

Things to consider when supporting care home residents, living with dementia, to drink: findings from the D-DRINC Study 🍹

Ellice Parkinson *(Research Associate: School of Health Sciences, UEA)*

Ellice.Parkinson@uea.ac.uk

@ElliceParkinson

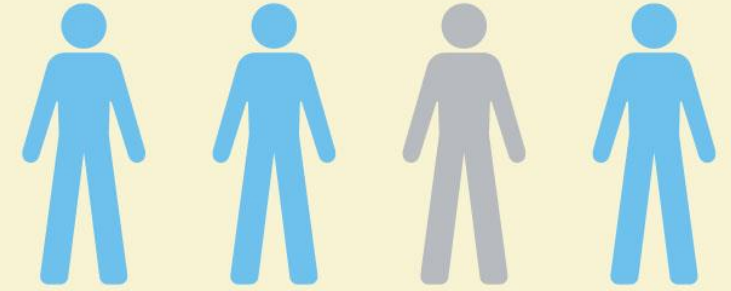
Disclaimer

- The research findings reported within this presentation come from my fully-funded PhD project, which was very kindly co-funded by UEA, NIHR ARC East of England and South Norfolk and Suffolk CCG.
- This study/project is funded by the National Institute for Health and Care Research (NIHR) Applied Research Collaboration East of England (NIHR ARC EoE) at Cambridgeshire and Peterborough NHS Foundation Trust. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care

But first, some context...

1 in 4 older people are dehydrated

Did you know that 1 in 4 older people are dehydrated?



Our research found that 1 in 4 non-hospitalised people aged 65 years and older, are dehydrated from not drinking enough¹.

To prevent dehydration, you should **drink at least 2L or 3.5 pints** of non-alcoholic drinks a day:

Dehydration is linked with kidney problems, diabetes, memory problems, UTI's, infections, pressure sores, dizziness, falls, confusion and headaches.



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Older people are more at-risk of dehydration

- Dehydration is difficult to accurately detect in older people – common signs and symptoms do not work.
- Physiological changes, mobility, cognitive ability, communication ability → these might make drinking more difficult.
- Some research shows that people with cognitive impairment, or dementia, are more likely to be dehydrated.



The D-DRINC Study

- To explore how **people living with dementia drink fluids**, in **long-term care** settings.
- NHS Ethics IRAS ID: 317892.
- The study had two parts: **D-DRINC A** and **D-DRINC B**

