

# Promoting quality care for older people in meal management: whose responsibility is it?

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## ABSTRACT

### Objective

To examine the role of registered nurses and allied health workers in meal management, assessment, safe environment and care planning for older people in residential aged care.

### Primary Argument

Nurses and carers are often the first to observe and put into place strategies to prevent choking in residents with swallowing difficulties. Coroners' reports have raised issues with regard to the role of the registered nurse, resident autonomy and the effectiveness of speech pathologist assessments in avoiding incidents that compromise resident's health and well being.

### Conclusions

In residential aged care the role of the registered nurse involves managing a complex environment. In the area of meal management, nurses are struggling to have their knowledge and expertise recognised. Nurses need to develop strategies to articulate and demonstrate their contribution to meal management in order to promote their knowledge and skills. Nurses must actively continue to develop their body of knowledge through research; otherwise 'expert' knowledge will be accessed from elsewhere. This paper will outline a number of areas for future development and research which focuses on the needs of older people and staff in this area.

## INTRODUCTION

Two Coroners' reports (Vicker 2004; Chivell 1997) describe tragic circumstances where two elderly people in residential aged care died of choking. The reports may be read as asserting nurses working in residential aged care lack essential knowledge and skill in assessment and care planning for residents around meal management. A deficiency in research attesting to the knowledge and skill of nurses working in aged care has resulted in allied health professionals gaining attention and acknowledgement for their expertise rather than registered nurses, who are central to resident care needs. Both Coroners' reports appear to assume speech pathologists are accessible in residential aged care and that funding to access specialist services in residential aged care is available and adequate for the assessment and ongoing review of residents. The Coroners' reports infer speech pathologists are essential for the provision of safe and adequate nutrition and hydration needs of older people in residential aged care and assume meal management is straight forward. The Coroners found the registered nurses and carers to be negligent for not referring to or adhering to advice from allied health professionals. This implies that registered nurses do not have the expertise to assess the needs of residents with regard to diet and swallowing. (Vicker 2004; Chivell 1997).

## CASE STUDY

A resident choked after ingesting a piece of toast obtained while she was wandering through the aged care facility in which she was a resident. The resident was one of 102 people in high care, 86% of whom were severely compromised by dementia. The resident had been some years in the facility and had an advanced Alzheimer type dementia with symptoms of hyperorality and agnosia. Dietary care planning had been a challenge involving her general practitioner, her husband and nursing staff. The resident's husband, also a high care resident in the same facility, was involved in many of the care

needs of his wife and gave full assistance with her meals. The husband was extremely independent and nurses did not make it known to him that they monitored both (husband and wife) during meals. The couple had, on occasion, demonstrated symptoms that alerted staff to the fact that they experienced swallowing difficulties. Thickened fluids had been encouraged but the resident and her husband did not respond well and rejected drinks if thickener was added. The husband insisted on his wife having her well loved cup of tea without thickener and nurses requested he spoon feed her drinks.

The resident in question had not been seen by a speech pathologist. Her general practitioner was not in favour of a referral and agreed with flexible nursing interventions aimed at optimal hydration and dietary intake. The resident's behaviour vacillated between cooperative and uncooperative. Her fluctuating swallowing condition combined with the requests by her husband for certain foods and drinks on her behalf, proved challenging for nursing staff.

The residents' death was ruled as accidental by the Coroner with no further action required. The Coroner advised he was satisfied the nursing interventions were appropriate.

## DISCUSSION

Had the findings of the 1997 and 2004 coroners' inquests been applied to this case the fluctuating swallowing condition of this resident would have required an unrealistic level of review and intervention by a speech pathologist. Access to a speech pathologist is difficult in residential aged care and delays of up to three months before an appointment can be organised is not uncommon. A swallowing assessment would also have been difficult due to the resident's cognitive abilities, uncooperative behaviour and her husband's expectations. Farrell and O'Neill (1999) state the scope and utility of screening procedures is restricted when a person is debilitated.

It is not uncommon in aged care for care staff to report residents experiencing a choking episode and for

residents to have episodes of swallowing difficulties. Physical conditions in this age group fluctuate and swallowing abilities vary. Farrell and O'Neill (1999) argue that difficulty with swallowing, oropharyngeal dysphagia (OPD), is common in a variety of illnesses and identify those people with chronic obstructive pulmonary disease, substantial weight loss, or recurrent unexplained pneumonias as being likely to have swallowing difficulties. Residents with dementia are at even greater risk and if prescribed neuroleptic medication, the risk is considered even higher (Wada et al 2001).

Five cranial nerves and twenty-six muscles involving the mouth, throat, and oesophagus are needed in a synchronised effort to achieve swallowing and clear food, fluids and saliva from the mouth and throat. Age related degenerative changes are noted in the oral, pharyngeal and oesophageal phases of swallowing however it is not known how much these changes increase the risk of swallowing disorders. Sitoh et al (2000) state that changes in physiology give rise to delayed swallowing which has the potential for aspiration of substances into the airway.

Swallowed food or liquid takes seconds to pass through the mouth and throat. If a food or liquid gets into the airway, the substance can easily be coughed up and redirected to the oesophagus. The trachea and oesophagus share the same space at the level of the throat or pharynx, therefore breathing and eating cannot occur simultaneously. During swallowing the airway closes securely. This process includes: closure of the soft palate; closure of the epiglottis over the airway; elevation of the larynx; and closure of the vocal chords. When the airway is sealed, food or liquid passes into the oesophagus and it is safe to take a breath. Aspiration into the airway will occur if poor timing or positioning of any of the muscles involved with swallowing is exhibited. If food or liquid enters the larynx and drops below the vocal cords it will cause coughing, regurgitation through the mouth or nose, a wet quality to the voice, choking and possible airway obstruction (Hughes 2003; Terrado et al 2001).

