Dysphagia: Effects on the Older Adult

Dysphagia is a common problem among older adults, which impairs normal swallowing and complicates nutritional intake. Dysphagia may be acute or chronic. It is reported to have a broad incidence rate ranging from 9-77% (Chu, 2014). It is a symptom frequently associated with stroke (up to 67%) as well as neuromuscular diseases, throat or mouth surgery, head and neck cancer, dementia, nasogastric (NG) tubes, gastroesophageal reflux disease (GERD), or a diminished level of consciousness (Australian and New Zealand Society for Geriatric Medicine, 2011; Campbell, 2013; Geeganage, Beavan, Ellender, & Bath, 2012). Dysphagia can cause serious complications, including aspiration. Aspiration can be life-threatening and lead to pneumonia, resulting in death in the older adult. The mortality rate of the older adult with dysphagia is high and associated with poor patient outcomes (Geeganage et al., 2012; Hammond & Goldstein, 2006). Therefore, it is paramount for us to identify and recognize the patient at risk for dysphagia in order to mitigate complications.

With dysphagia, there is either a difficulty in the patient’s ability to orally prepare the food (through motor, sensory, or behavioral responses) or in moving the food from the mouth to the stomach. Patients with dysphagia can present with symptoms such as a weak, voluntary cough; a cough before, during, or after a swallow; a wet or gurgly voice; gagging; an inability to control food or saliva in the mouth; an increase in secretions; or an inability to recognize food. If these symptoms are present and a concern for dysphagia exists, the nurse should cease oral intake and notify the provider and speech pathologist for evaluation.

In order to capture patients at risk for dysphagia, screening should be conducted soon after admission and include a patient history, medical chart review, reports by family members on perceived swallowing dysfunction, a physical exam, and a bedside clinical exam (3 oz. water test) performed by trained personnel. A thorough patient history alone can identify up to 80% of patients with dysphagia (Hines, Kynoch, & Munday, 2014). The goals of management should focus on minimizing the chance for aspiration, maintaining hydration and nutritional status, and functional recovery of swallowing. The interventions to prevent aspiration include elevating the head of bed, preferably sitting up in a chair while eating, eliminating distractions, and cleaning the mouth. Modifying food and liquid consistencies and amounts will also decrease the chance for aspiration, yet concurrently aid in maintaining or improving nutritional status. If the oropharyngeal route is determined to not be safe for intake, an NG tube or percutaneous endoscopic gastrostomy (PEG) tube can be considered for nutritional maintenance.

Nurses are vital to the early recognition of dysphagia. There are many screening tools available that will assist the nurse in identifying patients at risk. Bedside tools such as the 3 oz. water test can provide additional insight. An interdisciplinary approach to the management of patients with dysphagia is key to developing a plan to promote safety while integrating the necessary nutrition.

References

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