Dysphagia Management: Safe Eating and Drinking (Long-Term Care)

Site Applicability

All VCH and PHC Long-Term Care Homes

Practice Level

Screening and Management:

- Basic skill for all regulated disciplines within the competencies of their scope of practice
- Basic skill for all unregulated health care providers:
  - As outlined in their roles and responsibilities and job descriptions; and/or
  - Within their employer training and job descriptions and under direction of appropriate regulated/unregulated health care professional

Clinical Swallow Assessment:

- **PHC:** Only Speech-Language Pathologists perform swallow assessments – Basic Skills
- **VCH:** Speech-Language Pathologists – Basic Skills
- **VCH**: Occupational Therapists – Advanced Skills (requires additional education)

Requirements

All health care disciplines are responsible for observing for and reporting signs of dysphagia (i.e., swallowing difficulties) during mealtimes or oral intake.

All long-term care homes must screen for dysphagia and have clear evidence-based care processes that promote safe eating and drinking. This includes:

- assessment and on-going evaluation on move-in, return from acute care or with any change in condition,
- individualized care planning that recognizes resident's values, beliefs, promotes resident's choice, safety, goals of care and well-being, and
- ensuring all staff have the required knowledge and skills to support safe swallowing, identify signs and symptoms of swallowing difficulties, recognize and respond to the signs of choking/aspiration.

The Resident Assessment Instrument Minimum Data Set (RAI-MDS) scheduled assessment is used to screen for residents at risk. Residents identified as at risk should receive further assessment and a care plan should be developed, as needed.

Need to Know

Supporting decisions in the context of dysphagia when people are unable to voice their wishes or concerns is complex and requires an interdisciplinary approach. In some cases, this may include a consultation with Ethics Services, Risk Management and Adult Protection Designated Responder. This guideline can be used to support decision-making.

Dysphagia or difficulty swallowing occurs in over 50% of older adult (age 65+) in long-term care. Residents with dysphagia are at risk of oral bacteria and food/liquid entering the lungs during meals and medication administration. This can result in aspiration pneumonia, which can be **fatal** in older adults and those with chronic conditions. Dysphagia can also cause malnutrition, dehydration and poor quality of life. Regular oral care reduces the risk of aspiration pneumonia. For residents with frequent aspiration pneumonias, mouth care should be performed before and after meals.

Signs and Symptoms of Dysphagia (before, during or after swallowing)

- Gurgly, wet sounding voice or respirations
- Coughing, choking or throat clearing
- Food residue in mouth after swallowing
- Regurgitation of food after eating and drinking
- Drooling
- Difficulty chewing and/or controlling food in the mouth/taking a long time to chew or swallow
- Change in, or labored breathing
- Recurrent chest infections/aspiration pneumonia
- Leaving more difficult to eat foods on plate, refusal to eat
- Anxiety at meal-times
- Pain on swallowing
- Delayed swallow/swallowing multiple times per mouthful (effortful swallowing)
- Unexplained weight loss
- Self-report/reported by family/Substitute Decision Maker (SDM).

Additional Risk Factors for Dysphagia

- Neuromuscular/Neurological disorders
- History of head or neck surgery/radiation/tumour or tracheostomy
- Gastrointestinal disorders, e.g. strictures, tumours, esophageal motility disorder
- Dyspnea or respiratory disorders
- Dry mouth
- Poor dentition or poorly fitting dentures
- Advanced age
- Dementia

- Difficulty maintaining alertness/safe posture during eating and/or drinking/heartburn
- Change in health status (e.g. reduced level of consciousness, exacerbation of a chronic condition, infection, delirium)
- Medications e.g. opiates, anxiolytics, antipsychotics, antidepressants.

Guideline

Screening and Assessment

Pre-admission

All new resident's RAI-MDS assessments and/or medical history are pre-screened for dysphagia risk by Director of Care (DOC), Clinical Nurse Leader (CNL) or Care Coordinator (CC) or Clinical Operations Supervisor (COS). Refer to Signs and Symptoms and Risk Factors.

