Position of the American Dietetic Association: Liberalization of the Diet Prescription Improves Quality of Life for Older Adults in Long-Term Care

ABSTRACT
It is the position of the American Dietetic Association (ADA) that the quality of life and nutritional status of older residents in long-term care facilities may be enhanced by liberalization of the diet prescription. The Association advocates the use of qualified dietetics professionals to assess and evaluate the need for medical nutrition therapy according to each person’s individual medical condition, needs, desires, and rights. In 2003, ADA designated aging as its second “emerging” area. Nutrition care in long-term settings must meet two goals: maintenance of health and promotion of quality of life. The Nutrition Care Process includes assessment of nutritional status through development of an individualized nutrition intervention plan. Medical nutrition therapy must balance medical needs and individual desires and maintain quality of life. The recent paradigm shift from restrictive institutions to vibrant communities for older adults requires dietetics professionals to be open-minded when assessing risks vs benefits of therapeutically diets, especially for frail older adults. Food is an essential component of quality of life; an unacceptable or unpalatable diet can lead to poor food intake, resulting in weight loss and undernutrition and a spiral of negative health effects. Facilities are adopting new attitudes toward providing care. “Person-centered” or “resident-centered care” involves residents in decisions about schedules, menus, and dining locations. Allowing residents to participate in diet-related decisions can provide nutrient needs, allow alterations contingent on medical conditions, and simultaneously increase the desire to eat and enjoyment of food, thus decreasing the risks of weight loss, undernutrition, and other potential negative effects of poor nutrition and hydration.

POSITION STATEMENT
It is the position of the American Dietetic Association (ADA) that the quality of life and nutritional status of older residents in long-term care facilities may be enhanced by liberalization of the diet prescription. The Association advocates the use of qualified dietetics professionals to assess and evaluate the need for medical nutrition therapy according to each person’s individual medical condition, needs, desires, and rights.

Long-term care covers a diversity of services provided over a sustained period of time to people with chronic conditions and functional limitations. Needs are met in a variety of care settings. Even within institutional settings such as nursing facilities, specialized units often termed “special care” and “subacute care” have emerged in an effort to meet the needs of residents such as those with dementia or with relatively short-term postacute needs. The expanded range of services and service settings reflects, among other things, better understanding of the preferences and values of people needing long-term care, medical and technological advances that allow more care to be provided outside all types of health care institutions, and pressures to cut costs by shifting care away from high-cost arenas. Changing perspectives within facility populations are also influencing the nature of care. These individuals not only have needs and vulnerabilities but also preferences that help to retain control over major elements of the care and services received. There are significant differences between long-term care and acute care facilities; a nursing facility is not a short-term situation in which limited choice and reduced quality of life are justified by short-term clinical goals. A person does not plan to live out his/her days in an acute care facility; this rarely becomes a person’s home. This is not true for the long-term care facility, which does become the person’s home where he or she may live out his or her life. Each food, dining environment, and staffing decision made will serve to either limit or expand the nutrition and eating pleasure available to the resident for a significant portion of their remaining life.

Currently, there is a nutrition care crisis in long-term care facilities (2,3). The downward spiral of health outcomes, especially common in residents, is associated with the high incidence of malnutrition and dehydration. ADA’s Report of the Task Force on Aging and the Council for Nutritional Clinical Strategies in Long Term Care’s Anorexia in the Elderly: An Update include the following findings (2,3):

- Pressure ulcers and unintended weight loss may be symptomatic of inadequate food and fluid intake.
- As many as 65% of residents experience unintended weight loss and undernutrition.
- Weight loss is common, with 10% of residents losing 5% of their body weight in 30 days or 10% in 180 days.
- Serum albumin < 3.5 g/dL occurs in 6% to 43% of residents and 99% of residents who are hospitalized from nursing facilities.
- Among the infirm older population,
literature depicts serious nutrition-related problems that are both cause and effect of physical decline.

- Malnutrition and poor nutrition increase the likelihood of infections, pressure ulcers, anemia, hypotension, decreased wound healing, and hip fractures and contribute to confusion and impaired cognition.
- A sizeable percentage of residents are at substandard body weight.
- There is concern that the incidence of malnutrition is underreported.

Care for residents must meet two goals: maintenance of health through medical care and maintenance of quality of life. These goals often seem to compete, resulting in the need for a unique approach to medical nutrition therapy (MNT). Unfortunately, knowledge of nutrient requirements for the older adult has not been fully researched. What is known is that physiological and functional changes that occur with aging can result in changes in nutrient needs. The Dietary Reference Intakes provide a more complete set of reference values for those over 70 years of age (4). The Dietary Reference Intakes may be used in assessing current nutrient intakes and planning future changes in the residents' diet. The Dietary Guidelines for Americans 2005 emphasize a diet rich in both fruits and vegetables; fluids; whole grains; low-fat milk; and foods high in potassium; decreasing sodium intake; and increasing vitamins B-12 and D from fortified foods, supplements, or both (5).

