Home Renaissance Foundation

Working Papers

Number 4

What is really important?

Demands on the nutrition of people with dementia
and what we can learn about the nutrition of the elderly

By Martina Feulner
May 2006

What's really important?
Demands on the nutrition of people with dementia
and what we can learn about the nutrition of the elderly

By Martina Feulner[1]

I. Introduction

The programme of our panel discussion on food, health and family announces: "Benefits of healthy eating from the early years to old age". My contribution is to take a look at the special nutritional requirements of the elderly;
a topic which is only beginning to be discussed – at least in Germany.

I shall do this with my experience in a specialist area which is known in Germany as "Hauswirtschaft"; in English "Home Economics".

Home Economics includes topics on nutrition, meal preparation, the care and cleaning of living space, laundry and the design of the living environment. The basic assumption of home economics is that every person has a household as their economic and living base, that is, that everyone lives in a household.

As personnel there are primarily the housewives and "househusbands" who care for their families, but also home help who work directly in the families as well as service providers for private households. For people living in care facilities personnel includes the workers in the canteen kitchen, service personnel in the dining hall or restaurant, cleaning and laundry services. My professional focus is on household services in care facilities for example at nursing homes and at facilities for the handicapped.

II. Nutrition and the Elderly: What do we know?

Concerning nutritional problems to be solved within families and in care facilities, we must deal with the fact that we are constantly aging. We find that today there are more and more very elderly people to care for. The population of the elderly is increasing along with the actual age of the average nursing home resident where people who are eighty, ninety and one hundred years old are becoming the norm.

Healthy nutrition for the very elderly raises new questions. The very elderly have had a long life with a lot of memorable experiences, personal and societal events. They have developed a deeply ingrained relationship with their own nutrition, developing lifelong habits and preferences which should not be neglected. We are well aware that these individual preferences, habits, and the social settings in which meals are consumed are an important factor as is the nutritional value provided by the food itself. It is especially notable with the very elderly that their nutritional methods played an important role in their lives: They have gotten very old with their way of living and eating.

[1] Diploma in Nutrition & Home Economics, Department of Catering & Hospitality, Caritas, Germany

Objective approaches to determine nutritional needs do remain important. They are considered the most important factor in the creation of menus. But the question must be asked, how the body's nutritional needs have changed in advanced years. It is assumed that the need for nutrients recedes as a person ages. At the same time the body requires more vitamins, minerals and vital nutrients for its difficult functions since the ability to optimally utilise the ingredients in food and drink recedes with advanced age.

There is little awareness of the special nutritional needs of the elderly in the nutritional sciences and medicine. Nutritional experts in all countries have developed benchmark figures which determine the need for nutrients. In Germany, these are the so-called D-A-CH reference values which have been collectively agreed upon by Germany, Austria and Switzerland.

But with regard to the informational value of these rates two points must be criticised: first, the oldest group defined is "older than 65"; values for the very elderly do not exist. A second critical point is the so-far non-existent discussion of the change and adaptation processes with which the human body must arrange itself during its lifetime.

Here are some pictures of Anna Langer to show how she has changed over the years. The question of nutritional needs for the elderly can only be limitedly oriented on nutritional recommendations. The pictures of Anna Langer, born in 1904, reveal how a body can change during a lifetime; how historical events for example the war years or the post-war years can mark a body. At the same time the body has developed compensation methods to hinder, for example, starvation or surplus weight. Later, age leaves its mark. Body mass becomes reduced. Dehydration processes take hold and bodily functions change. All this happens very individually – in a different way for each person. Established measurement procedures such as determining the Body Mass Index (BMI) have never been examined with regard to the elderly although it is still being used in Germany today. Slowly, critical voices are being heard and test results have shown that these procedures are only partially adequate to make a statement about the nutritional status of people.

In the final phases of life, situations may arise that make assistance, support or care necessary in order to offset or treat forgetfulness due to old age, physical handicaps or critical illnesses such as dementia. Here it is important to remember that these are adults who have lived their lives responsibly and independently for decades. It is not easy to find an appropriate way of helping the elderly who need support and aid. Aid measures should not incapacitate them but support their self-determination and participation. With children and teenagers this is easier because adults fulfil the role of educator. Children often express this very simply: adults make the rules – at least until the child comes of age.

But what does the role of aid giver for the elderly look like?

Caritas deals intensively with the question of how self-determination and participation in everyday life and in the life of the community can be supported through its service and facilities. But often we are limited since we have found it is absolutely necessary to know something about each

person's life in order to support them according to their needs even if they cannot fully communicate.