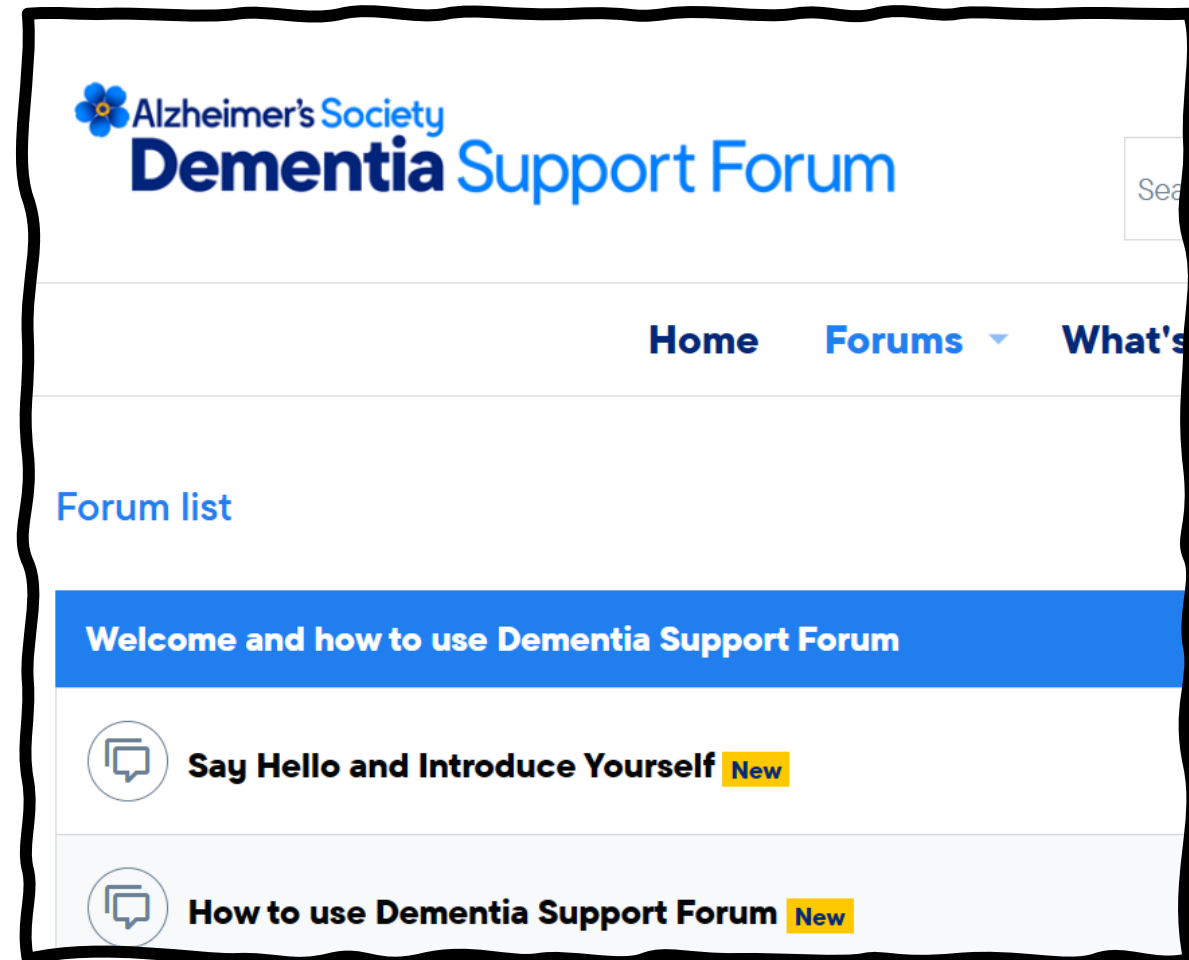
D-DRINC Study A

- 5-month ethnography
- 141 hours of day and night observations
- 17 Staff (maintenance, activities, management, kitchen and care staff)
- 5 Residents (Age range: 67-95, Various dementia diagnoses).



D-DRINC Study B

- ‘Dementia Talking Point Forum’ hosted by the Alzheimer’s Society UK.
- Search terms: drink, hydrate, juice, tea, coffee, milk, beer, dehydration, water, and **referring to someone living within LTCs.**
- 817 posts → 282 eligible posts included.