As people age, physiological factors alter eating and appetite. Food intake decreases even in healthy older adults (6,7) and is often called “anorexia of aging.” Anorexia of aging is the physiological decrease in food intake that occurs to counterbalance the declines in physical activity and resting metabolic rate that is generally seen in older adults. This occurs over time and includes the following: a decrease in the endogenous feeding drive, specifically a decrease in fat intake; increased levels of cholecystokinin and decreased nitric oxide synthesis, possibly lowering satiety; increased production of leptin; and altered taste thresholds and decreased olfaction (8). Among older people, weight loss is associated with frailty, functional impairments, immune disorders, pressure ulcers, hip fractures, cognitive impairment, low quality of life, and increased mortality. Research indicates it is critical that any weight loss in older adults be prevented (6,7).

Among the predictive factors of healthful aging, nutrition is one of the major determinants. These determinants maintain three key behaviors: low risk of disease and disease-related disability, high mental and physical function, and active engagement of life (9). Typically, the Nutrition Care Process includes assessment of nutritional status through development of an individualized nutrition intervention plan that frequently features a therapeutic diet appropriate for managing a disease or condition (10). MNT must always address medical needs and individual desires. This balance is especially critical for older adults in long-term care because of the focus on maintaining quality of life. Overall health goals may not warrant the use of a therapeutic diet because of its possible negative effect on quality of life. Often, a more liberalized nutrition intervention allowing a resident to participate in his or her diet-related decisions can provide for nutrient needs and allow alterations contingent on medical conditions while simultaneously increasing the desire to eat and enjoyment of food. This ultimately decreases the risks of weight loss and undernutrition (11).

### DEMOGRAPHICS AND TRENDS IN LONG-TERM CARE

The population over 65 years old numbered 35.9 million in 2003 (12), representing 12.3% of the US population. By 2030, there will be approximately 71.5 million, 20% of the population. The 85+ population is projected to increase from 4.6 million in 2002 to 9.6 million in 2030. Minority elderly populations are also growing, projected to be 26.4% of the older population by 2030 (up from 17.2% in 2002). These changes will have dramatic effects on health care and nutrition care of the nation’s older adults (13).

Nursing facility residence is an alternative to care provided at home or other community settings. Recent declines in nursing facility residence may reflect changes in the health care system affecting older Americans. Other residential care and services, such as assisted living and home health care, have become more prevalent.

In 2000, 1.56 million, 4.5% of all Americans over 65 years of age, lived in nursing facilities. When broken down by age group, percentages increased dramatically by age: 1.1% for people 65 to 74 years, 4.7% for those 75 to 84 years, and 18.2% for people 85 years and older. Compared with residents in 1985, those in 1999 were more functionally impaired and received more services. Approximately 97% of residents received assistance with one or more activities of daily living; 77% received assistance with four to six. The increase in assistance between 1985 and 1999 is greatest among residents receiving this higher level of assistance, indicating a serious deterioration in health and a loss of independence for individuals in nursing facilities (14).

The average length of stay in a nursing facility is 2.5 years, according to the National Center for Health Statistics’ 1999 National Nursing Home Survey (15). Because the length of stay is so long, the facility is considered the resident’s home. The current trend is toward improving quality of care and quality of life and increasing each resident’s role in making informed care decisions. These factors are outlined in the federal regulations issued by the Centers for Medicare & Medicaid Services (CMS) as a result of the 1987 Omnibus Budget Reconciliation Act (16) and in the Joint Commission on Accreditation of Healthcare Organizations’ Comprehensive Accreditation Manual for Long Term Care (17).

### INSTITUTIONALIZED OLDER ADULTS AND THE RISK OF MALNUTRITION

Residents in long-term care settings are often frail elderly adults, suffering from a host of chronic and acute diseases and conditions. Elderly people using long-term care are more likely to be women (75% of all residents) (14), cognitively impaired, and have a greater number of limitations with activities of daily living (18). They are more likely to experience a number of problems (physical, social, acute, chronic) that exacerbate poor health and compromise quality of life. Nutrition care is recognized as an important factor in improving longevity and quality of life, but the nutrient
requirements of this population are not yet well understood (19). Good nutritional status in older adults benefits both the individual and society: Health is improved, dependence is decreased, time required to recuperate from illness is reduced, and use of health care resources is contained (20,21). Undernutrition adversely affects the quality and length of life and, therefore, has aroused the concern of geriatric health professionals (22). The prevalence of protein energy undernutrition for residents ranges from 23% to 85%, making malnutrition one of the most serious problems facing health professionals in long-term care (23). Malnutrition is associated with poor outcomes and is an indicator of risk for increased mortality (24). It has been found that most residents with evidence of malnutrition were on restricted diets that might discourage nutrient intake (3). Dietetics professionals must overcome many hurdles to help residents obtain appropriate nutritional status. Barriers to adequate nutrition can generally be divided into two broad categories: physical problems and psychosocial concerns.

