



**SOUTHLINCS**

FOODSERVICE

*Committed to Quality Service*

# Residents with **Dementia and Dysphagia**



# Residents with Dementia and Dysphagia

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This leaflet provides a valuable insight into the nutritional issues experienced in dementia care. It gives lots of practical advice and examples for catering staff and carers to help ensure that the person with dementia receives not only a nutritionally balanced diet but is also allowed to maintain their independence and dignity while eating.

## 1. What is dementia?

Dementia is the term that refers to the symptoms that occur when the brain is affected by diseases such as stroke and Alzheimer's disease. It is a progressive process that gets gradually worse with time.

Symptoms include:

- **Loss of memory** – such as forgetting to switch the oven off or being unable to remember names or places.
- **Mood changes** – when parts of the brain that control the emotions become damaged, mood changes may be experienced. Depression is also common in people with dementia as they are worried or angry about what is happening to them.
- **Communication problems** – there will be a progressive decline in ability to talk, read or write.
- **Loss of manual dexterity** – ability to hold a knife and fork may be affected, so ability to eat may be compromised.

As symptoms progress, the person with dementia will become increasingly dependent upon others to help with carrying out everyday tasks.

## 1.1 Causes of dementia

Conditions that cause dementia include:

- **Alzheimer's disease** – the most common form of dementia. Brain cell death is caused by progressive changes to the structure and chemistry of the brain.
- **Vascular disease** – the brain is supplied with oxygen by way of the blood vessels. If any of these are blocked or obstructed in some way, for example in a stroke or series of small strokes, brain cells may die, causing symptoms of dementia that may come on suddenly (in the case of stroke) or progressively, where several small strokes are experienced.
- **Dementia with Lewy bodies** – this is caused by the development of tiny spherical structures in the nerve cells of the brain, causing death of brain tissue and subsequent symptoms of dementia. In particular, memory, concentration and language skills are affected.
- **Fronto-temporal dementia (including Pick's disease)** – damage occurs predominantly to the front of the brain, affecting personality and behaviour in the early stages.

## 1.2 Who gets dementia?

Currently, 750,000 people have dementia in the UK. While many of these are older people, over 16,000 people in the UK with dementia are under the age of 65. Both men and women get dementia and there may be an inherited cause of dementia, although this is rare and has yet to be investigated fully.

## 1.3 How is dementia treated?

Most forms of dementia are incurable. However, there is a lot of research being conducted into the development of drugs, vaccines and treatments.

Drugs may reduce or control the symptoms of dementia in the early to middle stages, by improving the supply of certain chemicals to the brain. However, these are not without their side effects, such as nausea, diarrhoea, insomnia, fatigue and loss of appetite. Some of these side effects may lead to malnutrition in people with

dementia, so it is important that enough food is consumed to ensure that adequate nutritional status is maintained.

## **2. Eating and dementia**

Eating is an essential action, not only to maintain life, health and nutritional balance but also to create social interaction. Eating is an emotional as well as physical activity and so difficulties that may alter a person's normal eating behaviour may have profound effects on their mood. At the first sign of problems with eating, carers should not step in and start 'feeding' the person with dementia. Not only is this disempowering and potentially humiliating for the person being 'fed' but it may create a level of anxiety that stops the person from eating enough.

It is essential to maintain the person's independence in eating, with minimal and sensitive assistance where required. Demeaning terms such as 'feeding' should be avoided. Changes should be made to the whole process of eating, the eating environment and so on, to ensure that the person with dementia eats enough food and does not suffer from a reduced appetite. The following sections will address the causes of problems with eating, followed by practical solutions to ensure that adequate nutritional status is achieved and maintained.

### **2.1 Eating problems in dementia**

#### **2.1.1 Loss of appetite**

Loss of appetite or lack of interest in eating may occur for many reasons in a person with dementia. It can have many negative consequences on nutritional status and health. Some of the causes of reduced appetite and weight loss are outlined below:

- **Depression:** Loss of appetite is a symptom of depression, which in itself is very common in people experiencing symptoms of dementia. If depression is suspected, contact a GP, who will recommend treatment. The appetite should return once the depression lifts.
- **Badly fitting dentures:** Badly fitting dentures and sore gums may make eating uncomfortable and so affect appetite. Regular dental care is important in ensuring that teeth and gums are clean, free of infection and that there is no discomfort. See section 3 for more detail on dental care.

- **Lack of exercise:** Lack of exercise or physical activity does not allow the person to work up an appetite. Try to encourage the person to take a walk or do some exercise during the day.
- **Memory problems:** In the later stages of dementia, the brain may be damaged to the extent that the person no longer understands the need to eat when food is given to them. Even if they are hungry, the messages do not get through to the part of the brain that controls the eating process. Dealing with these more complex issues is discussed in the section on practical solutions to eating difficulties.
- **Medication:** Medication to control dementia may also have effects on the appetite by causing constipation, a dry mouth or changes in taste. Constipation can be alleviated by ensuring sufficient fibre in the diet from fruit and vegetables, cereals, whole grains, pulses and granary breads and also sufficient fluid, 6 - 8 cups a day. Serving moist food with sauces and gravy can help eating when the mouth is dry.
- **Dysphagia:** Chewing and swallowing may become difficult as dementia progresses. This is discussed in the section on swallowing difficulties overleaf.
- **Manual dexterity:** Manual dexterity may become affected so the person with dementia may find it difficult to use a knife and fork. This may affect eating and appetite because the person may feel embarrassed when they drop food and may not be able to get sufficient nourishment because they cannot eat enough. Finger foods may be useful to boost confidence and help to maintain independent eating. These are discussed with examples in more detail overleaf.
- **Changes in food preference:** Changes in food preferences are often seen in people with dementia, either due to brain damage in specific regions or because the person has forgotten what they like or dislike. Try to cater for these likes or dislikes to an extent, although when food

preferences become very limited, the person may be inadequately nourished. In these cases, food fortification and enrichment with high calorie foods such as butter and cream may help to prevent malnutrition.