Admission

- Residents identified at risk by DOC/CNL/CC/COS are screened by a Nurse using the algorithm (Appendix A) and Aspiration Screening Tool (Appendix B).
- Residents not considered at risk will have their first meal observed by a Resident Care Aid (RCA) or Nurse using the Mealtime Observation Guide (Appendix C). If any signs or symptoms present, Nurse to perform screen using the algorithm (Appendix A) and Aspiration Screening Tool (Appendix B). Modify diet as per Appendix B.
- Residents identified as having difficulty swallowing must be referred to:
  - S-LP or OT with advanced competencies for swallowing assessment. Note: OT at PHC do not perform swallow assessments, and
  - Registered Dietician (RD) for an expedited nutritional assessment and modification of diet
- Nurse collaborates with pharmacy and Most Responsible Provider (MRP) (physician or nurse practitioner) to review medications that may affect resident's ability to swallow and to modify medication formulations to conform to recommended textures.
- Consider referral to dental hygienist/dentist for dental assessment and care planning to address dentition/dentures and oral care advice to reduce risk of aspiration pneumonia.

Change of Condition

Swallowing abilities can deteriorate **OR** improve depending on the underlying cause. When swallowing ability changes, the resident's care plan/care guide must be modified accordingly. On-going evaluation is vital to maintain safety, quality of life, and ensure residents are receiving the best possible nutrition.

Observing residents during activities that involve eating and drinking for signs and symptoms of dysphagia (e.g. during meal times, snack times, parties and when taking medications) enables early detection of changes in swallowing ability. All staff, family/SDM involved in these activities should be encouraged to look for signs and symptoms and report these to the nurse for further assessment.

It is recommended that screening and/or assessment by an appropriate clinician is performed:

- Quarterly at time of RAI-MDS and/or,
- When resident's condition changes (e.g. reduced level of consciousness, exacerbation of a chronic condition, infection, delirium),
- When observed activities involving food and drink suggest changes in resident's ability to swallow (i.e. any deterioration **OR** improvement in any of the signs and symptoms),
- If resident, family and/or SDM raise concern or report improvement in swallowing,
- If resident, family and/or SDM request a change in meal preference to improve quality of life,
- When there is a significant change in resident's goals of care, and/or
- As outlined in the resident's individualized care plan/care guide

Care Plans / Care Guides

It is important that all staff are aware of residents' care needs and follow care plans/care guides for activities that involve eating and drinking.

The resident and family and/or SDM (as appropriate) should be involved in developing care plans/ care guides. If resident is capable of making their own nutrition and hydration decisions, involvement of family and/or SDM should be done with the consent of the resident. For guidance on consent see: Capability and Consent Tool BC Edition.

The following six considerations should be used as a guide when developing individualized care plans/care guides:

1. **Ensuring Safety During Meal Times**
   - Ensure resident is alert. Position resident upright for meals. Resident should remain upright for a minimum of 30 minutes following meals

     Note: Additional instruction regarding position/feeding aids and techniques as recommended by S-LP, OT and/or RD should be included in resident care plan/care guide
   - Inspect mouth and ensure visible debris is cleared or perform mouth care as indicated before and after meals to reduce risk of aspiration of oral bacteria and debris. Resident should be encouraged/reminded to clear mouth independently when possible
   - Moisten mouth prior to meals to aid swallowing
   - Provide appropriate feeding utensils/adaptive equipment to facilitate self-feeding
   - Provide a quiet environment to maximize concentration and attention for meals by:
     - Minimizing distractions (e.g. TV and radio)
     - Orienting resident to task of eating and drinking
   - Provide meals as per dietitian/MRP diet order with recommended texture modifications and fluid consistency

Note: Do not change the texture of modified texture meals or fluids that have been specially prepared for resident by diluting with water, sauces or other fluids as this further alteration in texture may cause aspiration

- When engaging with residents during meals wait for them to finish chewing or swallowing
- Staff observe for signs of choking throughout eating and drinking and seek assistance/initiate intervention as indicated
- When a resident requires assistance with eating and drinking, consider additional interventions:
  - Identify resident specific needs regarding how long mealtimes/assistance with meals should take and include this in the resident care plan/care guide. Some residents may find sessions longer than 25 minutes tiring and this can affect swallowing ability. Other residents may require longer sessions so that they can enjoy their meal without feeling rushed.
  - Position self at same level as resident and make eye contact. Communicate that you are going to help with the meal or fluid
  - Use modified utensils or cup as recommended by S-LP and/or OT

