

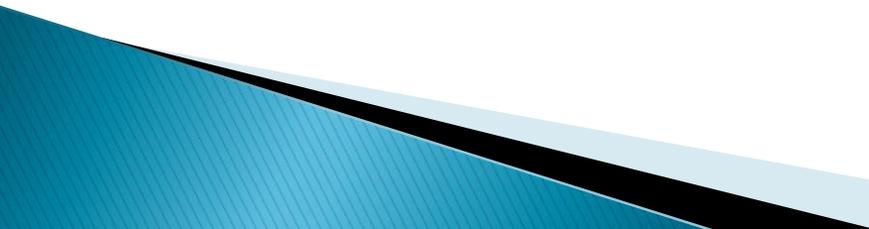
Collaborating with Dietitians: A Joint Approach to Dysphagia Management

By: Rachel E. Tarro M.S., CCC-SLP
VA Mather Hospital
Northern California Health Care Systems

Assumptions

- ▶ Working with Adults
 - ▶ Diagnosis of Dysphagia
 - ▶ Workplace has access to Dietitians
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- ▶ Who are you?
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Dysphagia Management

- ▶ Varies depending on each patient but usually involves the following 3 areas:
 - ▶ Modification of Diet texture (Puree, Mechanical Soft, Nectar thick liquids)
 - ▶ Strategies to reduce risk of aspiration (head positions, prosthetic devices)
 - ▶ Exercises to improve swallow effectiveness (Masako, SupraGlottic Swallow, etc)
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What does the research say?

- ▶ Evidence of greater success in outcomes for the dysphasic patient when they are treated with a multidiscipline approach.
 - ▶ (Heiss, Goldberg & Dzarnoski 2010; Tang & Hsieh 2010; Farneti & Consolmagno 2007; Logemann, JA 1998; Rofes, Arreola, et.al 2010)
- ▶ **Increased quality of life**
 - ▶ (Culp & Cacchione 2006; Sharp & Genesen 1996)
- ▶ **More knowledge for us as clinicians**
 - ▶ (Pelletier 2004; Sharp & Shega 2009; Sharp & Genesen 1996)

Qualifications of a Registered Dietitian

- ▶ A registered dietitian is a food and nutrition expert who has met academic and professional requirements
- ▶ Earned a bachelor's degree with course work approved by the Academy of Nutrition and Dietetics Accreditation Council for Education in Nutrition and Dietetics (ACEND). Coursework typically includes food and nutrition sciences, foodservice systems management, business, economics, computer science, sociology, biochemistry, physiology, microbiology and chemistry.
- ▶ Completed an accredited, supervised practice program at a health-care facility, community agency or foodservice corporation.
- ▶ Passed a national examination administered by the Commission on Dietetic Registration.
- ▶ Completes continuing professional educational requirements to maintain registration.
- ▶ Approximately 50% of RDs hold advanced degrees. Some RDs also hold additional certifications in specialized areas of practice, such as pediatric or renal nutrition, nutrition support and diabetes education. (Academy of Nutrition and Dietetics 2012)

Role of SLP & RD in various settings:

- ▶ Acute Hospital
 - ▶ Rehabilitation Facility
 - ▶ Long Term Care/Skilled Nursing Facility
 - ▶ Home Based Program
 - ▶ Out patient Care
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SLP & RD in Acute Care

- ▶ Assessment for dysphagia of critically ill patients
 - ▶ Initial treatment plans
 - ▶ Make recommendations for safest route of nutrition
 - ▶ Provide dysphagia therapy and education to patient and family
 - ▶ Hospice/palliative care
 - ▶ Recommendations for discharge to rehab facility
 - ▶ Educate staff about dysphagia topics
 - ▶ Collaborate with other disciplines for continuity of care
- ▶ Looking for malnutrition, risk for malnutrition and prevention of malnutrition.
 - ▶ Nutrition support (i.e. tube feeding/TPN)
 - ▶ Focus on education is small.
 - ▶ Identifying more long term problems and referring them to OP dietitian if needed.

