Guidelines & References

2015 ESPEN guidelines on nutrition in dementia: provides possible support based on stage of disease

Best practice guidelines for aged care

NICE Parkinson's Disease in Adults Guidelines

What is it?

Dementia	Parkinsons
It's a cognitive impairment with a decline in memory AND at least one other cognitive domain such as language, object recognition, motor skills, abstract thought, visuospatial or executive function. There are two major changes believed to interrupt normal processes of the brain: formation of amyloid plaques and formation of neurofibrillary tangles.	*Neurological condition where the brain cells in the brain stem are destroyed. These cells usually produce the neurotransmitter, dopamine, which is needed for control of movement and coordination. This results in a range of S/S that predominantly affects movement.*

Cause

unclear - Likely genetic & environmental factors

Risk factors

Dementia	Parkinsons
Age	Age
CVD	Sex (males more common)
Genetics	Ethnicity (less common in Asian/African Americans)

Dementia & malnutrition

Affects food purchasing, preparation & intake – smell and taste changes, loss of eating skills, loose the ability to recognise foods, disturbed eating patterns, refusal to eat, forgetting how to chew or swallow

Dry mouth: mouth rinses & gels. Adding gravies or sauce to meals.

Update preferences regularly

Stages & NIS

Stage		NIS
Early	memory loss & disori-entation	Difficulty shopping, preparing and storing food. Forgetting to eat. Food preferences change or unusual choice.
Mild-mod	loss of function in ADLs	Food not chewed or swallowed properly. Poor concentration. Impaired reasoning and judgement – ability to recognised hunger/th-irst/satiety. Agnosisa – cannot recognise objects or food Malnut-rition and dehydration risk.

Stages & NIS (cont)

Severe	communication difficulties and reliance on others for ADLs. May be bed-bound at this advanced stage and lack ability to communicate	Food refusal. Aphasia – inability to understand or produce speech. Dysphasia

Parkinsons S/S

Non-motor: depression/anxiety, memory problems, anosmia (loss of smell), Hypers-alivation (drooling), dysphagia, slowed gastric motility (gastroparesis), Sleep distur-bances, pain

Motor: Bradykinesia (slowness of movement), Akinesia (loss or impairment of the power of voluntary movement), Resting tremor, shuffling gait, mucle rigidity, postural instability

Assessment

Nut concerns: Vit D, B12, Iron

Chewing & swallowing: dentures, dry mouth, dysphagia

Dehydration: urine colour, thirst sensation

Constipation: linked w/ inadequate fluid/-food. Physical activity?

Altered taste & ↓ smell (hyposmia)

Appetite: when is it strongest?

Favourite flavours – changes likely

Parkinsons Medication

Levodopa

S/E [short term]: nausea, vomiting, loss of appetite, fatigue – usually subsides after continued use

S/E [long term]: delayed/absent response resulting in motor and non-motor fluctu-ations ('off periods') and Dyskinesia (invol-untary movements)

Parkinsons Medication (cont)

Take 30-45min gap between dosage and consumption of meal – since meals can slow down absorption due to **slowed gastric motility**

Parkinsons Management

IF pt taking levodopa AND experiencing motor fluctuations – redistribute protein to end of the day – majority in the evening - to maximise effectiveness of medication during the day

Avoid a reduction in total daily protein consumption

Vitamin D supplement – medical team

Do not offer creatine supplements

Don't take over-the-counter dietary supplements without consulting pharmacist or other HCP

Nut Reqs

Increase EER: restlessness, constant pacing up and down, tremors

Decrease EER: immobility, apathy (emotional indifference or lack of motivation), somnolence (drowsiness)

ESPEN: *no indications that nut reqs are generally different in persons with dementia* (*very low evidence)

Acute elderly: 100-125kg/day, 1-1.5g P/day (NEMO)

Repletion: 125-145kJ/day, 1.2-1.5g P/day (NEMO)

Strategies

Difficulty with ADLs

Easy, basic recipes

Frozen meals/snacks

Having someone with them at meal times

Adaptive utensils

Mealtime socialisation

Strategies (cont)

Flavour enhancers – herbs, spices, citrus, soy sauce, garlic/onion, oils

Pleasant eating environment

Help with grocery shopping – support worker – home care package

Forgetting to eat/drink - Reduced oral intake Fatigue

**Malnut screen*

Supervision during meals

Verbal prompting

Pouring fluids in front of them - acts as a prompt

Recognizing food and ability to eat independently

Feeding assistance

↑ time with nurses spent feeding

Identify flavour preferences

Offer one meal at a time or food – avoid having condiments out to choose from

ONS

Educating – eating even when you don't want to

Swallowing issues

Malnut screen

Texture-modification & swallowing assessment – speechies

Oral care

Dental treatment

Soft, moist food. Avoid: tough, crunchy, sticky, dry foods

Xerostomia (Dry mouth)

Check medication

Adequate fluid intake

Mouth rinse and gel

Offering drinks

Strategies (cont)

Moist foods – gravies, dressings, mayonnaise, sauce, custard, butters

Inadequate fluid intake

Assess med S/E that could interfere with adequate fluid intake

Edu: what fluid is

Schedule small frequent amounts of fluids (esp. surrounding meals)

Nausea

Small frequent meals

Cold foods

Sipping ONS/HPHE through straw

Limit fatty and fried foods

Ginger products

Levodopa may need to be taken with food if 'on/off' periods are stable

Loss of smell and taste

Flavour enhancers – herbs, spices, citrus, chilli, garlic, onion

Enhance food is presented nicely – variety/colour

Identify specific issue – bitter? Metallic?

Constipation (and overflow diarrrhea, urinary incontinence, abdo pain)

↑ fluid, adequate fluid

Physical exercise

Fibre supps – Metamucil

Example PESS

Inadequate oral intake

Inadequate protein-energy intake

Self-feeding difficulty, related to diagnosis of Parkinson's Diseases with increasing tremor and fatigue, as evidenced by observation at mealtime, calorie count and recent 5% weight loss.