    CAUTION: Do not use tablespoons or straws unless part of a care plan/care guide
  - Make sure resident's mouth is empty before the next spoonful. If needed, prompt swallowing and assist resident to clear mouth
  - **Do not** wash food down with liquid unless specified in care plan/care guide
  - Observe for signs and symptoms of dysphagia: Stop mealtime if signs present and report to Nurse
  - Maintain resident's dignity by:
    - responding to drooling/food or liquid spills
    - providing clothing protectors during meals
- At end of meals, Nurse/RCA:
  - Inspects resident's mouth
  - Removes any remaining food
  - Provides mouth care as needed
  - Provides opportunity for resident to wash hands and face
  - Removes clothing protectors

2. Ensuring Safety During Medication Administration

- Wherever possible Nurses should ensure that medications are supplied by pharmacy in a formulation or consistency that is tolerated by the resident without modification. If modification is required, follow VCH or PHC Safe Working Procedures for crushing or mixing with food or fluids

- Ensure resident's medication delivery instructions are individualized with consent from the resident or SDM and following pharmacy instructions
- All staff involved in medication assistance observe and communicate any difficulty in resident's ability to swallow medication to nurse

3. Monitoring Intake

- Weigh resident at least monthly and review weight trends using quarterly MDS-RAI assessment
- Refer to RD if unintentional weight loss of more than: 5% in 1 month, 7.5% in 3 months or 10% in 6 months
- Refer to RD if resident is eating less than 50% of food/fluids on meal tray
- RCA/Nurse/RD monitor nutritional and fluid intake and the care plan/care guide is updated as needed.

4. Communicating Resident Diet Orders and Nutritional Requirements

All long-term care sites must have a system in place to ensure kitchen and meal delivery staff are aware of resident's diet modifications and nutritional requirements along with a system for reporting and rectifying errors.

- Staff participate in informing family, SDM, volunteers, companions and others to follow the resident's care plan/care guide regarding eating and drinking. A copy of the care plan should be shared with the family/SDM, as appropriate.

5. Providing Psychosocial / Cultural and Spiritual Support

- There are many cultural, social and person values, beliefs and feelings associated with eating and drinking. It is important for staff to be able to facilitate expression of these and develop a plan of care to support residents' individual wishes without imposing their values and beliefs
- Offer an opportunity to explore fears, concerns, and beliefs with the appropriate care provider as determined by the resident/SDM or family, e.g. spiritual care provider, social worker, Indigenous Patient Experience Team, VCH Ethics Services
- Confirm resident's food preferences

6. Ensuring an Ethical Approach to Supporting Residents' Eating Choices

Dysphagia can be devastating for residents, as being able to eat and drink is commonly associated with living, socialization, enjoyment and quality of life. For each resident wanting to eat or be assisted with meals who is at risk of aspiration, staff have a responsibility to consider all the factors involved e.g. resident choice, values and beliefs, capability of resident to make decisions, harm to resident and/or others, and to determine what should be done or escalate care concern to appropriate discipline. When making decisions to respect the limits of what a resident wants to eat or drink, the following guiding principles, in addition to the Supporting Choices through Informed Decision-making and Collaboration guideline should be used to guide and support decision-making:

- The quality of life of a resident choosing to eat at risk or refusing to eat is always the prime consideration
- Capable residents (i.e. those who are capable of making their own decisions about whether to eat or be assisted to eat) have the right to make these decisions

For residents deemed incapable to make a decision related to eating at risk, family/SDM should be engaged in decision making when determining what is in the resident's best interest

