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Practice

EXPLORING MEMBERS' PRACTICE ISSUES

Practice is a quarterly update service from Dietitians of Canada. *Practice* includes information on scientific and clinical developments and Canadian dietitians' experiences and challenges in practice. Opinions expressed in articles are those of the authors and do not imply policy of the Association unless so stated. Articles are not peer-reviewed.

Submissions – Submissions are welcome from Dietitians of Canada members. Guidelines for writing reflective articles are available from the Coordinator. Submission deadlines are December 22, 2002 and March 22, 2003.

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Please forward submissions, suggestions and comments to the Coordinator:

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The 'Glass Half Full' Approach to Diet Counselling

Solution-focused therapy is a brief therapy model emerging in the literature and in practice. Although the work of counsellors is distinct from the work of dietitians who use counselling in the course of their work, there are some skills and techniques that can be adapted to enhance dietetic practice. Solution-focused interviewing focuses on solutions, strengths, competencies and possibilities, and is based on the belief that clients have the skills and expertise to meet their own problems (DeJong, 2002). I call solution-focused interviewing the 'glass half full approach' to counselling – looking for what is working and building on it. This article highlights possibilities for integrating solution-focused interviewing into nutrition counselling.

- *How can I help you today? When you leave this office how will you know that this session will have been useful to you?* This is the beginning of a dialogue that helps clients clarify what they want. We assume clients are the competent experts in their own lives and accept their perceptions about what they want.
- *I am curious to know if you have made any changes to your diet or lifestyle since booking this appointment?* In solution-focused interviewing, this question can begin to uncover clients' strengths and resources. If positive changes have already started, it is helpful to explore and acknowledge the positive health benefits that clients have already accrued by making those changes.
- *What will be different for you when your cholesterol/weight/diabetes is under control? How will you know?* Work with clients to elicit descriptions of what will be different in their lives when problems are solved. Clarify goals and outcomes with clients in clear, specific, positive, realistic behaviours.

- Listen respectfully when clients talk about what isn't working and why, but do not explore further. Instead, wait for an opportunity to ask another solution-focused question. *I am curious to know more about how you managed to choose low cholesterol foods at that family picnic? How could you do it again?* Finding 'exceptions' to when clients are focused on problems is an important part of the solution building approach. No one participates in problem behaviours all the time (Dolan, 1997). *I am curious about how you manage to make such good choices when you eat out for lunch?* Even if clients only managed to make one positive healthy choice, focus on that. *How did you manage to make that choice? How did you know? How could you do it again?*

Solution-focused interviewing assumes that clients are the experts in their own lives. It is therefore not appropriate to confront or minimize a client's worldview, which can be challenging if it

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The 'Glass Half Full' Approach to Diet Counselling

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conflicts with the dietitian's knowledge base, training and values. If a client chooses to do something that does not have much evidence to support it, ignore it (for example, the use of certain herbs or vitamin supplements). If a client is doing something that you know is documented to be harmful, then look for the positive, while giving information and offering an alternative. *I think it is great that you have been looking at all the different ways to get your cholesterol down. You might be interested to know that the latest research shows that taking antioxidant supplements along with your statins has been shown to decrease the effectiveness of your medication. If you like I can give you a list of foods that are high in antioxidants and we can take a closer look at ways to include more of those foods in your diet.*

Ask clients about what they believe their lives will look like when they have achieved their goals and are successful. Gather details about how their lives will be different when their weight and lipid levels are normal. There may be an appropriate opportunity for the dietitian to ask the miracle question: *If while you were sleeping tonight a miracle happened and you did not have this problem any more, how would you know things were different as soon as you woke up? What would you notice? How would you feel? What would others notice?*

After assessing a client's diet and thoroughly exploring his/her strengths and goals, there may be an opportunity to teach. *Would it be useful to you if we now spent some time discussing the basics of a healthy diet/how diet affects lipid levels/how skipping meals contributes to weight gain/drug/nutrient interactions etc.?*

Scaling can be a useful solution-focused skill where clients assess their own current motivation or confidence to make changes towards their goal. *On a scale of 1 - 10, one being the least motivated, couldn't care less and 10 being highly motivated,*

can you tell me where you would place yourself in terms of your motivation to eat a higher fibre, lower fat diet as we have discussed? What would it take to move up half point on that scale?

