Alzheimer's
QUEENSLAND

QUALITY PROCEDURE

RESIDENTIAL AGED CARE SERVICES

DYSPHAGIA MANAGEMENT

1.0 OBJECTIVE

Alzheimer's Queensland (AQ) will endeavor to and take all reasonable steps to promote nutrition and hydration of all residents including those that have dysphagia in a safe, evidence-based manner which take into account the preferences and choices of the individual resident.

2.0 RESPONSIBILITIES

2.1 The **Chief Executive Officer** or nominated representative is responsible for ensuring that resources will be provided to ensure that dysphagia requirements of residents are available and accessible, and that managers and supervisors (as appropriate) adhere to this procedure.

2.2 The **Director of Care** is responsible to ensure that residents' dysphagia requirements are managed effectively, residents are treated with dignity and respect and that staff conduct themselves in an equitable and professional manner.

2.3 All **Staff** are responsible to adhere to this procedure.

3.0 BACKGROUND

3.1 Dysphagia is a medical term for people who have difficulty or display an inability to swallow. There are many causes of dysphagia, such as stroke, progressive Neurological disorders, dementia, acquired brain injury, cancer, etc.

3.2 More than half of half of the elderly who live in aged care show some level of dysphagia. Food preparation for a resident with eating and swallowing difficulty is listed in the International Dysphagia Diet Standardisation Initiative framework (Appendix A).

3.3 **All residents are screened on admission for dysphagia and a referral to a Speech Pathologist is undertaken to establish an individual baseline for each resident.**

4.0 RECOGNISE THE SIGNS OF DYSPHAGIA

4.1 There are some common signs that can be recognized during/ after eating/ drinking:

- difficulty taking food/ fluids from a spoon/ fork/ cup
- drooling or loosing food/ fluids from lips
- holding food or fluid in mouth
- slow and effortful chewing
- residue food in mouth after swallowing
- increased time taken for meal or not finishing meals
- feeling of food/ fluids getting 'stuck'
- voice changes; wet 'gurgly' voice
- multiple swallows per mouthful
- avoiding certain foods/ fluids
- fear of eating/ drinking
- regurgitation
- recurrent chest infections
- difficulty managing oral secretions
- poorly fitting dentures or other barriers to effective chewing and mouth movement
- dehydration/ malnutrition
- weight loss

4.2 Staff need to report immediately to RN/CN/DoC when it is observed that a resident has any of the above listed signs. The RN will then assess resident's condition and refer to appropriate Allied Health staff.

4.3 Immediate action is taken to ensure diets and fluid consistency is increased until such review has occurred.

5.0 MANAGEMENT OF DYSPHAGIA

5.1 If a resident is identified as having possible signs of dysphagia, a referral to a multidisciplinary team may be needed to ensure safe and enjoyable mealtimes that meet nutritional, health and wellbeing need.

5.2 When a resident is identified with dysphagia. RN/CN will refer the resident to a Speech Pathologist to assess individual risks and diagnose and recommend appropriate modifications to the texture of foods and thickness of drinks, and the way the person eats.

5.3 When a resident has experienced dysphagia, a referral to a dietitian may be recommended to meet resident dietary requirements, food preferences or choices.

5.4 Resident may be also referred to an Allied Health professional e.g., a Dentist, if the resident has been identified on assessment as having issues related to dental or oral health.

5.5 The RN/CN is to follow up all referrals and update individual's nutritional and hydration assessment (and the care plan) in Clinical Manger with appropriate documentation of the modifications required to the texture of foods and thickness of drinks, and the assistance required by the resident.

5.6 The RN/CN is responsible for ensuring that all relevant staff are informed of all changes. Relevant staff include kitchen, care and lifestyle staff.

6.0 CLINICAL STAFF RESPOND TO CHOKING/ASPIRATION

6.1 When a resident experiences choking or aspiration, the steps of all staff will be:

- immediate cessation of current of food or fluid intake until such time as a clinical review by the RN takes place and it is deemed safe to resume intake;
- encourage resident to relax;
- ask resident to cough;
- immediate assistance is sought form the RN;
- if the airway is not cleared and the resident is having difficulty breathing call the Ambulance on 000;
- if the resident is showing signs of not clearing their airway independently then bend resident well forward and give up to 5 sharp blows on the back between the shoulder blades with the heel of one hand – check if blockage has been removed after each blow;
- if unsuccessful, give up to 5 chest thrusts by placing one hand in the middle of the resident's back for support and heel of other hand in the CPR compression position- check if blockage has been removed after each chest thrust;
- if blockage does not clear, continue alternating 5 back blows with 5 chest thrusts until medical aid arrives;
- if resident become blue, limp or unconscious, follow the principles of immediate first aid and call 000.

