APRIL 1, 2019 VOL. 4

THE NETWORK NEWSLETTER

Connecting Consultants of S & S Nutrition Network Inc.

IN THIS ISSUE

Spring is in the Air

The above picture isn't me but it might as well be.. The sun is out, birds are chirping and my mind is overflowing with spring projects! But I am the type that will step over the laundry to spring clean the spare bedroom, get my painting supplies out before I've moved the furniture out of the room, or (as pictured) look past the weed to plant my basil.

Sometimes steps have to be done in a certain order, but if not I might try to mix it up to disguise it as fun, pull a weed, plant a flower, repeat. Or I might try to break it up so it doesn't seem like such a big task, a load of laundry every day instead of 7 loads on Saturday. I've started pulling it into my work tasks too. Like updating my hours on my invoice daily and adding to reports weekly.

There are always going to be tasks we drag our feet on but when all the steps are done, don't the roses smell so much sweeter?

SAVE THE DATES:

S & S Nutrition Network Conference Call

When: April 30th 4 pm MST (3 pm PST)
Where: Sue's Community Clubhouse, 3460 Willowbar Garden City or
Call in: (712) 451-1061 Access Code 698998
If joining at the Clubhouse please RSVP by April 26th to Sue. Drinks and snacks will be provided!

Idaho AND Annual Meeting

When: April 25th & 26th
Where: Jack's Urban Meeting Place
Register: https://www.eatrightidaho.org/meeting/attend/registration/

2019 S & S Summer Meeting

When: July 9-10th
Where: Boise Centre
Register: Please contact Sue or Maureen to RSVP or to get further details.
Agenda will be coming out soon!

Want an excuse to travel..?

The 35th Annual Sports, Cardiovascular, and Wellness Nutrition (SCAN) Symposium, Navigating the Path of Wellness, will be held in Phoenix, Arizona, April 26-28th, 2019. The goal of the 2019 symposium is to explore evidence-driven wellness/well-being approaches and techniques complementary to medical nutrition therapy and nutrition counseling for sports and cardiovascular nutrition to improve overall performance, health, and quality of life. The Symposium will have a strong emphasis on practical applications, skills, and knowledge that can be integrated into each of SCAN's practice areas of sports, cardiovascular health, and wellness.
https://www.scandpg.org/symposium-2019

S&S Nutrition Network
Menu Services

S&S is pleased to announce that our menus now reflect IDDSI (International Dysphagia Diet Standardisation Initative).

Healthcare Standards are changing and so are we. Of course not everyone is ready to make the change to IDDSI today, so our menu spreadsheets are still appropriate for those who haven't made the transition, offering mechanical and puree extensions.

What changes can I expect?

1. Diet extensions are now printed in color reflecting IDDSI diet levels: 4 (pureed), 5 (Minced and Moist), 6 (Soft & Bite Size)
2. Descriptors are available for texture modifications at the bottom of each recipe.
3. Resources from IDDSI are included and printed in color Including; Audit sheets, food test cards and IDDSI Frame work.

$550 Menus will still include;
4 Weekly Alphabetized Recipe Books
Week at a Glance (WAG)
Daily Diet Spread Sheets (Improved!)
Alternate Recipe Book
Alternate Diet Guide Spreadsheets
Substiutions for Vitamins A & C
Measurement Reference Form
Food Preference Form

Current Diets include: Regular, Consistent Carbohydrate, Liberal Renal, 2 Gram Sodium Gluten Restricted and High Calorie/Fortified.

Anticipating IDDSI Menus available beginning mid-April.
If you aren't interested in waiting for all the IDDSI pieces menus are available April 1st.

Expect more changes in the future. We change so we can help you in meeting ever changing healthcare standards. Let's work together. Our current project is assembling some IDDSI friendly recipes for puree and pre-gelled bread products and we'd love your contribution.

