

About the author...



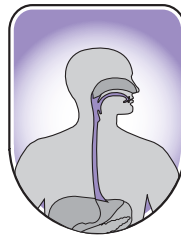
Estelle Joly, is an occupational therapist who is working with the Vigi Santé Ltée, long term care facilities since 1986. She is a graduate of Université de Montréal .

She is currently working at the CHSLD Vigi Pierrefonds and the day centre of Vigi's Centre in Dollard-des-Ormeaux.

Mrs. Joly also travels, if need be, to other Vigi Santé Centres to lend her clinical support and professional skills.

With her clinical experience and ongoing training, she has become somewhat of an expert in the field of dysphagia.

Together with dieticians and a clinical nurse, Mrs. Joly worked on implementing Vigi's interdisciplinary program on dysphagia.



DYSPHAGIA... When eating becomes a real challenge!



We eat and drink many times a day and we do so to survive, rebuild our energy, enjoy a variety of flavours, spend time in good company, and so on. Eating and drinking are automatic reflexes much like walking, for instance. A plate is set before us..., we pick up the food with utensils, bring it to our mouth, we chew and then swallow it... plain and easy. As we sit before our meal, we are not aware of the many repetitive and complex gestures that go into eating..

In long term care facilities, many residents have dysphagia.

Dysphagia is defined as trouble moving food, medication or saliva from the mouth to the stomach.

It is not a disease as much as a symptom, the unfortunate result of a disease affecting physical and/or cognitive abilities. Medical conditions causing dysphagia are many: the results of a vascular cerebral attack, Parkinson's disease, multiple sclerosis, Huntington's chorea, Alzheimer's disease and other types of dementia, cranial traumas, muscular dystrophy, amyotrophic lateral sclerosis and so on.

For the residents who have dysphagia, eating a meal or a snack becomes difficult, tiring, and even dangerous. Every mouthful and

every sip become a challenge. Often, there are residents in the dining-room who cough while others chew their food much longer than necessary. There are others who are repeatedly clearing their throat while others rub their chests because of the pain they have every time they swallow. These are only a few signs of dysphagia. According to the March 2005 statistics collected in Vigi Santé centres, 45% of the residents cannot eat regular food and 8% cannot drink clear liquids.

Dysphagia or difficulty in swallowing food can happen in the mouth (oral dysphagia), in the pharynx when a person swallows (pharyngeal dysphagia), or lastly in the oesophagus when food moves towards the stomach (oesophageal dysphagia).



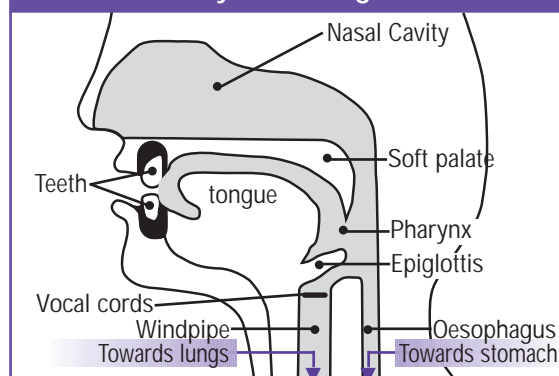
As soon as the meal begins, we have to have a strong and agile tongue to reach all the corners of our mouth for bits of food. The tongue also helps to break down solid pieces of food by crushing them against the palate and then gathers the mouthful in the middle of the mouth ready to be swallowed. We have to place our lips properly on the glass or utensil and keep them tightly closed so that nothing falls out. Our jaws and teeth break up the food, while our cheeks push against the food in our mouth and become taut so that food does not fall between our cheeks and gums.

If his or her mouth cannot make these movements, the resident faces quite a challenge when eating. The next time you eat, try not using your tongue, keeping your mouth partly open while chewing and drinking. Try chewing with very few facial movements or without tightening your cheeks. In doing so, you will begin to understand oral dysphagia.

Pharyngeal dysphagia means having a hard time to swallow. Swallowing is a reflex called deglutition reflex. The process of swallowing takes on the average 1 second (from 0.5 to 2.5 seconds depending on the person). A full series of movements must occur in a very specific order in this one single second in order for food to travel the right way and air passages be protected.

So what about this sequence? First, the soft part of our palate, at the back of our mouth, will move upward so that food does not go up our nose. Food will start to move down as the epiglottis lowers and vocal cords close in order to block the entrance to our lungs. The epiglottis is in fact a valve that must stay open when we breathe and speak in order to let in air. This valve must also

Anatomy of the deglutition



move downwards to protect our respiratory tract when we swallow. A lack of synchronization in these different steps will invariably cause coughing as a way of rejecting the food before it becomes engaged in our respiratory tract. We have all had this unpleasant experience during a meal, probably because we were talking and eating at the same time. Just imagine this happening at every meal, at every bite, at every sip! It's easy to understand how exhausted we would be and how fearful we would become about eating again. For a resident who has a slow or delayed deglutition reflex, food (mainly liquids) move to the pharynx before the epiglottis has had time to move down. Therefore the likelihood of coughing and even choking because of the food particles that have moved to the respiratory tract is great. Additionally, residents are not able to cough with any strength and often cannot cough up what has moved into their respiratory tract.

