The challenge of nutritional support in hospital wards

Eating and drinking problems among patients with dementia are too often overlooked in hospitals, as dementia care specialist **Joanne Brooke** discovered from personal experience

Dr Joanne Brooke is associate professor in dementia care at the College of Nursing, Midwifery and Healthcare, University of West London

There are well known challenges faced by healthcare professionals when providing nutritional support for patients with dementia in hospital and I want to consider them from two perspectives. The first perspective is a professional one, as I am qualified nurse and specialist in dementia care, and the second is personal, as I cared for my Mum who had Alzheimer's disease and was admitted to a hospital following a fall.

Eating and drinking problems affect over half of people diagnosed with dementia (LeClerc *et al* 2004). In the earlier stages of dementia these can include changes in taste, difficulties in planning, coordination, processing sensory information, development of attention deficits and possibly a lack of recognition of hunger and thirst (Volkert 2014). During the later stages of dementia, problems with swallowing may occur, leaving the person at risk of aspiration pneumonia (Dodds *et al* 1990). An admission to hospital can exacerbate existing eating and drinking problems.

Another reason for poor nutrition in people with dementia may be the result of an imbalance between nutritional intake and physical need; for example restlessness may increase energy use (Knopman 2008). There is also a positive correlation between weight loss and the severity of dementia: the greater the weight loss the more severe the dementia (Albanese *et al* 2013).

National focus on dementia

My Mum was admitted to hospital with a subdural haemorrhage following a fall. This happened in 2010, so it is important to understand that a focus on dementia had only just begun at a national level at this time. Two years earlier the Alzheimer's Society had published an influential report, *Dementia Out of the Shadows* (2008), which aimed to put the issue in the limelight, while the first National Dementia Strategy (Department of Health 2009a) soon followed and was accompanied by a report demonstrating the need to improve the quality of care for people with dementia in hospital (Department of Health 2009b).

Although there have been many developments in dementia practice in the years since, I firmly believe that my Mum's experience is instructive for practitioners even now. Following the subdural haemorrhage and subsequent fits my Mum was too drowsy to drink or eat, so intravenous (IV) fluids were commenced. No long-term plan was discussed with me or my family even though we held lasting power of attorney for health and welfare, which includes decisions regarding medical care and life-sustaining treatment.

On one visit I noticed the IV fluids had been removed. When discussing with a nurse why this had occurred, I was informed that a speech and language therapist had assessed my Mum's swallow and found no physiological problems. Therefore, the decision had been made that she just needed encouragement to drink. At this stage, my mother was only tolerating small sips of water, which were not enough to maintain her hydration. I suggested to the nurse that without IV fluids she might become dehydrated, which would make her drowsier and less able to drink, to which the reply came that my Mum would begin to drink when she became thirsty and that was why the IV fluids had been removed.

However, this was mistaken. People with dementia may not recognise they are hungry or thirsty or that they have just eaten or drunk (Volkert 2014). The theory that allowing a person with dementia to become dehydrated and thirsty encourages them to drink is incorrect.

As for the issue of being hungry in hospital, that was unfortunately not new either. One response was the development and implementation in 2003 of the Malnutrition Universal Screening Tool (Elia 2012) to identify patients who were at risk of malnutrition. It is a simple tool which can be used repeatedly with the same patient. The outcome of the screening can lead to a referral to the speech and language therapy team and the commencement of a food and drink monitoring chart. Some hospitals also link this to a patient receiving their meals on a red tray, so all staff are aware that the patient is at risk of malnutrition.

My Mum received appropriate nutritional screening, assessment and monitoring of her nutritional intake, with a care plan devised to support her needs. But poor understanding of dementia and the inadequate culture of caring for a person with dementia (at that time) prevented the implementation of supportive interventions. I feel strongly that the care my Mum received was marked by 'diagnostic overshadowing,' meaning that professionals could not see beyond her dementia diagnosis in order to treat her subdural haemorrhage or, for that matter, to treat her as a person with her own life history.

The culture of caring for a person with dementia traditionally focuses on the dementia itself and not on the person or their co-morbidities. I do not dispute that my Mum had a diagnosis of dementia, but this was not seen in context. Before her fall she was living in a residential care home with a good quality of life and enjoying visits from her family, her smile and laughter being testimony to this fact. But no one in the hospital asked me or my family about my Mum's condition prior to her fall.

Effective interventions

A number of supportive interventions have been researched in acute hospitals and found to significantly improve the nutritional intake of people with dementia (Brooke & Ojo 2015). These include: ensuring the dining experience occurs in a room that looks like a dining room (Perivolaris et al 2006), the use of coloured

crockery enabling food to be distinguished from the plate (Dunne et al 2004), good lighting to avoid shadows (Brush *et al* 2002), background music (Thomas & Smith 2009), and social dining with a table set for four people so they can interact while eating, changing the mealtime from a purely functional to an enjoyable social event (Timlin & Rysenbry 2010).

This research provides a starting point for evidence-based specialist care for people with dementia in acute hospitals, much of it having been completed and published prior to my mother's admission.

Yet none of these interventions were evident during my frequent visits and it has been recognised that it may take up to 17 years for the translation of research into practice (Morris *et al* 2011).

Slow process of improvement

It is important to emphasise, however, that changes have occurred in hospitals. In 2012 the Dementia Action Alliance (DAA) launched the first phase of the 'Right Care' campaign, where all acute NHS trusts in England were asked to make a public commitment to becoming dementia friendly. Many trusts adapted their elderly and dementia care wards accordingly, which included a focus on supporting nutrition through social dining. Dining areas were created away from patients' beds, tables were laid with cutlery for groups of patients and background music helped to produce a calming atmosphere (King's Fund 2013).