- **Weight loss:** Weight loss is common among older people with dementia, so it's important to check for signs of unintended weight loss e.g: through the use of the Malnutrition Universal Screening Tool ('MUST'). Weight loss is often caused by an insufficient calorie intake, so it may be necessary to fortify meals with extra calories. However there may be some other medical problem that requires investigation.

### 2.1.2 Overeating

Some people with dementia may eat too much food, either because they have forgotten that they have just eaten or because they have a preference for sweet foods such as biscuits and sweets, eating them throughout the day. This can become a problem if the person puts on too much weight, as this can affect their health and mobility. It may also affect the appetite at mealtimes and contribute to nutrient deficiencies, if fewer meals are consumed. Ways of dealing with overeating are discussed in section 2.2.9.

### 2.1.3 Swallowing or chewing difficulties - Dysphagia

Elderly people who have had a stroke and / or are suffering from dementia may have transient or long term swallowing difficulties. Stroke patients may regain their swallow within a few days, some take longer and some may never fully regain the ability to swallow.

Whatever the cause of swallowing difficulty (known as dysphagia), eating foods that require chewing and swallowing runny fluids may be hard and there is a greater risk of choking on food and fluid and a risk of aspiration (inhaling food or drink).

### **There are 2 stages to swallowing:**

1. The first stage is voluntary and involves chewing, manipulating and holding food within the mouth, controlled by the tongue, teeth and jaws. If the person with dementia has brain damage to those areas that control these activities, then food in the mouth may become a risk to the person if it causes them to choke or finds its way into the lungs, where it can become infected.
2. The second stage is involuntary and is a reflex action, causing swallowing to occur, while the windpipe is closed to prevent food from 'going down the wrong way' and causing choking. This stage may be delayed or incomplete.

Problems may occur at both stages detailed overleaf, leading to mal-coordination of swallowing and potential choking incidents.

### **Signs of a swallowing difficulty include**

- dehydration
- a gurgling voice after swallowing
- coughing during or after eating or drinking
- prolonged chewing
- pouching of food in mouth
- regurgitation
- excessive drooling

### **Dysphagic patients are at risk of**

- dehydration
- malnutrition
- micro and macronutrient deficiencies
- weight loss (all the above are due to a reduced intake)
- aspiration pneumonia, (due to food entering the lungs and causing infection)
- constipation (due to inadequate fibre and/or fluid intake)
- poor wound healing
- increased susceptibility to infection (both due to vitamin and mineral deficiencies)

- Patients also find their increased dependence on carers at mealtimes and their difficulties with eating degrading leading to further loss of appetite, anxiety and depression.

Practical ways of dealing with the sensitive area of dysphagia are discussed in section 2.2.10.

## 2.2 Practical solutions

This section describes practical solutions for the caterer and carer to ensure that the person with dementia not only receives adequate nutrition in an attractively presented format but also can maintain independent and safe eating for as long as possible, receiving discrete and sensitive assistance where required. As described overleaf, it's essential to deal with appetite problems that are due to depression or inactivity, by treating depression and encouraging regular physical activity. More detailed practical solutions are discussed over the next few pages.

### 2.2.1 Stimulate the senses

Food is not simply about taste. The ritual of food preparation, the smells, the sounds, the different textures of food and visual features all combine to stimulate the appetite. If residents can hear the sound of food preparation or of the table being laid, smell the food as it is prepared and see the kitchen activity, they are reminded that their meal is on its way and the familiar sounds, smells, feels and tastes will prompt the memory and stimulate the appetite.

“One of our residents, a lady with severe dementia, refused to eat anything at all. We discussed forcing her to eat but were reluctant to do this. After 3 days where she ate nothing at all, we started to bake cakes in the kitchen. When we put them in the oven and the smell began to waft through to the sitting room, her eyes showed some recognition. When we put the cakes in front of her, she eventually took one and began to eat it. After this, she ate more and even ate some other meals normally. This showed us how important the smell of food can be to people with dementia.”

Involving those with dementia in the preparation of food or the laying of the table where possible can also help to arouse the appetite and encourage a feeling of independence.

### 2.2.2 Prompts and reminders

Where the person with dementia no longer understands that the food in front of them is to be eaten, or have forgotten how to chew or swallow (assuming no swallowing difficulties), it may be helpful to prompt or remind them of the processes associated with eating.

Using visual prompts and verbal encouragement is useful. Carers eating their meals with residents is another way of setting an example to remind those with dementia of what to do.

