Dietetics in Health Care Communities
a dietetic practice group of the Academy of Nutrition and Dietetics

Connections UPDATE!
Volume 13, Number 2, Winter 2012

FROM THE CHAIR

Dear Members:

We are grateful for the support of Blue Bunny who has agreed to sponsor this edition of the Dietetics in Health Care Communities ***Update!*** They have provided the funding for this ***Update!*** and we have spotlighted their products and their latest product information. The Executive Committee has reviewed and tasted these products and they are worthy of your review.

This ***Update!*** also contains timely information on dysphagia.

I hope your New Year is going well. I never used to watch the weather, but now with so many peers and DHCC members as friends, I look daily to see what is happening in Seattle, Chicago, New York, Iowa, to name a few. Dress warmly, and know that we all are thinking of you who are caught in major snows or storms. We hope those of you in Alabama are OK after those major storms.

We have webinars scheduled for the next several months. A notice of the first will go out this week; it is scheduled for February. Please take advantage of this time saving, cost effective continuing education opportunity.

Thank you to over 800 of you for participating in our member survey. The Administrative Council of DHCC will meet in Houston in the next two weeks to begin the process of strategic planning for the next three years. Your input from the member survey will be very important to that process.

The American Dietetic Association has officially changed its name to the **Academy of Nutrition and Dietetics**. DHCC is in the process of changing our website pages and beginning the updating of our many tools.

The new name complements the focus of the organization to improve the nutritional well-being of the public, while communicating the academic expertise of our members and supporting our history as a food and science-based profession. The Academy of Nutrition and Dietetics quickly and accurately communicates our identity. Remember to refer to our organization name in its entirety or as the Academy.

In reviewing many of the signatures on the petition for the White House to reconsider the decision on reimbursement of medical nutrition therapy for obesity treatment, I was very proud to recognize so many of our DHCC members. Thank you for taking the time to make a difference.

Cynthia Piland, MS, RD, CSG, LD
Chair, Dietetics in Health Care Communities

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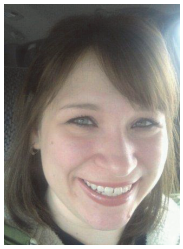


Angela K. Brekken, RD, LD, CLEC
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CPEU

"Swallowing difficulty related to impaired ability to move foods or fluids from mouth to stomach as evidenced by coughing, choking, or gurgling during meals" or "Inadequate oral food or beverage intake related to inability to consume regular consistency food and fluids as evidenced by need for mechanically altered diet" (1, p50). These nutrition diagnoses may be very familiar to registered dietitians (RD) working within the long term care setting when providing care to elders with dysphagia. Dysphagia is defined as difficulty swallowing (2, p1067) and can be divided into two subgroups; oropharyngeal dysphagia and esophageal dysphagia (3,4).

Oropharyngeal dysphagia is the difficulty of moving food or fluids from the mouth to the stomach due to muscular or neurological conditions such as cerebrovascular accident, multiple sclerosis, Parkinson's disease, amyotrophic lateral sclerosis (ALS), dementia or Alzheimer's disease, Guillain-Barre syndrome, cancer of the head and traumatic brain injury; also of note is the possibility of dysphagia occurring due to adverse side effects related to medications. Esophageal dysphagia occurs due to disorders causing mechanical obstructions of the esophagus such as cancer of the neck, and strictures (3-9).

The resident with dysphagia may present with the loss of food or fluids from their mouth, or pocketing of food in their cheeks when they are dining. They may cough or choke when trying to swallow. These presentations of dysphagia are key triggers when completing the Minimum Data Set (MDS) for long term care residents. Each of these symptoms of dysphagia is addressed within the MDS Section K for Nutritional Status. Residents may also have a "wet" or "gurgly" voice when eating or drinking due to food or fluids remaining on the vocal cords as a result of an inadequate swallow. Moreover, when completing the Care Area Assessment (CAA) for nutritional status, the need to address swallowing difficulties and mechanically altered foods and fluids is required. Perhaps some resident's dysphagia symptoms are primarily related to the "initiation of a new medication" or "adverse nutritional effects due to medication" addressed within the CAA. Moreover, decreased meal acceptance may be noted within the CAA due to the resident not accepting the recommended mechanically altered diet order.

The RD's nutritional assessment would include the interview of the resident, the resident's family or power of attorney if the resident is unable to provide reliable information, facility staff including dietary and nursing, and chart review regarding any signs or symptoms of dysphagia. Meal rounds performed by the RD are also greatly beneficial when completing the nutritional assessment and MDS for a first-hand observation of the resident's dining abilities.