The DAA then launched a second phase of their campaign in 2014 with a 'Dementia Friendly Hospital Charter'. The charter provides high level principles setting out what a dementia friendly hospital should look like, not just in elderly care wards but across the hospital as a whole. It is too early to assess the impact, but the broad remit is vital because good practice should apply in all wards to which a person with dementia may be admitted. For example, my Mum was admitted, via accident and emergency, to a medical assessment unit and then to a stroke ward.

But implementation of interventions and changes to the environment are not enough to alter professionals' understanding of dementia or the culture of dementia care. Following the National Dementia Strategy and the Prime Minister's Challenge (2012; 2015) the need for all health and social care staff to have the right skills to care for people with dementia has been recognised. Dementia awareness training (tier 1) is now mandatory and has been clearly defined in the Dementia Core Skills

> My Mum had a diagnosis of dementia, but this was not seen in context. Before her fall she was living in a care home with a good quality of life

Education and Training Framework (Skills for Health *et al* 2015). Tier 1 training aims to support and develop staff across specialities in understanding dementia and the importance of person-centred care, with an emphasis on the recognition of a person with dementia as a unique individual. All health and social care staff should have completed this training by March 2017.

Now attention has begun to shift to tier 2 training and embedding good practice so that the culture of dementia care continues to be strengthened. Much of this revolves around simulation training so that staff become actively involved and develop practical skills in a real-life setting.

Returning to the care my Mum received, I felt I had failed to support her at a time when she needed me most as she died following a four-month stay in the hospital. I acknowledge that professionals face the problem that they are not aware of a person's level of functioning prior to their admission, but this is where a person-centred approach and listening to family members is crucial.

Care for people with dementia in hospital is changing through research, enhancements to the environment and education of the workforce, but we are not yet in a place to relax. A great deal more still needs to be achieved. ■

References

Albanese E, Taylor C, Siervo M, Stewart R, Prince MJ, Acosta D (2013) Dementia severity and weight loss: A comparison across eight cohorts. The 10/66 study. *Alzheimer's Dementia* 9(6) 649-56.

Alzheimer's Society (2008) *Dementia out of the shadows*. London: Alzheimer's Society.

Brooke JM, Ojo O (2015) Oral and enteral nutrition in dementia: an overview. *British Journal of Nursing* 24(12) 2-6.

Brush JA, Meehan RA, Calkins MP (2002) Using the environment to improve intake for people with dementia. *Alzheimer's Care Quarterly* 3(4) 330-8.

Dementia Action Alliance (2012) *Right Care: creating dementia friendly hospitals*. London: Dementia Action Alliance.

Dementia Action Alliance (2014) *Dementia Friendly Hospital Charter.* London: Dementia Action Alliance.

Department of Health (2009a) *Living well with dementia: A National Dementia Strategy*. London: Department of Health.

Department of Health (2009b) *Improving quality of care for people with dementia in hospitals*. London: Department of Health.

Dodds WJ, Stewart ET, Logemann JA (1990) Physiology and radiology of the normal oral and pharyngeal phases of swallowing. *American Journal of Roentgenology* 154(5) 953-63.

Dunne TE, Neargarder SA, Cipolloni PB, Cronin-Golomb A (2004) Visual contrast enhances food and liquid intake in advanced Alzheimer's disease. *Clinical Nutrition* 23(4) 533-8.

Elia M (2012) *Screening for malnutrition: a multidisciplinary responsibility. Development and use of the 'Malnutrition Universal Screening Tool' ('MUST') for adults*. MAG, a Standing Committee of BAPEN (ISBN 1899467 70 X).

Health Education England (2014) *Dementia Education. Empirical development of curricula standards and criteria to support Dementia*. Leeds: Health Education England.

Kings Fund (2013) *Developing Supportive Design for People with Dementia*. The Kings Fund Enhancing the Healing Environment Programme 2009-2012. London: King's Fund.

Knopman D (2008) Go to the head of the class to avoid vascular dementia and skip diabetes and obesity. *Neurology* 71 (14) 1046-7.

LeClerc CM, Wells DL, Sidani S, Dawson P, Fay J (2004) A feeding abilities assessment for people with dementia. *Alzheimer's Care Quarterly* 5(2) 123-33.

Morris ZS, Wooding S, Grant J (2011) The answer is 17 years, what is the question: understanding time lags in translational research. *Journal of the Royal Society of Medicine* 104(12) 510-520.

Health Education England (2014) *Dementia Education: Empirical development of curriculum standards and criteria to support Dementia Education*. Leeds: Health Education England.

Perivolaris A, LeClerc CM, Wilkinson K, Buchanan S (2006) An enhanced dining program for persons with dementia. *Alzheimer's Care Quarterly* 7(4) 258-67.

Prime Minister's challenge on dementia (2012) *Delivering major improvements in dementia care and research by 2015*. London: Department of Health.

Department of Health (2015) Prime Minister's challenge on dementia 2020. London: Cabinet Office, Prime Minister's Office.

Skills for Health, Skills for Care, Health Education England (2015) *Dementia Core Skills Education and Training Framework*. Bristol/Leeds: Skills for Health, Skills for Care, Health Education England.

Thomas DW, Smith M (2009) The effect of music on caloric consumption among nursing home residents with dementia of the Alzheimer's type. *Activities, adaptation and aging* 33(1) 1-16.

Timlin G, Rysenbry N (2010) *Design for dementia: improving dining and bedroom environments in a care home*. London: Helen Hamlyn Centre, Royal College of Art.

Volkert D (2014) *ESPEN Guidelines on Nutrition in Dementia.* Presentation at the 36th ESPEN Congress 6-9 September, Geneva, Switzerland.