been found to be essential in the effective implementation of change in care homes?

Please type additional notes here . . .