Although dysphagia is addressed within the MDS Section K for Nutritional Status, which is often completed by the RD, the management of dysphagia requires a team approach. The key members of the dysphagia team begin first and foremost with the resident; also included are the resident's family or healthcare power of attorney, physician, speech language pathologist (SLP), RD, nursing, physical therapist (PT), and occupational therapist (OT) (3-9). The RD and SLP can prove to be an invaluable duo when recommending diet consistency changes for the resident with dysphagia. The SLP has extensive training in assessing the need for diet consistency alterations, along with the corresponding approaches such as a "double swallow with chin tuck" or recommendations for optimal postural body positioning with dining. The RD has a strong background in food science coupled with extensive macronutrient and micronutrient education to promote a diet that will coincide with the standards set by Dietary Guidelines for American's (5, 12). Most

often dysphagia is treated, after a thorough assessment from the Interdisciplinary Team (IDT) members, through texture modification of solids and thickening of liquids (3-9).

The SLP's assessment begins when the resident is identified through an informal screening or from a physician's order received from a nursing or dietary staff recommendation. It is pertinent that there is nursing documentation of swallowing difficulty within the medical record before the swallow evaluation order is placed for Medicare payment purposes. The resident is seen for a swallowing evaluation with a variety of diet textures and liquid consistencies, depending on the reason for the evaluation. The resident can either be seen at bedside or in the dining area. When the swallowing difficulty is identified through coughing, choking, or oral food loss, the resident is given food items that are modified in texture or in consistency. Along with the diet texture analysis, the resident's chewing ability, food bolus formation and propulsion ability, and amount of time in mastication and deglutition are examined. The oral structures including the tongue, lips, and mandible strength, range of motion, and coordination are also assessed with food and without. The written evaluation is completed and recommendations for the appropriate diet texture and liquid consistency are communicated to nursing staff, dietary and the resident's doctor. The recommendations go into effect immediately for optimum resident safety. An individualized treatment plan is formed to ensure adequate hydration, nutrition and safety for the resident.

A standard of practice for delivering food textures and thickened liquids to individuals with dysphagia began through the initiation of the National Dysphagia Task Force in 1996, which was comprised of the Dietitians in Physical Medicine and Rehabilitation dietetic practice group of the Academy of Nutrition and Dietetics along with Special Interest Division 13 of the American Speech-Language and Hearing Association. The result of this task force was the publication of ***National Dysphagia Diet: Standardization for Optimal Care*** by the Academy of Nutrition and Dietetics (published under former name American Dietetic Association, 2002). The four different dysphagia diet levels and fluid consistencies that were identified through the task force are examined below (10, 11). See Figures 1-4 for a more detailed "allow" and "avoid" food list that has been adapted from *National Dysphagia Diet: Standardization for Optimal Care* (10).

1. National Dysphagia Diet Level 1 (NDD Level 1)
   -Dysphagia Pureed
   Foods are smooth purees with no chunks or lumps that do not require chewing. Pureed foods should be the consistency of pudding.
2. National Dysphagia Diet Level 2 (NDD Level 2)
   -Dysphagia Mechanically-Altered
   Foods are moist and cohesive with some chewing required. Foods should be fork-mashable with no dry, crunchy, or sticky items allowed.
3. National Dysphagia Diet Level 3 (NDD Level 3)
   - Dysphagia Advanced
   Foods require more chewing than NDD Level 2. Items should be moist enough to cut easily and does not include hard, crunchy, sticky, or dry foods.
4. National Dysphagia Diet Level 4 (NDD Level 4)
   - Regular Diet
   Any solid food texture is allowed.

Liquid levels with the National Dysphagia Diet include; Thin, Nectar-like, Honey-like, and Spoon-thick (Pudding-like).

1. Thin liquids are clear liquids, milk, most nutritional supplements, water, tea, coffee, soda, broth, and juice. If able to handle thin liquids, foods with high liquid content are also allowed, such as watermelon, oranges, and grapefruit.
2. Nectar-like liquids are of a medium-thickness and include fruit nectars, some vegetable juices, and commercially thickened beverages.

3. Honey-like liquids are thicker than nectar-like and resemble the consistency of honey at room temperature. Liquids may be thickened with powdered or liquid thickening agents, or premixed thickened beverages.
4. Spoon-thick liquids are meant to be spooned into the mouth with the consistency of pudding. Liquids are thickened with commercial thickeners to this consistency.

