Position of the American Dietetic Association: Individualized Nutrition Approaches for Older Adults in Health Care Communities

ABSTRACT
It is the position of the American Dietetic Association that the quality of life and nutritional status of older adults residing in health care communities can be enhanced by individualization to less-restrictive diets. The American Dietetic Association advocates for registered dietitians to assess and evaluate the need for nutrition interventions tailored to each person’s medical condition, needs, desires, and rights. Dietetic technicians, registered, assist registered dietitians in the assessment and implementation of individualized nutrition care.

HEALTH CARE COMMUNITIES
Health care communities are living environments for persons with chronic conditions, functional limitations, or need for supervision or assistance. Health care communities include assisted living facilities, group homes, short-term rehabilitation facilities, skilled nursing facilities, and hospice facilities. Health care communities differ from acute care facilities in that long-term treatment and lifestyle goals take precedence over short-term clinical goals.

Care for individuals who reside in health care communities must meet two goals: maintain health and preserve quality of life. These goals can compete when it comes to delivery of nutrition care. Food must meet nutrition needs but also enhance quality of life.

Trends in Health Care Communities
America is aging rapidly. By 2030, predictions indicate that the older-than-age-65-years population will increase to approximately 72.1 million, or 19.3% of the population (1). This equates to a remarkable 52% increase since 2007. The number of people aged 85 years or older is projected to increase from 5.5 million in 2007 to 6.6 million in 2020, a 20% increase in the oldest old (2). These increases in the older population will have dramatic effects on the nation’s health care system in years to come.

FACTORS AFFECTING NUTRITIONAL STATUS
Physiological changes of aging can affect food intake, body composition, and weight. Food intake typically declines even in healthy older adults. This is often referred to as the “anorexia of aging” (4). Decreased appetite can be due to a decrease in offac-
tion, taste, and changes in levels of hormones that control satiety and food intake. As appetite diminishes, intake of energy and other nutrients decreases, which can result in weight loss and predispose an individual to increased risk of illness and infection. In addition, chronic disease, including cerebrovascular accidents, Parkinson’s disease, cancer, diabetes, and dementia, can contribute to changes in appetite, metabolism, and weight. Older adults can be subject to sarcopenia, a loss of muscle mass associated with aging, and/or cachexia, a loss of weight and muscle mass associated with underlying illness.

Depression, polypharmacy, drug–nutrient interactions, or side effects such as anorexia, nausea, vomiting; sensory loss that affects ability to see, smell, and taste food; and oral or dental changes that affect chewing or swallowing ability can all affect nutritional status.

As a result of the physiological and psychological changes associated with aging, food can be less appealing, and food consumption may decline as a result. Restrictive diets may exacerbate poor food intake leading to unintended weight loss and undernutrition.

The Risk for Undernutrition in Health Care Communities

Due to variations in definitions between undernutrition and malnutrition, determining the scope of the problem in health care communities is difficult. According to a recent literature review that used the mini-nutrition assessment as a parameter, malnutrition was observed in 2% to 38% of institutionalized older adults, and 37% to 62% were considered at risk (5). Consequences of undernutrition include increased mortality, loss of strength, depression, lethargy, immune dysfunction, pressure ulcers, delayed recovery from illness, increased chance of hospital admission, and poor wound healing (6). Older adults are at higher risk for pressure ulcer development due to age, skin frailty, unintended weight loss, and other factors. Although pressure ulcers have multiple causes, poor nutritional status is a contributing factor and is an important aspect of prevention (7). Since unintended weight loss can reflect poor intake or changes in metabolism of food and nutrients, it may be the best indicator of undernutrition (4).

Risks vs Benefits of Least-Restrictive Diets

A priority of nutrition care for most frail older adults in health care communities is to consume enough food to prevent unintended weight loss and undernutrition. Although therapeutic diets are designed to improve health, they can negatively affect the variety and flavor of the food offered. Individuals may find restrictive diets unpalatable, resulting in reducing the pleasure of eating, decreased food intake, unintended weight loss, and undernutrition—the very maladies health care practitioners are trying to prevent. In contrast, more liberal diets are associated with increased food and beverage intake (8). For many older adults residing in health care communities, the benefits of less-restrictive diets outweigh the risks. When considering a therapeutic diet prescription, a health care practitioner should ask: Is a restrictive therapeutic diet necessary? Will it offer enough benefits to justify its use?