Another key component of the solution-building approach is to take a pause about ten minutes before the end of the session. Say that you need a few moments to review your notes and ask clients to think about the next step. Take time to review their strengths, resources and goals. After a minute or two, return to the session with a compliment: *I want you to know that I am very impressed with how clear you are about wanting to take care of your health and coming to this appointment when you have so much stress going on in your life right now.* Summarize strengths and how those strengths relate back to their goals. Ask clients what they think they need to do next. Determine a task or homework assignment that would help clients reinforce their learning.

When clients return for follow up sessions, start by assuming that things are better. *What is better since last time we met?* The solution-focused practitioner focuses on what is better and amplifies it. Compliment and reinforce your client's ability to make positive changes. *What else is better?* Continue to assume positive changes and probe. If clients insist that nothing is better or they have developed a new goal, go back to reformulating goals.

The solution-focused interviewing model is a strengths-based, collaborative approach to supporting clients based on the assumption that the best way to facilitate change is to focus on what is working. I believe the model also offers benefits for dietitians. Focusing on others' strengths and resources supports an optimistic 'glass half full' approach to life that we know has a positive impact on our own health (Seligman, 1995).

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DeJong P, Kim Berg I, (2002). *Interviewing for solutions*. Pacific Grove, CA: Brooks/Cole.

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See www.springwellnutrition.com for upcoming events including those on solution-focused interviewing.

Let's hear from you!

If you have thoughts on this or any other article appearing in *Practice*, i.e., how writers' ideas have stimulated your thinking about your own practice, please consider "joining in the conversation" and sending an e-mail of your ideas (to the writer or to me). These can be included in a future issue of *Practice* as we did with the responses we received stemming from Gerry Kasten's article, "Remembering Food", and in response to Nonnie Polderman's article, "Tools not Rules". I look forward to getting your messages and incorporating your experiences and thoughts about dietetic practice in a future issue.

If you have an idea for an article for *Practice*, remember that writing guidelines are available from kikimorley@shaw.ca.

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Deconstructing the Placebo Effect and Finding the Meaning Response

Reading the following abstract lead me to pause and reflect on my professional practice.

Moerman DE, Jonas WB. (2002). Deconstructing the placebo effect and finding the meaning response. *Annals of Internal Medicine*, March 19; 136(6):471-6.

We provide a new perspective with which to understand what for a half century has been known as the “placebo effect.” We argue that, as currently used, the concept includes much that has nothing to do with placebos, confusing the most interesting and important aspects of the phenomenon. We propose a new way to understand those aspects of medical care, plus a broad range of additional human experiences, by focusing on the idea of “meaning,” to which people, when they are sick, often respond. We review several of the many areas in medicine in which meaning affects illness or healing and introduce the idea of the “meaning response.” We suggest

that use of this formulation, rather than the fixation on inert placebos, will probably lead to far greater insight into how treatment works and perhaps to real improvements in human well-being.