- In any situation where resident and family/SDM (if applicable) and staff are unable to reach an agreement to support resident's choice to eat and drink at risk or to decline nutrition, involving ethics, risk management is necessary. For VCH contact Ethics Services and Risk Management. For PHC contact Risk Management. Also refer to for additional guidance:
  - Resolution of disagreements about expectations for care considered non-beneficial
  - VCH Process map resolution of disputes about expectations for care not considered beneficial
- Licensed care facilities and Long-Term Care homes at VCH and PHC are obligated to offer and provide assistance with nutrition and hydration to residents. In circumstances where a family/SDM is requesting to cease the provision of oral nutrition and this is not due to worsening dysphagia or imminent death:
  - At VCH consult with VCH Ethics Services and Professional Practice and where applicable Client Relations and Risk Management and ReAct Adult Protection Program.
  - At PHC consult with Risk Management
- If there is any concern that the decision is abusive, neglectful, or harmful to the resident, a referral to a Designated Responder is required

Transitioning to a Palliative Approach

A palliative approach to care is an important consideration, particularly when a resident is experiencing progressive or worsening dysphagia when nearing end of life. Supporting personal choice around eating and drinking can be challenging. This may involve supporting residents who choose to continue to eat and drink at risk or may involve supporting residents who choose to cease eating and drinking. Consultation with palliative care may address concerns regarding worsening dysphagia, facilitate symptom management, end of life and comfort care.

Under circumstances where residents or their family/SDM are requesting options around artificial feeding, careful considerations of the risks and benefits for the resident is required. The VCH Ethical Decision-Making Framework for Tube/Other Feeding Options and involving Ethics Services can facilitate decision making around artificial feeding.

Ongoing Evaluation

Residents should be routinely assessed/monitored for appropriateness and effectiveness of dysphagia interventions. This includes:

- Need for formal re-assessment of dysphagia

- Adherence to recommended dysphagia management care plan/care guide
- Whether strategies have reduced frequency of signs and symptoms of dysphagia
- Whether the residents dining experience is enjoyable or having a negative impact on quality of life

Expected Resident Outcomes

- Resident discomfort related to swallowing difficulties is minimized
- Complications related to eating and drinking are prevented or detected early and appropriate strategies are implemented
- Capable residents' eating choices are supported and have agreed upon strategies in their care plan/care guide to minimize risks associated with dysphagia while incorporating their wishes. Note: capable residents must not be required to adhere to their care plan/care guide as they make this choice. For incapable residents, family/SDM and team have agreed upon strategies in their care plan/care guide to reduce risks associated with dysphagia while incorporating the resident's previously expressed/documented/known wishes as much as possible. Harm to others in both circumstances is reduced to a tolerable level.
- Resident/family/SDM (if applicable) expresses that nutritional needs, quality of life and dignity meet their expectations

Expected Staff Education Outcomes

Staff

- Recognize the signs and symptoms of dysphagia
- Use this guideline and implement appropriate strategies/referrals
- Follow the Ensuring an Ethical Approach to Supporting Residents Eating Choices when coming to a decision about a resident eating/or being assisted to eat and drink at risk

Staff Education

- New staff receive education on safe eating and drinking and managing dysphagia
- Existing staff receive education and updates as evidence changes and when determined by long-term care site education policies
- Staff receive education on ethical implications of supporting residents eating at risk, how to mitigate risks to resident and/or others and how to develop and implement care plans/care guides

Resident Education

- All appropriate staff provide individualized education about dysphagia to resident, family and SDM (if applicable), including information on eating at risk, safe swallowing, signs of worsening/improving dysphagia, modified textures and thickened fluids
- Staff provide information pamphlets to support education, see Related Documents

Documentation

Assessments, interventions and evaluation of care plan/care guide are charted as per profession's College Guidelines and Standards and long-term care site policy on appropriate assessment forms, interdisciplinary progress notes and resident care plan/care guide.

Resources and Related Documents

PHC and VCH

Mouth Care in Long-Term Care

VCH

Risk Management

Patient Care Quality Office (PCQO)

Ethics Services

Indigenous Health

Indigenous Cultural Safety

Indigenous Cultural Safety Policy

Cultural Competency and Responsiveness

Adult Protection: Abuse, Neglect, or Self-neglect of Vulnerable Adults - Policy

Capability and Consent Tool BC Edition

Diet Writing Guidelines

Ethical Decision-Making Framework for Tube/Other Feeding Options

PHC

PHC Ethics Services

Patient Safety

Patient Care Quality Office

Indigenous Wellness and Reconciliation

Adult Protection: Abuse, Neglect or Self-Neglect of Vulnerable Adults. Designated Responder Guideline