Disease-Specific Conditions and Restricted Diets

Diabetes Mellitus

The risk of developing diabetes increases with age. By one 2002 estimate, 26.4% of all persons admitted to nursing homes had a diagnosis of type 2 diabetes (9). Although there are numerous evidence-based guidelines for treating diabetes, few of the data supporting interventions were obtained from research studies in older persons (10).

Blood glucose can be affected by factors other than diet, including infections, obesity, diseases of the pancreas, endocrine disease, genetic defects of beta cells or insulin action, and common medications (9). Since 2000, the American Diabetes Association has held the position that sugar-consuming foods can be substituted for other carbohydrates in the meal plan or covered with insulin-lowering medications (11). There is no evidence to support prescribing diets such as no concentrated sweets or no sugar added for older adults living in health care communities, and these restricted diets are no longer considered appropriate (11). Most experts agree that using medication rather than dietary changes to control blood glucose, blood lipid levels, and blood pressure can enhance the joy of eating and reduce the risk of malnutrition for older adults in health care communities (11).

According to the American Diabetes Association, prevention recommendations and interventions for diabetes, elderly nursing home residents with diabetes can receive a regular diet that is consistent in the amount and timing of carbohydrates, along with proper medication to control blood glucose levels (11). The nutrition care plan should include education about appropriate food choices for managing diabetes.

Cardiovascular Disease

The use of low-fat, low-cholesterol diet prescriptions for older adults in health care communities is controversial. There is little data available to support the effects of lipid-lowering therapy on adults older than 75 years of age (12). However, the American Heart Association suggests that risks related to elevated blood lipid levels do not diminish with age and recommends treatment be considered for all older adults (12). Health care providers should be aware of cardiac problems while balancing an individual’s condition, prognosis, and the threat of undernutrition when making treatment decisions.

The relationship between congestive heart failure, blood pressure, and sodium intake in the elderly population has not been well studied. The American Heart Association recommends that older adults attempt to control blood pressure through diet and lifestyle changes (13) and recommends a sodium intake of 2 to 3 g/day for patients with congestive heart failure (14). However, a randomized trial of adults aged 55 to 83 years found that a normal-sodium diet improved congestive heart failure outcomes (15). A liberal approach to sodium in diets may be needed to maintain adequate nutritional status, especially in frail older adults (16).

The Dietary Approaches to Stop Hypertension (DASH) eating pattern is known to reduce blood pressure and may also reduce rates of heart failure.
The DASH diet is low in sodium and saturated fat but also high in calcium, magnesium, and potassium. The nutrition care plan for older adults with cardiac disease should focus on maintaining blood pressure and blood lipid levels while preserving eating pleasure and quality of life. Using menus that work toward the objectives of the Dietary Guidelines for Americans and/or the DASH diet can help achieve those goals. Physical activity that is based on each individual’s abilities can also help facilitate cardiac health.

Chronic Kidney Disease
Older adults with chronic kidney disease often have increased protein catabolism and uremia. Anorexia, nausea, and vomiting are common side effects of uremia. Undernutrition is especially difficult to define in this population because changes in body weight can be caused by shifts in fluid balance. Most experts agree that patients receiving dialysis lose protein with each treatment and, therefore, require an increase in dietary protein. Individualizing the diet prescription for chronic kidney disease patients receiving dialysis may increase total energy and protein intake and help prevent undernutrition. Patients in earlier stages of chronic kidney disease may need an individualized diet if food intake is poor or weight loss is detected.

