Eating, Drinking and Dysphagia in Dementia

SALT and Dietetics Departments
St Helier Hospital
Factors Affecting Oral Intake
Dysphagia in Dementia
Nutritional Implications of Dementia
Aims of Nutritional Therapy
Nutritional management of dementia
  - ward level
  - dietetic input
Nutrition and Artificial Feeding
Summary
Further Reading
What impact does dementia have on oral intake?
Early dementia

- Forgetting to eat / do shopping or forgetting that they have eaten
- Failure to recognise spoiled food
- Eating food that is too hot
- Change in food preferences – sweet/spicy/salty
- Unusual food choices
- Gorging particularly sweet food
As dementia progresses

- Holding food in the mouth and **not swallowing**
- Inadequate chewing
- **Don’t recognise** that they are **thirsty or hungry**
- Unable to **communicate** that they are thirsty or hungry
- Unable to help themselves/ feed themselves
- Eating non-foods
- **Increased requirements** as a result of wandering/pacing
- **Poor concentration** causing poor intake
- Wanting meals at odd times of the day or night
- **Decreased sense of taste/smell** with ageing: Food needs to be tasty to encourage eating
- **Depression & Paranoia**: Loss of interest in food or suspicion of food
Advanced dementia

- Not recognising food, utensils, hunger
- Patients refusing to open mouth or turn head away
- Aphasia – cannot ask for food/fluids
- Apraxia – cannot initiate movements to open mouth and chew
- Dysphagia – impaired swallow
What impact does dementia have on swallowing?
CAUSES OF SWALLOWING DIFFICULTIES

Acute Causes
- Oral thrush/oral or dental infection
- Infection e.g. urinary tract infection, chest infection
- Decline in consciousness due to acute illness
- Acute neurological event e.g. stroke
- Medication
- Foreign body in throat
- Reaction to anaesthetic during surgery

Chronic Causes
- Progression of dementia
- Swallowing difficulties following a stroke
- End of life (due to disease progression)
- Depression/ anxiety (loss of appetite, food refusal or abnormal perception of food)
- Throat stricture or tumour
- Progressive neurological condition e.g. Parkinson’s disease, Motor Neurone Disease, Multiple Sclerosis
Signs of chewing/swallowing problems and/or aspiration

- Eating very slowly or long periods chewing food.
- Extra effort or pain on chewing/swallowing.
- Coughing/choking/change of colour during meals.
- Throat clearing when eating/drinking.
- Swallowing several times for a single mouthful of food.
- Sounding ‘chesty’/wheezing/shortness of breath after eating/drinking.
- Repeated chest infections.
- Gurgly voice or drooling or slurred speech.
- Residue – food left in the mouth.
Other factors affecting intake

- Dry, sore, painful mouth
- Loss of sense of smell and taste
- Decreased appetite
- Constipation
- Insisting on eating the same food at every meal
- Extremely slow at eating
- Visual or contrast impairment
- Loss of independence / dignity
- Depression, paranoia, confusion → food refusal
- Side effects of medications
## Medications and Oral Intake

<table>
<thead>
<tr>
<th>Drug</th>
<th>Possible side-effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotics and sedatives</td>
<td>Dry mouth, loss of taste/smell, restless, constipation, disinterest, sleepiness, increased appetite</td>
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<tr>
<td>High blood pressure eg:Captopril</td>
<td>Dry mouth, loss of taste, constipation</td>
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<tr>
<td>L-Dopa (used for Parkinson’s)</td>
<td>Anorexia</td>
</tr>
<tr>
<td>Lithium</td>
<td>Dry mouth, metallic taste, nausea, increased thirst, apathy</td>
</tr>
<tr>
<td>Tricyclic antidepressants</td>
<td>Dry mouth, sedation, restless, constipation, increased appetite</td>
</tr>
<tr>
<td>SSRIs (antidepressants)</td>
<td>Heartburn, constipation or diarrhoea, loss of appetite, drowsiness, restless, nausea</td>
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</tbody>
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Source: Caroline Walker Trust
Nutritional Implications

- Weight loss
- Low BMI
- Wasting
- Impaired immunity
- Poor wound healing
- Pressure sores
- Increased requirements
- Gastroenteritis
- Risk of aspiration → aspiration pneumonia
Management
What are our aims?

- Prevent malnutrition and dehydration
- Ensure swallow safety
- Optimise intake, although it may not be nutritionally adequate
- Promote enjoyment of food
How can we achieve our aims?

- Ward Level
  - Screening and monitoring
  - Environment
  - Person-centred care
  - Nutritional management
Screening and Monitoring

- Food record chart and fluid balance chart
- Documenting and reporting any swallowing difficulties (SALT referral)
- Regular nutrition screening MUST (weekly)
  - Action for at risk patients (MUST = 1)
    - red tray
    - energy dense options (ED)
    - hot puddings
    - nutritious drinks (ie milk)
    - snacks
- Action for malnourished patients (MUST = 2)
  - as above and refer to a dietitian
How can the environment help?

