Promoting good nutrition in patients with dementia


**Summary**
This article aims to raise awareness of good nutrition, the specific nutritional needs of individuals with dementia and the importance and implementation of protected mealtimes to prevent malnutrition in the hospital setting.

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**Aims and intended learning outcomes**
This article aims to help nurses and other members of the multidisciplinary team to understand the importance of providing a balanced, nutritious diet for patients with dementia in the hospital setting. This information will help nurses to recognise some of the difficulties encountered when attempting to meet the nutritional needs of such patients and encourage staff to challenge practice that does not provide a positive mealtime experience, delivered with dignity and respect. After reading this article you should be able to:

› Outline the contributory factors to poor nutrition in patients with dementia.

Introduction
Malnutrition is a common problem in older individuals in the hospital setting. Six out of ten older people are at risk of becoming malnourished, thereby causing their illness to worsen, while in hospital (Age Concern 2006). Individuals with dementia are among the most vulnerable members of society. It is estimated that 560,000 people in England have dementia and this trend is predicted to rise (National Audit Office 2007). Dementia may result in the individual’s inability to feed him or herself and may alter appetite resulting in potential nutrient deficiencies.

However, although dementia may result in malnutrition, it is important to note that the condition is caused by multiple factors, which may be cognitive, physical, functional and service provision related (Box 1). These factors may include the patient’s inability to communicate his or her dislike of certain foods, a lack of knowledge of the patient’s eating habits, a lack of awareness of the patient’s specific nutritional needs and cultural and religious preferences, and poor presentation of food. The lack of adequate staffing at meal times and inadequate levels of training may also function as barriers to good nutrition. Prentice (1992) highlighted that patients with conditions such as Alzheimer’s disease were not being given enough food to eat in hospital. Research on poor nutrition in the hospital setting concurs with this view (McWhirter and Pennington 1994, ...
Nutritional challenges in dementia care

Eating and drinking are activities that involve complex co-ordination of physical movement and mental activity (Siebens et al 1986). In some cases, where the ageing process merges with progressive neuronal loss such as dementia, memory, perception, reasoning, planning and communication skills may be affected. Other symptoms of dementia include disorientation, loss of independence and disturbed eating behaviour. Research conducted by Joosten et al (1997) highlighted significant weight loss and vitamin deficiency in patients with Alzheimer’s disease. This weight loss can lead to general deterioration in the patient’s health, increased risk of fractures following falls, poor concentration, wandering away at mealtimes and disturbed eating behaviour. Other factors contributing to weight loss in patients with dementia include:

- Lifestyle – if the patient lives alone, he or she may forget to eat or purchase appropriate healthy foods. This may be compounded by diminished cooking skills. The consequences of this, coupled with self-neglect, may necessitate admission to hospital. Frequent monitoring of weight and the introduction of a well-balanced diet may prevent further weight loss. Best practice dictates the use of relevant tools such as the Mini-Nutritional Assessment (Guigoz et al 1996) and the Malnutrition Universal Screening Tool (MUST) (BAPEN 2003). The MUST can be applied to all adult patients in all care settings. It uses a body mass index scale with colour-coded indicators to guide the user in determining whether or not the patient is malnourished.

- Atrophy of the mesial temporal cortex – a deterioration in this aspect of the brain affects eating behaviour, memory and emotions in patients with Alzheimer’s disease. There appears to be a correlation between the atrophied area of the brain and body mass index, body weight and the decrease in cognitive functions (Grundman et al 1996).

- Dysphagia – swallowing difficulties may arise for a number of reasons including poor dental health, stroke, cancer and Parkinson’s disease. Whatever the cause, the patient’s nutritional status may be compromised as a result of reduced nutritional intake. Individuals with dementia may have additional problems other than those associated with the ageing process. Choking incidents are common in psychiatric hospitals, particularly among older patients who have organic brain disease and those prescribed antipsychotic medication (Fioritti et al 1997).


The provision of food during a hospital stay is an essential component of the healing and recovery process (Archibald 2006), and inadequate nutrition may increase the risk of pressure ulcers, fractures and delays in hospital discharge (Crawley 2002). It is essential to consider a robust nutritional and feeding assessment in the light of concerns regarding a patient’s nutritional status to provide optimum care.

Malnutrition in hospitals is a significant problem which has been discussed in the National Service Framework for Older People (Department of Health (DH) 2001a), Essence of Care (DH 2001b) and Clinical Governance Review Framework (Commission for Health Improvement 2001). These documents highlight the importance of ensuring a conducive and enabling environment for patients to eat, nutritional screening and assessment, monitoring the amount of food patients eat and encouraging healthy eating habits.