### 2.2.3 Presentation of meals and portion size

The presentation of meals is important for all residents but is particularly relevant for those with small appetites or those on texture modified diets (see section 2.2.10). Not only should attention be paid to the attractive arrangement and serving of the meal on the plate but the portion size should be manipulated to encourage the greatest consumption of food. Some people with dementia may be distracted by colourful or elaborate garnishes and this may shift their attention away from eating. By serving simply presented dishes, the attention can be focussed back onto the meal.

A large plate, filled with food can be daunting for someone with a small appetite or a slow eater. By serving smaller portion sizes and encouraging second helpings that have been kept warm in the kitchen, the person will usually eat more than if they had been served everything on one large plate.

Also, serving smaller portion sizes at meals but encouraging consumption of nourishing snacks between meals may help to prevent weight loss and improve nutritional status in those with small appetites. It may also help to serve dessert some time after the main course, rather than at the same time.

**Ideas for between meal snacks are given below:**

- Sandwiches e.g. cheese, peanut butter, egg mayonnaise, tuna mayonnaise (or other canned fish), meat e.g. corned beef
- Cheese and biscuits
- Toast with melted cheese, peanut butter, paté, jam
- Buttered scones, toasted teacakes, buttered crumpets or muffins
- Fruit or malt loaf; bread pudding
- Milk pudding
- Fruit cake or gingerbread
- Sausage rolls or Scotch eggs

These suggestions may not be suitable if the resident has a swallowing difficulty. For those who eat slowly, e.g. due to reduced manual dexterity, serving small portion sizes at a time on warmed plates, can help to keep the food warm for longer. Insulating the plate by placing it on a second warmed plate can also help. Second helpings can be kept warm in the kitchen and served when the person is ready.

#### 2.2.4 Cater for the individual

People with dementia may experience a change in food preferences and may reject food they have previously enjoyed and choose foods they have previously disliked. For example, many people with dementia will form a preference for sweet foods and often eat their desserts first and leave the main course. You can improve the consumption of main courses by adding a little sugar, e.g. to quiches or a sprinkling on bitter vegetables such as sprouts. Also, try serving sweeter vegetables such as parsnips or carrots. Other people with dementia may form a preference for highly flavoured foods. Try experimenting with different herbs and spices or try different styles of cuisine. You may like to consider the names of the menu items, however, as 'Italian style beef with vegetables' may be rejected as being unfamiliar, the same item may be accepted when labelled 'beef stew'.

It is important to cater for each individual to ensure that they are eating enough food. Some people will have 'good eating' times. For example, they may be more alert in the morning than evening, so try to give them a good meal at breakfast, if they are less likely to eat well later in the day.

"Mrs M's dietitian described breakfast as her worst meal from a consumption point of view. When the lady's daughter was consulted, she confirmed that she had never been a big eater at breakfast, preferring to eat a larger meal in the evening. However, Mrs M tended to get tired in the evening, so was eating less at this meal too. Staff at the care home remedied the situation by serving a light breakfast, larger lunch and medium sized, easy to eat main meal in the evening. They served her evening meal earlier than usual, before Mrs M began to feel tired. By altering the timing of the largest meal, her intake began to increase, and the weight that she had lost began to come back on."

It is important to understand the person as they were before the dementia, as this may influence the way they choose to eat. Someone who was used to cooking for the family in the past may respond well to being involved with food preparation or setting the table. Therefore, where possible, try to speak to the family about past practices and preferences, so you can tailor the meals and eating patterns to the individual.

### 2.2.5 Fortification

Those with small appetites may not be able to consume large enough amounts of food to ensure adequate nutrition. Serving smaller portion sizes and offering second helpings may encourage greater consumption but fortification is useful for those who really struggle to eat.

Fortification involves adding high calorie, non-filling ingredients to food, so that the calories are increased without making the meal too filling.

#### **Examples of foods with which to fortify a dish are given below:**

- Eggs
- Powdered milk
- Grated cheese
- Powdered protein e.g. Complian
- Full-fat cream, milk
- Full-fat yoghurt or crème fraîche
- Fruit purée, stewed with sugar, syrup or honey
- Melted butter, oil
- Custard

## 2.2.6 Finger foods

It is important to maintain independent eating for as long as possible and to only assist where necessary. For people with dementia who have problems holding a knife and fork, finger foods are ideal. They are prepared so as to be easy to eat with the hands, allowing independence at mealtimes, boosting confidence and improving appetite.

In addition, for those who find sitting at a table difficult and prefer to walk around at mealtimes, finger foods are helpful as they can be eaten on the go.

When serving finger food for the first time, the below may help to ensure that they are well received:

- **Introduce finger foods over a few days** – this will help get the person used to the new way of serving food.
- **Tailor the food to the individual** – not just their likes and dislikes but also their ability to manage different types of food.
- **Provide snacks in between meals** – these are also easy to hold and eat, to maintain an adequate intake.

