

BP Blogger

Myth Busting: The Swallowing Issue

Myth 1: Few residents have swallowing problems

Swallowing difficulties, also known as **dysphagia**, occur as a result of direct and indirect damage by numerous diseases to the swallowing muscles. These may be neurological or neuromuscular (28- 64% of persons with stroke, up to 81% with Parkinson's disease, and 24-34% with MS), structural (tumors, salivary), immunological, environmental, psychological, or social. The severity can vary from mild to severe with any of these causes. Swallowing is complex and involves 26 muscles !!!



food and liquids; and can lead to aspiration, choking, suffocation, dehydration, malnutrition, decreased quality of life; and frustration for residents, family and staff. Swallowing, eating and chewing problems are common among LTC residents. Up to 70% of residents will have signs of swallowing problems. Signs of swallowing difficulties are usually obvious during meals.

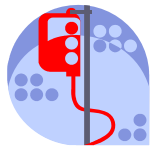
Signs of Swallowing Difficulties

- Coughing when eating or drinking
- Food or liquid spilling from the lips when eating or drinking
- Trouble moving food or liquid around in the mouth
- Prolonged chewing
- Trouble starting to swallow once food or liquid is in the mouth
- Clearing throat when eating or drinking
- Coughing or clearing throat shortly after a meal
- Has a wet or gurgly sounding voice
- Complains feeling that something is "stuck" after swallowing
- Shortness of breath during or right after mealtime
- Has frequent heartburn or bitter taste in the mouth
- Unexplained weight loss
- Recurrent chest infections
- Refusal to eat or reluctance to have food in the mouth
- Pocketing food or liquid in the cheeks or holding food in mouth

Dysphagia is an uncomfortable, frightening and potentially life-threatening condition because it interferes with the oral intake of

See April's BP Blogger re: Mouth Care and June's BP Blogger re: Fluids, available at www.rgpc.ca

Myth 2: Tube feeds prevent aspiration and prolong life



Tube feedings are sometimes implemented for those who are severely dysphagic or malnourished. For residents with reversible conditions, tube feeding may be viewed as a temporary intervention and the goal might be to retrain to eat again. One reason why many families opt for tube feeding in LTC homes is the belief that tube feeding will prolong life. Many studies have concluded that using tube feedings does not prolong life nor improve quality of life especially for those with

severe cognitive impairment. Placement of the feeding tube may result in a weaker esophageal sphincter, increasing the risk of stomach contents regurgitating into the esophagus and the lungs. Residents on tube feeds often don't eat any food by mouth and this can result in poorer mouth care. Tube feeding can increase the risk of **aspiration pneumonia** from both stomach contents and oral secretions. In fact, severely dysphagic residents who are orally fed have much fewer episodes of aspiration pneumonia.

Inside this issue:

Myth 1:	1
Few residents have swallowing problems	
Myth 2:	1
Tube feeds prevent aspiration and prolong life	
Myth 3:	2
Thickened liquids aren't hydrating	
Myth 4:	2
Dysphagia does not cause pneumonia	
Myth 5:	2
Feeding and positioning techniques don't affect swallowing	
BPGs and Resources	2
Contacts for Information	1 & 2

More information on This and Other Best Practices

• **Contact** your **Regional LTC Best Practices Coordinator**. They can help you with Best Practices Info for LTC.

Find them at:

www.shrtn.on.ca click on these links "Tools and Resources" → "Current Research BP Practice Initiatives" → "LTC Regional BP Coordinators"

• **Check out** the **Hamilton Long Term Care Resource Centre** www.rgpc.ca

• **Surf the Web** for BPGs Some sites and resources are listed on pg 2.



Cutting Through the Foggy Myths Using Best Practice Guidelines in Long Term Care

Editors

Mary-Lou van der Horst
Best Practice Coordinator
Long-Term Care-Central South
Village of Wentworth Heights
1620 Upper Wentworth Street
Hamilton ON L9B 2W3
mvanderhorst@
oakwoodretirement.com

Shannon Buckley
SHRTN Library Services-Hamilton
Long Term Care Resource Centre
88 Maplewood Ave
Hamilton ON L8M 1W9
SBuckley@stpetes.ca

Find it on the Web at
www.rgpc.ca or www.shrtn.on.ca

Myth 3: Thickened liquids aren't hydrating



Some dysphagic residents may have difficulty swallowing thin liquids such as water, coffee, tea and juices.

They may have difficulty controlling the liquid in their mouth before swallowing or clearing it during the swallow. Thin liquids may spill into the upper airway before they are ready to swallow, increasing the risk of "aspirating" fluids into the lungs. A cough usually clears the airway but for dysphagic residents their cough may be weak or absent. Aspiration of food may cause blockage in the lungs and could lead to an infection called "aspiration pneumonia". Even non-dysphagic residents may aspirate when fed if they are tired, lethargic, inattentive or sedated.

