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.

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 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 nutrition and dietetic service, including a nutrition support plan.

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

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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 (Perivolakis et al 2006), the use of coloured...
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
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 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.
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References