Especially with food and drink it becomes apparent that these can only be enjoyed by the elderly if they compliment his life – his likes and dislikes. As gerontologists and practical experiences have shown, with regard to the elderly, habits, likes and dislikes are especially important. With increasing age they become more and more a significant part of the structure of everyday life.

In Germany we have just ascertained during a project that a quality level of food and liquids for people in nursing homes has been developed which is supported by scientific literature. The data and general awareness is inadequate but the facilities do call for a discussion of this issue because the Health Insurance's Medical Services – the controlling authority in Germany for the quality of care in facilities – has been warning for some time about deficient specialist knowledge in the field of nutrition. The subject of malnourishment has become an important topic and solutions have been indicated. These requirements have been directed towards a care system for the elderly who in the past has considered this type of care solely a maintenance task and often regarded it only from the cost aspect.

III. One Area of Insight: Nutrition of the Elderly suffering from Dementia

During the past years an intensive discussion about the care of people with dementia has taken place. This in turn has strongly influenced the conceptual planning of facilities for the elderly. The main conclusion was that people with dementia should live in an environment which on the one hand protects them and on the other hand offers stimulation to help orient themselves in their everyday life, weekly routines and in the course of the year. Facilities are criticised for offering meals on a tray arriving from the canteen kitchen and delivered to the residents who live in groups because it does not resemble normal everyday life.

Small living units in which everyday life is experienced together are supportive and helpful. Here residents can prepare meals together and share many other experiences of daily life. In the context of such small living units ("Haus- und Wohngemeinschaften" as they are called in Germany), Jan Wojnar has collated important conclusions on nutrition which, from the home economics point of view, are important for the nutrition of the elderly and can be used as a basis for the development of a supportive culinary culture at facilities for the elderly.

Let us now take a look at the situation of people with dementia. Some of the typical accompanying phenomena of dementia are disturbances while eating and drinking:

- The refusal of food which used to be eaten willingly
- Food and drink arranged on the table are not recognised as such
- Feelings of hunger and thirst are ignored although they are obviously there
- Intensive questioning or force feeding leads to fits of rage.

Malnourishment, dehydration and pneumonia as after-effects of a weakened immune system are mentioned in epidemiological studies as the most frequent cause of death among patients with dementia.

The clinical picture of dementia reveals that with changes in the brain certain abilities are lost, for example, dealing with nutrition as we are accustomed to:

- We can interpret feelings of hunger and thirst
- We think about food and decide what we want to eat, when and with whom we want to eat it
- We are aware of the daily task of caring for ourselves.

These abilities are lost in the advanced stages of dementia.

Jan Wojnar has observed in people suffering from dementia that their basic need for nourishment, the ability to sense hunger and their appetite for food is disturbed due to the illness itself and medication. The foundation for independent decision-making concerning food intake is missing. People suffering from dementia are constantly dependent upon someone to explain interrelationships and offer hands-on experience.

Upon this background Jan Wojnar developed specifications for the nutrition of people suffering from dementia. After reviewing these proposals, I feel they should form the basis of a nutrition concept in facilities for the elderly.

Most importantly the care of dementia patients requires an adequate supply of energy and enough fluids which should be administered with the least amount of stress possible for the patient and his caregiver. It is always helpful to remember that the patient cannot feel hunger or thirst, cannot determine the time of day and cannot remember what meals have already been eaten. The caregiver must also understand that the environment, that is the caregiver or caregivers and their intentions cannot be recognised. Reactions and the behaviour of dementia patients are determined by coincidental memories and inherited behavioural traits

For people suffering from dementia, food and drink are more than just nutrition. Offers of food and drink should be oriented towards the meal at which they will be consumed. The following points are important as well:

- A relaxing and pleasant atmosphere
- Food consumption according to the patient’s capabilities and inabilities
- Suitable food and drink.

I consider it very important that the meal is considered not only a time for food consumption but also a social event which structures the day. It also has its own space and all persons who are in the room during the meal contribute to the meal’s atmosphere. Here are some examples:

The Atmosphere

If food is prepared entirely or partially in the living unit there are always sounds and smells which can be associated with the impending meal. Cooking can be observed and it offers the opportunity for participation. Having a kitchen and being present during meal preparation can reinforce the feeling of being at home.

It is important that care givers and patients sit and eat together during the meal and that each meal begins with a ritual. This can take the form of a prayer or the wish to enjoy the meal ("Bon appétit"!). Through their own food, patients with dementia are reminded to eat. Familiar motions are activated and specific actions support the eating process such as serving the food and passing a beverage. These are accompanied by expressions such as "We haven't had that in a long time" or "That tastes good – try it" or a conversation about the food and drinks.

