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Dysphagia in Patients with Dementia: What’s the SLP to Do? - Part 2

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Moderated by:
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Dysphagia in Patients with Dementia: What’s the SLP to Do? Part 2

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Objectives

As a result of this course, participants will be able to:

1. Identify 3 modifications to improve environmental factors for patients with dysphagia and dementia.
2. Explain how to evaluate effects of diet modification on patients with dysphagia and dementia.
3. Describe effective caregiver education strategies for working with families of patients with dysphagia and dementia.
**Evaluation - Key Questions**

- Is this problem acute, acute on chronic, or chronic?
  - Infection, medication, etc. may cause acute issues
- What was the patient’s prior level of functioning over the past weeks, months?
- Are there any patterns to the dysphagia?
- Is there a medication that may be affecting the swallow?
- What type of caregiver support exists in the patient’s normal environment?
- Does the patient have an advanced directive/living will?
- Is this patient on palliative care?

**Evaluation**

- Case history, review of medical co-morbidities
- Patient interview, review of symptoms
  - May use QOL instrument such as SWAL-QOL
- Clinical Assessment of Dysphagia (BED)
  - May include standardized instruments like SAFE or MASA
  - Tools such as pulse oximetry, 3 oz water screen, cervical auscultation
- Instrumental Assessment of Dysphagia
  - Barium Swallow (Esophagram)
  - Videofluoroscopy (MBSS)
  - Fiberoptic Endoscopic Evaluation of Swallowing (FEES)
  - Manometry
Key Considerations for Treatment

- If this is an acute dysphagia, was there a specific incident that can be remedied without diet changes?
- Even if the patient has a PEG, can you provide oral, non-nutritive stimulation for potential rehabilitation of the swallow?

Early Conversation is Key!

- Don’t wait until the end stages to have conversation with patients/ families
  - In early stages, patient can provide input on wishes
  - Families need to be educated that no PEG does not mean “no food”, “no care”, or “give up”
  - Educate on quality of life feeding
Theory of Retrogenesis

Treatment or Intervention

- Medical Interventions
  - GERD meds, surgery, feeding tube placement
- Prevention
  - Maintenance of good oral hygiene
  - Routine exercises to maintain strength
- Intervention by the SLP
  - Rehabilitative Strategies (fix the physical problem)
  - Compensatory Strategies (compensate for the physical problem)
  - Free Water Protocol
- Precautions/ Caregiver trained intervention
  - Positioning
  - Feeding techniques
  - Specialized dining equipment
Supplements/ Alternates?

- Magic Cup
- Super Doughnuts
- Liquid Supplements (Boost, Ensure, etc.)

Management of Dysphagia

- Consider the patient’s alertness
  - If the patient is alert, give extra portions!
- Be flexible with feeding time, speed, and environment
- Use written cues if beneficial to assist patient in recalling compensatory strategies
- When teaching strategies, use 1-step directions, visual cues, and memory/recall strategies if appropriate
- Use physical cues for chin tuck, etc.
Modifications to Environment

- **Lighting**
  - Avoid low lit environment. Use well lit area
  - Reduce glare
- **Place Setting**
  - Placemat
  - Place Cards
- **Contrasting color of placemat/plate**
- **Single color plates (no patterns)**
- **Square tables to designate personal space (round tables are difficult)**
- **Keep the eating area clutter-free**

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Modifications to Environment

- **Familiar sounds, smells, and sights help create a welcoming environment**
- **Do not sit resident with others who he/she may dislike**
- **Encourage residents who are highly social to sit with others**
- **Allow “payment” or receipts, meal tickets**
Modifications to Food Presentation

- Smaller portions
- Divided plates
- Cups/glasses that are easy to grasp
- Colors alternated
- Molded foods for puree
- Glassware, tableware “normal”
- Limit utensils (only spoon or fork)
- Have food precut to maintain dignity and allow appropriate bite size
- Limit garnishes

Modifications to Food Presentation

- Alternate savory/sweet
- Add sweetener to food (sweet is the last taste to go)
- Alternate temperatures
- Provide high flavor food or drink to stimulate stronger response
- Provide ice cold drink at beginning of meal to stimulate
Other modifications

- OT may provide adaptive equipment suggestions
- Finger Foods- encourage self-feeding
- Use spoons for patients having difficulty scooping food
- 6 small meals per day instead of 3 larger ones
- Nutritious, high calorie, high protein snacks
- Allow the patient to wander/walk and eat if safe
- Have hydration readily available throughout the day
- Establish routine (my place)

Other modifications

- Adding calories to food if patient is losing weight (cream, butter)
- Allow favorite foods (recognizing that tastes may change)
- Don’t mix foods, but recognize that patients may do this themselves at times
- If the patient is up during the night, allow the patient to eat
Modifications in End Stages

- Full liquid diet may be appropriate if patient refuses food textures, including puree
- Anticipate the needs of the nonverbal patient
- Identify non-verbal indicators of discomfort, pain, dislike

What About Patients Who Are Overeating and Gaining Weight?