With the use of thickened liquids, the resident's foods must match with consistency. If, for example, a patient is on a NDD Level 1 and honey-like liquids and receives pureed vegetables with a high liquid content, the foods must be thickened to ensure that they correspond with the appropriate liquid consistency. Also of note is that the thickness of liquids can be altered by the length of time the product was stirred or allowed to stand before being offered to the resident. Additionally, the temperature of the liquid can change the viscosity or thickness of the fluid (8); an example of this can be found with some commercial supplements being nectar consistency when chilled and thin when at room temperature.

After the resident is assessed by the IDT and texture modification is warranted, the SLP will recommend a diet texture. This recommendation is shared with the resident and their family or healthcare power of attorney, nursing, OT, PT, RD and dietary staff. Recommendations from the dysphagia evaluation are made to reduce the risk of aspiration pneumonia, malnutrition, and dehydration (6). When a resident is placed on a modified diet texture, their individual wants and needs are also taken into consideration. If they are unable to chew meats adequately and are placed on NDD Level 2, but are still able to tolerate toast that is moistened with butter and jam, or dipped in a beverage, diets can be personalized to the individuals' abilities as long as the foods are tolerated coupled with the supervision from the SLP or nursing staff.

The Frazier Free Water Protocol is utilized within some healthcare settings to allow residents who require thickened beverages to be allowed regular water at times throughout the day. This is done in an effort to increase the resident's perceived quality of life and dining satisfaction, along with hydration status. One study found that by utilizing this approach, the individuals in the intervention group which was provided with thickened liquids during meals and allowed regular water during specific intervals throughout the day after completion of a strict oral hygiene protocol consumed an average of >300 mL more fluid per day than the control group that was only allowed the thickened liquids (7). Since thin liquids are most easily aspirated, water is provided due to being pH neutral and carrying a lower risk of promoting bacterial lung infections or damage if aspirated. Since the risk associated with aspirating water is lower than any other fluid, the reduction of bacteria within the mouth through oral hygiene is of the utmost importance when utilizing this protocol. Strict procedures of brushing the teeth or dentures along with mouthwash as necessary must be followed in order to facilitate the Frazier Free Water Protocol. After thorough cleansing of the mouth and at least 30 minutes after the last meal, regular water alone may be provided to the resident – this means that there can be no other food or beverage item presented to the resident when drinking the regular water (4, 7). These procedures must be followed facility-wide and require extensive staff, resident, and family education. With such strict procedures required with this protocol it is often-times unobtainable in the long term care setting.

Residents do have the right to make informed choices about their diet as long as they are cognitively able to do so. If the resident refuses the recommended diet texture which is meant to reduce risk to the patient and benefit their health rather than hinder them, an IDT meeting should be called (13). The resident, family or healthcare power of attorney and IDT join together to educate the resident about the risks and benefits of not adhering to the recommended diet texture. If the resident and/or family do not agree, education is reiterated, if again, the resident and/or family do not agree, the level of assumed vs. real risk is assessed. The "assumed risk" is the possibility that there will be a poor result and subsequent negative effect on their health and the "real risk" is that since the diet recommendations are not being followed, that there are current clinical signs that are impacting the patient's health currently, such as an existing aspiration pneumonia, undesired weight loss, or fever (6).

Documentation of this process is crucial to ensuring that the resident and their family is aware of, acknowledge and accept the possible adverse effects (or risks) of choosing not to follow the recommended diet textures. The RD could employ the following nutrition diagnosis in such circumstances: Limited adherence to nutrition-related recommendations related to not accepting prescribed mechanically altered foods and fluids as evidence by poor meal intake of prescribed consistencies and consuming regular consistency foods and fluids when in their room (1). Just as the resident may choose not to follow texture recommendations, they may change their mind and choose to follow the recommended diet texture at any time. This is why it is so important to review with the resident at least quarterly to determine if choosing not to follow the recommended texture modification is still what they desire. These quarterly assessments coupled with a care conference are the perfect venue to ensure the resident's desires are being honored, and to address any questions or concerns that they may have. Moreover, encouraging an open line of communication with the resident and their family ensures that they will be more comfortable approaching any member of the healthcare team to discuss concerns, questions, and to provide reeducation as issues arise. A very useful algorithm for the decision making process for Dysphagia diet modifications was developed by Kaizer, Spiridigliozzi, and Hunt and published in *Dysphagia* in 2010 (6).