Thickened liquids often help prevent aspiration pneumonia because they flow slower and allow for the swallowing reflex to be triggered. Pre-thickened products are offered in nectar, syrup or thick texture consistencies. Thickened liquids take longer to digest and they don't feel as thirst quenching but they do provide hydration as the body digests the product and absorbs almost all the water from it.

Myth 4: Dysphagia does not cause pneumonia

Aspiration of food or liquid means that residents are at greater risk of developing pneumonia.

Aspiration pneumonia rates are highest in LTC homes, up to 44%.

Residents dependent for feeding are 20 times more likely to develop aspiration pneumonia. Pneumonia is the second most common infection after urinary tract infection, most common reason for transfer to hospital and a leading cause of death from infection in LTC. Because dysphagic residents have problems starting to swallow or a weakened swallow causing spillage or incomplete clearing of food in the throat, food can then fall into the airway (aspirate) when they start breathing. These large-volume aspirations are of great concern, because chunks of food can block airways and if not cleared, can lead to infection. Pneumonia can also result from aspiration of saliva loaded with oral bacteria (100 million bacteria per 1ml); reflux; weakened immune system; dependency on staff for feeding; and reduced mobility. With recent information on oral hygiene and lower incidence of pneumonia in those receiving regular oral care, providing oral care to residents who are dependent on feeding or on tube feeds could significantly lower the incidence of aspiration pneumonia in LTC.



swallow or a weakened swallow causing spillage or incomplete clearing of food in the throat, food can then fall into the airway (aspirate) when they start breathing. These large-volume aspirations are of great concern, because chunks of food can block airways and if not cleared, can lead to infection. Pneumonia can also result from aspiration of saliva loaded with oral bacteria (100 million bacteria per 1ml); reflux; weakened immune system; dependency on staff for feeding; and reduced mobility. With recent information on oral hygiene and lower incidence of pneumonia in those receiving regular oral care, providing oral care to residents who are dependent on feeding or on tube feeds could significantly lower the incidence of aspiration pneumonia in LTC.

Check out these Best Practices & Guidelines. Answers to the Myths came from them. Find out more!

Canadian:

Canadian Association of Speech Language Pathologists & Audiologists. *GULP. Here's the bottom line on swallowing disorders FACT SHEET*. Ottawa: CASLPA. www.caslpa.ca

Canadian Stroke Strategy (2006). *Canadian best practice recommendations for stroke care: 2006*. Ottawa: Author. www.canadianstrokesstrategy.ca

Canadian Centre for Activity and Aging. (1999). *Restorative care education and training: Feeding module resource guide*. Ottawa: Author. www.uwo.ca/actage

St. Peter's Hospital. (2005). *A self-directed program for feeding certification: Practical management of dysphagia in a geriatric setting (4th ed.)*. Hamilton: Author.

Others:

American Medical Directors Association. (2001). *Dehydration and fluid maintenance*. Columbia, MD: AMDA. www.amda.com

American Medical Directors Association. (2001). *Altered nutritional status*. Columbia, MD: AMDA. www.amda.com

National Health and Medical Research Council. (May 2006 enhanced). *Guidelines for palliative approach in residential aged care facilities*. Canberra Australia: The National Palliative Care Program. www.caresearch.com.au

Centre for Education & Research on Ageing. *Swallowing on a plate. A training package for nursing home staff caring for residents with swallowing problems*. Concord, Australia: Concord Hospital. www.cera.usyd.edu.au

Myth 5: Feeding and positioning techniques don't affect swallowing

74% of residents in LTC have an eating disability and 50-66% of residents require some level of assistance at mealtime. Staff have an important role during mealtimes to ensure dysphagic residents successfully eat and enjoy their meals. Rushed and inattentive feeding may place residents at risk of aspirating. Residents with oral pain may have eating problems which may cause them to try to swallow larger amounts of food and choke. Some residents may have responsive behaviours during mealtimes such as turning their head away, spitting or pushing the spoon away. They may be inappropriately labeled as "difficult". In fact when they refuse, they are protecting themselves from choking. Feeding and

positioning techniques help to ensure safe swallowing, adequate nutrition and hydration and promote an enjoyable mealtime experience.

Feeding and Positioning Techniques:

- Know which residents are at risk for aspiration and observe for changes
- Monitor meal served for appropriate textures
- Only feed residents that are awake and alert
- Position upright, head midline, chin slightly tucked
- Sit at eye-level with the resident
- Feed slowly using teaspoon-sized amounts of food
- Give verbal and visual prompts as needed
- Check the mouth is clear between bites and at the end of the meal
- Keep in comfortable upright position 1h after meal
- Monitor for signs of dysphagia
- Ensure resident has swallowed between bites
- Do oral care after each meal
- Do nursing swallowing/eating assessments
- Consult with Speech-Language Pathologist or Dietitian as needed

Special thanks in Central Ontario to the Speech Language Pathologists & Registered Dietitians at St. Peter's Hospital-Hamilton, Regional Geriatric Program-Central, Seniors Health Research Transfer Network, Central South Regional Stroke Program, Canadian Centre for Activity and Aging-London, The Village of Wentworth Heights LTC-Hamilton