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DYSPHAGIA AND TEXTURE MODIFICATION: DO PATIENTS GET ENOUGH CHOICE?

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The medical term for swallowing difficulties of food and drink is referred to as dysphagia (1), where the specialist is the speech and language therapist (SLTs). There are two types of dysphagia: oral from problems in the mouth cavity and pharynx or oesophageal dysphagia from the oesophagus (1). There are many conditions leading to swallowing difficulties, such as dementia, head and upper gastrointestinal cancers and Parkinson's disease. It can also result from events such as stroke, head injury or treatment, for example radiotherapy (1).

It is clear that the elderly population are at high risk of experiencing dysphagia. Swallowing difficulties increase their risk of malnutrition and dehydration due to restriction of oral foods and liquids (1). In addition, the risk of food aspiration, choking (1) and aspiration pneumonia all impact on the patients as well as the NHS, from increasing hospital length of stay, frailty, illness, anxiety and decreased survival (2).

Early diagnosis and swallow exercises are essential to prevent malnutrition and dehydration and can help improve or recover swallow function (3). SLTs help patients use these techniques and define the 'safe' food and drink consistency (3), improving food choice, oral intake and quality of life. The new Dysphagia diet food texture descriptors (2012) were published to help health professionals communicate the texture requirements to food providers to improve patient safety (1) (see Table 1). Often, these textured foods are hard to make in-house as this involves liquefying, sieving out bits and ensuring 100 percent safe consistency for patients. Therefore, Texture C is more commonly outsourced to reduce texture related aspiration risks. Many hospitals with their own kitchen can make Texture E meals, but there are many challenges from the variety they can offer due to restrictions in the foods available on the main menus.

Table 1. Classifications of Dysphagia diet food texture descriptions (2012)

Texture B: Thin Purée Dysphagia Diet
- Purée for no chewing and sieved for no bits
- Does not hold a shape

Texture C: Thick Purée Dysphagia Diet
- Purée for no chewing and sieved for no bits
- Can be moulded into shape but do split

Texture D: Pre-mashed Dysphagia Diet
- Moist food needing a little chewing
- Very thick sauces that holds its shape and can not be poured

Texture E: Fork Mashable Dysphagia Diet
- Soft tender and moist food but needs some chewing
- Fork mashed

Kattya qualified in 2009 and worked at GSTT in haematology, respiratory and HIV before joining the Initial Healthcare Services Catering team at UHL. She is a Member of BDA subgroups NAGE, food counts, Oncology and Allergies.

Since qualifying in 1992, Lorraine has been at the Dietetics department at University Hospital Lewisham since 1995. Her career-long interests include elderly care, stroke, nutrition support and gastroenterology.

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Trialling these foods can help to appreciate how patients have to adapt in accepting these as their diet either for the short or long term. Many patients don't want to accept these changes as they feel they are giving up something else, food is often the only thing they can still control. Food is also an essential part of daily life and companionship. Making these changes can add to patients' fears of isolation. In the elderly population all of these issues are distressing as they near the final stages of their life.

We trialled two companies to provide Texture C meals. Both companies had positive and negative aspects. Through a scoring system for tasting, presentation, and nutritional provision, both companies were discussed by a texture foods multidisciplinary group. There was a clear preference for tasting, appearance, colour and presentation in the national company (company 1) which uses moulds and technology to guarantee particle size and texture. We found a lack of ethnic meal choice on offer.

As UHL is in a diverse multicultural area of London, company 2, a family run company, had a reputation for quality and tasty ethnic meals. They scored well in ethnic meal tastes, but underperformed in the presentation and appearance of their products. However, it was interesting to see that they used basmati rice as their main thickening and binding source, believing that keeping food as natural as possible is best. We liked this concept, but also needed to consider the impact of the increased proportion of carbohydrates on monitoring of patients with elevated glucose levels, and inform our patients who are 'carbohydrate aware' through our new menu coding. The nutritional content was comparable, but they will be reviewed to meet the new 2012 guidelines (4).

We were able to select the main meals from both companies and to increase the menu choice and diversity; company 2 provides ethnic meals including Asian, Halal, Caribbean, African and Kosher. This has posed some challenges in heating and delivery at ward level as they differ in the temperature and times needed to reconstitute, but through better understanding of the heated trolleys we are able to provide this.

Informal pilot interviews in the elderly care and stroke wards were conducted by the specialist dietitian of four patients (two female, both English European and two male, both African Caribbean) and specialist health professionals (matron, nutritional assistance and SLTs). All patients had the purée meals; one had both ethnic and normal purée options. All liked the purée meals; one lady did not like puree food or thickened drinks but tolerated the meals; one gentleman was allowed 10 spoons of the food by SLTs and wanted more and the other gentleman was happier with the purée food rather than having a nasogastric tube for feeding. The last lady was unable to speak, so her daughter expressed that her mother enjoyed the food and they wanted to know the company details to order these meals on her mother's discharge. All the health professionals were happy with the choice and the ethnic meals; all liked the improved presentation of food due to the use of moulds and, furthermore, they expressed no problems with this service. SLTs added that patients always find purée diets hard to come to terms with, but this was not a reflection of the food being offered.

This has been a successful process working with a texture foods multidisciplinary group, including health professionals who work with Care of the elderly and stroke, ranging from STLs, dietitians, nurses, matrons and catering. We have been able to broaden food choice for this patient group.

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Questions relating to: *Dysphagia and texture modification: do patients get enough choice?*
Type your answers below and then **print for your records.** Alternatively print and complete answers by hand.

Q.1	What is dysphagia and describe the two types of this condition.
A	
Q.2	Give some examples of what conditions can lead to dysphagia.
A	
Q.3	What are the risks associated with dysphagia in elderly patients.
A	
Q.4	What is the classification for Texture E in the 2012 food texture descriptors?
A	
Q.5	What are some of the challenges faced by hospitals when making textured foods inhouse?
A	
Q.6	What issues can elderly patients face when adapting to a textured food diet?
A	
Q.7	How did UHL increase the menu choice and diversity of textured food for their dysphagic patients?
A	

Please type additional notes here . . .

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