Obesity and Desired Weight Loss
In 2005-2006, 37% of individuals aged 65 to 74 years and 24% of those aged 75 years and older were classified as obese. Evidence suggests that weight loss in obese older adults improves physical functioning and quality of life and reduces medical complications. However, some experts suggest that adverse health outcomes of obesity and benefits of weight loss in older adults have not been proven. Weight loss in obese older adults results in both a loss of fat mass and sarcopenia, thus contributing to functional decline. If an individual desires weight loss, the care plan should provide adequate energy and protein along with regular physical activity to help preserve lean body mass. In most cases, a resident’s usual body weight before decline or admission, rather than ideal body weight, is the most relevant basis for weight-related interventions. Caution should be applied in determining which older adults are appropriate for weight loss programs to avoid undernutrition and complications such as pressure ulcers.

Alzheimer’s Disease and Dementia
The prevalence of Alzheimer’s disease in individuals aged 85 years is between 24% and 33% in developed countries. Unintended weight loss is common in people with Alzheimer’s disease and is thought to be part of the disease process. Meal intake is often poor, usually due to cognitive decline. The goal of nutrition care for older adults with Alzheimer’s disease or other forms of dementia is to develop an individualized diet that considers food preferences, utilizes nutrient-dense foods, and offers feeding assistance as needed to achieve the individual’s goals.

Palliative Care
Supportive care is the most realistic goal for a dying patient. Decisions about care should be made with the patient and/or family. Accommodating individual food and fluid preferences is essential for acceptance and consumption. The nutrition care plan should allow provision of any food and beverage that the individual will safely consume, regardless of medical diagnosis. If texture modifications are recommended, education may be needed on the risks vs benefits of consuming certain foods. More information on this topic is available in the Position of American Dietetic Association: Ethical and legal issues in nutrition, hydration, and feeding.

Compliance with Federal Long-Term Care Regulations
The State Operations Manual of the Centers for Medicare and Medicaid Services—Appendix PP—Guidance to Surveyors for Long Term Care Facilities—states, “A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident’s quality of life.” Facilities must respect ethnic, cultural, religious, and other food and dining preferences, and protect and promote the rights of each resident. Providing a therapeutic diet against a resident’s wishes is a violation of resident rights. Note: proper counseling should be provided to ensure the resident understands the risks vs benefits of following a therapeutic diet. In an effort to enhance quality of life, respect resident rights, and promote person-centered care, many facilities are enhancing their dining programs to include creative ideas that demonstrate improvements in dining, food intake, and/or quality of life.

The State Operations Manual also addresses nutrition and recognizes the potential benefits of liberalized diets. According to the manual, “it is often beneficial to minimize restrictions consistent with a resident’s condition, prognosis, and choices.” Providing a more liberal diet may help prevent an F-325 citation (nutrition and unintended weight loss) because the intent is to ensure that residents maintain acceptable parameters of nutritional status.

The Role of Registered Dietitians (RDs) and Dietetic Technicians, Registered
RDs should utilize the Nutrition Care Process and develop an individualized care plan that is consistent with needs based on nutritional status, medical condition and personal preferences. RDs should assess nutritional status, determine a nutrition diagnosis, plan appropriate nutrition interventions, and monitor and evaluate outcomes. Dietetic technicians, registered, support RDs in the Nutrition Care Process and may complete parts of the process as assigned by an RD. Collaboration between the patient, family, and members of the health care team will help achieve these goals. RDs and dietetic technicians, registered, should be actively involved in developing facility policies and procedures and educating staff, residents, and family members on the benefits of a less-restrictive diet based on each individual’s needs.

Conclusions
Undernutrition, weight loss, poor food intake, satisfaction, and acceptance are serious issues in health care com—
munities. Despite the growing body of evidence discouraging the use of therapeu-
tic diets in older adults, these diets are still regularly prescribed. Research has not demonstrated ben-
efits of restricting sodium, cholesterol, fat, and/or carbohydrate in older adults (9). Additional research is needed to help practitioners make evidence-based decisions about nutrition care of older adults in health care communities.

RDs should evaluate each individual and assess the risks vs the benefits of a therapeutic diet. Maximizing meal intake can help prevent under-
nutrition and unintended weight loss, which can lead to additional health complications. Individualizing to the least-restrictive diet can enhance nutritional status and improve quality of life, particularly for an older adult with poor food/fluid intake or uninten-
tended weight loss.

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