For Practitioner

When and How Nurse's Interventions are Beneficial for Dysphagic Patient?

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ABSTRACT To eat and to hydrate represent two basic needs and constitute the base of Abraham Maslow's pyramid, a theory which identifies human basic needs. A swallowing disorder (also called dysphagia) is difficulty or discomfort in swallowing. As a result, it can be difficult to eat and drink. Food represents the energy source and the biological substrate for our body cells. Water and food are introduced into the body through natural (digestive tract) and parenteral way (pathological conditions). Dysphagia represents a negative aspect that affects the development of this physiological need, so vital for survival. Swallowing difficulties can occur at any point along the swallow, from when the food or drink enters the mouth, to when the bolus passes through the esophagus and into the stomach. *Dysphagia is probably more common than you think*.....The nurse, as a member of the interdisciplinary medical team, plays an important role in the medical care of patients registering such pathology. Consequently, the following questions are asked, which? how? and when? are nursing interventions essential for the dysphagic patient? To answer these questions, the nurse has to know closely the causes of dysphagia, its clinical aspects, as well as the interventions needed to provide the patient's optimal nutrition, nutrition should represent a safety measure in such pathology.

KEY WORDS *dysphagia, nursing interventions*

Introduction

Dysphagia was defined as a difficulty in performing the act of deglutition. We find it in all groups of age. It may be present both in children and adults presenting congenital anomalies. At the same time it is a problem which appears more frequently older persons in hospitals and asylum houses and constituting as an anxiety sign. Persons with a high risk of presenting dysphagia are mainly those patients with cerebral vascular accident, degenerative neuromuscular diseases (Parkinson, plate sclerosis) madness or other cognitive diseases, larynx or oro-pharinx cancer.

Signs revealing dysphagia presence:

- suffocation following liquids consumption
- weight decrease
- hanging food habits
- sore throat after meals especially accompanied by coughing during the food ingestion
- exaggerate movements of the neck muscles during the deglutition act
- losing salivary secretion food or liquids at the level of oral cavity
- food storing at the level of the oral cavity
- presence of recurrent pneumonia

Feed techniques in a dysphagic patient:

Whatever the cause leading to dysphagia appearance, meals represent most of the times, period of frustration and failure both for the patient and the nurse. First attempts to feed such a patient represent a challenge for the nurse who is not used to the patient's limits, yet. Even later, advancing is not always constant and therefore each meal is a continuous adaptation.

- for that patient who cannot control his/her head and trunk a hand should be placed at the frontal region level to make the cephalic region stabilized.
- the nurse feeding the patient should sit down in front of the latter at the same height to hold his/her head in flexion.
- for that patient who cannot open his/her mouth by himself/herself, it is kindly pressed by a teaspoon at the level of the lower lip, which usually stimulates the oral cavity opening. If it fails a gentle pressing is applied at the level of the mentum, by a finger, simultaneously asking the patient open his mouth.
- the nurse teaches the patient to adopt a safe position during meals, the latter should not lay while eating (as there is a risk for the food be inhaled into the airways) but sit down and having his/her legs placed against the floor, his/her hips angled at 100 degrees, his/her knees at 105 degrees, having the trunk as steady as possible, with his/her cephalic extremity

directed on the body line and slightly flexed towards the anterior side. That head position of a slightly anterior flexion enables the food passage into the esophagus and also assures an optimal trachea protection. Head hyperextension prevents or makes deglutition be difficult, the nurse may place a pillow at the shoulders level when that hyperextension need correction.

- a patient that cannot be feed by teaspoon due to his/her lips inability also need help from the nurse, using straws to give the patient liquids of a viscous consistence is gradually achieved. Drinking by a straw need means less energy consumption from the patient but, at the same time, the nurse must watch for the straw not to be placed to deep into the oral cavity level. More than that, the straw should be placed into the healthy side of the oral cavity in the patients with hemiplegia.
- food rests sometimes accumulate at the oral cavity level following the tongue mobility diminishing or sensitivity affection at the oral level. The nurse can help the tongue to move by a slightly touch with a lingual spatula upon different parts of the oral cavity to which should then direct his/her tongue.
- reducing the salivary secretion which is for many times caused by some drugs administration can be diminished by different flavors and by an esthetic presentation of the food to be used. At the other side when the salivary secretion needs to be diminished, the nurse may train the patient to control himself/herself such a hyper secretion by swallowing it periodically.
- concentration and effort is necessary for the deglutition to be performed and to oppose the fear associated to dysphagia. A calm environment (without a radio, a large number of persons) is important for the dysphagic patient.
- the nurse should evaluate neurological status of the patient to make sure that he/she is able for deglutition and the former also presents a minimum level of understanding for a correct answer to the latter's requirement. On the contrary, the patient might forget the presence of the food at the level of the oral cavity and, to swallow as a consequence.
- the nurse establishes the presence of the vomiting and coughing reflexes before any oral cavity administration (food, liquids, drugs) in order to prevent an aspiration at the level of the trachea or an aspiration pneumonia, accidents appearing in the cases of those reflexes diminishing o r total absence. In accident aspiration cases, the nurse must be prepared by having ready all the materials to help by achieving an efficient aspiration having as an aim to set the airways free. Orally feeding for a patient not presenting an adequate state of vigilance is not recommended to start. Oral cavity hygiene should precede and follow each meal. After feeding the patient, food rests from the oral cavity level should be cleaned away to prevent infection at that level and maintain an adequate salivary secretion. After having his/her meal, a patient should remain in a sitting position for 15-30 minutes to prevent a tracheal aspiration by a gastro-esophagian reflux. In the case of the patients having a total dental protheses, the nurse makes sure that the patient uses it during his/her meals and adjust it for the best comfort. That late activity needs a special attention as, while the upper part of the protheses was fixed, the patient cannot touch directly the oral palate by his/her tongue and, as the consequence he/she cannot establish food position at the oral cavity level.
- it is peremptorily necessary that the nurse should know and practice, if needed, Heimlich maneuver.

Evaluating and caring a patient presenting dysphagia is based on and is the result of interdisciplinary. Dysphagia is a symptom found in a relatively large number of professionals in the field: family doctors, oto-rhino-laringologists, pneumophtiziologysts, ergotherapeuts, physio-therapist, gastroenterologists, neurologists, nurses, nutritionists, etc.

Own vision of any discipline we mentioned above allows the patient global evaluation enriching, precising the risk of aspiration and working out a complete and personal intervention plan based on the patient wishes and capacities and also on the available resources. The main part of the nurse consists of the direct caring given to the dysphagic patient according to the personal therapeutic plan and the evaluation of the intervention result along an average or long period of time based on *caring*, permanently.

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