

# Do You Know Where I Can Get Something to Eat?

## Nutrition and the Dementia Resident

© Becky Dorner, RD, LD, adapted from the presentation  
“Nutrition and the Dementia Resident”; also in *Dietary Manager*, 2/99.

I'll never forget Anna. I met her 17 years ago—my first job out of college. I was the full time dietitian and food service director in a 225 bed nursing facility. I got to know my residents very well. They were in the facility for a long period of time, and I became attached to a number of them. Anna was one who I truly enjoyed. She was special...Anna had Alzheimer's disease. She spent much of her time walking the halls, talking to everyone, forever being cheerful and happy—a joy to be around. Like many other residents with dementia, Anna would frequently wander and pace the halls. She would also forget she had eaten, and she'd tell me she hadn't had anything to eat that day. ***“Do you know where I can get something to eat?”*** she'd ask me. Somehow she seemed to know that I would always find her something to eat.

Despite the fact that she seemed to be eating all day long, Anna was still thin. At mealtime, she was distracted, and we had a hard time getting her to sit still long enough to finish the meal. Anna's condition deteriorated quickly, and within nine months, she forgot how to use her utensils, and had to be reminded how to eat. She lost the ability to walk, to talk, and eventually lost her ability to eat by mouth. They had to place a tube to feed her. And then, sadly, Anna died...It broke my heart.

I've met a lot more residents like Anna over the years. I know a lot more now, than I did then. And maybe, if all of the other staff had known then what we know now, Anna would have had a longer, higher quality life. The Omnibus Budget Reconciliation Act (OBRA) for nursing homes has improved our knowledge and practices tremendously, but we still have a way to go.

## **Dementia and Malnutrition**

Dementia is a common problem: 70 percent of nursing home residents “have some organic brain disorder usually accompanied by dementia. The single most common symptom is confusion, which afflicts 44 percent of all residents. These residents may also suffer from anorexia and involuntary weight loss”(1). The American Dietetic Association (ADA) estimates the incidence of malnutrition in the institutionalized elderly any where from 10 percent to 85 percent, which could make malnutrition one of the most serious problems in long-term care today (1). The Journal of the American Geriatrics Society states that as many as 85 percent of nursing home residents face a high risk of malnutrition, and a study by Pinchcofsky-Devin and Kaminski indicated a 52 percent incidence of malnutrition and 76 percent incidence of anemia in nursing home residents (2).

Weight loss is also a major problem. “One study found that 70 percent of the residents in a nursing home had lost more than 10 pounds each during their stay at the facility.

Unintentional weight loss has been correlated with increased mortality, compromised

ability to resist infections, and increased incidence of pressure ulcers”(1). Many of the greatest risk factors for weight loss and malnutrition can be easily addressed.

We know that under-nutrition in nursing homes is caused by multiple factors: physical, functional, cognitive, and even caregiver related.

- Dementia syndromes may impair the ability of residents to feed themselves, may alter appetite and increase energy need.
- As many as 50 percent of residents in a skilled nursing facility may require assistance with eating (1).
- In addition, many require altered food consistencies – “as many as 50 percent of Americans have lost all their teeth by the age of 65 years”(1).
- Many dementia residents are on medications that can alter food intake. In fact, the average long-term care resident is prescribed eight medications a day. “Of the more frequently used medications, 23 are known to cause reduced food intake and have side effects such as anorexia, nausea, vomiting, food aversions...and disinterest in food”(1).

In her research on malnutrition in nursing homes, Dr Jeannie Kayser-Jones has found the major barriers to good nutrition to be:

- Lack of adequate staffing at meal time
- Poor oral health
- Undiagnosed swallowing disorders

- Lack of ethnic food
- Insensitivity to individual needs (3)

## **Prevention**

When it comes to nutritional care of the dementia resident, prevention is the key. Good nutritional care will prevent many other problems such as weight loss, malnutrition, pressure sores, poor wound healing and resistance to infection.

Facilities must first have **good preventive systems** in place:

- Interdisciplinary communication systems that work
- Weight tracking: accurate and timely weights, timely calculation of weight loss percentage
- Food intake records: simple systems, good staff training, meal rounds to assure adequacy of feeding assistance, accurate record keeping
- Food replacements for uneaten foods—food first, supplements last
- Nutrition screening tools for early identification and intervention
- Nutrition assessment that focuses on important issues
- Interventions that make sense for the individual—and that are effective

Facilities must also have good systems in place for staff training. Facility staff need to know what signs and symptoms to look for when it comes to nutritional problems, what to do when they identify concerns, and what interventions should happen *automatically* when concerns are identified.