The New Dining Practice Standards were formed by the Pioneer Network and the Rothschild Foundation in August 2011 to support "individualized care and self-directed living versus traditional diagnosis focused treatment". The New Dining Practice Standards promote and recommend that the resident have full control of dietary wants and needs. As long as the resident has the ability to cognitively make independent decisions, they are allowed to have any food items requested regardless of recommendations. If the resident is not cognitively intact, their family and/or healthcare power of attorney can make the decision for a regular diet. If it absolutely medically necessary for a diet modification, some diets can be individually written to be between NDD diet levels such as "puree to mechanical soft" depending on the resident's tolerance. The standards also recommend frequent reassessment of diet texture to upgrade the diet when able (13).

The IDT including the RD and SLP can help the resident work through any concerns they may have with texture modification, altering the plan of care to include tolerated items that are not technically on their prescribed diet order, finding foods that are enjoyed at the modified texture, and troubleshooting any adverse effects associated with the provision of mechanically altered foods such as decreased meal and fluid intake. Although, with the focus of care being directed by the resident, members of the IDT may feel that they are going against everything that thy have learned in their studies when they "allow" the resident to make choices for themselves whether or not to adhere to the recommended diet consistency order. It is important to note that residents do have the right to autonomy, and therefore the right to refuse medical advice. Stringent and complete charting by every member of the healthcare team is needed in these instances to ensure that risk versus benefit is fully understood and accepted by the resident and their family or healthcare power of attorney. The IDT charting will be a facility's saving grace if legal issues may arise in the future.

Figure 1

NDD Level 1: Dysphagia Pureed

Food Group	Allowed	Avoid
Starch	Pureed Bread and pastries, hot cereals – if oatmeal is provided it must be pureed, pureed pasta and rice, pureed potatoes	Unpureed breads, pastries and crackers; dry cereals and unpureed oatmeal; unpureed pasta and rice, unpureed potatoes
Fruit	Pureed fruits without pulp, mashed bananas	Whole fruits
Vegetables	Pureed vegetables without seeds	Vegetables with seeds
Combination Foods	Pureed casseroles, and soups	Casseroles or soups with chunks or lumps
Meat & Meat Substitutes	Pureed meat and eggs, hummus, softened tofu,	Cottage cheese, cheese, peanut butter unless pureed into foods, unpureed eggs
Desserts	Pureed, smooth desserts (most desserts without nuts and seeds can be pureed – it is important to offer the dessert served to "regular" diets in pureed form as often as possible instead of pudding in place of brownies for example. If thin liquids are allowed - smooth chocolate candy without nuts or sprinkles, truffles.	Desserts with lumps, chunks, and sprinkles
Beverages	If not on thickened liquids - Smooth beverages without pulp, ice chips	If not on thickened liquids: Beverages with pulp
	If on thickened liquids - beverages thickened to appropriate consistency	If on thickened liquids - Malts, ice cream, frozen yogurt, sherbet, gelatin, eggnog due to becoming thin liquids when at body temperature

Figure 2

NDD Level 2 – Dysphagia Mechanically Altered

Includes all foods on the NDD Level 1 Diet in addition to the following

Food Group	Allowed	Avoid
Starch	Soft pancakes moistened with syrup, soft toast with butter or jelly without seeds or dunked in beverage such as coffee or tea. Slightly moistened dry cereals with little texture – if thickened liquids are required must moisten with the recommended consistency milk. Soft cooked pasta moistened with sauce.	No rice unless pureed. Cereals with nuts, seed, and dried fruit or coconut. All others
Fruit	Soft drained canned or cooks fruits without seeds or skins, soft bananas; if thin liquids are allowed – watermelon without seeds	Dried fruits; fresh, canned or cooked pineapple
Vegetables	All soft – easily mashed vegetables < .5 inch. Pureed vegetables that have husks or skins such as corn and peas.	All regular vegetables with husks or skins such as corn and peas
Combination Foods	Easy to chew casseroles and soups with chunks under .5 inch thickness, if meat <.25 inch in thickness. If on thickened liquids – soups must be thickened to recommended consistency	All others. Sandwiches. Pizza.
Meat & Meat Substitutes	Moistened, ground or soft cooked meat, poultry or fish. Meat pieces should not exceed .25 inches. Scrambled or soft cooked eggs – use pasteurized shell eggs within the long term care setting.	Meat with large chunks of onion or celery. Dry or tough meats such as sausage or bacon. Cheese slices or cubes. Eggs cooked with crisp edges.
Desserts	All except "Avoid" list	Dry cakes or cookies. Anything with nuts, seeds, coconut, pineapple, or dried fruits.
Beverages	Any beverage depending on recommended consistency	