I have long held the notion that if I have had any positive impact on the folks for whom I provided nutritional counseling, it had as much to do with a human connection, empathy and caring as with my knowledge, experience or skills. Over the past three years, as I have undertaken advanced professional training in the communication technology of “coaching” and been immersed in the world of integrative medicine, I have become convinced that as health care practitioners it is our responsibility to understand the power of relationship and the therapeutic encounter. As a health care consumer, I have personally experienced the detrimental effects when this power is unacknowledged. As a health care practitioner, I have felt rather than seen the mutually

beneficial effects of positive human interaction. I see that as a group of nutrition professionals, a shift is needed. What if the “placebo effect” as we have understood it is actually the value or meaning ascribed by our clients to the depth of the interaction, not the content of the information? What if “who we are” as dietitians is as important as “what we know”? How can we, as a professional group, begin this shift? Perhaps it starts with answering the questions, *Who are you? How does who and what you are influence your interactions with clients?*

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Breastfeeding and Allergy: Contemplating the Connection

Many of you may have heard about the recent study by Sears et al. associating breastfeeding with an increased risk of allergic conditions (asthma and respiratory allergies) later in life. The newspapers had a heyday with this article, touting that breastfeeding seems to “increase the risk of allergies.” The study followed over 1,000 subjects for over 20 years, so in some regards it might seem like a powerful study. This is an opportune time to point out the necessity of learning the details of the study design, inclusion criteria for different subject groups, etc. Some of the flaws in the study included:

- most of the “exclusively” breast-fed infants were given infant formula in the first three to four

days of life (a very susceptible period for setting up an allergic “career”)

- “breastfeeding” was defined as breastfeeding for as little as four weeks, which is not a widely accepted definition of breastfeeding in lactation research.

The study was published in the *Lancet* and the *British Medical Journal*.

References:

Sears M, Greene J, Willan A, Taylor D, Flannery E, Cowan J, Herbison G, Poulton R. (2002). Long-term relation between breastfeeding and development of atopy and asthma in children and young adults: a longitudinal study. *Lancet*, September 21; 360(9337):901.

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Be sure to read the rapid responses to this article on the BMJ Web site.

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Community Nutrition Graduate Student's Nutrition Screening Project Experiences

ARAMARK at the Toronto Rehabilitation Institute (Toronto Rehab) sought a community nutrition graduate student for a summer project. The goal was to help bridge the gap between the hospital and community settings. The project was aligned to the Geriatric Rehabilitation Program and resulted in the development of a nutrition screening tool.

Other health care professionals can use the tool to screen individuals over age 60 for nutritional risk. Individuals identified as being at nutritional risk can be referred to a dietitian for nutrition assessment, nutrition intervention or linked to appropriate nutrition and/or other support services.

While the tool was developed at the Geriatric Rehabilitation Program, its potential use encompassed the Regional Geriatric Program Outreach Team, Geriatric Day Hospital and patients discharged from the inpatient geriatric rehabilitation service. The dietitian has had involvement in the Geriatric Day Hospital by referral only and no involvement with outreach or discharged patients.

The Nutrition Screening Tool was developed and administered to 13 participants; the dietitian's clinical judgement was used to confirm the effectiveness of the screening tool. Scores for each patient were compared with the dietitian's risk assessment (high, moderate or low). While the screening tool correctly identified all high-risk individuals as being at high risk, it was not as successful in correctly identifying low and moderate risk individuals.

The screening tool developed at Toronto Rehab has not undergone rigorous validation or reliability testing, nor was it possible to conduct statistical analysis because of small numbers. Four points for further exploration are:

- Cognition and memory problems affect data collection. Presence of caregivers or family members might help with information recall.

- Simplicity of questions is important in light of the above point. Careful wording of questions may improve reliability of responses.
- The elderly involved in this project did not seem to be preoccupied with weight. Small changes went unnoticed but larger weight loss was remembered. Annual weight checks might provide a better point of reference for nutrition risk screening.
- Food intake is difficult to quantify (especially fruits and vegetables). Will aging 'baby boomers' have a better sense of serving size and food intake?