Any questions? Contact kdimondrd@gmail.com

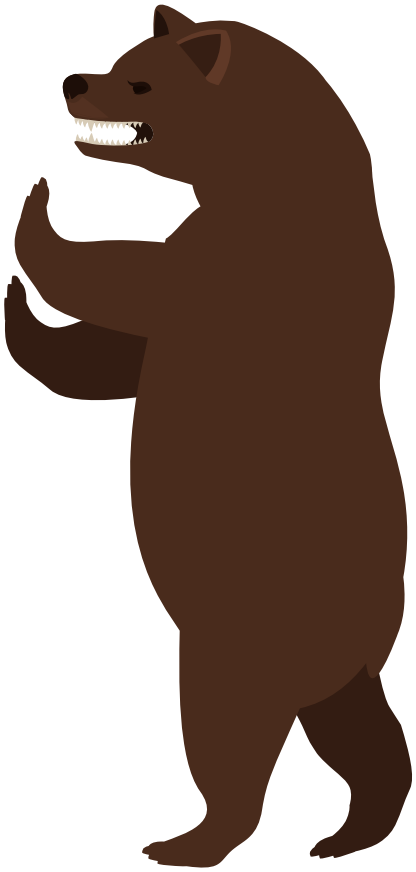
Member Spotlight: Rachell Larsen

I became interested in dietetics my senior year in high school. My grandmother was a Type 2 diabetic and struggled with understanding her diet restrictions and staying compliant. Over time, the need for beta blockers and diabetes caused ESRD, and the struggle with diet continued. I was extremely interested in working with patients to help them realize their disease doesn't control their life, they control their life.

If I was actually honest, I would have to say I enjoy the survey process the most. I really like the challenge not only during the year helping to ensure the buildings are in compliance. However, I really love survey week. I feel this is our chance to shine. I also use this as a way to identify any weaknesses I have as a consultant.

I'm not sure I could actually name one specific rewarding experience with S & S. I have been with the company most of my career. I feel the entire experiences has been rewarding. Sue and Maureen have been incredible leaders and mentors. The S & S Team has helped build my confidence and growth as a consultant.

I enjoy spending time with my family which includes following my kids' sporting events, camping, hunting, snow skiing, and running.



I have 60 acres and love that I live where there aren't any street lights. I chased my husband around the playground in the third grade, and started dating him in the eighth grade. I drive an average of 120 miles each day or around 31,000 miles a year to work. I had to start running circles in my house for my running workout to avoid the bear that was hanging around my running route.

Dining Distinction Award Winner

Terri Perez is the recipient of the 2019 Dining Distinction Award. The Association of Nutrition and Foodservice Professionals (ANFP) awards 8 outstanding CDMs at their annual national conference. A CDM from Idaho has won this honor 2 years in a row (2018 winner Lisa Berrett).

The winner receives a complimentary registration to the ACE convention and is honored at the Honors Gala event.

See below for an excerpt from her nominee submission written by Betty Trounsen and Sue Linja.

Teresa (Terri) Perez puts the care of every resident first—before herself or anyone else.She approaches each residents' needs with grace, respect and generosity.She has been a CDM in long term care facilities for nearly 20 years - and although she hasn't changed jobs often, everywhere she does go improves by 100% within months of her arrival. Terri is not only a food service and customer service expert, she is also a clinical nutrition wizard. Terri is also leading the way with IDDSI in the facility. She is on the Idaho IDDSI workgroup and she has started doing skills fair in her facility to get the nursing and dietary staff up to speed on the new texture altered diets. She has a "this is an exciting change" attitude, instead of being negative about all the work it will entail. Terri is resourceful and budget minded, but her focus is on quality not quantity. By doing this, she has improved residents intake, reduced food waste and food cost and improved residents overall nutritional status.

A big Welcome to these additions to the S & S family

Kelsey Bernier

Let's Celebrate this Quarter's Anniversaries!

>5 Years

Mimi Cunningham (5 years)

Kimberly Wagner (8 years)

>10 Years

Mary Martinez (10 years)

Deanna Gillette (19 years)

Nutrition / Dietary Deficiency Free this quarter:

AHC Colorado Springs
Julie Richardson

The Orchards of Cascadia
Teresa Hockett

Good Sam Moscow
Marissa Rudley

Valley Vista in St. Maries
Renee Legan

Cascadia Wellsprings in Nampa
Lori Tollinger

Teton Post Acute Care Idaho Falls
Kimberly Wagner

AHC Albuquerque
Mary Martinez

On a Side Note,

The F812 citation (Food Sanitation and Safety) is not cited nearly as often in Idaho and Region X (AK, OR, WA, ID) as it is national. Whew!! We should pat ourselves on the back!

