POLICY & PROCEDURE NUMBER: ***4.18***
DEPARTMENT: *Dietary* **SUBJECT:** ***Dysphagia Management***

APPROVAL DATE: August 1985 **REVISION DATE:** January 2015
REVIEW DATE: May 2018; Oct 2019; Dec.2020

POLICY:

Residents who experience signs and symptoms associated with dysphagia will have their nutrition and hydration needs met in a safe, coordinated manner as managed by the interdisciplinary care team.

OBJECTIVES:

To ensure timely access to a swallowing assessment for those residents identified with swallowing problems

To ensure an optimal nutrition and hydration intake for residents identified with dysphagia.

To ensure that residents with dysphagia receive their foods and fluids in a manner that promotes their safety.

To promote the role of the Registered Dietitian as part of an interdisciplinary care team in the screening, assessment, treatment and ongoing management of dysphagia within the Long Term Care Home setting

To prevent or minimize the significant consequences or complications/adverse effects associated with dysphagia.

PROCEDURE:

1. As part of the admission nutrition assessment, the Registered Dietitian (RD) evaluates the swallowing ability of all newly admitted residents, noting any past swallowing difficulties and including observation of the resident swallowing foods and fluids.

2. Based on the admission nutrition assessment, the RD verifies that the admission diet order and texture meets the swallowing needs of the resident or makes the necessary changes and creates the Nutrition Care Plan.

3. Recognizing the high percentage of residents with swallowing problems in Long Term Care Homes, all members of the interdisciplinary care team receive relevant in-service education and are familiar with the signs and symptoms of swallowing problems (dysphagia). *See below*

4. All residents are monitored on an ongoing basis by the interdisciplinary care team for any signs/symptoms of dysphagia, which may include but are not limited to, the following:

   SIGNS/SYMPTOMS of DYSPHAGIA

   - resident choosing to avoid eating all or certain textures
   - complaints of food getting stuck
   - refusal to eat
   - weight loss, especially 1.5 kg in 7 days
   - choking or coughing
   - drooling, excessive secretions
   - difficulty chewing
   - frequent upper respiratory infections
   - gurgling in throat
   - poor air intake
   - very slow eating, resident complains of taste of food
   - food or drink running from the nose
   - chronic constipation
   - dehydration
   - signs of malnutrition
   - pocketing of food in cheeks

5. The RD is informed by any member of the interdisciplinary care team involved with feeding residents of **any** resident whom they believe:
   - is exhibiting signs/symptoms of dysphagia;
   - needs a reassessment of their food texture and/or fluid consistency modification;
   - has a change in health status which is affecting their ability to chew and/or swallow foods and fluids

6. **All residents experiencing acute signs and symptoms of a stroke are kept NPO until their swallowing ability has been assessed; all such residents are referred to the RD.**

7. Upon receiving the referral for assessment/ reassessment, the RD observes the resident for at least 10 minutes as resident eats a meal and completes the Dysphagia Assessment and Identification Tool. (See Registered Dietitians Dysphagia Identification and Assessment Tool). The RD attempts tests to determine severity of resident's condition and strategies to improve resident's intake. Input from Registered Nurse and front-line staff is essential. (See tests to determine severity of conditions)

8. The RD develops the Nutrition Care Plan, including goals and interventions for safe food and fluid consumption, informs all staff of the treatment strategies, discusses the need for interventions with the resident/Substitute Decision Maker (SDM) and reviews any changes in food texture and fluid consistency with the MSS; the MSS informs/instructs Dietary staff, as required, and ensures that the Dietary kardex is updated.

9. Choking incidents must be documented in the progress notes by staff in order to identify specific foods/fluids that are problematic and that may require modification or elimination from the resident's diet.

10. The RD reviews the interventions and treatment strategies on a regular basis and, in consultation with the physician, makes a referral, when required, to a Speech Language Pathologist for further recommendations and follow up [*in Ontario, services of a SLP are usually arranged through the Community Care Access Centre*]. When possible, the SLP visits are coordinated with days when the RD is in the Home.

11. To maximize resident independence, residents are referred to the Restorative Feeding Program, as appropriate

12. Food brought in from outside the Home is assessed by the Registered staff to determine suitability and safety for the resident. At the time of the admission and annual care conferences, family members/Substitute Decision Makers (SDMs) are

kept informed regarding any texture modification of foods and fluids that are required by residents.