Figure 3

NDD Level 3 – Dysphagia Advanced

Includes all foods on the NDD Level 1 & 2 Diet in addition to the following

Food Group	Allowed	Avoid
Starch	Any breads, biscuits, pastries, etc that are well-moistened with butter, syrup, jelly, etc. All well-moistened cereals.	Dry bread, toast, crackers. Coarse or dry cereals.
Fruit	All fresh, soft fruits without seeds; soft berries with small seeds are allowed. All canned and cooked fuirts.	Crisp fresh fruits. Fruits that are stringy or have a lot of pulp. Fruits with skins or peels. Uncooked dried fruits. Fruit leathers or snacks.
Vegetables	All cooked tender vegetables. Shredded Lettuce.	All raw vegetables except shredded lettuce. Cooked corn. Rubbery cooked vegetables.
Combination Foods	All soups except those on "Avoid" list. Casseroles with small chunks of meat.	Soups with tough meats. Corn or clam chowder that has not been strained. Soups with chunks >1 inch.
Meat & Meat Substitutes	Thin-sliced, ground, or tender meats and poultry. Well moistened fish. Any prepared egg.	Tough, dry meats and poultry. Fish with bones or dry. Chunky nut butters.
Desserts	All except on "Avoid" list.	Dry or chewy cakes or cookies. Anything with nuts, coconut, seeds, pineapple, or dried fruits.
Beverages	Any beverage depending on recommended consistency	

(10)

Figure 4

NDD Level 4 – Regular Diet

Includes all foods allowed with a regular consistency
(10)

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Will the Academy of Nutrition and Dietetics be known as "AND"?

- For at least the first year using our new name, we will *not* use the abbreviation "AND," in order to strongly reinforce the organization's entire name.
- The full name "Academy of Nutrition and Dietetics" will be used on first reference in all materials.
- In subsequent references, we will use "Academy" or "Academy members."
- In spoken references, we will *not* call the Academy by the acronym pronounced "and."
- The abbreviation will be the letters "A.N.D." (with periods between the letters in writing).

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Dysphagia- A Dining Approach

Mary Piciocco, MA, RD

Dysphagia can be defined as a disordered eating according typically due to a swallowing dysfunction. Problems could occur during each of the phases identified during the swallowing process. The root cause of the dysphagia may include neurological, cognitive and muscular impairments. Because of the wide nature of the problem, the treatments also vary.

For clinical dietitians, working with residents experiencing dysphagia is oftentimes a challenge. For safety, many in this population have altered consistency diets, whether food, beverage or both. As the consistency is more restrictive, residents may consume less. Fortunately for the practitioner, there has been an increase in the products available to make dining more pleasurable. This does not erase the stigma however, associated with eating "baby food" or for those needing a smooth consistency, the mistake that the food is "the same every day".

Considering the resident as a whole, what other dining experiences can be reviewed to help the resident tolerate the least restrictive consistency?

One of the first approaches, other than coordination with a speech language pathologist (SLP) and occupational therapist (OT), is to make sure that the environment is relaxing, pleasant and stimulating to the senses. Residents with dysphagia may become anxious at mealtimes. Even though they are hungry, the thought or expectation of choking or food "sticking" in their throat makes them tense and may actually exacerbate the problem.

Some residents are a fall risk and as a result, they are provided with chairs that lean back. During mealtimes, these residents need to be repositioned, so that their chairs remain in as close to 90 ° as possible. Extra safety precautions should be care planned, such as direct supervision while remaining in this position. Residents should remain in the upright position for 30 minutes after the meal or snack intake. If the resident needs to remain in a lower chair, an alternate "table" should be investigated. There are tables that can adjust the height, also an accommodation for residents with a short stature. If not possible, a dining cloth draped over an adjustable end table and placed next to a non -adjustable dining room table can provide a dignified atmosphere.

Foods provided at mealtimes can be a challenge. Residents with some types of dysphagia can handle more advanced consistency but only if provided one at a time. For that reason, mixed dishes containing a variety of consistencies such as soups and stews with pieces should be strained and components provided separately. Nice fruity desserts served with their juices may also need to be drained. A bite of solid food consistency can be followed by one or two sips of liquids after the food is swallowed. The SLP is extremely helpful in deciding if any of these strategies should be used.