**Physiological Problems**
Common physical problems affecting nutritional status include poor appetite, weight loss, pressure ulcers, chronic disease, eating dependency, sensory loss, and poor oral health. In addition, older adults often take several different medications at once, a situation that may impact nutrient intake and utilization. Any of these problems can lead to or exacerbate existing malnutrition. Families, caregivers, and the health care team need to find a balance between the benefits and risks of therapeutic diets for those residents identified with having poor appetite and weight loss.

Loss of appetite is a major cause of undernutrition in long-term care. Unrecognized anorexia may lead to debilitation, primarily from weight loss (25). As appetite diminishes, intake of total energy, protein, vitamins, and minerals is reduced, depleting the body of necessary nutrients. This predisposes older adults to an increased risk of illness and infection. At the same time, infections may lead to a higher metabolic rate, increasing total energy and protein needs. A vicious circle ensues. Stringent diet restrictions limiting familiar foods and eliminating or modifying seasonings may contribute to poor appetite; decreased food intake; and increased risk of illness, infection, and weight loss.

Weight loss in residents may be the result of a number of physical and emotional circumstances. Unintentional weight loss has been correlated with increased mortality, compromised ability to resist infections, and increased incidence of pressure ulcers (26,27). Protein-energy malnutrition (PEM) is common in connection with chronic disease and is associated with increased morbidity and mortality. Because the risk of PEM is related to the degree of illness, causal connections between malnutrition and a poorer prognosis are complex (24). In a review of changes in lean body mass, Demling and colleagues noted that changes in body composition are more reliable indicators of morbidity than are changes in body weight, with a decrease in lean body mass of 40% associated with 100% mortality (28).

When trying to minimize weight loss, limiting appealing foods may be counterproductive, whereas increasing exercise may increase food intake in older persons (29).

Older adults experience a higher incidence of risk and development of pressure ulcers. One study found that 11.6% of adults over 70 years of age experienced pressure ulcers, compared with only 6% of younger persons (30). Pressure ulcers are costly, with an estimated yearly median cost of $25,000 to $30,000 (30). Another study estimates costs between $47,713 and $94,640 (30,31). Among residents, pressure ulcers are associated with a fourfold increased risk of death, and a sixfold increase if the wound does not heal (30). Although pressure ulcers have multiple causes, nutritional status is a contributing factor. Residents who refuse to eat unpalatable and unappealing foods because of a restrictive diet order and bland food are at risk of decreased food intake that can contribute to poor nutritional status, increasing risk of pressure ulcer development, and/or poor wound healing.

Older adults also suffer from a higher incidence of chronic disease, notably cerebral vascular accident, arthritis, Parkinson’s disease, diabetes, and dementia. Some diseases (e.g., chronic obstructive pulmonary disorder and congestive heart failure) may cause increased metabolic demands and diminished appetite. Dementia syndromes may impair self-feeding, alter appetite, and increase energy needs. Nutrition restrictions may make food less appetizing, resulting in diminished intake and weight loss.

Residents ingest an average of eight medications per day. Of the more frequently used, over 20 are known to cause reduced food intake and have adverse effects such as anorexia, nausea, vomiting, food aversions, somnolence, and disinterest in food (3). Accommodating food preferences may be essential to counteracting the effects of polypharmacy.

Dysphagia also contributes to the decline in oral intake and enjoyment of eating (32). Dysphagia occurs in more than 10% of older adults in acute care facilities, 30% to 60% of long-term care residents, and more than 75% of those with strokes affecting the brainstem (33). According to the CMS Online Survey, Certification, and Reporting statistics (May 27, 2005), 35.6% of nursing facility residents received mechanically altered diets (including pureed and chopped), up from 13% in 1992 (34). It is essential to maintain the highest level dysphagia diet tolerated and to prepare and serve altered-consistency foods in an attractive, appetizing manner.

Sensory loss is common in the aging process. Nutrition restrictions, coupled with sensory losses, may result in limited food enjoyment and compromised food intake, potentially leading to unintentional weight loss and malnutrition (35).