## Creative Solutions

Some residents come to facilities with nutritional problems, some will decline despite all our efforts and interventions, and some pose challenges that may need creative solving.

Let's begin by reviewing some of the nutrition-related challenges that our dementia residents may present to us.

- **Mealtime** is one of the most important areas where we can have a nutritional impact.

We need to spend time each day in the dining room, so we can get to know the residents, their preferences, and whether or not our interventions are working.

- **Dining atmosphere** can make a big difference for residents with dementia:

- ✓ Keep distractions to a minimum: Calming classical music, low noise level, soft colors, limit non-food items on the tray

- ✓ Strategic seating or separate dining area with a smaller group of residents—try family style dining

- ✓ Regular routine and structure to the dining experience

- ✓ Interesting meals with a variety of foods nicely presented

- ✓ Allow enough time to eat

- **Sundowner Syndrome**

The Alzheimer's Association makes these suggestions for Sundowner Syndrome:

Do You Know Where I Can Get Something to Eat?

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5 of 12

- ✓ Decrease caffeine (coffee, tea, sodas, chocolate) or restrict it to morning hours to decrease agitation and sleeplessness
- ✓ Offer an early dinner or a late afternoon snack (4)

## **Problems with Dementia**

- **Eating Assistance** is extremely important for residents with dementia. Frequently, residents with dementia lose the ability to use utensils for eating.
  - ✓ Promote independence: Adaptive feeding devices, finger foods, cueing, hand over hand assistance if needed, positioning to promote independence with eating
  - ✓ Supervise and monitor, and redirect as needed. Residents may stop eating halfway through the meal or may rearrange food and not actually eat it, or they may get up and leave without finishing the meal. Promote dignity and self-esteem by providing gentle reminders and encouragement.
  - ✓ Assure that adequate staffing is available to supervise, monitor, redirect, and assist/feed as needed
  - ✓ Start a feeding rehabilitation team comprised of nursing staff, dietary manager, dietitian, occupational therapist and speech therapist.

## **Weight loss and malnutrition:**

- Studies have indicated that Alzheimer's patients are more likely to lose weight compared to control groups (5). This may be due in part to increased energy requirements as a result of higher metabolic levels, wandering and pacing, agitation, and increased levels of growth hormone (5).

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6 of 12

- Couple this with forgetting how to eat, being distracted from eating, inability to communicate hunger... You get the picture.

A complete **nutritional assessment** started by the dietary manager or dietetic technician and completed by the registered dietitian, should include a calculation of nutritional needs based on:

- 34-35 kcal/kg body weight for caloric needs (4,5,8)
- 1.0-1.25 gm protein/kg/day unless otherwise indicated (decreased needs due to renal problems, or additional needs secondary to malnutrition or pressure sores)
- 30 cc/kg/day fluids (decreased needs if in renal failure or increased needs if dehydrated or draining wounds are present). (5)

**Other recommendations to prevent weight loss:**

- Offer nutrient dense foods
- Have snacks available at all times
- Address chewing and swallowing problems and offer appropriate consistencies
- Be very attentive at meal time

**Liberalized Diets**

The American Dietetic Association's position statement on liberalized diets for older adults in long-term care is: "that the quality of life and nutritional status of older residents in long-term care facilities may be enhanced by a liberalized diet." (1).

There are many physical and psychosocial issues that can affect our residents' nutritional status. Chronic disease, dementia, depression, infections, medications and medical treatments, reduction in functional abilities, chewing and swallowing problems all contribute to poor appetite, digestive problems and increased nutritional needs. Overly restrictive diets that reduce the palatability of foods can contribute to poor food intake, which leads to weight loss and malnutrition.

We need to assess each individual and ask whether therapeutic diets will benefit the resident in their particular situation. A diet is not effective for optimal nutritional status if it is not consumed. Weight loss and malnutrition may override the concerns for a therapeutic diet. We must educate our residents on the benefits versus burdens of therapeutic diets on an individual basis, and protect a resident's right to refuse treatments and to choose alternatives. Once the resident has made an informed decision, we must support that decision and act as an advocate for that resident.

### **Fortified Foods and Supplementation:**

Take a unique approach in your interventions for nutritional concerns. We can no longer think that nutritional supplements are the "*magic bullet*" for weight loss and malnutrition. We have discovered that residents get tired of receiving milkshakes 3-6 times a day—residents get tired of the same supplements and the same flavors multiple times a day, they refuse them, and they end up *feeding the wastebasket*.