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SLP & RD in Rehab Facility

- ▶ Re-assess after discharge from acute care
 - ▶ Update and modify treatment plan as patient progresses
 - ▶ Provide dysphagia therapy/education to patient and family
 - ▶ Make recommendations for discharge to home/next setting
 - ▶ Educate staff about dysphagia topics
 - ▶ Collaborate with other disciplines for continuity of care
- ▶ Nutritional Support
 - ▶ Prevention of skin breakdown (by getting enough nutrition)
 - ▶ Education

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SLP & RD in LTC/SNF

- ▶ Assess for Dysphagia
- ▶ Update and modify treatment plan as patient progresses
- ▶ Provide dysphagia therapy/education to patient and family
- ▶ Make recommendations for discharge to home/next setting
- ▶ Educate staff about dysphagia topics
- ▶ Collaborate with other disciplines for continuity of care
- ▶ Palliative care/Hospice issues
- ▶ Prevention of skin breakdown (by getting enough nutrition)
- ▶ Prevention of wt loss
- ▶ Prevention of becoming malnourished.

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SLP and RD in Home

- ▶ Assessment for dysphagia
- ▶ Provide dysphagia therapy/education to patient and family
- ▶ Collaborate with other disciplines for continuity of care
- ▶ Help make home environment conducive to safe oral intake.
- ▶ Intensive education.
- ▶ Long term management of patient with focus on environmental issues and social issues. (due to pt being home bound).
- ▶ Help to make their environment conducive to maintaining proper nutrition.

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SLP & RD in Outpatient Care

- ▶ Assessment for dysphagia
- ▶ Provide dysphagia therapy/education to patient and family
- ▶ Home program for Dysphagia management
- ▶ Collaborate with other disciplines for continuity of care
- ▶ Intensive education.
- ▶ Long term management of patient.



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How do we Collaborate?

- ▶ **Dysphagia Teams:** Multidisciplinary teams which meet at set times /frequencies to discuss , plan and execute plan of care for dysphagia patients.
 - ▶ VA Dysphagia Team: Speech Language Pathologist, Registered Dietician, Occupational Therapist, Nursing and Kitchen Staff
 - ▶ Similar to “rounds” or IEP meetings. Documentation is kept, tasks are assigned and SLP is usually the case manager.

 - ▶ **Education:** In–service education to your peers
- Dietician visits your “Dysphagia group”, In–service to the CNA nursing staff about safe feeding strategies, Serve a Dysphagia Diet brunch to your resident/intern team

Areas of Dysphagia Management

- ▶ Assessment
 - ▶ Diagnosis
 - ▶ Intervention
 - ▶ Maintenance/Monitor
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Assessment

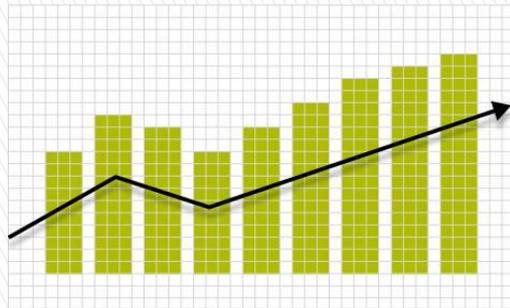
- ▶ Bedside swallow exam
 - ▶ FEES
 - ▶ VFSS/MBS
 - ▶ Interview/review medical records/chart
 - ▶ Labs
- ▶ Intake History
 - ▶ Weight
 - ▶ Review medical records/chart
 - ▶ Labs

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Lab reviews

- ▶ Typically we look at WBC (white blood count) to try and detect the possibility of infection (i.e. aspiration PNA)



- ▶ Albumin: help determine risk of malnutrition
- ▶ Prealbumin: Short term marker for malnutrition
- ▶ Sodium: Great marker for dehydration
- ▶ Hemoglobin A1C: 3 month marker of blood sugar control for diabetics
- ▶ Hemoglobin/Hematocrit: if low, pt with anemia of some type
- ▶ MCV (Mean Corpuscular Volume): this tells us what type of anemia the patient has.
- ▶ BUN and Creatine: for kidney function. Will be high if kidney failure.
- ▶ Ammonia Level: This is checked on Liver disease patients
- ▶ Cholesterol / Triglycerides / LDL / HDL : These aren't usually checked as inpatient, but more so as outpatient

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Collaborate during Assessment

- ▶ Interview patient together for medical history/general history portion (patient only has to report once)
 - ▶ Share results of findings with each other
 - ▶ If unable to co-assess, then make sure you keep eyes/ears open for flags that might clue you in on other problems. “I only eat canned foods.”
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Diagnosis

