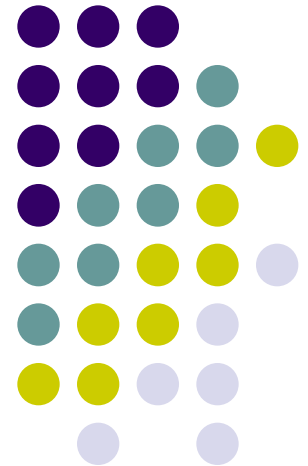
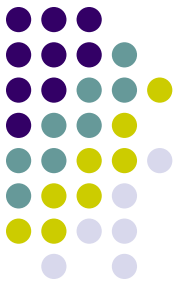


Feeding and Swallowing Difficulties in Dementia

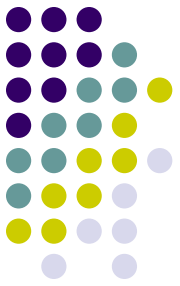




Aims of session:

- Swallowing anatomy and physiology
- Dysphagia- signs, symptoms, risks
- Characteristics of dysphagia in people with dementia
- Strategies to help

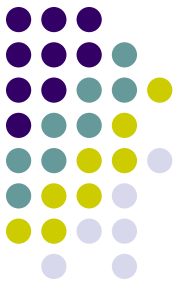
Dysphagia



Medical term for swallowing difficulty

Common in dementia-

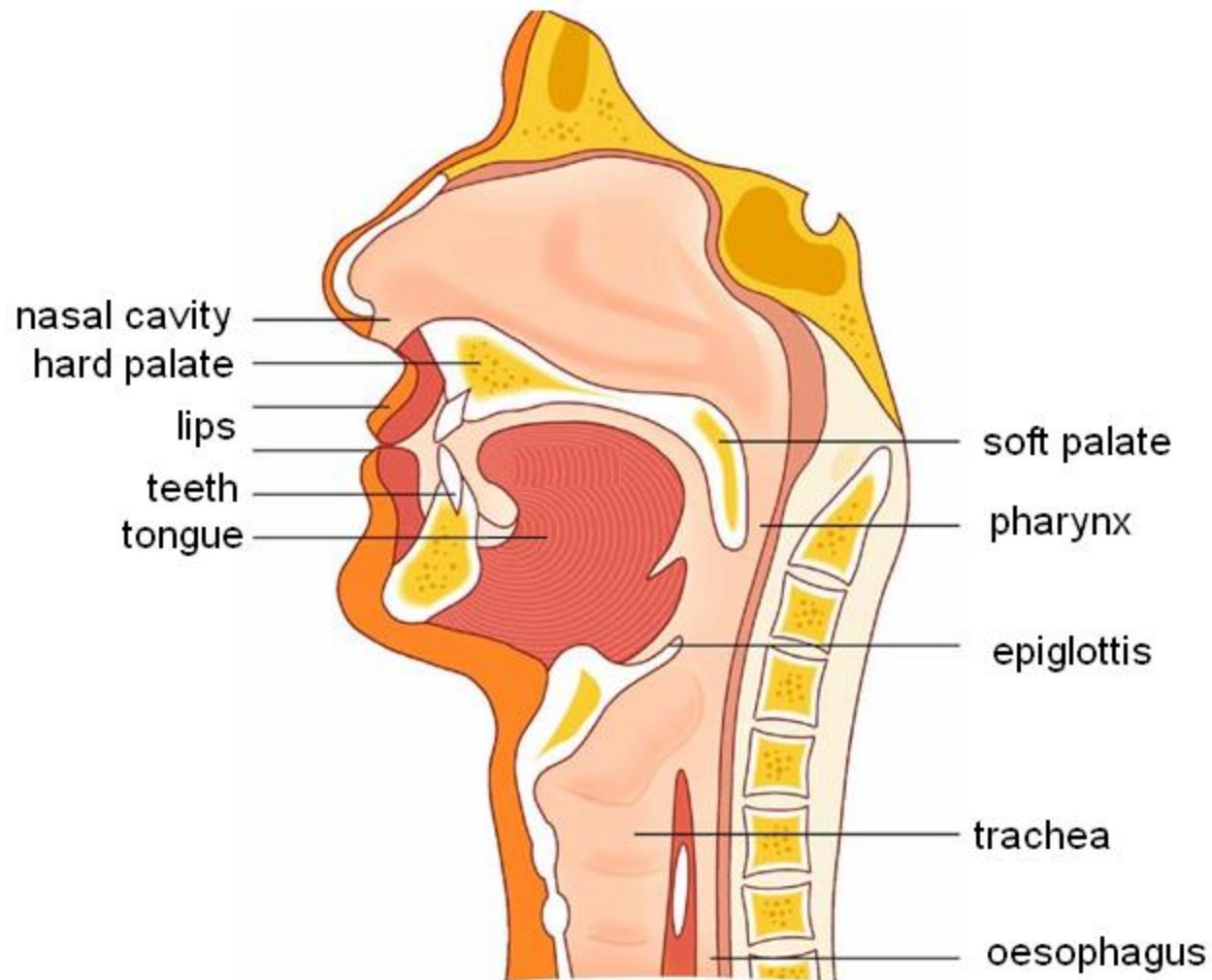
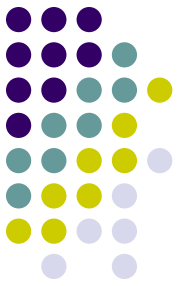
Study by Steele *et al* (1997) incidence 68%