Oesophageal dysphagia is harder to describe. It is also harder to assess by simply observing a resident. More advanced medical examinations are often necessary. But to get an idea of what the resident experiences, try to remember the last time you took too big a mouthful. The sides of the oesophagus had to stretch in order to handle the mouthful and you experienced pain as the food travelled to your stomach. Often, the problem is at the opening of the



oesophagus. The muscle which controls its opening and closing takes too long to react which causes a build-up at the opening and when the mouthful moves to oesophagus, it is much too big and causes pain as it travels.

Are there any solutions?

There are many resources available so that residents with dysphagia get all the nutritive and liquid requirements they need. Eating should remain a pleasant, comfortable and safe activity.

At Vigi Santé, an interdisciplinary action program has been created for cases of dysphagia and will come into effect in the fall of 2005. It includes a training program for nurses, assistant nurses, nurses' aides and staff from the recreation department. The training will be given gradually, one centre at a time, to meet the needs of residents with dysphagia.

Occupational therapists and clinical dietitians have all been trained. They will work with the nursing team, the resident and his or her family to assess the problem, look for appropriate solutions and suggest alternatives.

What options are available?

- Changes to the texture of food and consistency of drinks
- Change of position or feeding technique
- Use of special dishes
- Change of medication
- Training as a way of better understanding the problem

Food is available in different consistency, that is to say regular, soft, ground and pureed. A modified texture is preferable when residents can no longer handle food so that it can be safely swallowed. Many residents have a weak or paralysed tongue,

others are too slow or unable to open and close their jaw. Some cannot make the complex movements needed to chew properly while others have trouble coordinating their movements. They go on chewing and chewing regular food forever. Food with a different texture helps the process, prevents fatigue and will make the meal more enjoyable and safe. Modified food (either minced or pureed) do not have the same appearance as regular food. Nevertheless, they have the same nutritional value and good taste since they come from the daily menu.

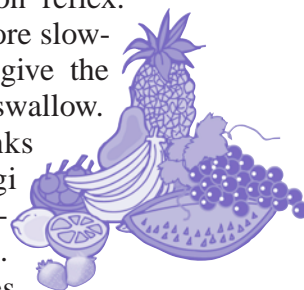
Thickened drinks (or drinks with a modified consistency) are given to residents who have a slow deglutition reflex.

These liquids travel more slowly in the mouth and give the resident more time to swallow.

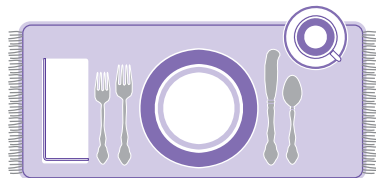
Many thickened drinks are available at Vigi Santé and have the consistency of pudding.

There are fruit juices, milk, nutritional supplements (Ensure) and water with a hint of lemon. Thickened coffee is also offered and has the consistency of honey. A glass of thickened liquid has the same hydration value as a glass of clear liquid. Our kitchen is in the process of testing new recipes in order to offer a wider choice of items.

Often, **simply adjusting the position or the technique used** to feed a resident will drastically reduce coughing spells or discomfort. It is important that the resident's head be slightly inclined forward and that the person helping the resident to eat be seated close to the resident in order to be able to make eye contact. Mouthfuls should be the size of a slightly heaping teaspoon. The meal should be paced according to the resident's ability to swallow. When assessing a resident, who feeds himself or herself, special attention will be given to the technique



used. Here are some helpful tricks: Have the resident swallow twice to be sure that the mouth is empty, refrain from talking during the meal so that the epiglottis can move...



Adapted cutlery and dishes can also make life easier. There is a variety of items such as glasses that do not require the resident to put his or her head back to finish the contents, plastic coated spoons that will not hurt the resident who cannot open his or her mouth well. Rimmed plates and large-handled utensils will help the resident who can feed himself or herself.

Medication must be assessed and modified in some cases. Many drugs have side-effects that increase eating problems (dry mouth, for example). Medication should be given in the easiest possible form, for example syrup rather than a pill. The pharmacist is a valuable resource at this level.

And if eating is no longer possible?

In long term care and residential centres, in the advanced stages of a disease, some residents can no longer control any food in their mouth. They simply cannot swallow mouthfuls or sips. These residents are well-

known to the staff, including the dieticians and occupational therapists. It is essential to provide support throughout all the stages of a disease. It is also important to remember that the resident's comfort should be provided by means that are appropriate to the situation. Inserting a feeding tube automatically means a transfer to the hospital (which in most cases is not what the resident, his or her family and the nursing team want) and could prolong the terminal stage of the disease unnecessarily. Furthermore, literature on the subject says that the lack of food or liquids does not cause a person in the final stage of a disease any pain since all the body's functions have slowed down. After talking to the physician and the other members of the nursing team, the resident's closest relatives must sometimes decide, with difficulty, to stop feeding him or her. Ensuring the resident's comfort is then the best option. Members of the nursing team are with the resident in this final stage and see that the mucus membranes are kept moist so that the resident's mouth does not dry out.

In closing, eating despite symptoms of dysphagia is quite a challenge! An understanding environment that is concerned with finding solutions and providing support is still the best step to enjoyable and safe meals for the resident with dysphagia.

The Collection "Between You & I" is published by a group of Residents' Committees (*Users' Committee in accordance with the Act*) from some Residential and long term care centres (CHSLD).

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The masculine form used in this document implies the feminine form and has been used solely to facilitate reading.