Idaho	Region X	National
#1 = F 880*	#1 = F 689	#1 = F 880
#2 = F 684*	#2 = F 684	#2 = F 812
#3 = F 656	#3 = F 656	#3 = F 656
#4 = F 657	#4 = F 880	#4 = F 689
#5 = F 689	#5 = F 687	#5 = F 761
#6 = F 758	#6 = F 758	#6 = F 684
#7 = F 883	#7 = F 610	#7 = F 657
#8 = F 761	#8 = F 842	#8 = F 758
#9 = F 812	#9 = F 686	#9 = F 641
#10 = F 686	#10 = F 812	#10 = F 550

IDR data Calendar Year 2018

8 = facilities — 11 = tags
2 = no change
2 = S/S change
4 = tags removed
1 = tag changed to a different tag
2 = tags pending outcome

Table 2-20
MDS 3.0 Measure: Percent of Residents Who Lose Too Much Weight (Long Stay)
(NQF #0689) (CMS ID: N029.01)

Measure Description
The measure captures the percentage of long-stay residents who had a weight loss of 5% or more in the last month or 10% or more in the last 6 months who were not on a physician prescribed weight-loss regimen noted in an MDS assessment during the selected quarter.
Measure Specifications
Numerator Long-stay nursing home residents with a selected target assessment which indicates a weight loss of 5% or more in the last month or 10% or more in the last 6 months who were not on a physician prescribed weight-loss regimen (K0300 = [2]). ***Denominator*** Long-stay nursing home residents with a selected target assessment except those with exclusions. ***Exclusions*** 1. Target assessment is an OBRA Admission assessment (A0310A= [01]) ***or*** a 5-day PPS assessment (A0310B= [01]), ***or*** a Medicare Readmission/return assessment (A0310B= [06]). 2. Prognosis of life expectancy is less than 6 months (J1400 = [1]) or the Prognosis item is missing (J1400 = [-]) on the target assessment. 3. Receiving Hospice care (O0100K2 = [1]) or the Hospice care item is missing (O0100K2 = [-]) on the target assessment. 4. Weight loss item is missing (K0300= [-]) on the target assessment.
Covariates
Not applicable.

Per F-Tag 812, one of the most widely cited tags, it's important to ensure your facility:
Obtains food for resident consumption from sources approved or considered satisfactory by Federal, State and local authorities.
Follows appropriate sanitation and food handling practices to prevent the outbreak of food borne illnesses.
Ensure food safety is properly maintained through out the storage , cooking and serving processes.

F-Tags InReview

Distinct Facilities Nationwide to Receive F-Tag 812
(As reported February 11, 2019)

4,685

Newsworthy:

PDPM and the S&S Nutrition Network Registered Dietitian in SNF

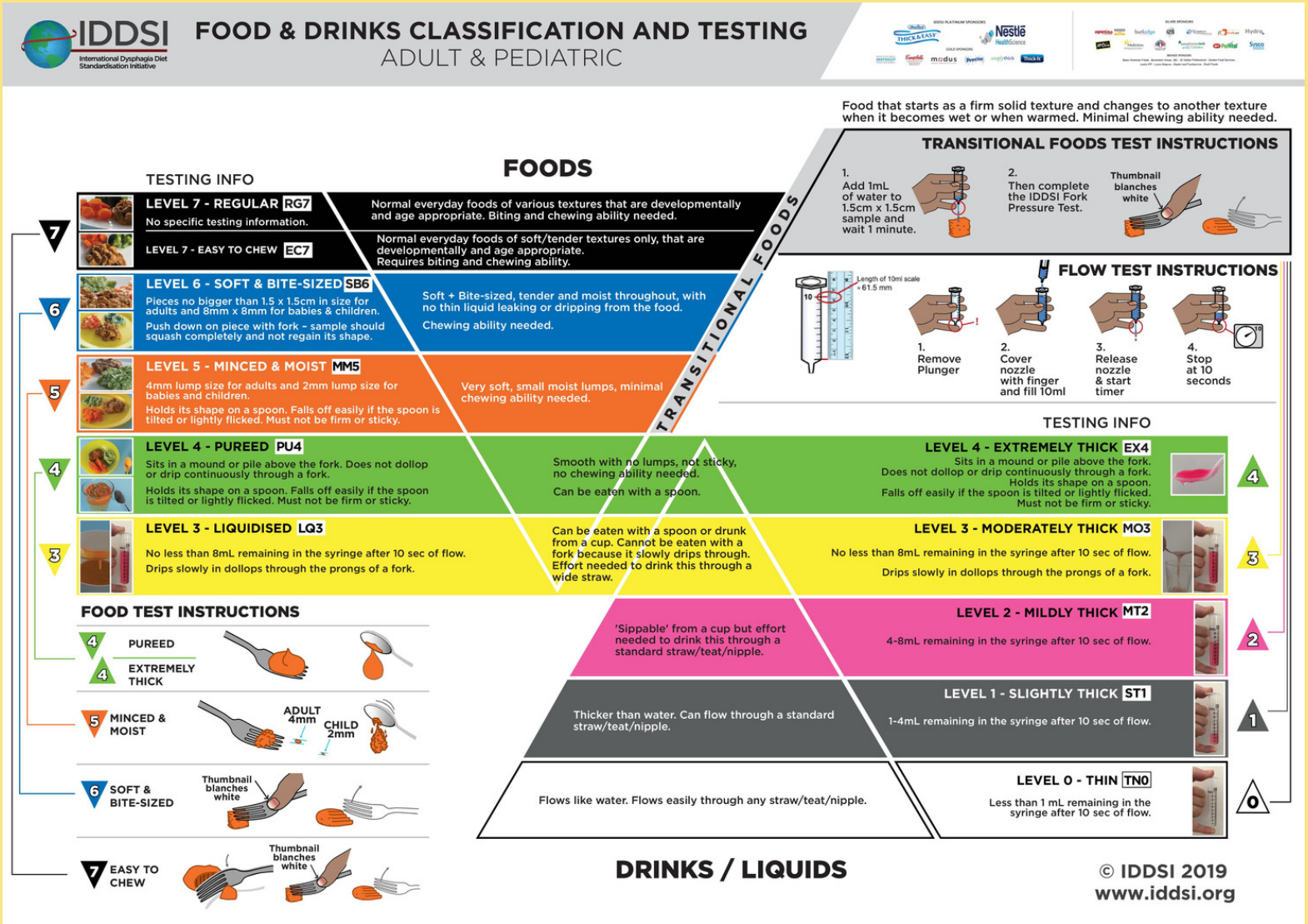
The Patient-Driven Payment Model (PDPM) for traditional Medicare A residents is set to replace the current RUG-IV Medicare payment model Oct. 1, 2019. With a payment change this big, you can't wait to begin preparing yourself or the food and nutrition team. As an integral part of the health care team in your skilled nursing facilities, it is important for the RD to have an enhanced knowledge of the components of the PDPM system - which includes reimbursement streams from morbid obesity, malnutrition, dysphagia, diabetes, EN/PN and more. Please consider coming to our Summer Workshop for S&S Nutrition on July 9th and 10th if you want to help prepare yourself and the food and nutrition department for this major transition.

Quoted from Debby Ransom, Chief, Idaho Bureau of Facility Standards on the Statewide Call....

"There is not place for a POST (or POLST)in a nursing home. It is not an Advanced Directive and does not take the place of an Advanced Directive." She went on to say that we need to have very clear DNR and advanced directives (DPOA and Living Will) in the chart and updated on the care plan. For us, this is important because the choice of having a tube feeding or IV is often differing on the POST vs the Living Will. We need the RD's to know to follow the direction on the Living Will, not the POST. If they identify discrepancies, please address this with your facility social worker, DNS and administrator.

IDDSI for All Dietitians

It's REAL, everyone. And as an RDN consultant with S&S Nutrition Network, you are expected to know the changes and help lead the charge within your facility/place of work. The International Dysphagia Diet Standardisation Initiative (IDDSI and yes, standardisation is spelled with an "s") created global standardized terminology and definitions for texture-modified foods and thickened liquids to improve the safety and care for individuals with dysphagia, a swallowing disorder, which affects an estimated 560 million people worldwide. Learn more about the IDDSI Framework at IDDSI.org. The Academy of Nutrition and Dietetics and the American Speech-Language-Hearing Association together support May 1, 2019, as the official launch date for IDDSI implementation in the United States. The announcement was made at the 2018 Food and Nutrition Conference and Expo™ in Washington D.C. The IDDSI website provides information on the framework, testing methods, FAQ and implementation resources. IDDSI.org also produces a monthly newsletter containing the latest news in the IDDSI community. Please check out their website and watch for various ways to become educated on these changes that will be rolled out in EVERY area of our field - hospitals, home care, communities, skilled nursing, assisted living and more. S&S Nutrition will provide some training at our annual conference in July as well.