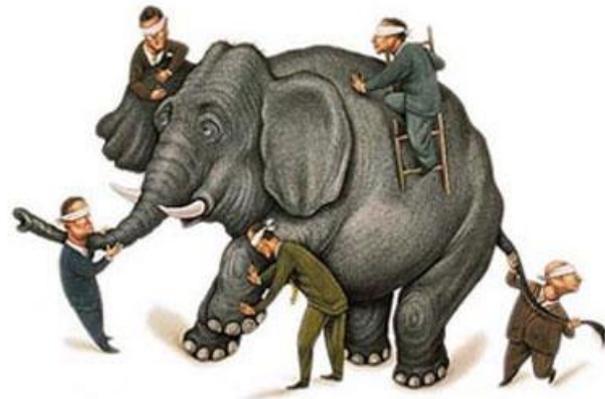
- ▶ SLP can diagnose swallowing disorders
- ▶ SLP can identify potential problems in related areas and make appropriate referrals (GI, nutrition, ENT, etc)
- ▶ Can determine history of weight loss/weight gain
- ▶ RD can identify potential problems in related areas and make appropriate referrals (GI, SLP, Dental, MD, etc)
- ▶ RD can diagnose malnourishment.

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Collaborate during Diagnosis

- ▶ Share results with one another
- ▶ Participate in “rounds” with other disciplines
- ▶ Work together as a team to diagnose those tricky patients
- ▶ The Blind Men & The Elephant



Intervention

- ▶ Change Diet texture
- ▶ Teach safe swallowing strategies
- ▶ Make recommendations for Enteral feedings if necessary
- ▶ Develop dysphagia plan and begin treatment
- ▶ Make NPO
- ▶ Recommend a Speech/Swallow Evaluation
- ▶ Change diet to a different texture
- ▶ Make recommendations for Enteral feeding formula if needed

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Enteral Feeding

- ▶ Nasogastric (NG) tube is used for feeding and administering drugs and other oral agents usually considered short-term
- ▶ Percutaneous endoscopic gastrostomy (PEG) tube– a tube is passed into a patient's stomach through the abdominal wall
- ▶ Jejunostomy Tube (J-tube) surgically implanted in the upper section of the small intestine called the jejunum which is just below the stomach.
- ▶ Total parenteral nutrition (TPN) is feeding a person intravenously, bypassing the usual process of eating and digestion. The person receives nutritional formula that contain nutrients such as glucose, amino acids, lipids and added vitamins and dietary minerals.

With ANY of these types of feedings, the RD makes the recommendation of formula to be administered depending on the individual patient's needs.

Collaborate during Intervention

- ▶ Communicate with RD your plan, verbally or by additional signer to notes
- ▶ Have RD visit patient to get food preferences so change in food texture isn't so drastic
- ▶ RD can make recommendations of “natural” thickeners (tapioca, flour, instant potato flakes, oats and matzo meal)
- ▶ During treatment cover each other's information. For the Diabetic who needs thickened liquids: Only drink unsweetened thickened liquids. Or the CHF who needs extra moisture with solids: Add low salt broth to rice for moisture.

Maintenance/Monitor

- ▶ Continue treatment plan and upgrade diet as safely able
- ▶ Education to patient and family
- ▶ Problem solve with patient, RD, caregiver etc to make sure patient is safe and tolerating required diet.
- ▶ Checking in for tolerance of texture. Is patient eating 75% or greater of meals?
- ▶ Patient likes/dislikes
- ▶ Reinforce SLP recommendations

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Collaborate during Monitoring

- ▶ Post safe swallowing strategies for patient and caregivers to see for easy carry-over
 - ▶ Stay in communication with your RD
 - ▶ Problem solve together any difficulties the patient may be having (aversions to texture, food allergies, cultural needs, etc)
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Shared patient populations

- ▶ Cancer Patients (Hematology/Oncology)
 - ▶ Parkinson's Disease
 - ▶ Stroke Patients
 - ▶ Spinal Cord Injury/Quadriplegia
 - ▶ Alzheimer's/Dementia
 - ▶ Muscular Dystrophy/ Multiple Sclerosis
 - ▶ Gastro-esophageal Reflux Disease (GERD)
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Cancer

- ▶ Head and Neck Cancer
- ▶ Esophageal
- ▶ Higher Protein needs, especially when on Chemo and XRT. High calorie needs. Goal is to maintain weight and protein stores. Anemia
- ▶ Oral Dysphagia: xerostomia, surgical removal of body parts, edentulous, decreased amylase (enzyme that begins the breakdown of starch into sugars) in mouth which makes carbs harder to digest, altered taste
- ▶ Pharyngeal Dysphagia: Fibrotic tissue s/p XRT, surgical removal of body parts, sometimes so severe results in FTT and need for alternate route of nutrition.
- ▶ Making transition from Peg to oral diet again

Parkinson's Disease

- Higher caloric needs due to involuntary movements/tremors.
- Malnutrition risks due to : Difficulty feeding self and can be embarrassed to eat in public due (dropping food on self/cannot feed self)
- Medications involved (Levodopa) can cause anorexia, dry mouth and nausea and vomiting.
 - ▶ Oral Dysphagia: Lingual Pumping, poor lingual control, poor bolus control, anterior spillage, drooling/sialorrhea
 - ▶ Pharyngeal Dysphagia: Silent aspiration, delayed swallow, decreased elevation and excursion of larynx, increased pharyngeal residue, increased risk of aspiration.

