

A Physician's Perspective on the Dining Experience in Long-Term Care

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Nursing Homes have long been the location where services are provided to individuals who suffer from chronic functional and cognitive impairments. Hopes to "cure" these chronic conditions are unfortunately unrealistic. The goals of a nursing home can be best summarized as one in which the facility cares for its "residents in a manner and in an environment that promotes the maintenance or enhancement of each resident's quality of life."¹ Maintenance and enhancement of quality of life become the focus, not cure.

Since mealtimes are often the highlights of a patient's day, they can become a significant source of improved quality of life, or a source of frustration and complaint, for the patient, family, and facility. Although there are many specialized diets from which to choose, most of these diets are not appropriate for use in a nursing home setting. Often, a more liberalized diet that provides for the patient's nutritional needs while considering the resident's medical conditions can increase the desire to eat and the enjoyment of food. This ultimately decreases the risks of weight loss and undernutrition.²

Prescribing Therapeutic Diets

Diets in nursing homes are often chosen for the patients by the attending physician based on the patient's medical condition. These are called "therapeutic diets." Therapeutic diets are defined as diets that are provided to meet the specialized nutritional needs of the patient based on his/her medical condition. The assumption is that the diet will improve the patient's overall health and condition. There are likely hundreds of specialty diets that are available for a patient. Most of them are chosen based on two parameters: texture and nutritional modifications.

Alterations in texture are chosen in order to minimize the

risks of complications. One obvious choice would be a pureed or thickened liquid diet. This diet might be chosen for a patient with a cerebrovascular accident that has resulted in some amount of dysphagia (difficulty in swallowing). Physicians prescribe these diets to minimize the risk for aspiration.

Nutritional modifications of the diet include such choices as increasing or decreasing calories or the addition of mineral or vitamin supplements. One example is to choose a cardiac prudent diet for a patient who suffers from coronary artery disease.

Initial orders for a patient's diet are usually contained within the FL-2 form* that the long-term care facility receives from the hospital. The hospital discharge summary may also serve as source of a dietary order that is either confirmed or changed by the patient's attending physician. Once a long-term care facility receives an order for a diet, there are several regulatory concerns. Long-term care facilities will create a written care plan that focuses on the specific needs of the patient. One of these needs will be the dietary restrictions that are set forth by the attending physician. "All diets... shall be ordered by the physician or other legally authorized person and served as ordered." The facility is also responsible to "ensure that each patient is provided with a palatable diet that meets his or her daily nutritional and specialized nutritional needs."³

Unfortunately, these types of "prudent" choices by a clinician may not always reach the intended goal of benefiting the patient in a long-term care facility. The use of therapeutic diets in long-term care is often unpalatable and, therefore, associated with weight loss. In fact, the American Dietetic Association recommends that, whenever possible, facilities offer a more liberalized diet to long-term care residents instead of strictly holding to therapeutic diets.⁴ Most clinicians would easily come to the same conclusion, but they are often bound by their training and experience.

* Most facilities require a physician-completed FL-2 form upon admission. The FL-2 form includes the patient's level of care and medical diagnoses and conditions.

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The training of physicians in the dietary needs and options of patients is usually limited. Most of the training occurs in a controlled hospital setting during residency. Physicians are then expected to apply this training to other settings, such as the nursing home. Applying his/her training in a new setting often presents the physician with a challenge in understanding what is best for the patient, based on the medical diagnosis versus the patient's preference. Compliance with a therapeutic diet is often very difficult for those patients with the best of intentions. It is even more challenging for those patients who have spent decades establishing their eating patterns, likes, and dislikes.

Unplanned Weight Loss

Weight loss within long-term care facilities has important clinical and regulatory significance. The prevalence of protein energy malnutrition for residents in nursing home facilities ranges from 17% to 65%.⁵ Malnutrition among elderly populations is associated with poor outcomes and is an indicator of risk for increased mortality.⁶ Research has shown that most long-term care residents who have evidence of malnutrition are on restricted diets, which might discourage nutrient intake.⁷

Weight loss is a complex issue within nursing homes, but there are several problems that can be identified as contributors. One such problem is that many residents are already nutritionally compromised by the time they are admitted to the nursing home. Acute and chronic medical conditions have often laid waste to their caloric intake. Additionally, medications, smoking, and a decline in taste and smell can all decrease food intake.

It is well established that people consume smaller amounts of food as they age. There are a number of reasons for reduced food intake among elderly people, which range from decreased physical activity to disease conditions to earlier or more powerful signals of satiety. This is called anorexia of aging.

The body of literature that focuses on the systemic effects of illness and food intake has been growing. Many of these studies have focused on cytokines. Cytokines are small proteins that are released by the body in response to most illnesses, such as cancer, heart failure, and infections. These proteins then regulate activities, such as inflammation, blood production, and fighting infection. These studies have shown that cytokines, such as interleukin 1 and 6, tumor necrosis factor, and ciliary neurotrophic factor, tend to cause muscle wasting and can reduce albumin, pre-albumin, and cholesterol.⁸ The effects of this anorexia are far reaching, producing systemic effects, such as anemia, immune dysfunction, increased infections, decreased cognition, decreased function, and orthostatic hypotension, to name a few.