**Time out 1**

Reflect on the patients in your clinical area and make a note of those you think are malnourished or susceptible to malnutrition. Consider the factors that contribute to this condition and state what steps you would take to establish recovery.

**BOX 1**

**Factors contributing to malnutrition**

- Poor oral health, for example, mouth ulcers and oral thrush.
- Swallowing difficulties.
- Socioeconomic factors such as social isolation, bereavement, poverty and institutionalization.
- Diminished sensory abilities, for example, sight, taste, smell and hearing.
- Physical impairments, for example, as a result of stroke, rheumatoid arthritis and osteoarthritis.
- Cognitive impairments, such as forgetfulness, confusion and depression.
- Digestive problems, for example, as a result of achlorhydria or hypochlorhydria, intestinal surgery and overproduction of bacteria.
- Drugs, for example, antipsychotic medications.
Other difficulties encountered at the oral stage of digestion may include swallowing without chewing, overfilling the mouth, hoarding food in the mouth, prolonged chewing and, at times, drooling saliva. These may occur as a result of agnosia and oral dyspraxia. It is essential to adopt a multidisciplinary approach in the management of dysphagia. Speech and language therapists can play a part in assessment and care planning, dieticians can assess and give advice on appropriate dietary needs and occupational therapists can provide information on cutlery, posture, seating position and appropriate furniture.

To provide a person-centred approach to care during patient hospitalisation, it is essential to ensure that adequate attention is given to the individual needs of the patient including his or her food preferences. This is particularly important following surgery when a patient may demonstrate negative behaviours such as the refusal of food and medication (Volicer and Hurley 1998). For the patient with dementia, and in particular, recovering from surgery, it is essential to adopt a positive approach to care and good practices (Box 2). Examples of best practice include dietary assessment on admission, use of nutritional screening tools, liaison with other multidisciplinary team members such as speech and language therapists, physiotherapists and dieticians.

**The nurse’s role**

Nurses have a key role in the promotion of good nutrition in hospitalised patients. They can provide assistance with eating and drinking, record food and fluid intake, monitor the amount and temperature of the meals provided, offer support and supervision during mealtimes and minimise distractions and noise, thus helping to ensure that the environment is conducive to eating.

To encourage best practice within care provision, the Royal College of Nursing (RCN) (2007) identified three key components:

- Accountability.
- Responsibility.
- Leadership and management.

Nurses should embrace these principles to ensure that the best possible care is provided for older patients, and particularly those with an additional vulnerability such as dementia.

**Case study**

Silvia has an established diagnosis of dementia and is being supported at home by a network of lay and professional carers. Her daughter, Louise, requires family support. Concerns regarding the safety of Silvia have been raised as she is becoming increasingly frail. Louise finds her mother on the lounge floor at 8am on her routine call to give her her breakfast. Silvia is cold, shocked and has obvious pain in her leg and hip. The ambulance is called. She has fractured her femur and is ‘fast-tracked’ on arrival at hospital, using an integrated care pathway designed to meet the immediate needs of a person with a fractured neck of femur. Silvia is withdrawn, drowsy and reluctant to take fluid or food following the operation.

The nurse in charge of Silvia’s care begins to record information from the patient, where possible, and from her daughter. The nutritional assessment takes into account the patient’s favourite foods and drinks. Silvia and her daughter are given comprehensive information regarding the anaesthetic, pain, medication, change of environment and trauma before and after admission.

The care plan is made available to the patient and her daughter. Assessment of Silvia’s post-operative condition acknowledges that she may not demonstrate discomfort, pain, thirst, hunger, bladder or bowel problems in the usual way and skilled interventions ensure that these are identified and managed. Rehabilitation processes acknowledge the patient’s short-term memory loss and skilled discharge planning, built on retained strengths and well-established support networks, ensures that discharge is timely and well supported.

(Adapted from Clibbens and Lewis 2004)
Accountability

This can be achieved by providing an aspect of nutritional care, which may range from direct care delivery to decision making at executive board level. Accountability involves assessing, planning, implementation and evaluation of the patient’s hydration and nutritional needs, in addition to regularly reviewing and monitoring the delivery using audit and clinical governance systems.