Stroke

- Easy to become malnourished due to weakness in extremities (cannot cut food, feed self)
 - ▶ Goal here is to prevent malnutrition
 - ▶ Oral Dysphagia: Oral weakness resulting in poor bolus control, drooling, pocketing of food.
 - ▶ Pharyngeal Dysphagia: Pharyngeal weakness or paralysis, swallow delay, excessive residue, risk of aspiration. Can result in aspiration PNA, FTT and need for alternate route of nutrition.
 - ▶ Making transition from Peg to oral diet again

Spinal Cord Injury/Quadriplegia

- Higher protein needs due to risk of skin breakdown
 - Extreme weight gain or loss is undesirable, good weight management is key
 - Difficulty feeding self or cutting up foods (depending on how high their injury is). May need foods chopped/diced.
 - Many of these patients are tube fed (long term PEG/J-tube).
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Alzheimer's / Dementia

- ▶ Dehydration/Malnutrition
- ▶ Food safety and oral safety
- ▶ May forget how to use eating utensils
- May require verbal cues to chew and swallow.
- Goals: prevent weight loss and prevent aspiration PNA
- Modify diet texture is usual plan as patients typically cannot “learn” safe swallowing strategies. Caregiver role vital!
- End of life issues (feeding tubes?)
- Study by Sharp & Shega (2009 AJSLP) reveals that while 74% of SLPs surveyed in the study would recommend a PEG to their patients only 11% would want them for themselves.

Muscular Dystrophy/ Multiple Sclerosis

- Weight management
 - Prevention of malnutrition
 - Oral Dysphagia: Muscle weakness, drooling, anterior spillage, difficulty with mastication
 - Pharyngeal Dysphagia: Decreased muscle control/strength, weak swallow, risk of aspiration
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Gastro-esophageal Reflux Disease (GERD)

- ▶ Diet/lifestyle changes to help prevent GERD symptoms
- Individualized nutrition plan with these patients as all are very different.
 - ▶ Medications: Omeprazole (PPI) or Ranitidine (H₂ blockers)
 - ▶ Low Acid Diet, raise HOB while sleeping, smaller meals, lose weight, no smoking/no ETOH, don't sleep 2–3 hours after dinner
 - ▶ Symptoms can include: hoarse voice, chronic cough, trouble swallowing, post-nasal drip, lump in throat, heartburn, and choking.

Case Studies

- ▶ JB is an 82 year old male with multiple medical problems including congestive heart failure, renal insufficiency, history of polysubstance abuse, old CVA ,dementia and respiratory failure. Hospitalized for respiratory failure, MRSA PNA requiring prolonged Trach and vent use.
- ▶ 8 months in the hospital (6 in ICU)
- ▶ Multiple documented aspiration events
- ▶ Weaned from the Vent and subsequent respiratory failure 3 times
- ▶ Weaned to PMV twice, never able to remove trach fully
- ▶ PEG tube placed, but still wanted oral for pleasure.
- ▶ Full Code
- ▶ Worked with RD almost daily for nutritional support and educating family on issues
- ▶ Discharged home once with PEG and trach, patient pulled out both and came back to ER within 24 hours–started over
- ▶ End result: Patient and family decided to change code to DNR/DNI, discharged home with PEG and trach, passed away within 48 hours.

Case Studies

- ▶ GB is a 64 year old male admitted for hypertensive emergency and subsequently found to have diabetes. Pt. is obese, suffers from sleep apnea and GERD. During the diet education portion of RD assessment, pt. discloses that he has chronic bad breathe and sometimes coughs up pills and whole chunks of food he ate hours ago.
- ▶ RD reports to MD.....MD orders swallow evaluation.
- ▶ SLP does bedside evaluation and requests MBS to further assess.
- ▶ Modified barium swallow study reveals large Zenkers diverticulum accounting for chronic bad breathe and regurgitation of undigested foods/pills.
- ▶ Patient referred to GI and ENT for treatment of Zenkers.

Questions??

- ▶ Thank you to Melinda Gong RD for her collaboration with this presentation.

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