### **Examples of foods with which to fortify a dish are given below:**

#### **Breakfast**

- Buttered toast fingers with jam, marmalade, yeast extract or peanut butter if desired
- Buttered English muffins or crumpets
- Hard boiled egg quarters
- Juices
- Slices of fruit such as melon, orange, apple or whole berries

#### **Snacks**

- Fruit as above
- Crackers with cheese
- Malt or fruit loaf with butter
- Buttered teacakes, crumpets, hot cross buns or English muffins
- Toast fingers as above (also try with paté)
- Fruit or savoury scones
- Cereal bars
- Dried fruit

## **Main Meals**

### **Meat and two vegetables**

- Sliced meat or small strips of moist breast or fillet
- Small roast potatoes, sweet potatoes, parsnips, new potatoes etc
- Cooked carrot sticks, broccoli, asparagus, sprouts or green beans

### **Snack Options**

- Sliced quiche
- Pork pie quarters
- Mini scotch eggs
- Chipolata sausages
- Pizza slices
- Veg/salad sticks - celery, cucumber, carrot, cherry tomatoes, peppers

### **Light Bites**

- Fish fingers / burgers or fish cakes
- Beef burgers or meatballs,
- Vegeburgers / sausages
- Potato wedges or chunky chips

### **Sandwiches etc**

- Sandwiches, rolls or wraps (e.g. egg mayo, tuna mayo, soft or sliced cheese, meat, paté)
- Cheese on toast

### **Bedtime snack**

- Milky drinks such as Ovaltine, Horlicks, hot chocolate or warm milk
- Biscuits, slices of cake, scones

Folate may be limited in finger food diets, as they are lacking in fortified breakfast cereals and leafy green vegetables, both of which are good sources of folate. This nutrient helps to prevent some types of anaemia, which is common in the elderly. To help get folate into a finger food diet, try including yeast extract on toast and liver sausage or pate. The latter is also a good source of vitamin A.

### 2.2.7 Plates and cutlery

For those with dementia for whom manual dexterity is a problem, special cutlery and crockery may help to maintain independence while eating.

Below are some tips for buying specialist crockery:

- Plates should be non-patterned and of a colour that allows the plate to be distinguished from the food and the table cloth. Also, a coloured rim can indicate the edge of a plate. This enables the person (who may have diminished ability to perceive colour contrasts and depth) to focus on the food and is useful for many people with poor eyesight as well. Non patterned table cloths are less confusing too.
- Lightweight cutlery with large handles is easier to handle and control.
- Large handles on cups and bowls aid grip and heavy bases minimise tremor and spillage.
- Cups with spouts should be used with care. They should be avoided in those with swallowing difficulties, as they allow the fluid to flow quickly into the back of the throat, increasing the risk of inhaling the liquid and causing choking.
- Plate guards and specially made rims can prevent food from sliding around or off the plate.
- Plastic place mats or suction cups may prevent the plate from sliding on the table.

## 2.2.8 The eating environment

While the food served to older people with dementia makes an obvious contribution to their nutritional status, the environment in which they eat also has a dramatic effect in helping (or hindering) older people with dementia to cope with meals and eating. It is important to de-institutionalise the dining area, to make eating a pleasurable process rather than an ordeal.

### **Layout of the dining area**

The seating plan is important to making care home residents feel at home. A café style layout is often used to help older people, especially those with dementia feel comfortable and therefore more like eating. By arranging small tables around the dining area, residents can sit together or choose to sit alone, if that is their preference.

The arrangement should be such that every position is accessible enough but the most accessible places should be allocated to those who have difficulty walking.

For those people who may not remember how to eat, it may be helpful for staff to sit and eat with residents when they are eating. Not only does this remind people and set an example of how to eat it also enables staff to offer help to those who need assistance with eating. Alternatively, those who require assistance may prefer to have their meals in a different room or at a different time. Flexibility is key to ensuring that each individual maintains their dignity at meal times.

### **Lighting**

Older people require lighting to be around three times brighter than younger adults. Therefore, try to add more lights into the dining room and direct existing lights towards the walls so the light can bounce off them and create a brighter effect.

Try to ensure that there are a lot of windows in the dining area, to allow maximum levels of natural light in addition to artificial light.

### **Minimise distractions**

Many people with dementia may be easily distracted. Any noise or visual stimulation may put the person off eating their food, leading to nutritional insufficiency.

Noise may be a result of many things, for example, others eating, rattling cutlery, kitchen staff cooking, cleaning up or talking, care staff talking to one another or the residents, the radio or television, residents talking and so on. All these are potential distractions and add to the stress of attempting to eat.

Noise can be dealt with in several ways. Hard surfaces such as walls, windows and uncarpeted floors allow the noise to bounce back, magnifying it. Curtains and acoustic panels attached to the ceiling or walls may help to avoid some of the noise. Staff members should avoid calling to one another across the room and should try to clear up after the residents have finished, to minimise the noise of banging crockery and cutlery.

In addition, visual distractions in the form of staff walking past, televisions left on or cluttered tables, may also reduce the person's ability to concentrate on their meal. Try to minimise these distractions by reducing movement or placing individuals with dementia away from the main path of traffic in the dining area. Turn off the television and ensure that the tables are not cluttered. Serve the different courses separately, so there are fewer items to deal with at the same time.

### **Minimise mealtime stress**

This area is closely related to minimising distractions. High levels of noise and other distractions can increase stress levels at mealtimes and reduce consumption.

For people with dementia, eating can be a very stressful experience. They may no longer have the manual dexterity to hold a knife and fork or may spill things easily, incurring ridicule from others at the table or even from members of staff. If assistance in eating is offered, it may be in a way that demeans or embarrasses the person. Anxiety decreases the appetite, so any stress felt at mealtimes will reduce the amount of food eaten, which can result in weight loss and malnutrition.