When considering the management options for patients in long-term care facilities, it is important to understand that these patients are already at a disadvantage for the previously stated reasons. As a result, facilities should provide residents with adequate calories, eating and fluid intake assistance, along with focusing on treating their underlying medical illnesses.

One situation worth noting concerns the use of supplements

to improve the nutritional status of patients. Many would argue that the supplements should be given during meals in order to avoid early satiety rather than giving them prior to a meal. One study sought to answer this question and showed that when nutritional supplements were given an hour before a meal, an older person consumed more calories than when the supplement was given during a meal.⁹ It has been shown that glucose infused into the duodenum produces less satiety in older persons.¹⁰ As a result, nutritional supplements that contain carbohydrates are less satiating than supplements that are high in protein.

Some additional suggestions to enhance the dining experience in older adults in nursing homes would include cooking for simplicity by focusing on flavor and appearance of food. Ideally, only a few simple diets would be offered. However such a restrictive focus would require the involvement of the administrative staff, nursing staff, and the medical director.

My experience has shown that most families do not expect a specialized diet to be provided in a nursing home. Many families realize their loved one is already experiencing nutritional decline. For this reason, family members often are happy if the patient can take in any food. However, families of assisted living facility residents have expressed greater concerns when they feel that an adequate therapeutic diet is not available. These concerns are likely based upon the family's perception that the patient's medical illness is not as advanced and, therefore, requires continued diet modification.

Most clinicians have treated patients whose medical conditions have required changing to a less-textured diet, which then resulted in the resident eating less due to the unpleasant sight or consistency of the meal. In order to maintain appropriate and adequate levels of oral intake, clinicians may decide to return the resident to a more "risky," liberally textured diet. This decision necessitates family involvement. Family and staff education are vital for a facility to successfully implement such changes.

Summary

Unfortunately, weight loss is frequently an expected part of a patient's normal nursing home residential trajectory. However, the clinical team should determine if the weight loss is reversible. The patient's clinical condition is often such that weight loss cannot be reversed or improved. Currently, life expectancy for a patient who has been admitted to a nursing home is approximately 2.2 years. These patients have been suffering from multiple medical conditions that have ravaged their body and mind and left them in a frail condition.

Food has many personal meanings to each resident that can improve the quality of a person's few remaining years. While many specialty diets are available to patients in a hospital, many of these diets may not be appropriate for patients who reside in a nursing home. Careful attention should be given to the prescription and preparation of meals in long-term care facilities. A focus on liberalizing diets in long-term care facilities can lead to improved quality of life for many patients. **NCMedJ**

REFERENCES

- 1 Requirements for States and Long Term Care Facilities. Code of Federal Regulations. [Title 42, Volume 3. Sec 483.15. Revised as of October 1, 2004. From the United States Government Printing Office via GPO Access. Page 502-571]. Chapter IV—Centers for Medicare and Medicaid Services, Department of Health and Human Services.
- 2 Kubetin S. New guidelines target simple fixes first to curb malnutrition in nursing homes. Family Practice News. February 1, 2001.
- 3 Requirements for States and Long Term Care Facilities. Code of Federal Regulations.[Title 42, Volume 3. Sec 483.35. Revised as of October 1, 2004. From the United States Government Printing Office via GPO Access. Page 502-571]. Chapter IV—Centers for Medicare and Medicaid Services, Department of Health and Human Services.
- 4 Liberalized Diets for Older Adults in Long-Term Care. American Dietetic Association position paper. Available at: http://www.eatright.org/Member/PolicyInitiatives/index_21039.cfm. Accessed July 25, 2005.
- 5 Morley JE, Silver AJ. Nutritional issues in nursing home care. Ann Intern Med 1995;123:850-859.
- 6 Akner G, Cederholm T. Treatment of protein-energy malnutrition in chronic nonmalignant disorders. Am J Clin Nutr 2001;74:6-24.
- 7 Buckler DA, Kelber ST, Goodwin JS. The use of dietary restrictions in malnourished nursing home patients. J Am Geriatr Soc 1994;42:1100-1102.
- 8 Yeh SS, Schuster MW. Geriatric cachexia: The role of cytokines. Am J Clin Nutr 1999;70(2):183-197.
- 9 Wilson MM, Purushothaman R, Morley JE. The effect of time of administration of oral nutritional supplements on subsequent caloric intake in older persons. J Am Geriatr Soc 1997;45: 68.
- 10 Cook CG, Andrews JM, Jones KL, et al. Effects of small intestinal nutrient infusion on appetite and pyloric motility are modified by age. Am J Physiol 1997;273:R755-761.

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