13. Family members/SDMs who disagree with texture modification needs, as assessed by the interdisciplinary care team, agree to take responsibility (as documented in writing in the resident's chart) for any adverse consequences that result from providing residents with foods or fluids in a texture that is considered to be unsafe. All known incidents of the resident/SDM or family providing a different texture/consistency of food/fluid other than what is considered safe are documented in the progress notes by the RD, with the team, including the MD, being aware of such incidents.

Resources, References and Regulations:

Ontario Regulation 79/10 made under the Long-Term Care Homes Act, 2007, Sections 68 and 71

"A Randomized Study of Three Interventions for Aspiration of Thin Liquids in Patients with Dementia or Parkinson's Disease, Logemann, J. A. et al. 2008

"Texture-Modified Foods and Thickened Fluids as Used for Individuals with Dysphagia: Australian Standardised Labels and Definitions, Nutrition and Dietetics 2007.

"Scope of Practice for Registered Dietitians Caring for Clients with Dysphagia in Ontario", College of Dietitians of Ontario, February 2016

Texture Modified Foods: A Manual for Food Production in Long Term Care Facilities, Wendy Dahl, Dietitians of Canada, 2008

"Management of Dysphagia in Acute Stroke", Heart and Stroke Foundation of Ontario 2006

"Defining the Role of the Dietitian in Dysphagia Assessment and Management", Dietitians of Canada March 2015.

"Dysphagia Manual - Helping People Who Have Difficulty Swallowing", Riverview Health Centre 2002

Dysphagia Manual for Long -Term Care, Jerrilyn Platt, 2001

BB&A Policy: "Dysphagia Diet - Thickened Fluids" and BB&A Policy: "Restorative Feeding"

Registered Dietitian's Dysphagia Identification and Assessment Tool

Resident Information:

Name:_____ Room: _____

Current Diet/Texture/Fluid Consistency: _____

_____

Current Food/Fluid Intake: _____

Nourishment/Supplement: _____

Current Weight: _____ IBW/Usual BW: _____ BMI:_____Weight changes:

_____

Medical History: _____

_____

Respiratory or Dysphagia Hx: _____

History / Observations:

Is resident alert enough to be assessed (awake during whole meal):	Yes	No
Is resident able to sit upright during meals with neck upright:	Yes	No
Is resident able to communicate/follow commands, either orally or visually:	Yes	No

If answer to the above questions is no, try another meal or another day.

Visual Assessment Before Meal:

Condition of Mouth	Condition of Dentures	Fit of Dentures	Condition of Teeth/Gums
☐ moist	☐ good U / L	☐ good U / L	☐ healthy gums
☐ dry	☐ poor U / L	☐ poor U / L	☐ cracked lips
☐ drooling	☐ broken U / L		☐ red or bleeding gums
	☐ missing U / L		☐ broken teeth
	☐ not worn		☐ oral hygiene/condition

Observation during Meal:

Meal Observed: *Breakfast / Lunch / Supper* Texture of meal provided: _____

Head Position	**Body Position**	**Hand Coordination**	**Seating**
☐ head upright	☐ sitting upright	☐ able to hold cutlery	☐ chair/wheelcha
☐ head tilted R L	☐ body leaning R	☐ hand steady	☐ tray on chair
☐ chin tucked	☐ body leaning L	☐ hand shaking	☐ gerichair
☐ head arched back	☐ body leaning forward		
☐ neck extended	☐ restless		

Difficulty Chewing	**Difficulty Swallowing**	**Tongue Movement**	**Food in Mouth**
☐ good mastication	☐ swallows well	☐ moves food in mouth	☐ no pocketing
☐ poor mastication	☐ clears throat	☐ tongue thrusting	☐ yes, left
☐ spitting	☐ hesitation	☐ no movement	☐ yes, right
	☐ change in breathing pattern		☐ residue in mou
	☐ holding food in mouth		after swallowin
	☐ obvious difficulty		

Choking/Coughing	**Voice Quality**	**Lip Seal**	**Self-Feeding Skills**
☐ not observed	☐ clear	☐ good lip seal	☐ independent motor skil
☐ coughing/choking eating	☐ wet	☐ oral spillage R L	☐ eating
☐ coughing/choking drinking	☐ gurgly during meal	☐ drooling	☐ drinking
☐ nasal regurgitation	☐ gurgly after meal		☐ hand dominance: R/L
☐ watery eyes			

Intake of solids: 100% 75% 50% 25%

Intake of liquids: _____mL

Length of time to complete meal: _____

Assistive devices required: _____

Other Findings:_____

_____

Summary of Observation:

Treatment Plan:
Signature: **Date:**

Revised from the original *developed by: Dietitians of Canada Long Term Care Action Group, January 2006*