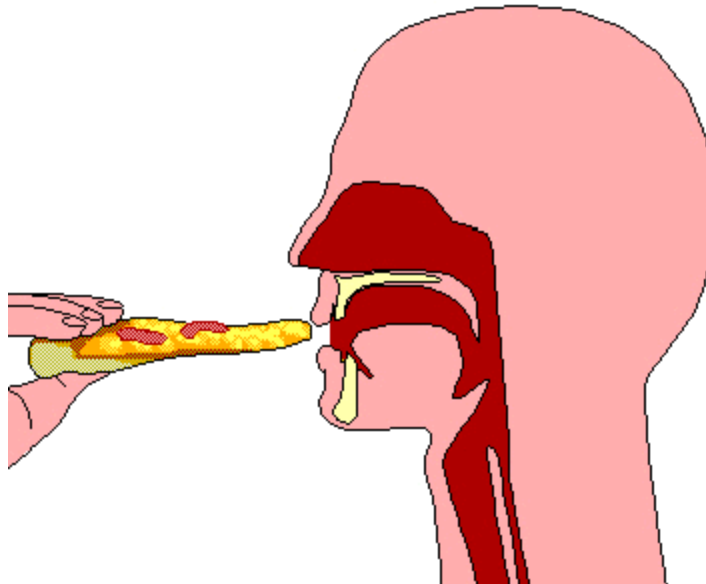
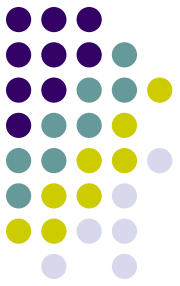
Implications of dysphagia

- Reduced intake – malnutrition, dehydration
- Aspiration pneumonia (life-threatening)
- Repeat hospital admissions
- Reduced quality of life

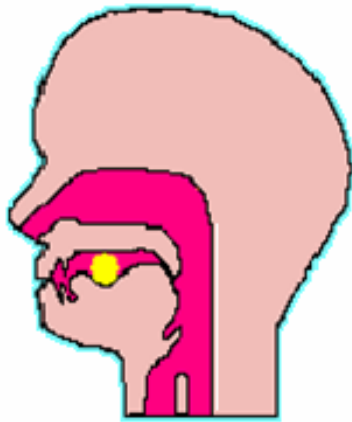
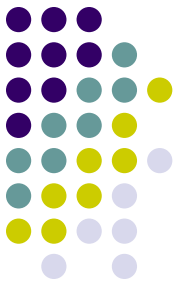
Normal Swallowing