Staff need to be calm before the mealtime begins, so they are less likely to feel stressed or frustrated while assisting in eating. Similarly, it may be helpful to give residents some 'wind down time' before meals, by way of a relaxing massage or by playing soothing music. Seating plans may need to be carefully thought out. As discussed above, seating those people who need assistance with eating in a place accessible for care staff may be practical but may result in the person being distracted by people walking by. Where possible, do not sit people together if they do not get on well. For example, if the person with dementia has problems using a knife and fork, try to avoid sitting them near someone who is likely to criticise them for any spillages or mistakes.

Where assistance is required, it should be offered both discretely and sensitively. Staff should sit with the person and offer help where required, without rushing the person or attempting to talk with other staff at the same time.

The case study below exemplifies the issues covered above in relation to the eating environment.

"Mrs B has mild dementia with no swallowing difficulties. She had recently been moved in the dining room to a table that was accessible to staff, being on the main path that the staff walked during meals, so that her eating could be monitored. She was sharing a table with 3 others, one of whom was hard of hearing and so her companions used to talk with raised voices. In addition, the table was fairly poorly lit.

Being in the middle of the room, with people constantly passing, and her table mates talking loudly was a big distraction for Mrs B, preventing her from concentrating on eating. Being seated away from the windows and wall light fixtures meant her table was a bit darker than others, so she had problems seeing her food. This was compounded by the fact that she had a white plate on a white table cloth, which caused problems for her, as her ability to contrast similar colours had been affected by her dementia. She was unable to cope with all that was going on around her and it affected her ability to eat her meals.

Mrs B was moved to a table in the corner, below a light fitting. The light was reflected off the wall and with the nearby window, ensured that her table was much brighter. A dark coloured table cloth was used so the white plate stood out against the dark background. Being placed in the corner meant that there was much less traffic around her table. The smaller table allowed her to sit alone, which was less distracting, or to invite one other to join her if she wished. The noise distractions were reduced by sitting alone and in the corner of the room and staff also tried to reduce the noise from talking to each other across the room.

By making these simple changes, Mrs B was able to eat her meal without distractions and the eating experience was far more pleasurable. Her intake consequently increased."

### 2.2.9 Discouraging overeating

Some people with dementia may eat too much food and may gain unnecessary amounts of weight. This may be due to changes in the brain that are part of the progression of the dementia or may be simply because the person has forgotten that they have just eaten. Some people may form a particular liking for sweet foods and may eat only desserts and sugary snacks. This can lead to imbalanced diets and nutrient deficiencies. Overeating that leads to weight gain should be managed, because the person may suffer mobility problems and staff may find them more difficult to care for. The person with dementia may also seek out food and consume unsuitable or even dangerous substances.

To prevent overeating, the tips below may be useful:

- Put items that may be consumed and foods that you don't want the person to consume away and out of sight. Out of sight, out of mind!
- Find an activity that may act as a distraction from the desire to eat e.g. exercise.
- If the person constantly seeks out food, provide healthy snacks such as chopped fresh fruit, vegetables or crackers.
- For those whose nutritional status is a real concern, the GP may prescribe vitamin or mineral supplements. However, these should only be used as a last resort.

### 2.2.10 Dysphagic diets

Those people with dementia who have difficulties with swallowing may require a texture modified diet. However, a proper diagnosis must first be made by taking a medical history and involving a multi disciplinary team of physicians, speech and language therapists, clinical nutritionists or dietitians and psychologists.

Texture modified diets should be offered only under exceptional circumstances and only after weighing of the relevant considerations, as it is very difficult to achieve sufficient nutritional and fluid intake.

Depending on the severity of the swallowing difficulty, the required consistency of food and fluids will be prescribed by the speech and language therapist. This information should be filtered down to the family and carers of the patient plus the catering staff in the care home.

The goals of nutritional management should be:

- To maintain and ensure adequate nutrition and hydration
- To implement the correct and safe texture modified diet
- To maximise nutritional intake while maintaining safe eating

### Different consistencies and textures

There are various consistencies of texture modified diet, offering different levels of control during swallowing. Puréed and mousse like diets offer a lot of control because the consistency is uniform and thick, without lumps or liquid.

Soft diets contain some very soft particles and can be mashed with a fork. These require some chewing, so are suitable for those with sufficient dentition or with less severe swallowing problems.

The table shows the Dysphagia Diet Food Texture Descriptors and details the consistency required for each texture.

Texture	General Description of Texture	Consistency
<b>B</b> Thin Purée Dysphagia Diet	<ul style="list-style-type: none"> <li>• Food has been puréed or has a purée texture. It does not require chewing.</li> <li>• It is a thin purée</li> <li>• It is smooth throughout with no "bits". It may need to be sieved to achieve this</li> <li>• It may have a fine "textured" quality as long as the bolus remains cohesive in the mouth</li> <li>• It is moist</li> <li>• Any fluid in or on the food is as thick as the purée itself</li> <li>• There are no loose fluids that have separated off</li> <li>• The texture is not sticky in the mouth</li> <li>• No garnish</li> </ul>	<ul style="list-style-type: none"> <li>• Doesn't hold shape on a plate when scooped</li> <li>• Cannot be eaten with a fork</li> <li>• The prongs of a fork don't make a pattern on the surface</li> <li>• It can't be piped, layered or moulded</li> <li>• Can be poured</li> <li>• Spreads out if spilled. A light disposable plastic teaspoon must be able to stand upright when the head is fully covered</li> <li>• If it doesn't do this, it's too thin</li> </ul>