Residents with cognitive impairment may not be able to tell when their mouth is clear. Introduction of new food before they have swallowed the last bite can lead to choking or coughing. Residents can benefit by provision of meal components one at a time and direct supervision to cue residents to swallow before taking the next bite.

Small, frequent meals sound counter intuitive but avoiding mealtime fatigue may help the resident tolerate more oral intake. Consistencies should be considered to match energy levels with a more downgraded consistency being offered during the meal when the resident is less alert or more tired.

Adaptive eating equipment is also available to residents with swallowing problems. Special cups can be purchased that help the resident maintain an appropriate angle to assist the swallow. Residents with kyphosis may find it difficult to lift their heads and may be helped with these devices.

Residents with poor swallowing ability may find it difficult to control the liquids taken in with a straw. The SLP may recommend that straws are avoided not only with thickened liquids but with thin liquids as well for certain residents. That would also include liquids provided at the bedside.

Working with the SLP can help the interdisciplinary team identify swallowing strategies during mealtime and during any eating activities. Our SLP has suggested that some residents perform a chin tuck when swallowing while others are encouraged to turn their head to the side. Residents may be instructed to repeat their swallow to make sure that the food is cleared before taking their next bite.

There are other health care providers that need to be included in the management of the resident with dysphagia. Nursing assistants often are responsible for the provision of fluids and direct care during the dining experience. Activity professionals may offer food and beverages during an activity or trips to restaurants. Family members need to be included and offered guidelines of the best possible snacks or favorite foods the resident can tolerate.

When do you know you have arrived at the best treatment? Not only when the resident's weight and labs come back within normal limits but when the residents look forward to their meals and have an improved quality of life. For that to happen, a resident centered treatment plan and dining experience and a multidisciplinary approach is the key.

http://occupational-therapy.advanceweb.com/Article/The-Dream-Dysphagia-Team-1.aspx

- www.nyee.edu/swallowing.html
- www.mayoclinic.org/**dysphagia**
- www.umm.edu/altmed/articles/**dysphagia**

Mary Piciocco, MA, RD, has been in practice for over 30 years. Currently in a position for a multi facility corporation, Mary enjoys working with customers residing in the short term subacute population, assisted living residents, skilled nursing residents and residents in the CCRC (Continuing Care Retirement Community).

eat right. American Dietetic Association

New Name, Same Commitment to the Public's Nutritional Health

In January 2012, the American Dietetic Association will be changing its name to:

eat right.® Academy of Nutrition and Dietetics

The Academy of Nutrition and Dietetics quickly and accurately communicates our identity – who we are and what we do.

The Academy of Nutrition and Dietetics is the right name. And this is the right time.

Sylvia A. Escott-Stump, MA, RD, LDN
ADA President 2011-2012

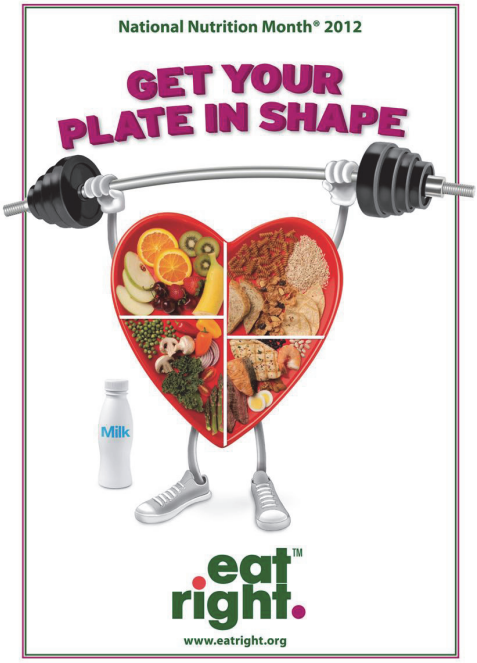
For more information on this exciting news, visit www.eatright.org/Members/namechange

eat right. Academy of Nutrition and Dietetics

Celebrate National Nutrition Month®
Get Your Plate in Shape

Each March, National Nutrition Month® celebrates and reinforces the importance of making informed food choices and developing sound eating and physical activity habits.

The theme for 2012, *Get Your Plate in Shape,* supports the 2010 *Dietary Guidelines for Americans* and USDA's new food icon, MyPlate.



Learn more and view the NNM catalog at www.eatright.org/nnm.