Visual impairment can diminish the appreciation of the color of foods and the ability to recognize them. The
role of aroma in stimulating appetite is diminished with the loss of olfactory ability. The flavor of foods may be altered because of loss of both olfactory and taste perception associated with aging, chronic health problems, and medications (6,29,36,37). Therapeutic diets low in sodium, sugar, and fat can contribute to poor appetite in residents because the food does not taste good.

Older adults are more likely to develop dry mouth and other oral-health problems. Several epidemiological studies have indicated that residents with impaired dentition and chewing ability consumed fewer calories (35). They consumed less protein, fat, carbohydrate, fiber, calcium, and antioxidants (38). Lack of teeth, extensive alveolar bone or residual ridge atrophy, or poor oral health reduces chewing ability and limits food selection. Poor dentition or use of dentures affects the ability to perceive food flavor (37,39).

STAFF IMPACT

ADA recognizes that the CMS has given extensive consideration to modifying regulatory policy to ameliorate the difficulties facilities encounter in ensuring that residents receive adequate nutrition and fluid intake. A federal report in July 2000 addressed the fact that understaffing contributed to “increased incidences of severe bed sores, malnutrition, and abnormal weight loss among nursing facility patients” (43). A study done by Kayser-Jones (41) indicates that a minimum of 20 to 30 minutes is needed to assist adequately a dependent resident with his or her meal and to promote a quality experience for the resident. Simmons and colleagues concluded that the Minimum Data Set (MDS) weight-loss quality indicator reflects differences in the prevalence of weight loss among long-term care facilities. Nursing facilities with a lower prevalence of weight loss have staff to provide verbal prompting and social interaction to more residents during meals; however, adequacy and quality of assistance care needs improvement in all facilities (44). Without adequate staffing, residents needing assistance will be at major risk of unintentional weight loss, malnutrition, and resultant complications.

Staff attitude toward food served may also determine whether the resident consumes the food provided. When food is presented in a positive manner, overall intake may improve. It is vital for the dietetics professional to involve and educate all levels of the nursing profession that come in daily contact with residents. This communication will lead to either success or failure of the nutrition measures in the long-term care arena.

Incidence of eating disability in nursing facilities is high. Data collected by the CMS in 1999-2000 indicate that 28% of nursing facility residents require assistance with eating; 19.2% are totally dependent on eating assistance (34). A decline in functional ability can be a factor in accessing adequate nutrition and is enhanced by staff shortages and the length of time required to assist residents with meals. Many residents require coaxing and encouragement to eat, increasing the staff time requirement.

An estimated 23% to 85% of residents suffer from malnutrition or dehydration (45,46). Research has shown that older people are much less likely than younger people to make up for poor food or fluid intake at one meal by eating more at subsequent meals (47). Inadequate intake at even a few meals per week will inevitably result in unintended weight loss and malnutrition. The only way to reduce the rate of malnutrition and dehydration is to ensure that food and fluid consumption are optimized during each meal, snack, and hydration opportunity. Many residents are physically dependent on others for assistance with eating and drinking (45). Older people, who are willing and able to eat with assistance and encouragement, should not suffer from malnutrition and dehydration, most certainly, not while residing in health care facilities.

THE ROLE OF MNT IN LONG-TERM CARE

For most frail elderly in long-term care, the challenge is simply getting food into their bodies. Nutrition sometimes takes a backseat to satisfying a resident’s wants and cravings. Overly restrictive diets, such as those low in cholesterol/fat, salt, and sugar, may take much of the enjoyment out of eating. Given the numerous problems faced by dietetics professionals who work in long-term care, it is necessary to evaluate the role of therapeutic diets in this population. The term “therapeutic diet” refers to a diet ordered by a physician as part of a treatment of a disease or a clinical condition to eliminate, decrease, or increase certain substances in the diet (48). Residents often find these diets unpalatable, which may lead to weight loss, low albumin levels, and orthostatis (49). Traditionally, low albumin levels have been considered indicative of PEM. Some have felt that the nutritional significance of this laboratory level has been strengthened by evidence linking low levels to increased morbidity and mortality. However, current evidence does not support the use of serum albumin as an objective marker of nutritional status because
it may be impacted by infection and acute inflammatory response (50).

The following questions need attention: Are restricted diets necessary? Do the diets offer health benefits to justify their use? Which residents will benefit from a therapeutic diet? These questions must be answered on an individual basis. Therapeutic diets, although designed to improve health, often create their own challenges. Modifications may have an impact on the flavor, variety, or texture of food, affecting its appeal. Research suggests that the goal of foodservice should be to create a meal situation as natural and independent as possible, comparable with eating at home; making choices from a wide range of menu items tailored to the resident’s wants; and seeking input from residents, family, and staff (51).

The use of a more liberalized approach produces several benefits, including better intake, lower incidence of unintended weight loss, more consistent blood glucose levels, and, perhaps most important, quality of life for the residents.