For a community nutrition graduate student still striving to meet competencies, this placement at Toronto Rehab proved to be a worthwhile and unique experience. Several reasons that made this project memorable were:

- The chance to liaise with other health care professionals and increase awareness of nutrition screening, nutrition services and RDs' scope of practice. It provided opportunities to discuss future possible dietitian involvement in areas where currently there are none.
- Researching and developing the nutrition screening tool allowed for identification and better understanding of other screening tools, and their strengths and weaknesses. Administering the tool personally created an awareness of how participants reacted to questions, and which were easy or difficult to answer. That, in turn, brought to the forefront the concept of practice-based research, and the importance of our everyday observations, especially in making suggestions about wording individual questions.
- Working with elderly patients proved very rewarding. One interview in particular provided something for me to think about. A woman in her 80s spoke of her view that young people thought

of seniors as second rate. She described having to stand on the streetcar and being cut in front of in the bank line. She then apologized for making me feel sad. She didn't have to. Her words made me more aware of and sensitive to issues affecting the elderly and it made me more conscious of not only my actions, but also my thoughts.

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Kids in the Kitchen: How to Start a Kids' Cooking Club

The tripling of obesity rates in Canadian children in the last 20 years is a disturbing trend. Many dietitians can feel overwhelmed and struggle with answers to this epidemic. While we know there are no easy solutions, we do know good nutrition is essential. The idea of teaching kids about basic foods, healthy eating and food safety has been around for a long time, as have programs or 'cooking clubs' that promote these concepts. The *Kids in the Kitchen* project grew out of two kids' cooking clubs in Winnipeg and the desire of a handful of community nutritionists to make this activity available in as many community settings as possible.

This project was a collaboration between the Winnipeg Regional Health Authority, Manitoba Milk Producers, First Nations and Inuit Health Branch (Health Canada), Youville Clinic Inc. and The Heart and Stroke Foundation of Manitoba.

The end result is an interactive nutrition program for children ages six to 11, complete with a community action kit including a 'how-to' manual and (almost) everything needed to

start a Kids' Cooking Club. The kit consists of:

- *Kids in the Kitchen* manual, with 21 lesson plans including recipes and nutrition activities for groups of 12 children or less, sample forms and letters for funders, parents and community partners
- aprons, measuring spoons and cups
- most of the teaching resources required for the nutrition activities.

Any community group or organization wishing to teach kids about healthy eating and food safety can use this kit without training. So far, family resource centres, Brownie groups, schools, Boys and Girls Clubs, First Nation organizations and community clubs have obtained kits. Copies can be downloaded from the Winnipeg Regional Health Authority Web site at www.wrha.mb.ca/fhcs/commcare/index.htm or the Youville Clinic Web site at www.youville.ca/english/news.html. A limited number of kits are available within Manitoba.

This project was an opportunity to pool scarce financial and human resources to create a unique tool that can be used by communities

to promote healthy eating. There were several roadblocks to overcome along the way, including:

- creating a financial partnership between five organizations.
- creating an 'ad hoc' distribution system to get kits out to communities. As none of the partners routinely has resources for sale, we had to devise a system that could work for everyone.
- manufacturing multiples of resources that were not available commercially. For instance, we needed to have 300 cloth food guide templates sewn!

Despite these challenges, the partnerships were very successful and we are excitedly exploring future collaborative projects!

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Tell Us of Your Experiences Pursuing Graduate Studies

Not everyone lives near a university that offers a graduate program that suits their interests and availability, nor are all dietitians who want to pursue graduate studies able to stop working for the duration of their studies. Perhaps you have had to travel to complete courses or to be away from home for extended periods to gather data while completing your graduate degree? Perhaps you were able to do distance courses or a program using the Internet? Perhaps you have had to take a different job with hours that fit around class times? Whatever your experience, others who are trying to sort through how they can do a degree without pulling up roots and

moving will be interested in your experiences. If you have completed an advanced degree (or have made arrangements to begin or are on the road to degree completion) despite logistical challenges, please share your story. These will be compiled for publication in a future issue of *Practice*.

