

COMPREHENSIVE MULTIDISCIPLINARY ASSESSMENT OF THE DEMENTED NURSING HOME RESIDENT WITH WEIGHT LOSS

Nursing home regulations have specific guidelines to define weight loss in the nursing home patient. A weight change is considered severe in these conditions: loss of five pounds in one month, loss of 7.5% of body weight or greater in three months, loss of ten percent of body weight or greater in six months. Although dementia patients lose weight over time, this “normal” decline does not exceed the OBRA guidelines, e.g., 1-2 pounds per year. Significant reductions in body mass must be explained in the medical record. Some weight loss does not require investigation, e.g., patients on weight reduction programs who are obese. Other patients may sustain a certain weight but actually lose body mass, e.g., patients who lose lean body mass but gain fluid weight due to fluid retention. Those individuals with documented weight loss that meet or exceed nursing home guidelines require a careful multidisciplinary evaluation that is clearly documented in the medical record.

Weight loss in the neuropsychiatric patient can be produced by a variety of psychiatric, medical, behavioral, environmental, or dietary issues. Weight loss requires a comprehensive assessment because of the serious consequences of diminished body mass. The medical doctor, nurse practitioner, psychiatrist, dietician, nursing staff, and dentist may play a role in assessment or management of weight loss.

The standard weight loss assessment begins with the dietician who reviews the patient diet, calorie intake, eating behavior during meals, and confirms that accurate weights were obtained. The dietician must determine whether the appropriate type of diet is provided with appropriate frequency of snacking, supplementation, and dining hall support. The dietician should observe the patient on a minimum two separate occasions over at least a 15-minute period during the feeding process. The dietician must determine the quality and character of eating

dysfunction, e.g., does the patient eat every meal or just some meals, does the patient begin and then terminate, does the patient eat for several days and then no oral intake?

The medical doctor or nurse practitioner should document a physical examination on the patient who loses weight. The examination should include appropriate oral and neck examination to exclude oropharyngeal disease. The examination should include the abdomen to exclude tenderness or fecal obstipation and a rectal examination to exclude impaction. Any question about fecal obstipation can be addressed via a flat plate of the abdomen to assess colonic distension. The physician should assess for other associated medical causes of diminished oral intake, e.g., GERD, ulcers, diverticulitis, chronic pain, or congestive heart failure. The physician may order laboratory tests as indicated e.g., albumin, pre-albumin, and exclude metabolic causes for diminished appetite.

The physicians or practitioners should examine the patient to exclude depression, delirium, and psychosis that will diminish the patient's appetite or impair their ability to chew/swallow. The physician should assess the stage of dementia to determine whether the person is sufficiently demented that they are now developing chewing/swallowing apraxia. The physician or practitioner should review medications and extra-pyramidal symptoms to determine whether the patient suffers from dysarthria, psychotropic medication induced dysphasia or esophageal dysmotility. The treating physician must exclude diminished appetite from prescription of psychotropic medications e.g., anti-depressants. The physician should assess whether new medications were added that may alter metabolism of existing psychotropic medications, e.g., alteration of P450 system. Levels can be obtained when appropriate. A neurology or psychiatry consultation may be helpful for complex neuropsychiatric cases.

The nursing staff should review the procedure for feeding the patient to include staff members who are assigned to assist with feeding. Nursing staff should determine whether one to one during meals is indicated or effective and the level of skill for the staff who are performing the one to one. Nursing staff should also assess the frequency and effectiveness of snacking procedures during the day as well as hydration. The nursing staff should assess the patient's environment to determine whether a new environmental stressor was introduced e.g., new roommate, chaos on the inpatient unit, loss of an experienced caregiver, etc.

The treatment team should identify as many possible causes of weight loss and attempt to correct these problems through behavioral, nursing or environmental manipulation. Medications can be prescribed to enhance appetite; however,

literature indicates that the success of these drugs, e.g., Megace, Marinol, is limited in neuropsychiatric patients.

Many advanced stage Alzheimer patient begin to loose weight when these individuals manifest swallowing/chewing dyspraxia or apraxia. Predictors of swallowing apraxia include advanced dementia, expressive aphasia, and frequent bouts of choking and aspiration pneumonia. The literature on the value of PEG tubes indicates that this intervention is not particularly helpful for end-stage dementia patients. A first step in defining the role of a PEG tube is to identify a surrogate decision-maker or commence the process of appointing a surrogate decision-maker. The treatment team should provide the family with a careful explanation of the value and limitation of PEG tubes and these decision-makers should be afforded the opportunity to choose hospice care for appropriate patients. Nasogastric feeding has limited value with high risk for aspiration, and the need for restraints to prevent tube extraction. Nasogastric tubes are only meant as a short term, i.e., less than one to two weeks option for patients with correctable or resolvable problems. Long term nutritional support should be achieved via PEG tubes. Families must be apprised of the risk to benefit ratio for PEG tubes and the likelihood of recurrent aspiration from swallowing dyspraxia. Ultimately, the treatment team should follow the advanced directive of the patient or the direction of the surrogate caregiver.