DISEASE-SPECIFIC CONDITIONS

Obesity

In 1999-2000, for Americans at or over 65 years of age, 68.8% were overweight, and 29.8% were obese (52). A recent systematic review of the literature found good evidence that, among older adults, the all-cause mortality risk associated with obesity diminishes with age (53). A recent study suggests that, among the elderly population, obesity affects disability but not life expectancy (54). Although risk of all-cause mortality with obesity is much diminished or absent by age 75 years, alterations in disease-specific mortality or morbidity risk are largely unknown. In addition, random clinical trial evidence for clinical benefits with weight loss is based on a select sample. Longitudinal data linking higher body mass index with lower incidence of and mortality from hip fracture in the elderly population, coupled with random clinical trial evidence of declining bone mineral density with weight loss interventions, indicate that intentional weight loss has adverse bone effects in older individuals. Obese individuals are at lower risk of osteoporosis than those with lower body weight (53). Use of liberalized diet prescriptions to maintain usual body weight should be incorporated in the resident’s care plan.

Diabetes

Research has shown that the risk of developing diabetes increases with age. It also confirms that older individuals living in institutionalized settings have a greater chance of being malnourished, a condition often associated with adverse outcomes. Providing adequate nutrition should be the primary concern in these facilities. Studies have shown that carbohydrates from sugars are no more rapidly absorbed than carbohydrates from starch when included as part of a meal plan (55). The goals of nutrition intervention should include the improvement of overall health through optimal nutrition. Residents eat better when they are given a less restrictive diet of regular foods rather than an energy-controlled diet (56,57). The current American Diabetics Association position statement reads as follows: “The imposition of dietary restrictions on elderly residents with diabetes in long-term health facilities is not warranted.” The position paper also states there is no evidence to support “no concentrated sweets” or “no sugar added” diets. It is preferable to make medication changes rather than implement food restrictions to control the blood glucose (55). Support for the use of regular diets for residents with type 2 diabetes is provided by a study of 28 residents, 14 who received a regular diet and 14 who received a no-concentrated-sweets diet. No change in the subjects’ hemoglobin A1c in either group was found after 6 months (58). The benefits of regular diets include consistent mealtimes and portion sizes and the potential to improve quality of life and intake. A key element in the use of regular menus in long-term care is consistency in carbohydrate intake at meals and snacks. Such an approach incorporates sucrose-containing foods as part of the carbohydrate intake, keeping with current recommendations (55).

Blood glucose levels should be monitored to evaluate the effectiveness of the nutrition intervention. Residents who do not tolerate a less restrictive approach need to be reevaluated by a dietetics professional so that recommendations for adjustment of diabetes medication or individualization to a more controlled diet can be made.

Cardiac Disease

Anorexia associated with cardiac disease may also lead to weight loss. Cardiac medications often suppress the resident’s appetite (59); other medications may increase serum lipids, most notably the corticosteroid prednisone and certain diuretics. Available epidemiological evidence indicates that, as age increases above 44 years, the importance of elevated serum cholesterol levels as a risk factor for coronary heart disease decreases, virtually disappearing after age 65 years (60-62). Therefore, the appropriateness of low-cholesterol diet prescriptions for older adults in long-term care facilities is questionable (63-66). Although practitioners should be cognizant of cardiac problems, malnutrition is a more serious threat for most older adults than elevated cholesterol (67). Menu planners should not attempt to improve a client’s lipid profile by implementing radical shifts in eating patterns. The goals of dietary modification are to maintain current weight and blood cholesterol levels, to encourage consistent dietary intake, and to preserve eating pleasure and quality of life. Menu modification may include using reduced-fat (2%) milk or, if tolerated, low-fat (1%) or nonfat (skim) milk; substituting polyunsaturated oils and margarines for saturated fats; and substituting lean cuts of meat for fatty meats (45). Older adults should make every effort to eat a healthful diet and follow the Dietary Guidelines for Americans 2005.

Emphasizing fruits, vegetables, low-fat dairy, and lean meats and reducing fat can still be appetizing and yet not overly restrictive. Using culinary expertise to enhance the taste and flavor of food may improve overall intake while still providing a heart-healthy diet (45).