Another aspect of deciding on a graduate program is determining whether you wish to advance your knowledge and skills in an area of practice you intend to continue working in, or to use the graduate studies opportunity to open up possibilities in other areas of dietetics or in some other field altogether. Your story of what you decided

to pursue, how you came to your decision, your reflections on the decisions you made and the process of completing the degree requirements would likewise be of interest. Your story may provide inspiration to someone else or offer insight into situations other readers of *Practice* have been trying to sort through, while providing you with an opportunity to feel pride in what you have managed to accomplish! Send your stories and advice to kikimorley@shaw.ca.

Thank you.

Catherine Morley, PhD, RDN, FDC
Coordinator, Practice

Dysphagia Protocol: Our Journey at Holy Family Hospital

The Interdisciplinary Dysphagia Committee recently completed an evaluation of the Dysphagia Protocol. Our protocol formalizes the roles of several core disciplines in the early identification of swallowing problems and in providing a comprehensive management program for patients with dysphagia. The protocol begins with a swallow screening conducted by Nursing Services before linking the interventions of the speech language pathologist (S-LP), registered dietitian nutritionist (RDN), occupational therapist (OT), physiotherapist (PT) and registered nurse (RN) in developing and discussing the dysphagia management plan with the patient and caregiver(s). The program is individualized and includes team plans for supporting patients and families who make dietary choices contrary to the team's recommendations.

The implementation phase included staff education that we hoped to make interactive and fun. We conducted a number of "lunch and learn" sessions with general information on dysphagia and a mock run-through of the protocol. The run-through was videotaped for use with orientation to new staff. Each discipline organized hands-on "Show and Tell" activities for staff to become familiar with discipline-specific equipment and procedures. I displayed different textures of foods from pureed to regular, foods that tend to be problematic for patients with dysphagia, and thickened fluids of various consistencies. We also showed a modified barium swallow (MBS) video. Each committee member provided inservice on the entire protocol to his/her respective discipline. We designed a Dysphagia Awareness quiz for staff to increase knowledge, and sent information packages to physicians.

As we reviewed the protocol, five highlights were:

3-ounce water test (DePippo et al) – a 3-ounce water test is given when dysphagia is not identified

from the swallow screening questions conducted by nursing. Patients drink water from a cup uninterrupted unless coughing occurs. The nurse checks for a wet gurgly voice or coughing during or within one minute after completion. A referral to RDN and S-LP is made if needed.

The hard-back chair – When a patient with dysphagia can safely transfer, s/he is provided a hard-back chair to sit in for meals (most of our patients are in wheelchairs). This allows for a better posture for swallowing.

Interdisciplinary dysphagia management plan – This individualized form has input from all core disciplines on eating/feeding recommendations for the patient. This plan serves as a summary for patient/caregiver and for facilities receiving the patient upon discharge.

Patient/family counselling related to alternative dietary choice – A decision tree was designed to guide therapists when patients choose diets contrary to recommendations. Aspiration risks are discussed by S-LP/RDN/physician and documented.

Patient survey – This survey is conducted by the S-LP at three months post-discharge to determine patients' understanding of their dysphagia care.

One-Year Evaluation

Results of the one year post-implementation evaluation are as follows:

- Nursing refers patients with dysphagia earlier to S-LP and RDN. The number of referrals has increased significantly since implementation (19 referrals made to S-LP on day of admission in six months preceding implementation compared to 83 referrals made on admission during the 12 months post-implementation).
- Forms have to be more user-friendly and less time-consuming to complete. The protocol should

be highlighted during new staff orientation. Constant re-education is needed to maintain compliance with the protocol, particularly with respect to timely documentation.

- Although we did not identify any specific cases of diagnosed aspiration pneumonia, we had a few difficult-to-manage cases where the protocol did not work well. The committee problem-solved effectively. In particular, a revision of the protocol for patient/family counselling related to alternative dietary choice is required to address issues related to patients whose level of cognition and understanding of aspiration risks are questionable. Discussion with physicians is required.
- The patient survey will be conducted during the patient's stay rather than three months post-discharge and be individualized for patients with cognition impairments.