The northern-most Idaho/Spokane dietitians past and present. Pictured is Carrie Davis, Julie Ohno, Emmylou Newell Tisha Whatcott, Maureen and Sue

How many dietitians does it take to fix a broken dish machine? Pictured from left to right Sue Linja, Rachell, Larsen, Marissa Rudley, Maureen Sykes

ROAD TRIP!!!

The Lewiston/Moscow/Clarkston crew. Pictured is Libby Reynolds, Lauren Keeney, Rachell Larsen, Contessa Heaton, Maureen Sykes, Marissa Rudley, and Sue

Provider
LONG TERM & POST-ACUTE CARE

When Eating Stops, Problems Start

Excessive weight loss can trigger a host of harmful issues.

JANUARY 2019

Joanne Kaldy

"Have you lost weight?" This question is often considered to be a compliment. But in older adults—particularly those who are frail and have multiple comorbidities—weight loss can cause a cascade of illness, disability, mental or cognitive issues, and physical decline.

The challenge is to catch it early, reverse it when possible, and balance interventions with personal preferences. This requires a team where everyone is on the same page, communicates effectively, and has the latest, best tools at their disposal.

The Many Ingredients of Weight Loss

Older adults are generally at risk for weight loss and malnutrition because of the problems and deficits related to aging—some physical, some mental or emotional, and others socioeconomic or cultural. All of these issues can contribute to poor appetite and weight loss and a cascade of conditions and illnesses.

The cause of weight loss may seem obvious—the person isn't getting enough calories and nutrients. However, it is much more complex. This problem often results from a combination of factors. Among the many problems that can contribute to weight loss and malnutrition are:

Dementia or other cognitive impairments that cause people to lose their appetite or forget to eat;
Malignancies or other illnesses, such as heart disease, thyroid disease, and infections;

- Depression;
- Certain prescription medications *(see table, below)*;
- Restricted diets;
- Lack of access to preferred foods;
- Limited income;
- Lack of transportation;
- Alcoholism or drug addiction; and
- Dental or oral health pain or problems.

Watch for Red Flags

It is important to note that unplanned weight loss in an elderly patient should always be a red flag and should lead to some assessment. "When I get a call from a nurse that a patient has triggered for weight loss, I have a protocol that I use," says David Smith, MD, CMD, president of Geriatric Consultants in Brownwood, Texas. "Tier one involves some historical questions and observations to uncover any circumstances that would indicate common reasons for weight loss or reasons that are uncommon but easy to identify—such as dental problems or other oral issues, distorted body image, or dissatisfaction with the food being served."

Tier two of Smith's protocol looks for issues that are a bit more uncommon and are more expensive to evaluate, such as the presence of swallowing problems or metabolic disease. If the cause is still undetermined after tier

one and two assessments, Smith goes to tier three, which involves more invasive and costly assessments designed to uncover issues such as a malignancy.

"People often jump to 'cancer' as a likely medical cause for weight loss. In truth, there are many other more likely culprits—from heart failure and thyroid issues to infections and depression," says T. S. Dharmarajan, MD, MACP, FRCP(E), AGSF, vice chair of the Department of Medicine and clinical director of the Division of Geriatrics at Montefiore Medical Center (Wakefield Campus) in Bronx, New York.

"If you encounter weight loss, you need to identify the root causes as quickly as possible, and not make assumptions or leap to conclusions," says J. Kenneth Brubaker, MD, CMD, medical director of Masonic Village in Elizabethtown, Pa. Start with the "low-hanging fruit," he suggests, such as drugs that may be causing or contributing to weight loss, or the patient simply doesn't like the food being served.

Dharmarajan agrees, noting, "Sometimes if you just ask, you will find out that it's something fixable such as they can't cut or chew the steak, or they don't like fish."

Finding out why someone isn't eating requires a bit of detective work, Dharmarajan says. The person's plate is one important clue. "Look at the patient's tray after he or she eats. You can see what and how much they're eating," he says.

While drugs that help depression can lead to improved appetite, Smith says that several nonpsychiatric drugs—such as clonidine, digitalis, levodopa, prazocin, reserpine, amiodarone, and steroids—actually can cause depression and negatively impact appetite and eating.

Even if there is a medical problem, it can be fixed fairly easily. For instance, Dharmarajan says, "I had a new resident who told me that she had no appetite for anything. I asked her simply, 'Do you miss your grandchildren?' She started crying. I put her on antidepressants, and within a few weeks, she was eating again. Her daughter thanked me for giving her 'mom back' to her."