Hypertension

Low-sodium diets are often poorly tolerated in older adults and may lead to loss of appetite, hyponatremia, or confusion (68). A decrease in intake in reaction to a low-sodium diet may
worsen nutritional status and facilitate the onset of cardiac cachexia, respiratory infections, or pressure ulcers. Diets low in sodium may be perceived as bland and tasteless, diminishing the pleasurable experience of eating and promoting unnecessary weight loss. The possibility that the benefit of antihypertension treatment does not extend to individuals beyond a certain age threshold has been supported by several researchers (69). A recent study found that a low-salt diet could actually increase the risk of dying from heart disease. Researchers found that intake of less than 2,400 mg of salt a day was associated with a 50% higher risk of heart disease. For each 1,000-mg reduction in salt intake, the risk for cardiovascular mortality increased 1% (70). Other research suggests that congestive heart failure in older adults could be controlled with the use of drug therapy and a mild sodium restriction of 4 to 6 g/day (the usual, nursing home regular diet) instead of the 2 g sodium diet prescription (68,71-73).

Evidence from Dietary Approaches to Stop Hypertension (DASH) should also be considered. Research suggests that this diet substantially reduced blood pressure in both nonhypertensive and hypertensive individuals. The diet is rich in potassium, magnesium, and calcium with restrictions/limitations in sodium, saturated fat, and cholesterol (74). The DASH diet is a diet reflecting nutrition needs, not just a diet for control of hypertension (75). Menu modifications may include the following: use fresh or frozen rather than processed and prepared foods, use less salt in cooking, and do not place a salt shaker on the table but allow flavoring with spice blend/enhanced flavor options instead of salt (46). Evidence is emerging that suggests that compensating for taste and smell losses with flavor-enhanced food can improve palatability and/or intake, increase salivary flow and immunity, reduce chemosensory complaints in both healthy and sick elderly, and lessen the need for table salt (74-76).

**Chronic Kidney Disease (CKD)**

Older adults with CKD in conjunction with other medical conditions often have a high incidence of malnutrition related to high urea levels causing poor appetite, nausea, and vomiting (77,78). Measurements to estimate malnutrition are not all useful with CKD. Body weight and albumin may not be reliable because of the water the body can withhold causing edema and/or fluid imbalances. Residents with CKD require special consideration (77). It is well documented that up to 50% of hemodialysis clients are malnourished (77). The standard for determining renal status is glomerular filtration rate. Generally, predialysis requires moderate protein restriction of 0.6 to 0.8 g/kg/body weight to reduce excess urea production. When glomerular filtration rate drops <15, indicating kidney failure and dialysis is started, extra protein is needed (79). There is an estimated protein loss of 8 g to 12 g with each dialysis treatment, increasing protein requirements for individuals already at risk (79). Protein loss cannot be prevented, but the gap between synthesis and loss can be decreased with the correct nutrition therapy. Interventions may include liberalization of the diet prescription. Laboratory values, food intake records, and weight loss/gain should be closely monitored.

**REGULATIONS**

Nutrition care for the resident is both driven and hindered by the regulatory environment. On one hand, regulations speak of physician-prescribed therapeutic diets, and, on the other, they speak of resident rights. Both regulations and ethics demand that facilities meet the nutritional needs of residents while maintaining their dignity and quality of life. Current federal regulations protect a resident’s right to refuse services or treatments and to choose alternatives. The law defines resident rights as the right to be free of interference, coercion, discrimination, and reprimand from the facility in exercising his or her rights. According to federal regulations, “The resident has the right to be fully informed in language that he/she can understand of his/her total health status (ie, functional status, medical care, nursing care, nutritional status, rehabilitation, and restorative)” (16). The dietetics professional should educate the resident (or legal guardian) about the risks and benefits of refusing the therapeutic diet. It is essential to document any conversations, care conference discussions, and decisions of the resident and/or family members regarding nutritional interventions in the medical record. The dietetics professional must take a lead role in the assessment and counseling and must continually reassess, reeducate, and discuss new information with the resident (or legal guardian) as the resident’s condition changes so that informed decisions can continue to be made.

In 1998, resulting from recognition of many of these problems, the CMS implemented survey initiatives focusing on four key areas: unintentional weight loss, pressure sores, dehydration, and dining and foodservice. The initiatives give guidance to surveyors on how to assess whether a facility is noncompliant in any key area. The initiatives are also a wealth of information for the dietetics professional and can assist in determining where changes are needed. Each of these investigative protocols addresses food and nutrition concerns. The pressure ulcer protocol addresses the need for complete, individual assessment to identify residents at risk of developing pressure ulcers, to identify the level and nature of the risks, and to identify the presence of pressure ulcers. It now includes parameters for protein (1.2 to 1.5 g/kg/body weight) for residents at risk or who already have pressure ulcers. The protocol for hydration addresses the need to assess the risk factors for dehydration, including whether the resident is dependent on staff for provision of fluid intake and whether the staff is providing sufficient fluids and providing fluids the resident prefers. The unintentional weight loss protocol addresses the need to assess risk factors such as malnutrition, dehydration, dysphagia, poor fitting dentures, taste and sensory changes, dependence on staff for eating assistance, and many others. This protocol also guides surveyors in assessing whether care plan interventions “such as . . . alternative eating schedule, liberalized diet . . . assistance and/or increased time to eat” have been developed to provide an aggressive program of consistent intervention by all appropriate staff.” The dining and food service protocol
addresses the need to provide nourishing, palatable, attractive meals that meet the resident’s daily nutritional and special dietary needs; to provide services to maintain or improve eating skills; and to ensure that the dining experience enhances the resident’s quality of life and is supportive of the resident’s needs, including food service and staff support during dining (80).

