



Dysphagia In Assisted Living

Dining programs can employ a variety of techniques for preparing and presenting pureed foods to residents with swallowing disorders.

EACH YEAR, 8 TO 10 MILLION people suffer from some degree of swallowing impairment, or dysphagia, and a growing number of them are assisted living residents. The effects of not being able to eat properly prepared foods can be emotionally and nutritionally devastating, perhaps even life threatening.

Difficulty in swallowing food or drink can arise as a side effect of many conditions, including stroke; motor neuron disease, such as amyotrophic lateral sclerosis; multiple sclerosis; Parkinson's disease; arthritis; drying of the mouth, which is often a side effect of taking medications; surgery to the neck and head; tumors or cancer treatment to the neck and head; and Alzheimer's disease.

In some cases, swallowing may improve as an individual recovers from a stroke or other event. But in other cases, such as with Parkinson's disease, the condition may deteriorate.

Suffice it to say that if swallowing problems remain untreated, the resident can become dehydrated due to the inability to swallow liquids.

Difficulty eating foods that require a lot of chewing or foods of a particular thickness can result in reduced alertness or weight loss that becomes malnourishment.

A Variety Of Consistencies

To help those with swallowing difficulties, special dysphagia diets have been developed. These are generally prescribed according to the consistency of food served, with "mechanically altered" and "pureed" as the most com-

mon designations. In a good dysphagia diet, foods and fluids should be easy to swallow, nutrient dense, and served in an appetizing way that encourages eating.

The National Dysphagia Diet, published in 2002 by the American Dietetic Association and developed by dietitians, speech language pathologists, and a food scientist, describes four levels of food preparation:

■ Level 1:

Dysphagia-Pureed—consists of pudding-like foods that have been pureed or blended to a smooth texture and require very little chewing ability, such as pureed chicken, mashed potatoes with gravy, and applesauce.

■ Level 2: Dysphagia-Mechanically Altered—consists of cohesive, moist, semisolid foods that may have been ground or mashed but require some chewing. Scrambled eggs and bananas are examples.

■ Level 3: Dysphagia-Advanced—includes soft foods that require more chewing ability, such as shredded lettuce with dressing, turkey sandwich with mayonnaise, and fresh ripe melon.

■ Level 4: A regular diet for those



Presentation is critical in encouraging residents with dysphagia to eat pureed food.

with no swallowing difficulties.

In addition to specifying the level of food consistency, all dysphagia diet orders should specify the thickness of liquids, such as thin, nectar-like, honey-like, or spoon-thick. It is best to purchase thickened liquids or have the nursing staff prepare them, since there is too much room for error when non-clinical staff members thicken liquids.

Testing Consistency

Measuring the consistency or viscosity of pureed foods can be tricky. But there's an easy way to do

this that does not require a lot of time or money.

Take a hollow PVC pipe or biscuit cutter and fill it with a known volume of product, keeping in mind that pureed products should be altered to the consistency of pudding.

Upend the container onto a plate and measure how far it spreads in 30 seconds.

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Now, set up a standard. Using pudding from the kitchen, test it to get a value. This can be used as the guideline against which to measure when staff make puree.

This simple test enables staff to develop a consistent product in food service operations.

It is important to keep in mind that as different ingredients are added to get the right puree texture, the total volume of the end product should be measured and divided by the number of original product servings. Also, be sure to use the proper scoop size to get the right nutritional value in the end portion.

Test For Taste

Taste, taste, taste! As a food service manager or member of the team, caregivers need to taste what they are serving the resident. Test not only for flavor but also for the appropriate texture.

The sample bite should be similar to what the resident would put in his or her mouth.

A sample should be placed on the tongue, past the front teeth, and then mashed with the tongue up toward the roof of the mouth.

Answer the following questions: Does it loosely run down to the sides of the mouth, risking aspiration, or does it collect smoothly in a bolus able to be swallowed with ease? What kind of viscosity does it have? What kind of consistency does it have? Is it too adhesive? Is it too gummy? Does a thickening agent or moisture need to be added?

In addition to a taste test, be sure to

test residents' responses. Conduct plate waste studies to determine if the food is being eaten. If not, why not? Find out and make the changes necessary to make sure residents are getting the nutrition they need.

Nutrition And The Menu Process

As people age, their nutritional needs may need to be modified, according to researchers with the U.S. Department

Therefore, large amounts of water—at least eight glasses each day—are recommended to aid digestion, help relieve constipation, and prevent dehydration.

Seniors may also need dietary supplements such as vitamin D, calcium, vitamin B-12, or others, since they may not be able to absorb sufficient vitamins and minerals in their diet.