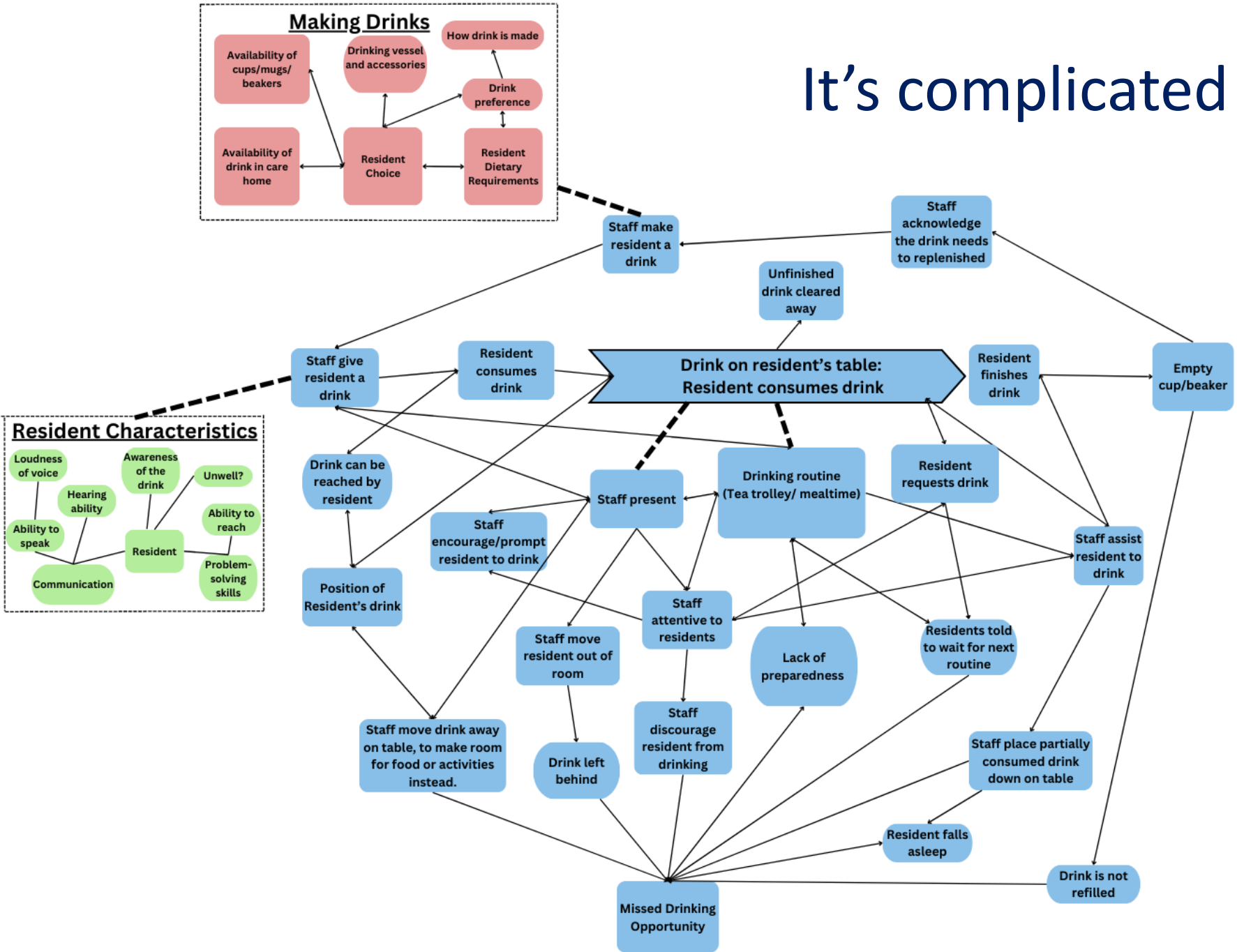
An Important 'Take-away'...

It is not a 'one size fits all'

- Every resident was unique, and some residents had no difficulty drinking or communicating to staff to request drinks.

However, it is not that simple...

It's complicated!



D-DRINC Study Findings!



Food is prioritised over drink (*Both Studies*)

- Drinks are substituted by fluid-rich foods, e.g. yoghurts, jelly.
- Weight loss is noticed and responded to, by prescribing fortified drinks, or giving calorie-dense milkshakes.
- Dining room signage shows eating, not drinking.
- Food intake is recorded, whereas drinks are not recorded for all residents.



Resident Characteristics *(Both Studies)*

- If the resident's voice is loud enough to be heard by staff.
- Problem-solving skills of resident to navigate a cup/beaker
- Ability to reach
- Ability to communicate
- Swallowing difficulties
- Resident's other health problems, *e.g. Falls, UTIs, Covid-19*



Drinking and Eating as Indicators of Health (*D-DRINC B*)

- When resident drinks well, family may report that the resident is 'improving'
- When resident is reluctant to drink, family report that the resident is deteriorating, or reaching advanced stages of the dementia.