We are planning to have physicians play a bigger role and to include pharmacy in the protocol.

The protocol has guided me with the development of dietary interventions for difficult cases without clear solutions and it has also given me a clearer understanding of each discipline's role. The protocol has increased staff awareness of dysphagia and has provided all of us with the tools to better manage dysphagia and thus to nourish our patients more appropriately.

Reference:

DePippo K, Holas M, Micahel J, Reding M. (1992). Validation of the 3-oz water swallow test for aspiration following stroke. *Archives of Neurology*, 49 (Dec), 1259-1261.

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A Self-Directed Learning Program for Diet Technician Training

Nutritional care plans are effective only when patients consume their meals and snacks. Many patients would greatly benefit from regular visits from diet technicians with expertise in obtaining patient food preferences. The literature provides support for expansion of the diet technician's role in health care (see references). Because dietitians are accountable for the nutritional care diet technicians provide, the dietitians employed by ARAMARK Canada Ltd. at the Toronto Rehabilitation Institute (Toronto Rehab) developed a *Self-Directed Learning Program for Diet Technician Training*. The program consists of three interrelated training modules prepared in PowerPoint, enhanced with graphics, written exercises and answer keys that the preceptor can hide and later reveal. The training modules are "generic" in that they can be adapted for use in any health care setting from acute to long-term care facilities. Descriptions of the training modules follow:

Nutrition Staff Performing Patient Visitation

This introductory module is geared to all nutrition staff and includes 18 written exercises (in scenario format) coupled with informative answer keys.

Learning Objectives:

- To be able to describe what "patient confidentiality" means.
- To understand how to obtain patient food preferences.
- To practice the steps in responding to food service complaints and issues.
- To understand when to inform a dietitian.

Purpose: All nutrition staff who interact with patients should have basic patient visitation training.

Diet Technicians Performing Nutritional Intervention

The second module provides an in-depth learning experience and includes ten multi-faceted questions

with corresponding answer keys intended to challenge diet technicians and augment their learning experiences.

Learning Objectives:

- To be able to implement the guidelines for diet technicians performing nutritional interventions.
- To be able to discern when you must confer with a dietitian before taking action, i.e., understanding your limits.
- To know how to maximize your potential contribution to direct patient care.

Purpose: Diet technicians can greatly support dietitians in patient care delivery if they have adequate training. Detailed guidelines for various nutritional interventions were developed encompassing food sent on trays; snacks between meals; weight trends; fluid balance, and monitoring biochemistry.

Diet Technicians Documenting in the Patient Health Record

The final module introduces new content while tying together previously learned material. It includes ten questions with corresponding answer keys to provide practice documenting nutritional interventions in the Patient Health Record.

Learning Objectives:

- To understand the policies and procedures for documenting in the patient health record.
- To know when to document nutritional interventions in the patient health record.
- To be able to write informative and concise notes in the patient health record.
- To be able to implement the guidelines for diet technicians completing nutrition screens.

Purpose: Because diet technicians must document the care they provide in the patient health record, it is important they receive appropriate training to know what, where, when and how to document. This module

is at an advanced level, providing background for performing nutritional screens.

A User's Guide was developed to accompany this training program, detailing:

1. Roles and responsibilities of preceptors and learners.
2. Tips for maximizing diet technicians' learning experiences.
3. Resources specific to your facility that should be accessible to diet technicians.
4. Obtaining formal approval for diet technician documentation in the patient health record.
5. Technical information, e.g. how to hide and unhide the answer keys and how to use the hyper-linked table of contents to quickly jump to another section.
6. Closing ideas for future development of the diet technician's role at your facility.

This is a comprehensive training program, consisting of over 200 slides/pages. The development of this program required many weeks of dietitian time over a two-year period from conception to completion. The program content would be equivalent to two or three workshop days for each diet technician. The *Self-Directed Learning Program for Diet Technician Training* is available for purchase on diskette or CD-ROM. See www.torontorehab.com/education for further details or enter the Member To Member discussion area and explore resources at www.dietitians.ca.