Responsibility

Responsibility relates to the provision of person-centred and evidence-based care. Nursing staff should ensure that individual nutritional needs are identified and managed. Some patients may have cultural and religious preferences relating to food, its preparation and in some cases the time of day food or certain foods may or may not be eaten. Special requirements may include vegetarian, kosher or halal meals, and some meats such as pork and beef or shellfish may be forbidden (Mootoo 2005). The National Survey of NHS Staff reported that more than 60% of staff had not received any training in diversity issues, including cultural and religious practices (Healthcare Commission 2007a). However, nursing staff require a good awareness and understanding of individual nutritional needs and food preferences to deliver person-centred care and maintain optimum levels of nutrition, dignity and respect.

It is also important to keep up-to-date with any changes in policy and practice by accessing and using quality information and evidence regarding nutrition and hydration through continuing professional development. Nurses should also challenge poor practice in relation to nutrition and hydration, assess the mealtime environment and ensure it is conducive to good nutritional care.

It is the nurse’s responsibility to evaluate nutrition and hydration care plans and identify necessary changes. They should contribute to the multiprofessional and multiagency working that achieves holistic nutritional care and dedicate time to prioritise the nutritional needs of patients, for example, protected mealtimes. Nurses are required to demonstrate an understanding of the recognised process in each organisation to anticipate, minimise, record and report nutritional risks to patients.

Leadership and management

As part of their leadership role all nurses are responsible for enabling others to provide good nutritional care. Executive nurses should ensure that appropriate systems are in place and that nutritional care is a priority that is supported at board level. Team leaders are responsible for enabling the effective organisation of care so that patients experience care that meets their actual and perceived needs.

**Time out 5**

Examine the food practices of a particular ethnic group. It possible share what you are doing with other members of the ward team and encourage them to examine a different ethnic group. You could use the information gathered to develop a ward resource pack, with the help of the ward dietician, to inform colleagues about special dietary needs of different ethnic groups.

Protected mealtimes

The RCN (2007) Nutrition Now campaign, defines protected mealtimes as periods on a hospital ward when all non-urgent clinical activity stops, patients are able to eat without being interrupted and staff can offer assistance. Research conducted by Mamhidir et al (2007) found that protected mealtimes led to patients gaining weight, increased staff-to-patient contact and a more pleasant atmosphere surrounding the mealtime routine. Weight gain was achieved in patients with moderate and severe dementia by adjusting the mealtime environment to the individual’s need. Education promoted skills and competence, and encouraged staff to adopt a person-centred approach to care (Mamhidir et al 2007).

The National Patient Safety Agency (NPSA) (2007a) states that protected mealtimes have ‘...the potential to improve patient safety by ensuring that patients receive the right meal at the right time with the right amount of help’. Focus group research conducted by Dickinson et al (2006) highlighted the value of protected mealtimes for patients and staff. Educational sessions that used role modelling in practice and staff development were developed following the outcome of the research. Staff identified problems, developed action plans and evaluated the impact of the changes. The action plans were found to have a positive effect on the recovery and rehabilitation of the older people in the study. Enjoying the mealtime experience and the opportunity for socialisation were reported as being particularly beneficial (Dickinson et al 2006).
Implementing protected mealtimes

To improve the delivery and quality of services provided during mealtimes and to take patients’ views into account, it is important to ensure safeguards to patient dignity and to be open and consultative during the process of change. The following points have been adapted from Prodger (2003) and should be considered when implementing protected mealtimes:

- All team members should be involved in ward observations such as the condition of the environment, lighting and noise levels, and other activities that occur during mealtimes. It may be beneficial to assess documentation relating to nutrition, for example, is the menu clear and easy to follow, what other nutritional information is available for patients about diets related to their condition and were drinks in easy reach? This information can then be linked to patient-focused benchmarks. Essence of Care provides ten key factors for food and nutrition with indicators for best practice (DH 2001b). It is important to liaise with patients and solicit individual views on the amount, quality, content and presentation of the meals served.

- Results of ward observations should be discussed with all members of the team. It is important to identify how things would need to change to implement protected mealtimes.

The various roles of staff members during the implementation of protected mealtimes should be outlined. Environmental changes, such as the use of a dining table or playing classical music, should be considered.

- Practicalities such as what will happen with the drugs rounds, staff breaks and any other activities that routinely take place at mealtimes should be discussed. Visiting times may need to be altered.

- Team members should be encouraged to look at the NPSA (2007b) CD-ROM entitled Protected Mealtimes CD-ROM, which provides advice on implementing protected mealtimes on wards and available audit tools. The benefits of protected mealtimes should be emphasised.

- Discussion should take place with other staff in clinical and non-clinical areas, for example, phlebotomy, catering and nearby wards. If other wards are planning to implement protected mealtimes a phased introduction and staggered mealtimes may be required. It is important to discuss potential changes with hotel services, for example, the delivery of laundry to the ward and floor buffing, as changes may affect how these services function.