Terrado et al (2001) claim registered nurses are frequently the first health care workers to detect and assess swallowing difficulties through: assessments prior to and after admission; reports from the resident or the resident's family; information from the general practitioner; reports from concerned carers or from concerned persons after an external outing; and comments from volunteers or visitors. The idea that assessment and intervention is a specialist activity performed only by a speech pathologist is unrealistic in residential aged care. Intervention is not always easy and can be restricted by lack of co-operation from residents and their families to recognise a deficit and accept meal alternatives and monitoring.

An entry in one of the Coroners' Reports cites the following hospital case notes by a speech pathologist: 'dislikes slightly thickened fluids, however safer for patient'. The coroner agreed with the speech pathologist that the patient's dislike of thickened fluids should be overridden by the issue of safety (Chivell 1997). The view of the coroner and the speech pathologist's may be in conflict with aged care regulation that recognises resident's rights and resident and family participation in matters pertaining to care, care planning and services.

Nurses in aged care are often faced with dilemmas and have to reconcile resident's desires with safe outcomes, accreditation expectations, and conflicting regulatory requirements. The coroner's stance ignores the complexities of working with residents and families in aged care facilities. Unless nurses working in aged care clearly articulate their skills and demonstrate their knowledge base in this area of work, there is a danger of unnecessary and inappropriate interventions being applied. This may range from enteral feeding to chemical and physical restraint as means of ensuring safety.

It could be argued that aged care is not funded, nor professionally positioned, to cater for acute conditions and provide ongoing surveillance however registered nurses have knowledge and skills on contemporary care practices although they often work in isolation from other nurses and must rely

on the observations of unregulated workers. Aged care regulation requires that registered nurses be responsive and flexible and recognise and respect the right of the individual in care. This requirement is difficult to reconcile with the views expressed in the Coroners' reports which suggest the focus of care planning as primarily concentrated on the individual's pathology and functional ability not on resident choice and the complex dynamics of workforce issues

Mealtimes in residential aged care can be stressful. Manthorpe and Watson (2003) discuss the numerous difficulties nurses face in ensuring adequate dietary intake for older people. These can include: time constraints; inconsistent skill mix; high resident dependency; loss of appetite; loss of ability to recognise food; eating inappropriate substances; bolus eating; difficulty with transferring food from plate to mouth; and problems with chewing and swallowing. A diminished ability to taste and smell can also increase the risk of choking. As a consequence, older people can be difficult about their food resulting in constant requests for alternative foods and demands for immediate action from nurses.

Other demands on staff are the provision of assistance with feeding for residents with cognitive impairment and other limiting physical conditions. Manthorpe and Watson (2003) describe helping someone to eat as being an interactive activity which relies on a range of movements for which co-operation is assumed. However staff encounter resistive behaviours such as residents spitting food, turning their heads away and refusing to open their mouths (Manthorpe and Watson 2003). The complexity of the issues associated with meal management and the maintenance of satisfactory nutrition and hydration levels for elderly residents is a constant source of tension for nursing staff. Watson and Dreary (1994) argued this was an area urgently requiring further investigation and research.

Another area impacting on staff and their ability to care of residents is the need to meet aged care accreditation standards, which requires compliance in four areas: management systems; staffing and

organisational development; health and personal care; and resident lifestyle, physical environment and safe systems (1997 <http://www.accreditation.org.au/AccreditationStandards>). These four standards are supported by forty four expected outcomes. Aged care facilities are required to meet all standards before accreditation is achieved (Gray 2001).

The coroner in *Parsons vs. Ray Village Hostel* (Vicker 2004 p.27) noted that staff in aged care work in an anxious environment, never sure of what constitutes minimum standards for compliance. The accreditation standards and expected outcomes lack specificity and direction for staff working in aged care and are subject to inconsistent interpretation by accreditation assessors. For example, the only direction given in expected outcome 2.10 'Nutrition and hydration' is that: *Residents receive adequate nutrition and hydration*. Other expected outcomes which impact on meal management are: 3.5 'Independence': *Residents are assisted to achieve maximum independence...*; 3.9 'Choice and decision making': *Each resident (or his or her representative) participates in decisions about the services the resident receives, and is enabled to exercise choice and control over his or her lifestyle while not infringing on the rights of other people*; and 4.8 'Catering, cleaning and laundry services': *Hospitality services are provided in a way that enhances residents' quality of life*. Additionally, each standard requires compliance with regulation, continuous quality improvement and education and staff development.

Individual assessors conducting accreditation visits are reported in some instances to recognise dietician and speech pathologist input as being necessary in the assessment of residents, while rejecting meal management plans developed by nursing staff, deeming them inadequate. Where there is no evidence of input from allied health, organisations have failed standards despite there having been no recorded adverse affects to residents health and well-being. Management responses to negative rulings have varied. Some organisations have

viewed negative outcomes as devaluing nurses and have appealed decisions (Australian Government Department of Health and Ageing 2004 p.20-21). Others have directed resources into allied health consultations despite research being unavailable to evaluate whether this is an effective course of action.

Kelly et al (2005 p.14) argue if registered nurses working with the older people are not able 'to articulate what it is they do' then other health care professionals will assume responsibility and dictate care, while Pearson (1998 p.205) warns 'de-skilling and a move away from the central values of sensitive, intelligent nursing will be an outcome for organisations and policy makers in the future'.

## CONCLUSION

Residents in aged care are some of the most complex and difficult individuals to evaluate and treat. Nurses are central to achieving positive outcomes, but need to articulate their role in a manner that instils confidence and gains recognition for a knowledge base sufficient to be acceptable to bureaucratic and regulatory authorities. Unless nurses rise to this challenge deskilling will occur and compartmentalising of aged care will be the result.

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