<p><b>C</b> Thick Purée Dysphagia Diet</p>	<ul style="list-style-type: none"> <li>• Food has been puréed or has a purée texture. It does not require chewing.</li> <li>• It is a thick purée</li> <li>• It is smooth throughout with no "bits". It may need to be sieved to achieve this.</li> <li>• It may have a fine "textured" quality as long as the bolus remains cohesive in the mouth</li> <li>• It is moist</li> <li>• Any fluid in or on the food is as thick as the purée itself</li> <li>• There are no loose fluids that have separated off</li> <li>• The texture is not sticky in the mouth</li> <li>• It is not rubbery</li> <li>• No garnish</li> </ul>	<ul style="list-style-type: none"> <li>• Holds its shape on a plate or when scooped</li> <li>• Can be eaten with a fork because it does not drop through prongs</li> <li>• The prongs of the fork make a clear pattern on the surface</li> <li>• It can be piped, layered or moulded</li> <li>• Cannot be poured. Does not "spread out" if spilled</li> </ul>
<p><b>D</b> Pre- mashed Dysphagia Diet</p>	<ul style="list-style-type: none"> <li>• Food is soft, tender and moist. Needs very little chewing.</li> <li>• It has been mashed up with a fork before serving (meat must be finely minced)</li> <li>• Any fluid, gravy, sauce or custard in or on the food is thick</li> <li>• No mixed (thick-thin) textures. No loose fluid</li> <li>• No hard, tough, chewy, fibrous, stringy, dry, crispy, crunch or crumbly bits</li> <li>• No pips, seeds, pith/inside sin. No skin or outer shells e.g. on peas, grapes. No husks</li> <li>• No skin, bone or gristle</li> <li>• No round or long-shaped foods e.g. sausages, grapes, sweets. No hard chunks e.g. pieces of apple</li> <li>• No sticky foods e.g. cheese chunks, marshmallows</li> <li>• No "floppy" foods e.g. lettuce, cucumber, uncooked baby spinach leaves</li> <li>• No juicy food where juice separates off in the mouth to a mixed texture e.g. watermelon</li> </ul>	<ul style="list-style-type: none"> <li>• Any fluid, gravy, sauce or custard in or on food must be very thick</li> <li>• It holds its shape on a plate or when copped can not be poured and does not "spread out" if spilled.</li> <li>• Thinner single texture foods may be suitable if a person is on thinner fluids - Speech and Language therapists to advise on an individual basis.</li> <li>• Texture D foods must be in a pre-mashed state when it reaches the resident</li> </ul>
<p><b>E</b> Form Mashable Dysphagia Diet</p>	<ul style="list-style-type: none"> <li>• Food is soft, tender and moist but needs some chewing</li> <li>• It can be mashed with a fork. (For meat - soft tender meat must be served no bigger than 15mms or finely minced)</li> <li>• Any fluid, gravy, sauce or custard in or on the food is thick</li> <li>• No mixed (thick-thin) textures. No thin loose fluid</li> <li>• No hard, tough, chewy, fibrous, stringy, dry, crispy, crunchy or crumbly bits</li> <li>• No pips, seeds, pith/inside skin. No skins or outer shells e.g. on peas, grapes. No husks.</li> <li>• No skin, bone or gristle</li> <li>• No round or long-shaped foods e.g. sausages, grapes, sweets. No hard chunks e.g. pieces of apple.</li> <li>• No sticky foods e.g. cheese chunks, marshmallows</li> <li>• No 'floppy' foods e.g. lettuce, cucumber, uncooked baby spinach leaves.</li> <li>• No juicy food where juice separates off in the mouth to a mixed texture e.g. water melon.</li> </ul>	<ul style="list-style-type: none"> <li>• Any fluid, gravy, sauce or custard in or on food must be thick – a light disposable plastic teaspoon would stand upright if the head were fully but just covered.</li> <li>• Thinner single texture foods may be suitable if a person is on thinner fluids –Speech and Language Therapists to advise on an individual basis.</li> <li>• Texture E products must be in a consistency that allows them to be mashed easily using a fork at point of service/consumption.</li> </ul>

The texture modified diet should meet the daily requirements for energy, protein, vitamins and minerals as a minimum. However, given that foods are diluted when puréed, to achieve the appropriate consistency, the nutrients themselves are diluted. Therefore, the nutrient density is lower than in a solid food diet and it is also harder to achieve the palatability of a normal food diet. Texture modified diets often tend to result in weight loss. Fortification of foods may therefore be necessary.

### **Examples of fortification**

Instead of using water to dilute blended foods, use:

- Full fat milk, or milk fortified with milk powder
- Full fat cream
- Melted butter or oil
- Sauces
- Gravy
- Honey, syrup, sugar
- Juice

Foods can be thickened with:

- Commercial thickeners
- Instant or mashed potato
- Gelatine or cornstarch
- Custard mix
- Fruit and vegetable purées (to add vitamins and minerals)

Liquids pose a problem for dysphagic patients as thin fluid may be difficult to swallow, risking a choking episode. Advice on thickening drinks can be obtained from a speech and language therapist or dietitian.