When Patients Live Alone, Nutrition May Suffer

Particularly when older people live independently—either in the community or senior housing where they have their own apartment—weight loss and/or malnutrition often stem from issues that are easily addressed.

"When they live alone, they often eat alone; and they may eat less. Or they don't want to cook for one and will skip meals or eat fewer balanced meals," says Marcie Rittenhouse, RDN, CSG, a consultant dietitian at central Pennsylvania-based LIFE/PACE program. "Some don't have family checking in on them regularly, so no one notices at first when their eating habits change or they start to lose weight." Even those elders who live with family can be at risk.

"We have some older people who live with an adult child or other family member who also eats poorly," she says. In these cases, an occupational therapist or social worker can make home visits and identify issues, such as Mrs. Smith doesn't know how to use her microwave, or Mr. Jones needs a way to get to the grocery store. Sometimes, the solution is as simple as helping to schedule rides to the store with a neighbor or arranging for the person to participate in a Meals-on-Wheels program or eat lunch at a local senior center.

Encouraging Elders to Eat

For residents of an assisted living community, they may just need some encouragement and incentive to go to the dining hall for meals. For instance, staff can introduce them to other residents who they can eat and socialize with.

In some instances, a more complex and urgent intervention is necessary. "Sometimes elders are in dysfunctional family situations that are affecting their ability to eat well. For instance, they have an adult child who has an alcohol or drug problem," says Rittenhouse.

It's important to realize that people have varying views about and relationships with food. For instance, Rittenhouse had one patient who lived with her daughter, who firmly believed that mom should sit at the table and eat a full hot meal. She was upset because her mother was resistant. "I had to remind the daughter that her mom is in her 80s and doesn't need as many calories or as much food as a younger person," Rittenhouse says.

She says another family wanted to use food as a reward or incentive for certain behaviors. “Food should never be used as a punishment or reward, and we shouldn’t pressure or force people to eat,” Rittenhouse says. “We should let them eat when they are hungry, and help ensure that they get food they enjoy.”

Communicating Choices

Sometimes, it may be difficult for families and caregivers not to impose their own feelings about food onto an elder. For instance, Rittenhouse worked with one woman who was emaciated but resisted eating more because she “likes to stay trim.”

If someone is very thin, Dharmarajan says to do a Body Mass Index (BMI) test and assess them for any problems. “If there are no red flags such as an excessively lower BMI, physical weakness, falls, depression, isolation, or lethargy, we shouldn’t push him or her to eat more,” he says.

Smith adds, “You must determine whether this is just cultural and ‘normal’ thinking or a psychological disorder, such as anorexia tardive.” He says that a psychiatric exam might be in order.

To help determine if there is a body image issue that may need to be addressed, ask patients to clip pictures from a magazine of people they identify as “too thin,” “thin,” and “obese.” This type of exercise can be very revealing, he says.

Such personal beliefs, as well as cultural issues and preferences regarding food, should be identified on admission.

“My mother is a lacto-ovo vegetarian, and we made sure the nursing staff at her facility knew this from the start,” Dharmarajan says. “I told them that she particularly loves yogurt, which she ate all her life. But I also told them that she can have anything she wants to eat, although she has diabetes.” At her stage of advanced dementia, her quality of life was more important, and avoidance of restrictive diets was at the top.

Facility staff should meet with families within a few days of admission to have a care planning conversation that includes a discussion of food and dietary preferences, including a review of medications, Dharmarajan says. He also recommends a nutritional evaluation of the patient on admission to determine if they are malnourished or at risk for malnutrition. He also recommends a nutritional evaluation of patients on admission to determine their nutritional status.

Patients often come from the hospital deconditioned and malnourished, particularly after a long illness, he says. “We need to assess them early and determine what needs to be done to help them recover their strength, regain lost weight, and be as nutritionally sound as possible given their condition,” he says.

Dietary Restrictions: Less Is More

Clinicians do not generally recommend restricted diets for older nursing facility residents, particularly those with a life expectancy of five years or less. “Generally, we allow these patients to eat what they want,” says Brubaker.

There have been many studies about the value of certain kinds of diet for cardiovascular and brain health as people age. However, Smith says, “Nutritional research related to diet and outcomes is fraught with difficulty, and the methodology for many population-based nutritional studies is flawed.” Nonetheless, he notes that the Mediterranean diet has been shown to have some value.

“Here in Texas, the Paleo diet is catching on. The philosophy is to emulate the diet of our cave-dwelling forefathers with a focus on meat and vegetables and a de-emphasis on simple carbohydrates and sugars,” he says.

