GUIDELINES FOR THE MANAGEMENT OF FEEDING AND SWALLOWING PROBLEMS IN DEMENTIA

Decision making process (see flowchart)

1 Initial Assessment

- Obtain a full history from family/carers as to patient’s usual level of eating and drinking, including assistance required, textures, adapted cups/cutlery, appetite, food preferences, usual weight.
- Ensure patients are weighed and screened weekly on nutrition screening tool to monitor risk of malnutrition.
- Assess the patient’s capacity and refer to the guidance as set out in Mental capacity Act 2005: Code of Practice

2 Consider the Clinical Prognostic Indicators to clarify at what stage of the illness the patient is. Does the patient have mild/moderate dementia (ref: Reisberg’s Global Deterioration Scale) or advanced dementia?

Indicators for Advanced dementia;
- Unable to walk without assistance, and
- Urinary and fecal incontinence, and
- No consistently meaningful verbal communication, and
- Unable to dress without assistance
- Barthel score < 3
- Reduced ability to perform activities of daily living
- Plus any one of the following:
  - 10% weight loss in previous six months without other causes, Pyelonephritis or UTI,
  - Serum albumin 25 g/l,
  - Severe pressure scores eg stage III / IV, Recurrent fevers, Reduced oral intake / weight loss, Aspiration pneumonia

Or the patient would typically have an MMSE score below 10 (NICE 2006)

Refer to the flowchart for the decision making pathway for mild/moderate dementia vs. advanced dementia

3 Initial Management and support of oral intake

- Ensure patients have the appropriate level of assistance for feeding from individuals trained in the appropriate feeding techniques.
- Refer to Speech & Language Therapist and Dietician if feeding/swallowing problems are identified
- Consider the eating environment, including reducing noise/calming music/seating/positioning
- Consider how food is presented in terms of texture, colour, consistency, time of day, quantity
- Offer small amounts of diet and fluids frequently throughout the day, as patients may be daunted by large meals.
- Give supervision, verbal/physical prompts, assist with cutlery/adapted cutlery, cut up food, alternate drinks/food
4 Consider whether the dysphagia is a transient problem, that may require investigation and treatment, or a permanent problem.

Transient problems swallowing may arise as a result of some of the following:
- Acute confusional state
- Sedative medication
- Depression
- Paranoid beliefs
- Acute stroke
- Nausea
- Lethargy
- Reduced appetite
- Denture problems
- Chest infection/aspiration pneumonia

5 Consider whether enteral tube feeding is appropriate

This should only be considered where dysphagia is a transient phenomenon. It should be a short term means to improve the nutritional status and the ongoing need should be reviewed every two weeks by the medical team.

Patients who have been placed NBM pending a decision about tube feeding should not remain NBM for longer than 5 days without clear objectives, and this should be reviewed every 2-3 days by the medical team.

Artificial feeding should not generally be used in people with advanced dementia (NICE guidelines 2006)

Where enteral tube feeding is not appropriate the following options should be considered:
- Careful oral feeding
- Palliative care/ Nil by mouth and oral care.
- Care of the Dying Pathway

Decision-making should involve a consensus of opinion within the clinical team and be clearly documented

The following key documents should also be referred to for further guidance:
- MCHFT Medical Guidelines (clinical)
- BMA Withholding and Withdrawing Life – Prolonging Medical Treatment (2001)
- MCHFT Enteral Feeding guidelines (2008)
- NICE Dementia Care guidelines (2006)
- Mental Capacity Act (2005)
- Oral Feeding Difficulties and Dilemmas (RCP 2010)
DECISION MAKING PROCESS

PATIENT PRESENTS WITH FEEDING/SWALLOWING PROBLEMS

Carry out Initial Assessment

- History from family/carers
- Nutrition screen and referral to Dietitian, if appropriate
- Swallow screen and referral to SLT, if appropriate
- Assessment of Mental Capacity

MILD/MODERATE DEMENTIA

- Cannot manage orally

MILD/MODERATE DEMENTIA

- Can manage orally with support

ADVANCED DEMENTIA

- Cannot manage orally

ADVANCED DEMENTIA

- PEG/NG is not generally recommended in advanced dementia (NICE 2006)

TRANSIENT DIFFICULTY SWALLOWING

- Consider time trialled NG for 2 weeks while cause of dysphagia is investigated and treated.

TRANSIENT DIFFICULTY SWALLOWING

PERMANENT DIFFICULTY SWALLOWING

- Consider PEG – discuss with MDT/patient/family

PERMANENT DIFFICULTY SWALLOWING

- If PEG not appropriate

Ongoing assessment from SLT and Dietitian. If dysphagia does not improve consider NG for a further 2 weeks. If no subsequent improvement consider PEG-discuss with MDT/patient/family

Consider the following options with family and MDT:

- Careful oral feeding
- Palliative care/NBM with oral care.
- Care of the Dying Pathway.