STRATEGIES FOR MANAGING RESIDENTS WITH DYSPHAGIA

PROBLEM/CONDITION	SIGNS AND SYMPTOMS	DIETARY CONSIDERATIONS
Oral Preparation Phase		
Reduced cheek or lip tone, Decreased lip closure Poor tongue control	Food is pocketed Poor bolus formation Food or liquid leaks from mouth Slow oral transit time with solids	Maintain semi-solid textures tha form a cohesive bolus
Poor rotary jaw movement Reduced tongue movement Reduced jaw range	Choking during or after swallow Particles remain lodged in throat	Maintain semi-solid or chopped textures Use moist, well-lubricated food
Reduced tongue movement	Limited ability to form bolus and push to back of throat Bolus separates, food particles fall into throat before swallow	Use foods that form cohesive bo
Reduced oral sensation or awareness Preferences to taste: sweet/s hot/cold	Food lodges in areas with reduced sensitivity	Close supervision to assess abilit manipulate foods/liquids and sa swallow
Dry mouth due to: medicatio cancer treatments	Excessive or thick saliva, difficulty lubricating and manipulating food, gagging, spittir	Use moist, well-lubricated foods Add gravies, sauces, margarine Use artificial saliva or juice to thi secretions, avoid milk
Oral Transit Phase		
Delayed or absent swallow re Reduced coordination due to neuromuscular disease	Pooling and overflow of food and liqui into the airway	Use cohesive foods Possible use of highly seasoned a extreme temperature foods Use thickened liquids Avoid sticky or bulky foods
Pharyngeal Transit Phase		
Reduced airway closure	Aspiration before the swallow	Use cohesive foods that do not fall apart
Reduced or slowed movement through the	Food residue remains at base of tongue, particles may fall into airway	Use moist, well-lubricated foods that maintain a cohesive

pharynx		bolus
Decreased laryngeal elevation	Food remains on top of airway and falls into airway when it opens to restore breathing	Use soft solids and thick to spoon-thick liquids Avoid sticky, bulky foods that fall apart
Esophageal Transit Phase		
Weakened closure of airway and pharynx	Food material returns from the esophagus into the pharynx and spills into the airway	Use semi-solid moist foods that maintain a cohesive bolus
Reduced esophageal peristalsis	Food bolus remains in esophagus	Avoid sticky and dry foods Try dense foods followed by liquid
Esophageal obstruction	Narrowing of esophageal passageway	Use thin liquids and pureed or soft foods Avoid sticky, dry foods

Reference: Manual of Clinical Dietetics, 6th edition, page 672 – 674

TESTS TO DETERMINE SEVERITY OF CONDITIONS

PROBLEM/CONDITION	TEST FOR SEVERITY	RESULT AND IMPLICATION
Suspected poor tongue control	Ask resident to touch tongue to nose Ask resident to touch tongue to chin Place small amount of honey or smooth jam on upper or lower lip or corners of mouth	Assess ability to move tongue around inside mouth to manipulate food and to clean oral cavity with tongue
Oral cavity poorly hydrated	Place tongue depressor flat on tongue and press lightly	Tongue depressor comes off tongue dry if poorly hydrated Comes off easily and wet if tongue is well-hydrated
Poor swallowing	Put spoon in mouth and press lightly on tongue	Light pressure should stimulate first swallow. Put food on spoon and press again. Alternate empty spoon

	Put spoon into ice water. Press gently onto tongue and remove quickly.	and spoon with food to feed resident. If swallowing is successful, keep three spoons in ice and rotate use.
Poor mouth opening	Ask resident to mimic your open mouth Try to open mouth with tongue depressor. Place small amount of food on inside of lower lip	Apply heat to jaw to relax muscles. Resident is able to open mouth and lick food. Continue until resident opens mouth enough to be fed.
Holds jaw slack or in open position. Drooling from slack jaw.	Ask resident to mimic you as you close your mouth. Place your hand under jaw and gently try to close mouth.	Prop resident's hand under jaw with elbow on table to control jaw closed between spoons of food.
Poor lip control	Ask resident to mimic you as you close and open your lips. Ask resident to smile and then to blow out a match.	
Coughing while drinking	Check head positioning.	Maintain head in neutral position. Use "nosey" cup so resident can drink without tilting head.
Choking on solids	Give resident soft solids without extra additional liquid.	Change eating pattern so that solids are fed first and liquids follow at end of meal Possible texture change.

Reference: Canadian Nursing Home1:2, May/June 1990