The design of the room, the choice of dishes and table decorations should not be accidental. When dealing with dementia patients, less is often more.

Colour contrasts are important so that the food can be recognised more easily.

Supportive food intake

Food intake often needs specific supportive measures:

- a comfortable and upright sitting position
- handing over spoon and fork and the careful support of movements while eating
- silverware and dishes which can be easily handled
- filling food and drink into appropriate containers so that the patient can eat as independently as possible (for example, yoghurt in a bowl)
- preparing food as finger food
- a specific massage or touch to encourage swallowing

Suitable Food and Drink

The choice of suitable food and drink is not determined by earlier habits or recommendations for healthy and balanced nutrition but by the attempt to offer the patient what he or she enjoys eating and eats enough of. It is therefore important to know which foods and drinks are preferred and what type of preparation whets the appetite thereby reinforcing food intake.

Experience has taught us that:

- Sweets are preferred which can be traced back to a change in the sense of taste. If certain foods are refused, these should be sweetened slightly to avoid a bitter taste. Meat, for example, can be served with a sweetened sauce; sandwiches with cold cuts or cheese can be refined with a sweetened spread.
- Fatty foods are also preferred. This has to do with fat being an important taste provider.
- During the chewing process, stringy foods or small accessories such as chopped almonds are considered bothersome and are often spit out.
- Floury and crumbly foods feel like sand in a dry mouth and are therefore pushed around with the tongue without creating a swallowing reflex.
- Because of disturbances while swallowing, pure water or mineral water should be avoided. Fruit juice is more appropriate.

Initially there is a food and drink menu consisting of food and beverages which will really be consumed. This goes so far as to push certain diets to the background in favour of food intake. For example, in the case of diabetes mellitus, food intake takes preference over the special diet for

diabetes. However, blood sugar must be closely monitored as well as other signs which indicate raised blood sugar levels (for example thirst, tiredness or increased amounts of urine).

With regard to food and drink menus in nursing homes I refer to the important insight that we must see food and drink as the patients experience it. For this reason the rooms in which the meals are eaten and the people in them take on a new meaning. Especially with the elderly, not only nutritional satiation is important but also meals which structure the day as well as contact to food service personnel or employees who assist patients while eating. I refer again to the statement that food and drink is more than just nutrition and the provision of liquids. Or as Justus von Liebig once said: The whole is more than the sum of its parts. This conclusion becomes especially important when we realise that facilities for the elderly have systems in which personnel from different occupational groups fulfil tasks to cooperatively organise care.

IV. The Task: Developing a culinary culture supported by all employees

Facilities for the elderly are still confronted with working out the topic of integrating food and drink into everyday life. The aim must be that food and drink and especially the meals themselves satisfy the needs of the patients while at the same time preventing deficiencies.

In my considerations for an age-based culinary culture, I act on the following assumptions:

- Food and drink cannot be considered detached from its related contexts. When reduced to food on a plate or a drink in the feeding cup, a meal consists only of nutrients and amounts of liquid. Important elements are ignored: the enjoyment of a meal, food as a sensual experience, the nice feeling of being a guest who can sit at the set table and have food served, the awareness that a meal was consciously prepared for him as a guest. If detached from its related contexts, it is easily forgotten that food and drink are directly connected to everyday life and the comfort of the residents.
- Different professions participate in food and drink even if they are not fully aware of this. These include kitchen and home economics personnel as well as care personnel. They, too, are responsible for food and drink: They must be aware of this responsibility so that catering can really be geared towards and used by all residents.

I have chosen this general point of view to satisfy a number of conceptual approaches in facilities for the elderly which also influence catering. There are many types of centralised and decentralised catering services at facilities for the elderly. Some employ private caterers while others hire their own personnel. These are complemented by conceptions of care which are based on different specialist principles. The solution – in my opinion – does not lie with a defined catering concept combined with a certain care concept. Finding a sensible solution calls for recognising the value and meaning underlying the topic of food and drink. From this the cornerstones for sensible catering concepts can be developed and implemented.