Indigenous Cultural Safety

The Framework for Ethical Decision-making

Diet Writing Guidelines

Dysphagia Management Acute Care

Patient Health Education Materials: VCH or PHC and search for 'dysphagia'

Site Specific Resources

RH:

Nutritional Care for Dysphagia

VA:

Thickening Fluids by Nurses

Swallow Screening for Dysphagia

VC:

Dysphagia (Swallowing) Management: Feeding Assessment

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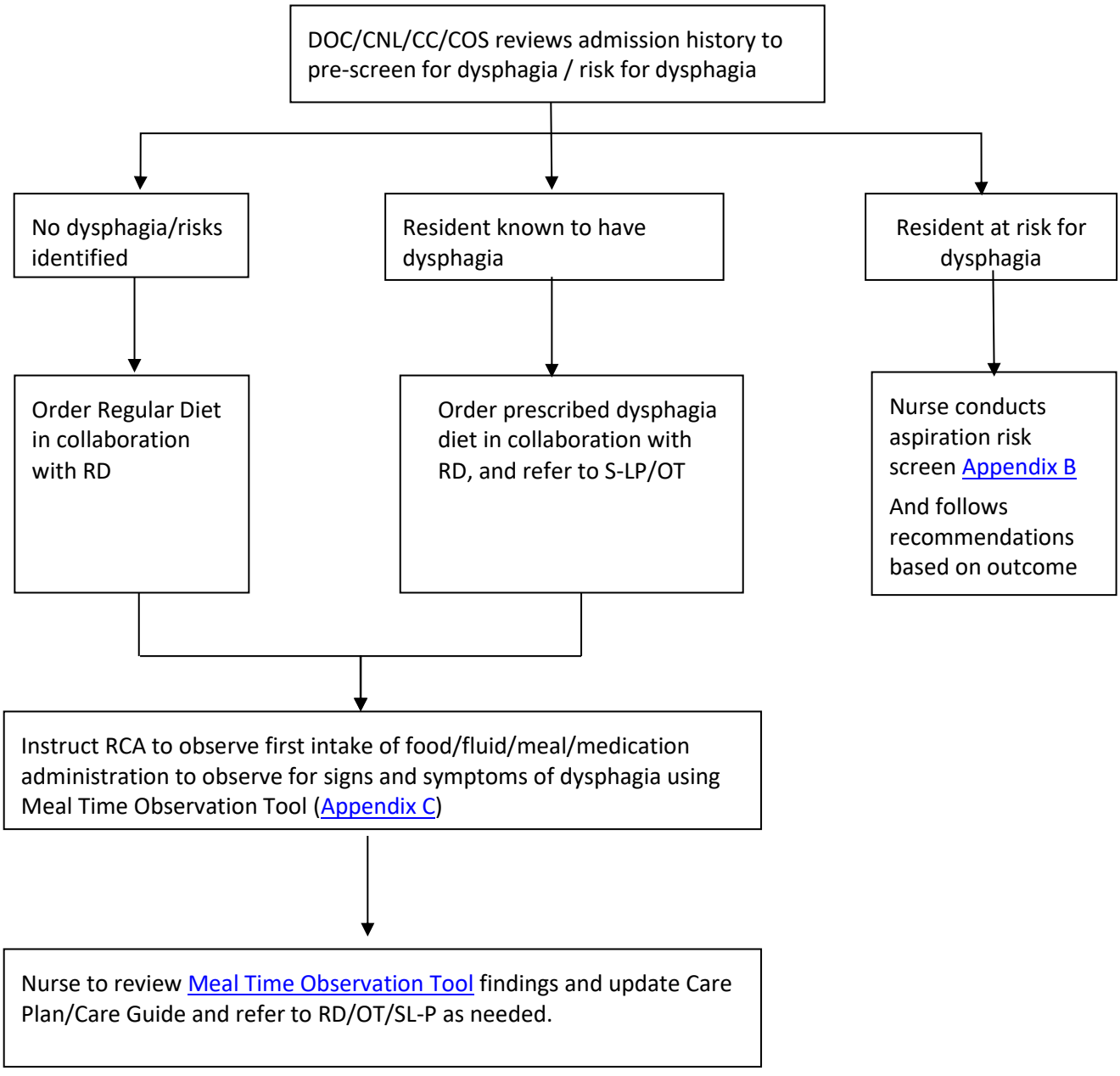
Appendices