- Once an agreement has been made to implement protected mealtimes, a decision needs to be made about when to start the new procedure. It is best to avoid starting the new system on a day when the ward is known to be at its busiest.

- It is important to decide what information, for example, signs and leaflets, is going to be made available to patients, visitors, staff and other departments. Proposed plans should be discussed with patients and relatives before the introduction of protected mealtimes.

- It is vital to be realistic as things will not change overnight. Relatives may turn up outside visiting times, ward rounds may run late and emergencies may happen.

- Persistence is the key to success. Protected mealtimes should be reviewed regularly. It is important to continue to work at resolving obstacles and barriers and positive feedback should be provided when the system is working well.

- Audit and observation should be repeated as a means of demonstrating changes and improvements as well as highlighting areas which require further development. Positive results should be shared among all members of the multidisciplinary team.
learning zone nutrition status

Addressing malnutrition: best practice

For patients with dementia, it is important to consider the social significance of mealtimes and the patient’s wellbeing in relation to the mealtime experience and the symptoms of dementia. Best practice involves screening, assessment, planning, implementation and evaluation of food and nutrition programmes; multidisciplinary engagement with support at board level is also essential in combating malnutrition among older adults.

Listening to older people, their relatives and carers

It makes economic sense to consult older people about hospital menus, special requirements and preferences. Patients with stroke, dementia or a learning disability may have specific needs in relation to eating and drinking as a result of swallowing difficulties or cognitive impairment (Healthcare Commission 2007b). Other examples of best practice include (Age Concern 2006):

- Heatherwood and Wexham Park Hospitals NHS Trust – the trust operates a ‘food group’ which meets quarterly and includes patient representatives. These representatives taste the food and agree changes to the hospital menu.
- The Queen Elizabeth Hospital Trust – the trust invites members of the Greenwich pensioners’ forum to discuss the quality of hospital food and tour one of the wards for older patients.

Becoming ‘food aware’

From the time of admission, care should be taken to find out from the patient what type of foods he or she normally eats. This information should be shared with all members of the multidisciplinary team. At Homerton Hospital, London, healthcare assistants are nominated to take the lead role in monitoring patients’ nutritional status and appropriate training is provided. Patients’ food charts are completed in a timely fashion and the healthcare assistants ensure that patients requiring help with eating are allocated a nurse at mealtimes (Age Concern 2006).

Following professional codes of conduct and guidance from other appropriate bodies

Commitment from all members of the multidisciplinary team is essential to ensure that priority is given to implementing core standards on food and help with eating is provided, as stipulated by the DH (2001b). The Nursing and Midwifery Council (NMC) Code of Professional Conduct (NMC 2004) sets out the standard for conduct, performance and ethics: ‘... to inform the professions of the standard of professional conduct required of them in the exercise of their

References

professional accountability and practice’. As a regulatory body it safeguards the health and wellbeing of the public by conducting reviews and promoting nursing standards.

Introducing protected mealtimes Patient care should be organised around the needs of the patient rather than the needs of professionals. All non-urgent activity such as ward rounds, phlebotomy tests and drug rounds should not take place during mealtimes. Norfolk and Waveney Mental Health NHS Foundation Trust have piloted protected mealtimes and have received positive feedback from patients as well as staff (Norfolk and Waveney Mental Health Partnership NHS Trust 2007). A forum: ‘making mealtimes special and slow’ has been established and is co-chaired by an educational facilitator and lecturer or practitioner. Meetings are held on a regular basis and are attended by the dietician, catering personnel, primary care link worker and ward staff representing adult as well as older people services. The forum seeks ways to improve the menus offering better patient choice and the supply of extra fruit and snacks for patients. Fairfield General Hospital has also piloted protected mealtimes. Positive responses were received from patients, the majority stipulating that they would prefer mealtimes not to coincide with visiting times (Age Concern 2006).

Conclusion
Meeting the nutritional needs of individuals with dementia is a challenging experience that requires time, patience and support. Multidisciplinary working and the implementation of nutritional assessment and protected mealtimes will go some way to help reduce the incidence of malnutrition in vulnerable individuals in the hospital setting. An understanding of the importance of good nutrition and an awareness of the multiple factors that can affect an individual’s nutritional status will help to prevent weight loss and ensure that patients receive quality care NS

Time out 8
Review the aims and learning outcomes. With the help of a colleague, discuss ways to involve carers in meeting the nutritional needs of patients with dementia.

Time out 9
Now that you have completed the article you might like to write a practice profile. Guidelines to help you are on page 48.

References

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