Because seniors may get filled up on less food—and require less energy—the nutrition they get from their diet should be maximized with nutrient-dense foods.

The 75+ pyramid encourages a variety of fruits and vegetables rich in vitamins A and C, whole-grain foods, low-fat dairy products, lean meats, fish, and poultry. These foods can help to meet the nutritional needs of older Americans and help maintain a healthy cardiovascular system.

Presenting Good Taste

Presentation is just as important to people

with swallowing impairment as it is to any other diner—who wants to eat something that isn't appealing? Fortunately, a few tricks of the trade can help altered foods look just as appealing as non-pureed foods.

Food molds shaped like various meats or vegetables, available from equipment supply houses, can be used to enhance appearance of a pureed diet.

Several companies make specialty products for foods that are difficult to puree, such as pasta, rice, bread, biscuits, and rolls.

There are also puree recipe books with recipes that can be used and

The Need To Screen

As increasing numbers of baby boomers find themselves in an assisted living facility because it is too risky for them to live on their own, facilities will need the right tools to serve this population.

To increase the independence, safety, and quality of life of these residents, an assisted living facility needs a team—the staff, speech pathologist, doctor, nurse, dietitian, and food service director.

One important tool is a screening mechanism for swallowing disorders that begins with a simple question for each resident moving in: "Do you have difficulty swallowing?"

As follow-up to the initial screening, each member of the team should be trained to note the signs and

symptoms of swallowing disorders: coughing or choking with swallowing; swallowing a single mouthful of food several times; food sticking in the throat; drooling; unexplained weight loss; and a change in the resident's dietary habits, voice, or speech.

Without effective treatment, residents with these symptoms can face malnutrition, dehydration, weight loss, choking, aspiration, pneumonia, depression, decreased quality of life, increased hospital stays, and possibly death.

Although many cases of swallowing disorders go undiagnosed or untreated, at-risk seniors can benefit from early identification and treatment for this debilitating condition.

of Agriculture (USDA) Human Nutrition Research Center on Aging. USDA developed the Food Guide Pyramid for people 75 and older, one for men and one for women, through the direction of a variety of experts in the health care field.

According to the agency, older Americans have some differences and specific nutritional needs. To begin with, a decrease in thirst sensation is common with aging. As a result, adequate hydration is a chronic problem for many older Americans.

Some medications may also affect the body's ability to regulate fluid balance.

adapted to residents' particular needs. Pastry bags are useful for piping pureed foods in order to simulate normally shaped foods. For example, pureed kielbasa can be simulated into sliced kielbasa using a large pipe tip on a pastry bag.

Creating special effects by mixing two different colored vegetables, such as peas and carrots, is also an option.

It is important to garnish pureed recipes just as they would be garnished for a regular diet. Here are a few examples:

- Use sauces and gravies.
- Garnish pureed pancakes or French toast with syrup, jelly, or margarine.

■ Creating special effects by mixing colors is also an option.

- Sprinkle pureed cottage cheese with colored gelatin powder.
 - Use smooth tartar sauce and lemon juice for fish.
 - Use mustard or mayonnaise for pureed sandwiches.
 - Sprinkle dessert with powdered sugar or whipped topping.
- A bit of imagination can help ensure

the puree diet plate receives the same attention as the regular diet plate.

In The Thick of It

Another way to make pureed foods more appealing and safer for swallowing is by using a commercial food-thickening product. Some come in a powder form that blends quickly and smoothly and is gluten free. Others add texture and shape to foods, such as squares for sandwiches and meats; cubes for beef cubes; sticks for fish sticks; triangles for sandwiches; wedges for pizza, quiches, and casseroles; layers for lasagna and sandwiches; and rounds for meat pies, omelets, and soufflés.

Study Links Restraints To Health Decline

Using physical restraints on nursing facility residents can lead to lower physical or mental health, according to a study published in the August 2008 issue of *The Gerontologist* from the Gerontological Society of America.

Authors John Engberg, Nicholas Castle, and Daniel McCaffrey acknowledge that this idea is already widely believed, but few studies actually show the association between the health decline and the start of the use of physical restraints—until now.

They examined eight mental and physical traits in samples of nursing facility residents in Pennsylvania after they had been restrained.

“Even after controlling for prior health status and resident facility and market factors, we found that restrained residents are significantly more likely to exhibit low cognitive performance, low activities of daily living [ADL] performance, and more walking dependence than similar residents who are not restrained,” the study says. “The magnitude of the findings would suggest that the benefits to residents of not using restraints are substantial.”

The authors believe their study provides further justification for policy makers to implement restraint-reduction policies and can be used as a source to promote restraint reduction.