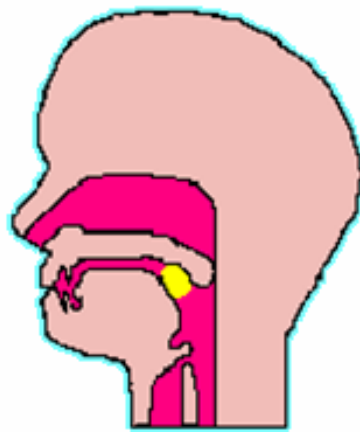
Swallowing



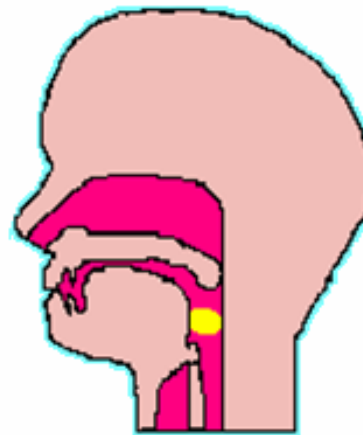
Swallow Stages



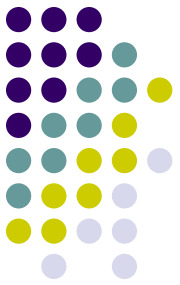
Oral Stage



Pharyngeal Stage

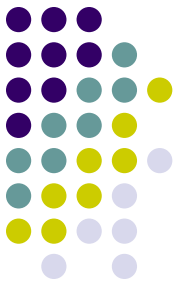


Oesophageal Stage



Oral Stage

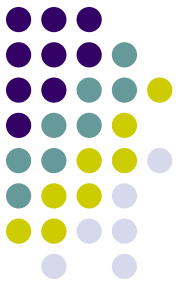
- Anticipation, awareness,
- Transfer from plate to mouth,
- Chewing,
- Controlling the bolus,
- Propelling to the back of the mouth



Pharyngeal Stage

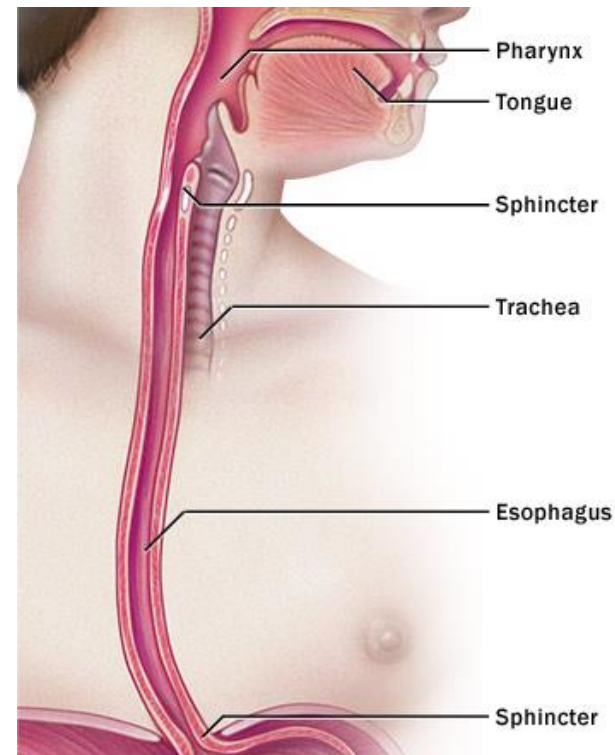
Priority = Airway Protection

- Swallow trigger,
- Soft palate elevation,
- Suspension of breathing,
- Airway closure,
- Laryngeal movement,
- Propulsion of bolus through pharynx.