While a healthy diet for all is ideal, maintaining weight and strength is a key goal for the elderly, and this often requires flexibility. “In the not-too-distant past, we were recommending therapeutic diets for the elderly; then expert opinion determined that these diets don’t really benefit this patient population because of their shorter life expectancy,” Smith says. However, he stresses that restrictive diets are appropriate for younger nursing facility patients.

“While we can’t make them eat healthy, of course, we should always educate younger patients about why they should or shouldn’t eat different foods,” Smith says, admitting that this can be challenging when patients have limited mental capacity or an inability or unwillingness to hear and retain information.

Dharmarajan stresses the importance of discussing liberalized diets with family members up front. “If a man had been a diabetic for years and was on a strict diet, you don’t want his family to see a cookie on his tray and get upset. You want to help them understand why you are liberalizing their father’s diet,” he says.

Brubaker agrees that these family discussions are essential. “Some families are very committed to things such as tight diabetic management. However, when we talk to them about the benefits of a liberalized diet, most will understand,” he says.

Are Supplements Super?

“I would rather patients eat food than spend their money on things like vitamin waters, energy drinks, and vitamin or herbal supplements,” says Rittenhouse. Another problem with these is that they can be costly. “We had a woman who was buying $2 bottles of mineral water that she couldn’t afford, and whatever benefit she might be getting from it wasn’t worth the cost. We have to consider what is affordable, as well as what will produce the best outcomes.”

Appetite stimulant medications might seem like a quick fix, but Smith cautions against them. None is approved by the Food and Drug Administration for use by the elderly, he says. At the same time, most appetite stimulants are expensive and have more risks than benefits for this patient population. It is better to evaluate patients and find the root cause of weight loss, he says.

Skilled nursing facility patients generally have a need for or can benefit from nutritional supplementation, such as vitamin D, Smith says. However, he says, “These patients don’t need more pills, and nurses don’t need more med passes to make.” One solution might be food additives, Smith suggests.

“Fortify the ‘real food’ so that it better meets the resident’s needs. This could be done across the board so all residents get the benefit. Of course, additives can be individualized to resident needs when giving something to everyone isn’t appropriate or necessary,” he says.

How Surveyors See Weight Loss

The prevalence of weight loss is a quality indicator for skilled nursing centers, and regulations state that facilities must ensure that residents maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless a resident’s clinical condition demonstrates that it isn’t possible. According to the Investigative Protocol for Unintended Weight Loss in nursing centers, a more than 5 percent unplanned drop in weight after a month, greater than 7.5 percent after three months, and 10 percent after six months are considered “significant” losses.

To help ensure that surveyors understand the reason for unplanned weight loss, it is important to document regular weights, interventions taken, and discussions with the patient and/or family members regarding nutrition and weight.

It is important to document efforts to balance patient choice with sound clinical care. This isn’t always easy, Smith admits. “I have encountered surveyors who say that a resident has the right to eat whatever he or she wants, even if the person’s legal guardian and I both agree that the resident shouldn’t be able to spend money on candy and sodas. We have to protect the resident’s rights. But it’s also our responsibility to take charge of decision-making areas where they lack capacity.”

“Staff often worry that weight loss will result in survey citations,” Dharmarajan says. “But surveyors just want to be sure that patients aren’t losing weight because they aren’t getting enough to eat or the food is of poor quality.”

It is key to document how weight loss is assessed and addressed; what care goals related to weight loss are established; and the progress made on the approach, including conversations about the issue with the patient and/or family members, he says. This documentation will show surveyors that staff have identified the problem, are managing it appropriately, and are respecting the patient’s wishes and autonomy.

The Trouble with Tube Feeding

Dysphagia, especially as a patient nears the end of life, often leads to conversations about tube feeding. “Family members sometimes believe that a PEG [Percutaneous Endoscopic Gastrostomy] tube will help their loved one and make him or her feel better,” Dharmarajan says. However, “The reverse is true. This intervention doesn’t increase life expectancy or improve quality of life.”