- Have small, healthy snacks available for the patient
- Serve smaller portions at mealtime, but offer additional if the patient is still hungry
- Keep the patient occupied with activity, so that he is not bored or lonely
What about the patient holding food in his/her mouth?

- Offer an empty spoon (or one with minimal food)
- Offer a sip of liquid
- Verbally ask the patient to swallow, then stroke the larynx upward
- Ask a question of the verbal patient
- Use genuine touch to gain attention and encourage swallowing

What about the patient with paranoia?

- Routine is crucial
- Don’t mix medication and food
- Serve simple, easily recognizable foods that are familiar to the patient
- Explain what each food is before the patient eats it
- Prepare food in front of or with the assistance of the patient
- Eat with the patient, even if only a few bites
Feeding the combative patient!

- If the patient is on PT caseload, have that therapy conclude right before mealtime
- Use suction cups to affix plates to the table
- Use cups with lids
- Sit on the non-dominant side of the patient
- Provide calm environment, and do not respond loudly to combative behavior
- Provide one food at a time
- Allow finger foods
- When all else fails, re-approach at a later time

Strategies for Education of CNAs/ Caregivers

- Don’t interpret inattention to lack of desire to eat
- Biting the spoon may be reflexive, not a sign of refusal to eat
- Turning the head away may mean the patient needs more time between swallows, not that the patient is finished with the meal
- Sit down to feed patient. Don’t feed from above
- Give patient eye contact and speak to them, not over them.
- Provide normal bite sizes. Don’t rush!
- Feeding someone is a loving, nurturing act, not a job
When Patients Refuse Recommendations

- Is the patient still competent to make that decision?
- Is the family in agreement with it?
- Care plan
- Waiver/AMA document?

“Safety” vs. Quality of Life: Counseling Families of Patients in End Stage

- Starvation vs. decreased nutritional needs
- Metabolism
- Hunger/thirst are not common, with minimal intake meeting those sensations (Gillick, 2000)
- While NPO is not encouraged, counsel families on safe positioning and alertness for small amounts of nutrition/hydration
Instead of Tube Feeding

- Oral supplements
- Full liquid diet
- Careful hand feeding
  - Hand over hand
  - Not causing excess disability
  - Pacing with patient cues
  - Normal bite sizes

Interactive Case Study

Juan is nearing end of life. Hospice requests that you evaluate him due to coughing during meals. You determine Juan is at high risk of aspiration, but he has an advanced directive for no artificial nutrition/hydration. What do you do?

a) Respect the patient’s directive and offer strategies to caregivers for safe consumption of PO intake when patient is alert and responsive

b) Tell the family they are killing the patient by forcing food

c) Call the doctor and complain that a feeding tube needs to be placed

d) Make the patient NPO so it lowers the risk that he will aspirate
Interactive Case Study

Viola is on a pureed diet and her family is concerned that she is not eating as much. What can you suggest?

a) Eat with Viola. Choose naturally pureed consistency foods so that your food looks identical to hers.
b) Use food molds in order to make the pureed more visually appealing
c) Watch the food temperature….cold pureed meat isn’t very appetizing!
d) All of the Above

Interactive Case Study

Mary was a 90-year old female in the moderately severe stage of dementia. Each day in the dining room, Mary would take food, place it in a napkin, and hide it in the side pocket of her wheelchair. If staff attempted to take the food items out of the wheelchair, Mary became extremely agitated, and would scream/cry. Left alone, she would take the food back to her room and place it in her bedside table drawer. Nurses and CNAs expressed concern due to the potential for spoiled food and/or pests that may be attracted to Mary’s food stash.
Interactive Case Study

What do you need to consider in this situation? (select all that apply)

- What is the purpose behind the hoarding behavior?
- Could this behavior harm Mary?
- How can we support Mary by validating feelings but maintain safety and cleanliness?

What types of interventions could be useful? (open answer)

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Margaret is an 80-year old female resident of a SNF who is in the later stages of dementia. Recently, Margaret had an episode of choking on meat, which led to a diet downgrade to mechanical soft, which she is tolerating well. The doctor ordered a MBSS, which revealed that Margaret is silently aspirating thin, nectar, and honey thickened liquids. The SLP conducting the MBSS recommended PEG placement due to liquid aspiration. However, Margaret has an advanced directive stating that she wants no form of artificial nutrition/hydration. Margaret is no longer competent to make her own decisions, and continually asks for ice water.
Interactive Case Study

1. Are we obligated to respect the AD?
   • Yes
   • No

2. What is the most important consideration when discussing our options for recommendation?
   • Margaret has not been diagnosed with aspiration pneumonia
   • Her advance directive is clear, and POA is in agreement
   • Margaret’s QOL is impacted negatively if we take away the 1 thing she is requesting

Thank you for your attention and participation!