### **Presentation of puréed food**

In the past, puréed meals were blended together so that all meal components e.g. meat, potatoes and vegetables would be liquidised together with gravy, producing an unappetising thick soup. Patients often did not consume much of such meals and hence, undernutrition became even more of a cause for concern. This was compounded by adding water to the food whilst pureeing, leading to a dilution of nutrients.

Nowadays, presentation of foods is key, especially for dysphagic patients to maintain appetite. Modified consistency foods should be made up separately, usually involving some kind of fortification, and piped onto the plate while still hot and served immediately. Care staff should avoid mixing the different components of the plated meal together as this can undo a lot of good work on behalf of the catering team to ensure the meal's presentation is good.

Natural food colourings can be used to enhance the appearance of purèed foods that lack natural colour, beetroot, blackcurrants or blackberries, cherries, spinach, tomato purée and other brightly coloured fruits and vegetables can be added to enhance the appearance (and taste) of dishes.

### **Foods that cannot be purèed easily**

- Chips
- Battered or bread-crumbed foods
- Pastry
- Nuts and seeds
- Tough meat and Bacon
- Sausage skins

### **Tips for purèeing**

- Use strong flavours in the food, so that it is still tasty when diluted and purèed e.g. parmesan and stilton rather than cheddar
- Use strong flavoured herbs such as thyme, sage and tarragon
- Taste food before serving – would YOU like to eat it?
- Lemon juice thickens double cream for use in desserts and also adds flavour
- Thick home made soups can be made with interesting and flavoursome combinations such as broccoli and stilton, carrot and corriander or cinnamon, tomato and bacon.
- Skin peaches, nectarines or tomatoes by immersing in boiling water for 20 seconds then putting them into cold water. Remove stones and pips and purée.

## **Monitoring of the dysphagic patient**

Regular and close monitoring of the dysphagic patient is imperative.

Reviews should include a nutritional assessment and weight check, once a week, to ensure that the person is not losing weight and that they are receiving sufficient nutrients.

In addition, those who prepare food for dysphagic patients should have access to training that raises their awareness of the risks related to swallowing difficulties and the correct way to thicken fluids for patients with this need.

## **Soft food diets**

Soft foods with a mince-mash consistency may be suitable for those with less severe swallowing problems, chewing problems or for those who have few of their own teeth left. Foods should be soft enough to mash with a fork but should not be sticky or crumbly and should not have tough skins or a stringy texture. Foods with solid particles in a liquid medium such as cereal in milk or minestrone soup should be avoided, as they create a choking hazard, being difficult to control within the mouth. Also avoid sticky foods or foods that become sticky on chewing such as white bread and peanut butter.

## **Below are some examples of suitable foods for a textured soft diet:**

### **Breakfast:**

- Weetabix or All bran soaked until soft in warm milk
- Porridge or Ready Brek
- Thick and creamy style yoghurts or fromage frais
- Brown and wholemeal bread or soft toast without crusts
- Tinned or stewed fruit e.g. apple, peach, pear, apricot, plum, rhubarb, mandarin (remove pips), fresh banana – ensure that these are well cooked and without stones or skin / membrane

### **Snacks:**

- Plain cake mixed with custard, ice cream or cream
- Ice cream
- Thick and creamy style yoghurts or fromage frais

### **Main meals:**

- Thick homemade soup
- Minced meat (beef, pork, lamb, chicken or turkey) – avoid gristly or stringy meat and serve all meat with a thick sauce.
- Soya mince, served with a thick sauce
- Steamed or poached fish (without bones) – serve all fish with a thick sauce
- Tinned fish, mashed
- Omelette or poached egg – mashed
- Cut up spaghetti in a well mixed dish such as spaghetti Bolognese
- Steamed burger products (meat and vegetarian) if easily mashed with a fork
- Carrots, cauliflower, swede, courgette, cabbage (not stringy), spinach, tinned tomatoes, mashed potato or sweet potato – ensure these are well cooked and not stringy
- Cheese in dishes and sauce
- Sago, tapioca, rice and ground rice puddings.
- Plain cake mixed with custard, ice cream or cream
- Ice cream or blancmange
- Thick and creamy style yoghurts or fromage frais

### **Unsuitable foods:**

- Sticky foods such as white bread, peanut butter and cheesecake
- Crumbly foods such as fruit cake or dry sponge cake
- Vegetables with tough skins such as sweetcorn, red kidney beans, peas, broad beans, processed peas and green beans

## **3. Dental care and dementia**

### **3.1 Brushing teeth**

In the early stages of dementia, the person will still be able to use a tooth brush to clean their own teeth. However, they may need to be reminded to brush their teeth or supervised while doing so.

As manual dexterity decreases, an electric toothbrush may help to maintain independence, as can toothbrushes with modified handles to improve grip.

As the dementia progresses, the person may no longer be able to brush their teeth, or may lose interest in doing so. Carers may then need to assist. A dentist can provide guidance on how to do this.

The easiest way is for the person to sit on a dining chair with the carer standing behind them, supporting the person from behind and cradling their head in their arm. They can then brush the person's teeth with a damp toothbrush and a little toothpaste.