- Protected mealtimes
- Multi-sensory cues signalling time to eat i.e. sitting patient upright and ensuring glasses and dentures are worn
- Minimise distractions i.e. TV, extra objects on the table/tray
- Dedicated assistance – red tray
- Meals should be relaxed and unhurried
- Serving small portions with one course at a time
- Availability of high contrast crockery
- Appropriate cutlery / crockery
- Uncovering food / opening cartons
- Remove from view items that the person may confuse for food
Person-centred care

- Normal eating routine
- Food likes and dislikes – record
- Cultural and religious beliefs
- Special dietary requirements
- Assistance and prompting with eating and drinking? Family?
- Making the most of ‘good’ times of the day/ ‘good’ days
- Serving appropriate textured food/drink – SLT referral?
- If refuse food – remove from sight for 10 minutes and try again
- Only feed when the person is fully awake and alert
- Sit at eye level or slightly below and either immediately in front of or to one side of the person
Tips to increase fluid intake

- Make drinks available frequently throughout the day.
- Transfer drinks from a carton with straw to a cup or glass as a person with dementia may not be able to use a straw.
- Lighter plastic cups may be helpful.
- Put the cup/glass into the person’s hand to prompt them to drink, rather than leaving it on the table.
- Some people may need thickened fluids – as advised by SALT
- Encourage fluid-based foods ie sauces, soups, jellies, custard
Tips to help when feeding

- Making sure food is correct texture and temperature.
- Softer or pureed food, may be easier to chew and swallow. (follow SALT recommendations)
- If not opening their mouth: gently prompt or touch lips with spoon
- Place food or utensils in person’s hand and encourage to self feed or assist with hand-over-hand feeding
- Gently massaging cheek or throat to stimulate swallow reflex.
- Reminding the person to chew and swallow.
- Checking the food is swallowed and the mouth is empty before offering more food.
- Making sure dentures are in and teeth, gums or dentures are not painful.
Special diets

Wide range of diets available from the catering department for different medical conditions

- Healthy Choice
- Energy Dense
- Vegetarian
- Soft
- Texture modified (fork mashable, puree)
- Renal (low potassium and phosphate)
- Low salt
- Milk free
- Gluten and wheat free
- Cultural and religious menus
- Low residue

These options are available on the main menu

- These options require separate menus
Nutritional Management

- Small, frequent meals and snacks
- Energy dense menu options
- Finger foods
- Variety of foods
- Safest consistency options (soft, fork mash, puree)
- Appropriate portion sizes
- Food fortification – butter/preserves/cheese
- Encourage fluids
Energy dense choices

- Beef lasagne (300 kcal / 16g protein)
- Wedges and peas (190 kcal / 7g protein)
- Apple crumble & custard (500 kcal / 4g protein)
- Full cream milk (150 kcal / 8g protein)

Total = **1140 kcal / 35g protein**

Non-energy dense

- Chicken breast (108 kcal / 17g protein)
- Mash and swede (73 kcal / 2g protein)
- Tinned fruit in juice (38 kcal / 0g protein)
- Tea (13 kcal / 0g protein)

Total = **232 kcal / 19g protein**
What else can we do when a patient refuses to eat?
Nutritional Supplements
Artificial nutrition – Enteral Feed

Is artificial nutrition (tube feeding) appropriate in patients with dementia?
Artificial Feeding & Nutrition

- Need to weigh up the risks and benefits – what are we trying to achieve?
- Take into account patients’ previously expressed views/wishes and family’s wishes
- Inconclusive evidence around benefit of enteral tube feeding in dementia patients. No evidence of increased survival, nutritional status or pressure sores (Sampson et al, 2009)

Royal College of Physicians (2009) Mortality rate post PEG placement in patients with advanced dementia:
- 54% at one month
- 90% at one year
Artificial nutrition - guidelines

**ESPEN**
- Early and moderate dementia – ONS and occasionally tube feeding
- Terminal dementia – TF is not recommended

**Royal College Physicians**
- Enteral nutrition as a medical treatment
- MDT approach
- What are we trying to achieve? Medical condition reversible?
- If appropriate, trial of NG feeding with clear objectives. If not met tube feeding can be withdrawn
Take home messages

- Dementia is a progressive disease
- Decreased appetite and changes to nutritional intake are very common
- Patients with dementia will commonly lose weight and become malnourished
- At ward level there are a number of environmental, person-centred and nutritional approaches
Take home messages

- Oral nutrition supplements can be used to supplement intake but emphasis should always be ‘food first’
- Artificial tube feeding is not usually indicated in dementia but must be assessed on an individual basis
Further reading

- Alzheimer’s Society, Food for Thought Leaflets, available at: [www.alzheimers.org.uk](http://www.alzheimers.org.uk)
- Eating Well for Older People with Dementia, Caroline Walker Trust at [www.cwt.org.uk](http://www.cwt.org.uk)
- Enteral Tube Feeding for Older People with Advanced Dementia (2009) Sampson et al. Cochrane Review
- Living Well with Dementia: A National Dementia Strategy