6.2 The Registered Nurse on duty will:

- respond to all calls of a resident experiencing choking or aspiration immediately;
- render first aid as appropriate to the clinical circumstances;
- assess each resident for safety including:
  1. the position of the resident when intaking food or fluids;
  2. the level of assistance being offered;
  3. the physical condition of the resident including vital signs observation;
  4. if deemed clinically appropriate will increase level of modification;
  5. complete documentation – progress note, incident report and clinical assessment;
  6. the principles of Open Disclosure are practiced, and EPOA/family are kept informed of the incident recommendations and actions taken in response to incident & treating medical officer is informed;
  7. referral to other professionals is based on the clinical judgement of the RN at the time.

7.0 REFERENCED DOCUMENTS

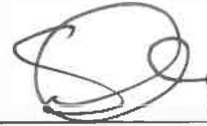
AAQ-F-019	Incident Reporting Form
RNC-F-035	Nutrition and Hydration Assessment
RNC-F-036	Swallowing Screening Tool
	Care Plan
	Progress Notes
	Clinical Manager
Appendix A	IDDS Framework

International Dysphagia Diet Standardisation Initiative

First aid fact sheet–Choking adult. St John Ambulance Australia.

Supporting safe and enjoyable mealtimes for people with swallowing difficulties. Aged Care Quality and Safety Commission, Australian Government.

Reviewed by Food Solutions Speech Pathologist 2024 prior to distribution

APPROVED BY: 

CHIEF EXECUTIVE OFFICER

DATE: 22/8/24

Appendix A

The IDDSI Framework

Providing a common terminology for describing food textures and drink thicknesses to improve safety for individuals with swallowing difficulties.

© The International Dysphagia Diet Standardisation Initiative 2019 @ https://iddsi.org/framework/
Licensed under the CreativeCommons Attribution Sharealike 4.0 License https://creativecommons.org/licenses/by-sa/4.0/legalcode.
Derivative works extending beyond language translation are NOT PERMITTED.

AppendixB

SPEECH PATHOLOGY REFERRALS

Does this referral involve a choking episode?
(Choking is an airway obstruction when an object e.g. food or medication blocks the airway and the person cannot breathe. Choking requires immediate first aid assistance)

YES – THIS INVOLVES A CHOKING EPISODE

1. Notify RN/CN immediately, and follow your facility choking protocol.
2. Ensure choking episode is documented in resident's progress notes and clearly states what food / object resulted in choking episode.
3. If choking episode involved food item - commence immediate downgrade to Level 5 Minced Moist Diet. RN/CN to observe next meal with resident to ensure tolerance / suitability of diet downgrade.
4. If choking episode involved medication - please liaise with GP /Pharmacy regarding suitability of crushed or alternative medications.

Refer for speech pathology assessment

Email your Food Solutions Speech Pathologist

Referral information to include:
- Date of choking episode
- Food/foreign item involved
- Any clinical concerns/changes (example resident deteriorated, resident impulsive)

Your facility speech pathologist is:

Name:

Email:

NO – THIS RELATES TO OTHER SWALLOW OR COMMUNICATION CHANGES

1. Notify RN/CN of identified swallow or communication changes. Ensure to document these changes in the resident's progress notes and include any relevant information (example resident unwell, resident impulsive).
2. If indicated, RN/CN to commence downgrade in diet or fluid level (ONE Level ONLY example:Level 7 Regular Diet downgrade to Level 6 Soft and Bite Sized Diet or Level 0 Thin Fluids downgrade to Level 2 Mildly Thick Fluids). RN/CN to observe next meal with resident to ensure tolerance / suitability of downgrade.

Dysphagia (swallow) changes:
- Coughing when eating / drinking
- Throat clearing when eating / drinking
- Changes to voice (wet, gurgly)
- Respiratory changes (chest changes, increased work of breathing when eating / drinking)
- Changes to saliva / not managing secretions
- Holding food / fluids in mouth
- Slow or effortful chewing
- Difficulty using utensils
- Feeling that food is becoming "stuck"
- Difficulty swallowing medications
- Dislike or refusal of diet / fluids
- Unexplained or concerning weight loss

Communication changes:
- Resident unable to understand staff/family
- Difficulty understanding resident
- Slurred speech
- Changes to voice

Refer for speech pathology assessment

Email your Food Solutions Speech Pathologist

Referral information to include:
- Dysphagia or communication indicators (as above)
- Any clinical concerns/changes (example resident deteriorated, resident impulsive)