“These kinds of activities would

■ Researchers studied trunk, limb, and chair restraints.

include additional training, practice guides, and emphasis by state surveyors,” they say.

Of the 12,820 nursing facility residents in Pennsylvania with an admissions assessment and three subsequent assessments at least three months apart, about 2.3 percent were restrained during the third quarter of their stay, according to the report. They did not include residents who had been restrained during their second quarter at the facility.

Researchers compared the resident's

health in the fourth quarter after the restraint initiation looking specifically for falls, walking dependence, ADLs, pressure ulcers, and contractures, according to the report.

For mental health they examined cognitive performance, depression, and behavior problems.

The researchers studied trunk, limb, and chair restraints and did not include bed-rail restraints.

Based on their analysis, when a resident is restrained, one can expect a “5 percent lower ADL performance, 10 percent more walking dependence, and 4 percent lower cognitive performance compared to no restraint use,” according to the study.

The researchers did not find a significant relationship between physical restraint initiation and depression, behavior issues, falls, pressure ulcers, or contractures.

“Nonetheless, the higher expected resident health outcomes associated with simply not using physical restraints are large,” the report concludes.

—Suzanne Struglinski

These products consist of agglomerated, modified food starch that mixes easily with any type of pureed food without lumping. They will not over-thicken or add any flavor or taste to the food. These products are also freeze-thaw stable, so they can be added to food, frozen, and then reheated without losing any consistency.

Another benefit of food thickeners is that food becomes dense and cohesive, which eliminates the problem of thin

■ To begin with, a decrease in thirst sensation is common with aging.

pureed food running down the throat and into the lungs (and the potential for a resulting pneumonia).

Finally, always be sure the pureed

meal is garnished, served on an appropriate dish in proper portions, and similar in shape or form to the similar non-pureed item.

The goals of a puree program should be to prevent choking and aspiration, maintain good nutritional status and weight, and facilitate independent eating.

The result? Residents will enjoy enhanced pleasure in eating, improved quality of life, and restored dignity. ■

Staff Respect Leads To Better Care: Study

Incentives for nurses and care aides can help long term care facility administrators improve individualized care for their residents, according to a new study published by the Gerontological Society of America.

Recognition and rewards for good work, access to educational opportunities, and a role in decision making can improve care provider work life. This can translate into better resident care, say study authors Sienna Caspar and Norm O'Rourke in the July 2008 issue of the *Journal of Gerontology*.

"Management initiatives to enhance individualized care must ensure that supervisors motivate and empower others by actively respecting, valuing, and utilizing the knowledge and skills of those with whom they work," the study says. "It seems that a balanced focus of management initiatives that address the needs of both care providers and care recipients is needed if the goal of increasing the provision and quality of individualized care in [long term care] facilities is to be achieved."

The pair surveyed a group of 117 registered nurses and 65 licensed practical nurses, and a separate group of 326 care aides in British Columbia, Canada, asking for specifics on their work environment, including support they receive, access to information and

resources, and perceptions of power among their colleagues.

The groups also answered questions on individualized care within their facilities, including communication with other staff and the residents, their knowledge of individual residents, and resident autonomy.

Staff Value Training

Results showed that access to structural empowerment—a collective term for opportunities to increase knowledge or skills, ability to give or receive feedback, use discretion on the job, or other related actions—had a "statistically significant and positive direct effect on reported provision of individualized care" in both groups.

"Although we anticipated statistical significance, this strength of association between latent constructs greatly exceeded our initial expectations," say Caspar and O'Rourke.

Their analysis found that 39.6 percent of care aides and 26.4 percent of nurses say they have little to no discussion of further training or education opportunities, and 54.6 percent of the care aides and 45.8 percent of the nurses received few, if any, rewards or recognition for good work.

Care aides also reported that they "do not consistently feel respected by

their supervisors, nor do they experience the ability to exert meaningful influence on the quality and type of care they provide."

"Due to the nature of their jobs, this may directly influence resident care," say the authors.

In the study, care aides indicated supervisors do not ask for their opinion or ideas on management. Other studies have found that professional respect and positive relationships with supervisors lead to better resident satisfaction and care.

"It would seem that one cannot overlook the quality of care providers' work lives when attempting to improve the quality of life for long term care residents," the authors conclude.

They say their study's findings "lend further credence to the need for improved training and educational opportunities for frontline staff, combined with management practices that enable staff appreciable access to empowerment structures."

"If care providers have access to informal power, formal power, information, support, resources, and opportunity structures, they may be more empowered to contribute effectively to the provisions of individualized care," the study says.

—Suzanne Struglinski