- Appendix A: Identifying Residents at risk of Dysphagia on moving in / return from acute care / significant change in medical or functional status
- Appendix B: Aspiration Screening Tool for Residents with Suspected Dysphagia – Guide for Nurses
- Appendix C: Meal-time Observation Tool for RCA

Appendix A: Identifying Residents at risk of Dysphagia on moving in/return from acute care/significant change in medical or functional status



Appendix B: Aspiration Screening Tool for Residents with Suspected Dysphagia – Guide for Nurses

Do not use for residents with known dysphagia – follow prescribed diet.

Date _____Name of Resident _____Nurse signature and designation_____

Equipment and Supplies

- Oral care supplies, 90 mLs cold drinking water, cup, wash cloth and clothing protection for resident.

Aspiration Risk Screen using Water

Observe for the following signs of aspiration throughout test: wet or gurgly voice/respirations, cough, choking, or laboured breathing. If signs observed discontinue test and follow instructions below - At Risk of Aspiration

1. Position resident upright, support head as necessary and ensure resident is alert and able to participate in screen
2. Explain procedure and obtain consent (written consent is not required)
3. Perform Oral Care
4. Administer 90 mLs cold water
5. Provide 2 to 3 small sips from a cup with at least a breath between sips
6. Observe for signs of aspiration. If no signs present, move to Step 7
7. Provide larger (normal sized) sips until 90 mLs of water has been consumed with at least a breath between sips and observe for aspiration

Signs of Aspiration

☐ **YES** **At risk of Aspiration**

1. Refer to SLP/OT for formal swallow assessment and RD for nutritional assessment
2. With resident/SDM agreement change oral intake to pureed diet with nectar thick fluids
3. Initiate recommended interventions for safe eating and drinking in section "Ensuring Safety during Eating and Drinking"
4. Observe/supervise resident during meals for further signs of aspiration and dysphagia
5. Monitor vital signs document and report to MRP changes to baseline indicative of aspiration pneumonia: fever, hypoxia, cyanosis, increased respiratory rate/effort, increased sputum, decreased level of consciousness

☐ **NO** **Passed test: commence on/continue with regular diet and thin fluids**.

Repeat screen if resident shows signs of aspiration

If resident shows other signs of dysphagia – pocketing of food in mouth or cheeks, effortful swallowing, food or fluid coming from nose, complains of painful swallowing or food getting stuck, refer to SLP/OT for further swallow assessment and discuss with RD regarding nutritional recommendations.

Appendix C: Meal-time Observation Tool for RCA

Ensure resident is sitting upright and alert prior to meal.

Observe for the following signs / symptoms. **If ANY are present,** remove food or stop assisting with meal. Inform resident of risk and report to Nurse immediately:

Check all that apply (✓):

- ☐ Wet or gurgly voice/throat clearing/wet respirations
- ☐ Coughing or choking after swallowing (if choking persists seek immediate nursing/MRP support)
- ☐ Laboured change in breathing after swallowing or after a meal
- ☐ Food or fluid coming out of nose
- ☐ Food residue in mouth/cheeks (pocketing) despite prompting resident to clear and swallow

NOTE:

If providing assistance with meal, refer to section Care Plan or Care Guide: Ensuring Safety during eating and drinking.

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Approved By: *(committee or position)*	VCH	PHC
	VCH: (Regional DST Endorsement - 2nd Reading) Health Authority & Area Specific Interprofessional Advisory Council Chairs (HA/AIAC) Operations Directors Professional Practice Directors Final Sign Off: Vice President, Professional Practice & Chief Clinical Information Officer, VCH	PHC Professional Practice Standards Committee
Owners: *(optional)*	VCH	PHC
	Regional Practice Initiatives Lead (Allied Health), Professional Practice	Practice Consultant, Professional Practice