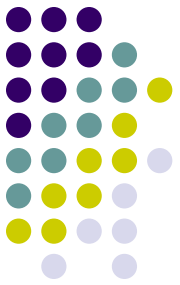


Oesophageal Stage

- Clearance of the bolus through the cricopharyngeal sphincter,
- Peristalsis/gravity to the stomach,
- Opening of lower oesophageal sphincter



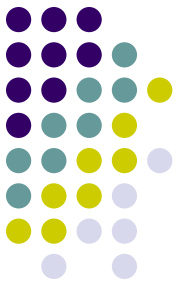
Signs/Symptoms of Dysphagia



- Drooling
- Loss of food/fluid from mouth
- Oral residue/pocketing
- Eating slower than usual
- Coughing or choking when eating/drinking
- Wet sounding 'gurgly' voice
- Shortness of breath during or after eating/drinking
- Repeated chest infections
- Weight loss
- Anxiety around eating or drinking
- Patient complaint e.g. food sticking in throat



Aspiration

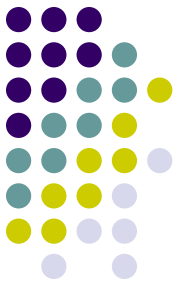


Food or fluid entering the airway

Can occur before, during or after swallow,

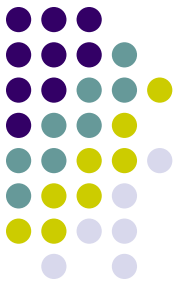
Cough reflex should protect, but..

Silent Aspiration – aspiration without a cough



Signs of Aspiration

- Coughing or choking when eating/drinking
- Wet sounding 'gurgly' voice
- Shortness of breath during or after eating/drinking
- Repeated 'chestiness' or chest infections
- Changes in observations (temperature, oxygen saturation, respiratory rate)



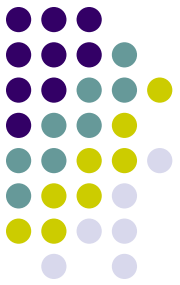
Aspiration Pneumonia

Caused by repeated aspiration into the lungs

Risk Factors:

- feeding dependence
- poor mobility / posture
- poor oral hygiene
- Dependence for oral care
- Number of decaying teeth
- Number of medications
- Level of cognition
- Multiple co morbidities



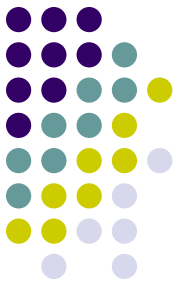


Dysphagia in Dementia

Neurological changes impact:

- Awareness, appetite,
- Behaviour, communication, attention,
- Remembering to eat/drink,
- Ability to feed themselves,
- Muscle control for swallowing,
- Sensation for swallow and cough reflexes.

Each patient is unique!

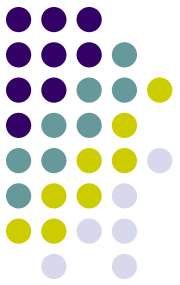


Features

Alzheimer's Disease

- Earlier stages- memory, spatial awareness,
- Later stages- dependence, reduced awareness:
 - over-chewing,
 - holding / pocketing,
 - spitting,
 - reduced oral control





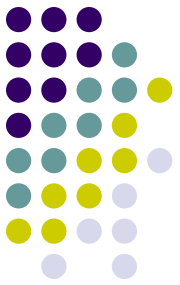
Features

Vascular Dementia

Difficulties related to site of infarcts (less predictable progression)

May be more able to self-feed,

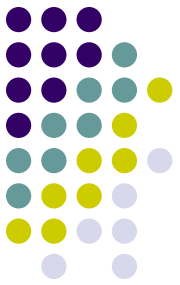
More likely to have difficulties with oral control, swallow timing and airway protection.



Features

Lewy Body Dementia

- Impaired motor control : possible oral control difficulties,
- Visual Hallucinations : spatial awareness for self-feeding,
- Fluctuating cognition : attention to meals/drinks,



Features

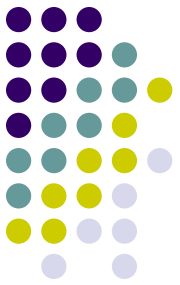
Fronto-temporal Dementia

Personality and behaviour changes:

- May eat too quickly (cramming),
- Dietary changes (crave sweet foods),

Likely to be able to self-feed,

Late stages- may need to change food texture to reduce risk of choking. Aspiration of fluids less likely.



