

The Rehab Professional's Role in Dining for Persons with Dementia

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There have been many advances that have brought about an increased understanding of the etiologies and contributing factors of Alzheimer's disease and related dementias. There also has been a great deal of information surfacing on the best ways to provide care and interventions for those with dementia. Considering the fact that this disease ultimately causes impairments in ADLs, mobility, balance and safety, rehab professionals are the most qualified to provide interventions with these individuals in these areas of deficit. Surprisingly, many therapists lack formal training and have limited experience in working with individuals with dementia and Alzheimer's disease and, therefore; shy away from treating these people. Many therapists have a certain level of anxiety in working with dementia patients as these individuals don't respond to the "normal" therapy interventions and the therapists just don't know how to make a difference. Added to this, are the frequent reimbursement denials that rehab providers have historically received when treating dementia patients. In short, this patient population has been significantly underserved by rehab professionals. Recent advances in the understanding of dementia, increases in available education for rehab professionals in regard to dementia care, and reimbursement policy changes have all contributed to positive attitudinal changes within rehab communities regarding the importance of rehab involvement with dementia patients and dementia units.

The dining experience is one of many areas where rehab professionals can have a positive impact. Rehab expertise can span the range from suggestions for environmental

changes and adaptations to resident-specific interventions. Each rehab discipline has a unique perspective on the dining experience and should be an active part of the dementia care team.

Physical therapists (PT) should focus on positioning during the meal. It is optimal to have all residents sit in regular dining chairs. These chairs should have arm rests to provide trunk stability during meal time and support when going from sit to stand. In order to allow safe swallowing, the patient optimally should be sitting at 90° of hip and knee flexion with the back as straight as possible. A regular dining chair with arm rests is the best way to provide this posturing as well as contributing to increased dignity and confidence. Sitting in a dining chair involves transferring from the wheelchair so the PT may find it necessary to provide intervention for optimal, safe transfers and balance if there is a deficit noted. The training not only focuses on the resident, but also on the caregivers so they are aware of the most effective ways to provide transfer assistance and cueing. If someone needs to remain in a wheelchair during meals, the PT may want to provide some individualized external positioning support to maintain the most efficient posturing. All resident wheelchairs should have a solid seat insert to support upright posturing. The height of the wheelchair seat and the cushion should allow their feet to reach the floor for independent mobility until they are no longer able to self-propel. It is important to ensure that all caregivers know how to properly use positioning devices and properly position the residents for optimal eating. As the disease progresses, many patients are left in reclining wheelchairs or Geri chairs during meals and eat in unsafe positions. Regardless of the physical state of the resident, they should be placed in the most erect posturing possible. This may require a good deal of creative positioning and

training for the caregiver, but it is our responsibility to provide for a safe eating environment. The PT should make observations at different meal times to assess if the resident's needs change at different times of the day and make the necessary adjustments. An example of a goal for this intervention can be as such: *Resident will demonstrate appropriate wheelchair positioning for eating 4/4 observations over a period of one week.*

The occupational therapists (OT) primary role is to focus on the feeding ability of the resident. Feeding deficits may be present at various levels, such as: decline due to cognitive deficits, decline due to functional limitations and/or decline due to medical conditions. Residents should be grouped by similar feeding ability in small pods in the dining room instead of at long tables. Examples of some possible groupings are: independent eaters, those requiring only verbal cues for sequencing, those requiring minimal assistance with utensils only, those requiring significant assistance but can still participate to some degree, those who can self feed with finger foods and dependent eaters. OTs should also evaluate each resident for appropriate adaptive feeding tools and provide adequate training and follow-up for staff. Training for the caregiver is a big part of the OTs intervention. Training should include, but is not limited to, the following. The caregiver should *sit* to the side of the resident as the resident can easily feel rushed when the caregiver is standing beside them. All caregivers need to be encouraged to be patient and flexible as rushing these residents can bring about adverse behaviors. Due to visual deficits which OTs are very familiar with, the OT should provide training in such things as providing color contrast between the table and plate and the plate and the food, reducing visual clutter on the table, etc. OTs can provide training on sequencing skills

for the resident, if appropriate, and the staff. If the resident gets easily confused or overwhelmed, OTs can teach the caregivers to limit food choices and only place one type of food on the plate at a time. When appropriate, the OT can recommend bite-sized portions for a resident and possibly finger foods for ease in feeding. If the goal is for residents to be as independent in feeding as possible, eating finger foods independently is more functional than being dependent with utensils. Something else that can adversely affect the residents at all times but especially at meal times are environmental distractions. OTs can educate staff on how distractions such as background noises, certain types of music, busy patterns and clutter on the tables can affect the resident's cognitive ability to focus on eating and they can offer suggestions on how to make the environment more conducive to eating. There are many other areas where OTs can have a positive impact, but the last reviewed at this time is to help increase staff awareness in allowing the resident to choose their menu items, as ability allows. There is cognitive decline with dementia residents, but they still may have the ability to choose their favorite foods. As caregivers, we need to afford residents the dignity of choice in all of the areas where they still have the ability to make conscious safe choices. When the resident no longer can choose, family can offer suggestions as to the resident's favorite food so staff can make appropriate selections. The resident is more likely to participate in the eating process if the food is appealing to them.

As with PTs and OTs, the speech therapist's (ST) role is one of both direct resident intervention and staff training. The ST should regularly inquire with all staff as to any episodes of choking while eating or taking medications and provide proper screens for safe swallowing. Training should be provided for the staff on appropriate approaches

to eat that encourages safe swallowing and optimal food intake. The ST can provide recommendations on safe textures and consistencies of food for each resident. Staff training should include stimulation techniques; such as the use of lemon glycerin swabs or lemon ice to stimulate the chewing and swallowing mechanisms. Textured foods, such as toast, also encourage chewing and swallowing. Due to the ST's knowledge of cognitive rehab, the ST can assess an individual's language and speech abilities and provide training as to the proper means of communicating and applying appropriate cueing techniques to optimize communication for each individual. As the disease progresses, often times residents have an increase in inappropriate communication, comments and poor table manners. The ST can provide interventions and suggestions on dealing with this from the perspective of the resident, the staff and other residents who might be present.

One of the mantras of rehab is that we provide services for patients that optimize their highest functional level in order to encourage the highest quality of living. This should be the same whether it is for an orthopedic patient, a resident who has suffered a stroke or those individuals with Alzheimer's disease and related dementias. In order to do this, rehab staff should focus on and emphasize what the individual CAN do, not what they can't do – to encourage what skills they STILL have and not what they have lost. Therapists are experts at identifying functional problem areas and developing a plan of care to correct the problems and return a patient to the prior level of functioning. With the dementia resident, the therapist's skill has to go one step further. The areas of deficit are identified and a plan of care is put in place to minimize the deficit, BUT then the therapist needs to identify what skills are intact. A plan of care needs to be developed to

use these skills as well as any compensatory techniques and adaptive equipment for the resident so the resident can function at the highest level possible. Staff training on all of these areas completes the circle. Rehab staff need to be a very visible and viable part of the dementia care team providing quarterly screenings, resident interventions and, probably most significantly – individual-centered training for the staff and caregivers.

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