Fear relating to drinking (*D-DRINC Study B*)

- Resident might choke on fluids
- Giving food and drink might prolong/worsen a resident's 'condition'



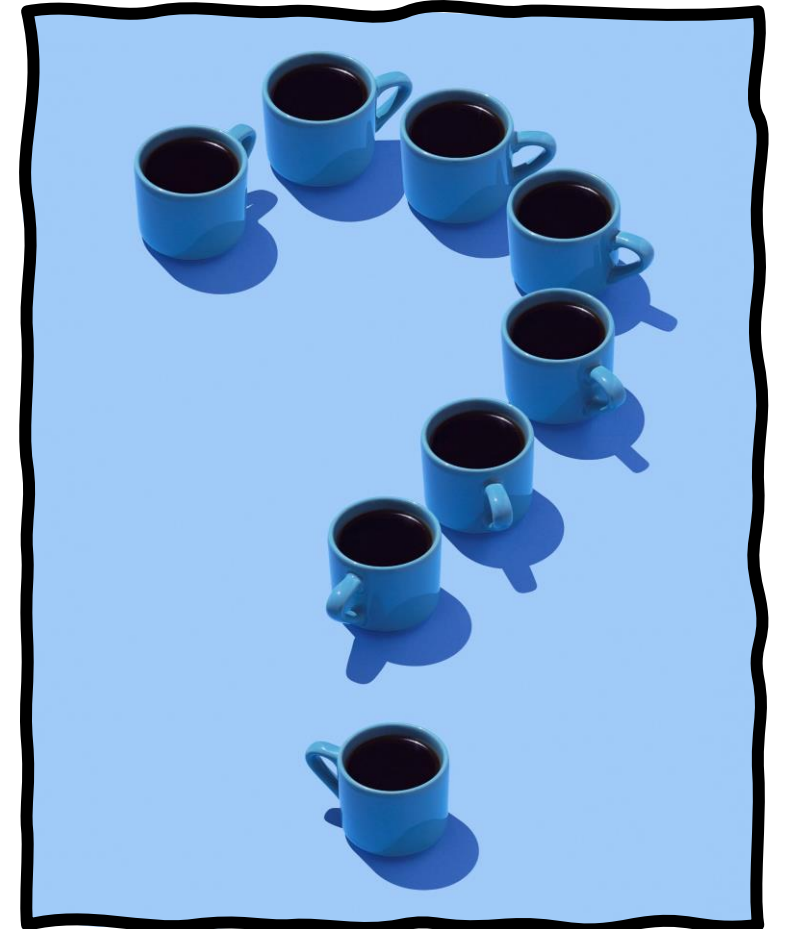
Role of the family visitor (D-DRINC Study B)

- Advocates for the resident
- Social drinking opportunities
- Assists resident to drink
- Brings favourite drinks into the home



External Support in hydration care (D-DRINC Study B)

- GPs
- SALT
- Nurses
- Paramedics
- Dieticians
- Social workers



The role of Staff (D-DRINC Study A)

- **Staff presence** led to routines being acted upon (*e.g. tea trolley, or mealtimes*), where staff served residents drinks.
- **Knowledge of resident's dietary requirements** – thickener, soya milk, pre-diabetic (*sweetener*)
- **Staff attentiveness** – “Milkshake dance”, staff hearing and responding to resident's drinks requests, and encouraging drinking.
- **Knowledge of preferred drinking vessel and drinks preferences** - *use of China mugs, use of paper cups etc.*



Furniture and Objects (D-DRINC Study A)

- **Preparedness for drink making?** –
unwashed cups, no sweetener on tea trolley
- **Availability and accessibility of resident tables** – these facilitated drinks being served to residents
- **Residents encouraged to stay seated** →
reliance on staff to provide drinks



Drinking opportunities – taken or missed

(D-DRINC Study A)

- **Resident falls asleep/sleeping**
- **Drink not refilled**, after it has been consumed
- **Minimising language** relating to drinking – *(E.g. encouraged to leave a drink to cool down, or to just take a sip).*
- **Prompting not followed up.**
- If a resident is moved, **drink not moved with them**
- **Interruptions** – phone call, doorbell rings, staff needed elsewhere.



Thank you for listening!

- I thank you so much for listening to my talk today and I hope that it has been useful for considering how to support someone living with dementia to drink, in a long-term care setting.
- Thank you to my wonderful supervisors for their guidance and support: Dr Diane Bunn, Dr Lee Hooper and Professor Fiona Poland.
- Thank you to UEA, NIHR ARC EoE and South Norfolk and Suffolk CCG for funding my PhD, which has enabled me to conduct this really important research.
- Ellice.Parkinson@uea.ac.uk

Link to my UEA Drinking webpage →