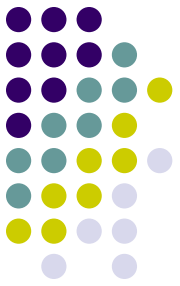
Environment

Influences intake, enjoyment, safety

Areas to consider:

- Positioning,
- Food/Fluid Consistencies,
- Level of assistance,
- Prompts / Communication

Positioning



Important to position upright and in midline

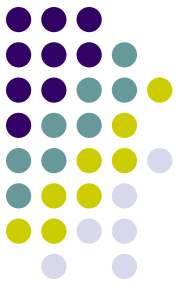
Yes ☒



No ☐



Improves breathing, digestion, alertness,
swallow safety



Positioning

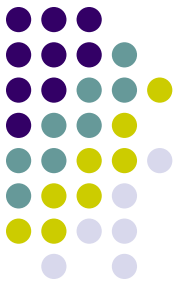
Consider patients' vision

Study with people with advanced Alzheimer's disease showed that changing to highly visible red cups and plates led to a 25 per cent increase in food intake and an 84 per cent increase in liquid consumption (Dunne et al, 2004)

Think about where to put the food/drink

Make sure it's in reach and the patient is aware of it

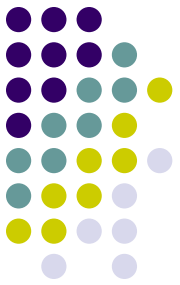
Food / Fluid Consistencies



Speech Therapist will assess which types of food and drink are safest for patients with dysphagia

May need thickened fluids or modified diet

Information on yellow poster above bed and in nursing notes



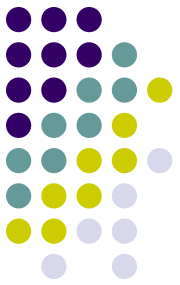
Food / Fluid Consistencies

Some patients benefit from finger foods

- Don't need to coordinate cutlery
- Can eat when they feel like it
- May be more tempting

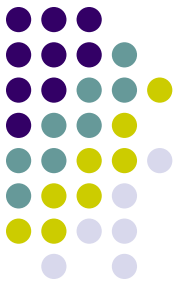
e.g. cut up sandwiches, biscuits, cut up fruit

Must be the correct consistency



Level of Assistance

- Full assistance: you hold the spoon/cup. Need to prompt to make patient aware of next mouthful.
- Hand-over-Hand assistance: you and patient hold cup together. Can increase awareness.
- 1:1 supervision: may be needed to give prompts to a patient who is self-feeding e.g. slow pace.
- Intermittent supervision: set patient up for meal, check periodically for any difficulties.



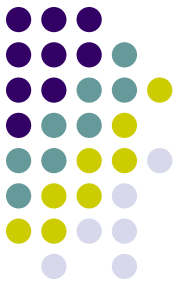
Prompts/Communication

To increase anticipation, awareness and remind them what to do:

“it’s lunchtime” “here’s a cup of tea” “this soup looks lovely”

“ready for the next mouthful?” “open your mouth”
“chew”

“swallow” “is it all gone?” “this is the last spoonful”

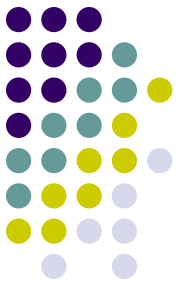


Non –oral feeding

NICE Guidelines

“Nutritional support, including artificial (tube) feeding, should be considered if dysphagia is thought to be a transient phenomenon, but artificial feeding should not generally be used in people with severe dementia for whom dysphagia or disinclination to eat is a manifestation of disease severity”

Is this dysphagia a result of disease progression or acute illness? Will it resolve? Will aspiration, malnutrition and dehydration continue to be a risk long-term? Does the patient have capacity to make this decision for themselves?



At-risk feeding

- Oral intake is to be perused despite the risk of aspiration.
- Discussion with patient, NOK, IMCA as appropriate. Aware of the risks?
- Plan in the event of aspiration?
- End of life care?
- Patient comfort is paramount and should be weighed against distress.