THE ROLE OF DIETETICS PROFESSIONALS IN THE MANAGEMENT OF MNT FOR LONG-TERM CARE RESIDENTS

Dietetics professionals’ primary role in the management of MNT for long-term care residents is to develop a nutrition care plan consistent with each resident’s nutritional status, overall medical condition, personal preferences, and needs. Dietetics professionals can implement MNT in the following steps using the Nutrition Care Process:

1. Assess Nutritional Status

The dietetics professional should work with the health care team to evaluate all aspects of the resident’s nutritional status. The dietetics professional should also determine the resident’s goals and desires relating to MNT and especially the resident’s feelings regarding special diet therapy. According to the 1987 Omnibus Budget Reconciliation Act, it is the resident’s right to refuse treatment if they have first been informed of the risks vs benefits of refusing that treatment (16).

There are many tools available to assist in the nutrition assessment process. The Nutrition Risk Assessment developed by the Long-Term Care Task Force of ADA, in conjunction with the Consultant Dietitians in Health Care Facilities dietetic practice group, specifically addresses issues pertinent to older adults in long-term care facilities (81).

The Nutrition Screening Initiative has developed tools to assist in screening noninstitutionalized older adults for early detection of nutritional risk. The DETERMINE Your Nutritional Health checklist may be helpful for early identification of potential problems (82).

The CMS, the ADA, the American Academy of Family Physicians, and the National Council on the Aging, Inc developed the Nutrition Care Alerts to assist long-term care staff in identifying the warning signs of unintentional weight loss, pressure sores, and dehydration. The tool assists staff in learning the warning signs and provides suggestions on interventions (83). In addition, the CMS developed the Nutrition and Hydration Care Fact Pac for Nursing Home Administrators and Managers. This includes information for use in training staff on the early warning signs that may indicate risk for malnutrition and dehydration along with appropriate interventions to avoid problems (84). The ADA also has numerous publications that can help the dietetics professional in the area of assessment.

2. Determine the Nutrition Diagnosis

Development of this area continues as the Nutrition Care Process is fine-tuned. Dietetics professionals should include diagnostic problems or labels, identify the cause/contributing factors, and review the signs and symptoms or defining characteristics gathered during the assessment phase. A nutrition diagnostic statement should be developed in a PES format that states the problem (P), the etiology (E), and the signs and symptoms (S).

3. Determine Appropriate Nutrition Intervention

After gathering assessment information, the dietetics professional recommends the appropriate nutrition intervention addressing medical, psychosocial, and quality-of-life needs. The Nutrition Risk Assessment (81) includes suggestions for appropriate interventions for each of eight strategy areas including weight status, oral nutrition intake (food), oral nutrition intake (fluids), medications (nutrition related), relevant conditions and diagnoses, physical and mental functioning, laboratory values, and skin condition. In addition, the Clinical Guide to Prevent and Manage Malnutrition in Long-Term Care, developed by the Council for Nutrition (85), suggests specific interventions to consider for the family, physician, dietetics professional, pharmacist, and nursing staff, including discontinuing the therapeutic diet and discussing food preferences (eg, ethnic, comfort foods, and favorite foods).

The dietetics professional and food-service manager should work closely to develop menu offerings and dining experiences to increase the enjoyment of eating. Efforts should be made to provide a pleasurable dining experience that preserves resident dignity and accommodates preferences. Together, they should coordinate a dining environment that maximizes residents’ potential to enjoy meals and the associated social aspects of dining.

The dietetics professional should integrate the nutrition care plan with the interdisciplinary plan of care. The resident and his/her family are encouraged to participate in the care planning conference and assist in the development of goals and approaches. Interdisciplinary care plans are developed from a federally mandated resident assessment instrument known as the Minimum Data Set (MDS) and the Resident Assessment Protocol (86), along with additional in-depth assessments by long-term care professionals and include nutrition assessment and monitoring. The health care team, including the dietetics professional, needs to take into consideration the resident’s wishes, assessed needs, and quality of life in developing an acceptable approach. Implementing, monitoring, and evaluating the nutrition intervention also involves an interdisciplinary team approach. It is important that the health care team supports the resident’s decision and continues to advocate for the resident.