Mechanisms That Cause or Contribute to Weight Loss

- Altered taste or smell
- ACE inhibitors
- Calcium channel blockers
- Levodopa
- Propranolol
- Dry mouth
- Anticholinergics
- Clonidine
- Loop diuretics
- Anorexia
- Metformin
- Opioids
- Stimulant medications
- Dysphagia
- Bisphosphonates
- Doxycycline
- Iron supplementation
- NSAIDs
- Potassium supplementation
- Typical antipsychotics
- Nausea or vomiting
- Amantadine
- Digoxin
- Dopamine agonists
- Selective serotonin reuptake inhibitors
- Tricyclic antidepressants

Source: https://fpnotebook.com/Endo/Pharm/MdctnsAsctdWthUntntnlWghtLs.htm

Nonetheless, family members or decision makers often are influenced by factors suc feeding and hunger, an inadequate understanding of the natural course and progression of dementia, lack of understanding about evidence regarding the risks and benefits of tube feeling, and cultural or religious beliefs. This is where a good practitioner-family relationship is so important, he says.

"No tube is placed without informed, educated consent, and this requires a serious conversation with the patient and/or his family or decision maker," Dharmarajan says. The decision about a PEG needs to be based on understanding and weighing the risks and benefits, not on presumptions. Undue expectations should not be offered.

In instances where the patient lacks decision-making capacity, has no living will, advance directive, or designated decision maker, "Clinicians must assume that a patient wants nutrition therapy until proven otherwise or until evidence is found to the contrary," Dharmarajan says. However, there is much controversy surrounding the ethics of placing PEGs in patients for whom there is reduced or limited clinical benefit. This intervention is associated with complications that may be related to the tube itself, aspiration pneumonia, and pressure ulcers.

In advanced dementia, PEGs are typically placed to prevent aspiration and pressure ulcers, improve function, and prolong life expectancy. However, the risks in reality outweigh the benefits, Dharmarajan says. For instance, patients can't move with the tube inserted, so they become bedbound and susceptible to pressure ulcers, deconditioning, muscle weakness, and other issues. Also, he notes, "Converting from hand feeding to a PEG deprives the patient of touch, taste, nurturing, and social interaction."

In fact, family members or caregivers often are the ones who gain a real benefit from a PEG. "The family's or caregiver's quality of life usually improves, as their frustrations may be tempered and they believe—falsely—that they are preventing their loved one from suffering due to hunger or thirst, he says.

An honest, open conversation with the family can help clear up misconceptions. However, this isn't always the case. "Sometimes, a family member is insistent, even after being presented with all of the information and facts," Brubaker says. "Often this is because they are dealing with their own feelings about death and dying."

When this happens, he says, it may be helpful to refocus the discussion on what their loved one would want. "We need to be aware of this and try to determine why someone insists on a PEG, even when the risks outweigh the benefits."

Sometimes Weight Loss Is Welcome

Obesity is epidemic in the United States, and it is problematic in nursing centers as well. "We are seeing more obese patients, and they often have related problems such as diabetes, heart disease, stroke, and vascular problems," says Brubaker.

"We can't expect people to change lifelong habits late in life, but we can try to reduce caloric intake and have discussions about diet and nutrition."

"You won't perform miracles with obese patients, but we can always attempt to help them lose some weight and be healthier," says Dharmarajan. "This includes trying to get them to be more active, if possible." He says it is important to be positive and encouraging and not make patients feel bad. "Set realistic targets for weight loss, and always praise the patients for positive behavior." Help them understand how weight loss is related to quality of life.

Particularly for younger patients, bariatric surgery might be an option, Dharmarajan says, but the first approach is always to address lifestyle: diet and physical activity. Always individualize, taking into context the individual's overall illness and life expectancy.

Don't Wait on Weight

Having the ability to monitor weight and quickly address weight loss is essential to keep patients as happy and functional as possible and, importantly, to keep them out of the hospital. “In the hospital, deconditioning happens remarkably quickly, and many patients come to us with malnutrition,” says Smith.

Being proactive and staying on top of weights is essential. At the same time, facilities can be creative about ways to encourage resident nutrition and healthy weights. For instance, Kings Harbor in New York, which caters to Indian seniors, has chefs and dietary teams who make authentic Indian meals. The Lott Residence, also in New York, has its dining hall on a top floor so that residents can enjoy a breathtaking view of the city while they eat.

Other facilities have private dining areas where residents can cook and eat with family members, and many communities offer special meals and celebrations featuring ethnic and regional foods popular among their residents.

“Put yourself in your patients’ shoes,” Dharmarajan says. “If you serve foods I don’t like, I’m not going to eat them. Food is one of life’s great pleasures, and we need to enable our residents to preserve this joy for as long as possible.”

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