### 3.2 Drugs and dental care

Certain drugs used in dementia can cause a dry mouth. This may cause dentures to become loose and cause discomfort. Special denture fixatives and artificial saliva may help in some cases. Ask your dentist for advice.

Care should be taken to keep the mouth clean in those with a dry mouth, as saliva not only lubricates, it also cleanses the mouth, preventing plaque formation, gum disease and tooth decay. Chlorhexidine and fluoride varnishes may help to prevent tooth decay.

Where possible, sugar free medication should be given as sugary syrups may contribute to dental decay. A reduced sugar diet is also advisable, restricting sugary snacks such as sweets, biscuits and cakes.

### 3.3 Dental treatment

#### **As dementia progresses, the person may be less able to:**

- Clean their teeth
- Understand or remember that teeth need to be kept clean
- Express the need for treatment or explain the symptoms
- Make decisions about their treatment
- Give informed consent
- Feel comfortable with treatment

Given that the person may no longer be able to vocalise their symptoms or needs, the carer will need to observe their behaviour to determine whether dental problems are being experienced. Below are some common signs of dental problems:

- Refusal to eat (especially cold or hard foods)
- Touching or pulling the face and mouth
- Refusal to wear dentures
- Restlessness, moaning or shouting
- Poor sleep
- Refusal to take part in normal daily activities
- Aggressive behaviour

### 3.3.1 Consent to treatment

Where possible, it is important to involve the person with dementia in the decisions about their dental treatment. The dentist should explain simply what is going to be done and why, offering the opportunity for discussion.

If the individual cannot give informed consent and especially if the procedure is irreversible, the family or carers will be involved in the decision making progress. The dentist may also seek a second opinion to make sure the treatment is in the patient's best interest.

### 3.3.2 Coping with treatment

Some people with dementia may find a visit to the dentist very distressing. Where the person is distressed and confused in the unfamiliar environment, it may be difficult to perform any treatment.

It may be helpful for the dentist to make a home visit, if the unfamiliar environment is too challenging to the person with dementia. Alternatively, if the person is relatively comfortable with attending the surgery, it can help if they are accompanied by a familiar face, who stays within view during the treatment.

It is best if dental care is scheduled at the best time of day for the individual. If possible, reschedule appointments for 'good' days.

In the early stages of dementia, most types of dental care are still possible. However, advanced treatment such as crowns or bridges may only be considered if there is commitment by carers to keep the area clean once the person with dementia is unable to brush their teeth themselves.

As dementia progresses, the types of treatment offered will change to prevention of further disease, maintaining comfort in the mouth and emergency treatment.

### 3.3.3 Denture wearing

Good oral hygiene is essential for denture wearers as plaque may form much more easily around the existing teeth while wearing dentures.

If further teeth are lost or when dentures go missing, a new set will be required. These may be very difficult to get used to and perseverance must be encouraged by carers. If old sets of dentures are still available, new sets can be made using features from the existing ones, as these should then be of the correct shape and allow adequate space for the tongue.

### 3.3.4 Denture loss

Replacing lost dentures can lead to problems if the person is without dentures for long enough to forget how to wear them. The new set will invariably be different from the old, so getting used to wearing them may be difficult.

Again, it helps for a familiar person to accompany the person to the dentist for denture fitting. If the fitting is too distressing and co-operation is low, it may be advisable to fit only the top set for the sake of appearance.

Many people with dementia may get to a stage where they can no longer tolerate dentures in the mouth.

### 3.3.5 Finding a dentist

Where possible, the person's usual dentist should still be used. Some care homes will have a dentist who visits regularly.

For those whose dementia has reached a stage where their dentist can no longer cope, a referral to the Community Dental Service may be made. This service provides dentists who are experienced in treating people with disabilities and complex medical conditions. Your local health authority can provide details of your nearest Community Dental Service.

## **4. Final Comments**

The progression of dementia can have profound effects on the person's ability to eat and therefore on their nutritional status. The solution to the eating problems encountered is not simply to 'feed' the person until their nutritional status is adequate. Dementia care should focus on maintaining independence for as long as possible, treating the individual with respect and preserving their dignity.

With this in mind, when laying out the dining rooms, setting the table, preparing food and assisting with eating, bear in mind how you would feel in that environment. What would you like to see, eat and feel?

## 5. Useful links and references

The Alzheimer's Society - [www.alzheimers.org.uk](http://www.alzheimers.org.uk)

Pick's Disease Support Group - [www.pdsg.org.uk](http://www.pdsg.org.uk)

Food Glorious Food: Perspectives on Food and Dementia (2003) Edited by Mary Marshall. Hawker Publications Ltd

Eating Well for Older People with Dementia (1998) Voices and Gardener Merchant Healthcare Services

Food, Drink and Dementia by Helen Crawley. Available from Dementia Centre at Stirling University. [www.stir.ac.uk/dsdc](http://www.stir.ac.uk/dsdc)

Nutrition and Mental Illness. Carl C. Pfeiffer, PH.D., M.D. ISBN 0-89281-226-5

The Importance of Food and Mealtimes in Dementia Care: Grethe Berg.

Jessica Kingsley Publishers [www.jkp.com](http://www.jkp.com)

Dysphagia Diet Food Texture Descriptors [www.bda.uk.com](http://www.bda.uk.com)

## 6. Acknowledgements

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