References available from the writers.

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Clearing Occluded Feeding Tubes: Moving From Ginger Ale to Enzymes (or taking the “Cotazyme Challenge”)

I was surprised when I read in a critical care procedure manual (Lynn-McHale and Carlson, 2001) recently purchased for our Intensive Care Unit that carbonated beverages (ginger ale or cola) were recommended to unclog feeding tubes. I had thought that this practice had been eradicated! Clearly, this was not the case! This realization, supported by conversations with colleagues about current practices to unclog feeding tubes, prompted me to want to share my experience working on a small project to devise a standard method in our facility to clear occluded tubes.

I previously worked on a surgical unit with a large number of enterally fed patients. During that time I became frustrated with the number of requests for ginger ale and cranberry juice to unclog feeding tubes, with little success.

The literature clearly showed the most effective method for clearing clogged tubes was the use of pancreatic enzymes, e.g. Cotazyme™, Viokase™. I discussed this with the surgical nurse clinician who asked me to develop a policy reflecting best practice.

With the enlisted expertise of one of our pharmacists, we took on the “Cotazyme Challenge”. Our goal was to ensure the pancreatic enzyme method worked in practice before developing a policy. The pancreatic enzyme solution was:

- Mix the contents of one Cotazyme™ capsule with one crushed 325 mg tablet of sodium bicarbonate.
- Add 5 mL warm water to powder mixture.
- Stir well until dissolved.

We initially attempted to clog feeding tubes (Entriflex™; 12 Fr) in vitro, using enteral formula and acetic acid. This was unsuccessful, since all the “occlusions” easily cleared with water flushes. Next, we went to wards in search of occluded

tubes. Brightly coloured notices with headings such as *CALL THE DECLOGGERS* or *SAVE THOSE CLOGGED FEEDING TUBES* were posted in the nursing stations. The notices informed staff about the informal study underway on approaches to clearing clogged feeding tubes, and to request that they contact the pharmacist or me when they encountered occluded tubes. If occlusions occurred at night or on a weekend, and the RN was unable to unclog it with water, the tube was removed and kept refrigerated for our study. The posters and our presence on the wards helped to bring awareness to the problem and “unfreeze” the ingrained practice of trying to clear clogged tubes with sodas and cranberry juice.

Over a five-month period, we were called to unclog five in vivo tubes. None of the tubes could be cleared with water flushes. Our policy was to first attempt to clear the occlusion with 20-30 mL warm water using a back and forth pumping action on the plunger of a 35cc syringe with a Terumo Safeed Connector-100™ tip. The smaller 35cc syringe was essential to exert sufficient pressure. The feeding tube (Entriflex™) manufacturer recommends limiting the size of the syringe to no less than 35cc to prevent excessive pressure that may perforate the tube.

When water flushes failed, we tried the enzyme method. We were successful in unclogging four out of the five tubes using the pancreatic enzyme solution as described above. Two of the tubes were Entriflex™ tubes, one was a percutaneous endoscopic gastrostomy tube (24 Fr!) and one was a percutaneous fluoroscopic gastrostomy tube (8 Fr). In the one failed attempt at declogging an Entriflex™ tube, the tube was found to be occluded with a 2 cm clog of food debris from the patient’s oral intake (i.e., the pancreatic

enzyme solution would not have been able to clear this mass).

With an 80% success rate on the “Cotazyme Challenge”, we proceeded with implementing an “Unclogging Feeding Tube Policy” using the above Cotazyme™ solution. This is very cost-effective, as one Cotazyme™ capsule is \$0.25 and a tablet of sodium bicarbonate costs approximately \$0.02.

Four years later, I am pleased to report that the use of the Cotazyme™ solution to unclog feeding tubes continues to be successfully practiced here at Surrey Memorial Hospital.

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