The health care team must educate the resident and/or the family/guardian about the nutrition intervention. To help the resident make informed decisions, the dietetics professional should explain the type of MNT indicated.

4. Monitor and Evaluate Outcomes

The dietetics professional, with assistance from other members of the health care team, must monitor the outcomes of MNT and provide ongoing assessment of the resident’s nutrition needs throughout the year. This includes ongoing communication with the resident about his or her individual nutrition needs and allowing...
the resident the opportunity to change his or her mind regarding treatment at any time. As long as the resident is deemed competent, his or her decision stands and must be acknowledged.

SUMMARY
Malnutrition, weight loss, and resident satisfaction are serious issues that need to be addressed by dietetics professionals working in long-term care. Despite the growing body of evidence discouraging prescribing therapeutic diets for residents, these diets are still commonly prescribed, sometimes to residents with clear evidence of malnutrition. MNT for these residents is multifaceted and critical to reducing the risks of malnutrition and weight loss. To meet these needs, dietetics professionals must consider each person holistically, including personal goals, overall prognoses, benefits and risks of treatment, and, perhaps most important, quality of life. When should therapeutic diet prescriptions be used? When there is some point in doing so—when a realistic overall goal is for stabilization or improvement and when adjusting calories and macro- and micronutrients and/or fluids have some plausible potential to affect a resident’s physical functioning, well-being, and quality of life. Health care professionals must understand that liberalizing the diet prescription for those residents does not represent a disregard for the person’s health but is an appropriate response to the shift in health care priorities. A liberalized approach to diet prescriptions, when appropriate, can enhance both quality of life and nutritional status. This will increase the resident’s satisfaction with the meals provided, reducing the risks of malnutrition and weight loss, and, in the end, save facilities from survey citations and litigation.

Dietetics professionals must help residents and health care team members assess the risks vs benefits of therapeutic diets. At present, no marker of nutritional status other than weight has proven reliable (sensitive and specific) enough to be used routinely in a long-term care population. Laboratory results alone cannot show that a nutritional intervention is needed (87). Changes in diet and exercise patterns are most effective in the prevention of nutrition-related conditions when instituted early in life, but positive effects can occur at any age (88). Optimal nutritional status ultimately depends on adequate food intake. A diet cannot be effective if it is not eaten. If a resident is noncompliant and does not support the prescribed MNT, the diet may be ineffective and frustrating for both the resident and the health care team. In addition, if a resident’s appetite is extremely poor or if substantial weight loss is a problem, treatment of malnutrition may override concern for an elevated serum cholesterol level or a history of hypertension. Restricting food in an effort to control blood glucose is not appropriate because of the risk of malnutrition; instead, the resident’s medication should be reviewed.

A liberalized approach to diet prescriptions, when appropriate, can enhance both quality of life and nutritional status.

Food has emotional as well as physical importance. The relationship of food to culture, ethnicity, religion, or personal meaning is a special consideration in any nutrition intervention. The pleasurable experience of food and eating contributes notably to a person’s quality of life and nutritional status (89). Dietetics professionals must help residents and health care team members prioritize nutrition problems and recommend the nutrition intervention that balances both medical and quality-of-life needs. Thus, it may not be advantageous to initiate a restrictive nutrition prescription for a resident who suffers from poor appetite and substantial, unintentional weight loss.

References


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ADA position adopted by the House of Delegates on October 26, 1997, and reaffirmed on June 22, 2000, and on May 25, 2004. This position will be in effect until December 31, 2009. ADA authorizes republication of the position statement/support paper, in its entirety, provided full and proper credit is given. Requests to use portions of the position must be directed to ADA Headquarters at 800/877-1600, ext. 4896 or ppapers@eatright.org. Author: Kathleen C. Niedert, MBA, RD, FADA (Western Home Communities, Cedar Falls, IA). Reviewers: Digna Cassens, MHA, RD (Country Villa Health Services, Los Angeles, CA); Dietetic Technicians in Practice dietetic practice group (Deborah Redditt, DTR, Clinical Nutrition Management Consultant, Palm City, FL); Becky Dorner, RD (Becky Dorner & Associates, Inc, Akron, OH); Karen Funderburg, MS, RD (University of Oklahoma Health Sciences Center, Oklahoma City, OK); Mary Hastings Hager, PhD, RD, FADA (ADA Government Relations, Washington, DC); Rona Martiyan, MS, RD (GER-NUTRITION, Ellicott City, MD); Jennifer A. Weber, MPH, RD (ADA Government Relations, Washington, DC). APC Workgroup: Naomi Trostler, PhD, RD (chair); M. Patricia Fuhrman, MS, RD, FADA; Georgianna Walker, MS, RD (content advisor).