There are so many **other interventions** we can use.

- Adequate assistance at mealtime is the most important

Do You Know Where I Can Get Something to Eat?

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8 of 12

- Appropriate assessment and intervention for physical and psychosocial concerns
- Assuring residents actually receive the interventions that have been recommended
- Fortified foods: cereals, soups, potatoes, sauces—boosting calories and protein in the food we already serve
- High calorie and high protein foods such as puddings, milk and milk products, etc.
- Daily multivitamin if needed

## **Dehydration**

Dehydration is another major concern for our residents with dementia due to altered thirst sensation, functional status changes which impair the ability to request fluids, poor access to fluids, and medication side effects. We can get creative here as well.

- ✓ Beverage carts with fruit slushes, milkshakes, gelatin, popsicles, sherbet or ice cream
- ✓ Train staff to use **TAPS**: Turn, Align, Position, Sips, for residents who need to be positioned
- ✓ Offer fluids at every resident contact

## **Advance Directives**

We've reviewed a lot of different interventions...But what about the resident who just can't or won't eat enough to maintain weight and health status? Who just doesn't seem to respond to anything we try to get them to eat or drink? When a resident is malnourished, has lost weight and is unable to maintain or improve at their current rate of food intake,

Do You Know Where I Can Get Something to Eat?

Becky Dorner, RD, LD 800-342-0285

9 of 12

and when all normal interventions have been exhausted, then we must make some decisions. Every resident has the right to make their own informed medical decisions—to choose to accept or refuse any treatment that the facility or the physician recommends after first being given adequate information regarding the disease and the treatment options. This includes providing information on the risks and benefits of each choice.

Advance directives can safeguard the residents' interests in directing their medical care. The advance directive document takes effect in situations when the resident is unable to make their own decisions. Residents can choose in advance, which treatments they think they will want or won't want for each situation or condition. They can also name a Durable Power of Attorney—another person whom they trust to make medical decisions for them if they become unable to make their own decisions.

Advance directives should be reviewed with the resident and/or family at least once a year to be sure that it continues to reflect the resident's wishes. Advance directives for nutrition and hydration can be a highly emotional issue because it involves the moral and ethical beliefs of the different individuals on the team. It is important to know what the resident's wishes are regarding feeding tubes and IVs or TPN, and in which specific situations (coma, terminal illness, irreversible chronic illness, etc.). Many facilities struggle with decisions on the "To feed or not to feed" dilemma. The interdisciplinary team should develop protocols to address these difficult challenges. (6, 7)

## Summary

**Prevention is the key** to avoiding weight loss and malnutrition among our residents with dementia.

- Good systems for tracking and communicating information
- Accurate nutritional assessment
- Appropriate nutritional interventions
- Creative dining strategies
- Appropriate use of advance directives for nutrition and hydration

It takes a great deal of compassion, patience and skill to care for residents with dementia.

God bless those of you who have it. I hope that this article has given you some insight and ideas, so that you will have the right answer when one of your residents asks you,

***“Do you know where I can get something to eat?”***

1. Position of the American Dietetic Association: Liberalized diets for Older Adults in Long-term Care <http://www.eatright.org/adap1298a.html>
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3. Thayer, Leah. “A recipe for malnutrition?” *Contemporary Long Term Care* December 1997: 21.
4. Graham, Heather, Dietetic Senior, UC Davis. “Alzheimer’s Patients Require More Calories.” *Gerontological Nutritionists* Winter, 1997:7.
5. “Topics on Nutrition and Dementia: Research and Resources.” <http://outreach.missouri.edu/hesnutrnews/fnr96-5.htm>
6. Dorner, Becky, RD, et al. “The ‘to feed or not to feed’ dilemma”. *Supplement to Journal of The American Dietetic Association* October 1997: S173-S176.
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Do You Know Where I Can Get Something to Eat?

Becky Dorner, RD, LD 800-342-0285

11 of 12

8. Spindler, AA, et al. “Nutritional status of patients with Alzheimer’s disease: a 1-year study”. [http://www.ncbi.nlm.nih.gov/htbin-post/E.../query?uid=8841163&from=6&db=m&Dopt=.](http://www.ncbi.nlm.nih.gov/htbin-post/E.../query?uid=8841163&from=6&db=m&Dopt=)