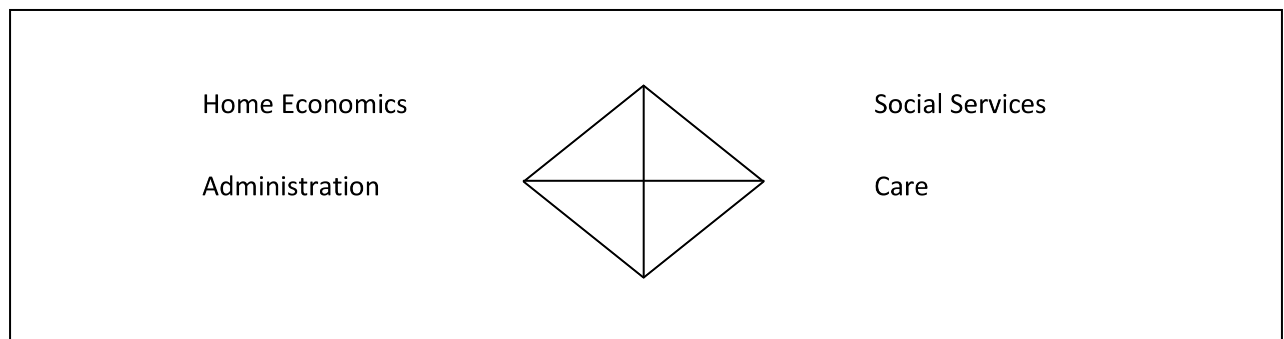
V. Cornerstones for culinary culture in facilities for the elderly

The following cornerstones can be devised on the basis of these conclusions:

Cornerstone 1
Each facility must develop its own **culinary culture** as a basic principle founded on the residents' needs.

Catering offers must be specified according to the residents' needs. Their needs form the basis for all considerations. The gauge for catering offers are not the meals themselves and how they are listed on the menu but how these meals are served to high-maintenance care patients, residents suffering from dementia and residents who are terminally ill. It is important to think of food as a meal until it has been consumed. Where the meal takes place becomes just as important as service and support while eating.

Cornerstone 2
Food and drink is a topic which touches on all specialist areas of a facility. It can only be handled as a cooperative effort in which everyone follows the same aim.



In practice, approaches from the past hinder the development of new methods. In the past, these approaches allocated certain topics to certain groups of employees and did not look at these processes in their entirety.

Cornerstone 3
Therefore there are also important **specific professional points of view to overcome:**
- Food and drink must not be reduced to serving food.
- Kitchen personnel must think of the catering process right up to the resident.
- The meaning of service must no longer be ignored.

In our approach we begin with the meals which take place in everyday life. We do not follow the approach that adaptive solutions must be found for a deficient situation. Taking everyday life as a basis without, for the moment, considering special circumstances like, for example, the necessity of a stomach tube (PEG Percutaneous Endoscopic Gastronomy), special needs of dementia patients or psychological problems, the following becomes clear:

- The production process must be taken into account which, as a rule, is the responsibility of kitchen personnel.
- This is followed by the serving of food, an area often neglected. Food is served by different people; often by people from different professions.

- The third phase involves the food itself and whether or not it can be eaten independently or with aid; in this case involving other personnel as well.

Mistakes and sources of risk become apparent when we take a closer look.

Here are two situations from everyday life:

- Serving a meal when I do not know what it is.
- Cooking a meal if I do not know who my guests are.

I refrain from further comment. In many facilities these situations are – unfortunately – still reality. By operating in narrowly defined fields of responsibility, barriers are created between caregivers and residents. Tasks unable to be delegated were ignored

Cornerstone 4
If the resident is really the focus of attention, perceptions and actions will change. With this perspective, food and drink become a central and enjoyable event appealing to all the senses.

If a topic interests more than one group of employees then it becomes a topic of discussion. Here management is called upon to highlight the topic of food and drink in the facility so that a consistent plan of action can be developed and implemented for all personnel.

Both the physical environment and social setting of a meal play a role in determining how much we eat. Disturbances such as uncomfortable surroundings, disagreeable company at the table, unfriendly service or too little time are all factors which seem unimportant. But it is especially these things that strongly influence food intake. The atmosphere of a meal is of utmost importance.

Here we are confronted with a basic experience and conclusion from the area of Dietary Nutrition. Findings from Bober in the area of communal catering show that the food itself is secondary as to how much is actually consumed. Most important is the social, personal and spatial environment!

Cornerstone 5
Decisive for the implementation of a culinary culture in facilities for the elderly is to familiarise oneself more than ever with the perspectives of the residents

And of course, the food on the plate is important, too. Do I recognise it as food? Does it taste good? Is the eating environment appropriate – alone or with others? Who is at my table? Is the environment pleasing or not? Are aid measures really supportive or are they bothersome?

Here it is very important to put yourself in the position of the residents who for the most part have found their last home at the facility. Then certain aspects of food and drink take on a significance which has often been neglected in the past.

It is essential that in a facility, this basis – a defined culinary culture – exists. Building up on this or derived from this, cases of malnourishment, eating disorders or refusal of food can be treated. The first important step is that between the actual provision of food and drinks and the meal itself there are many steps and opportunities for creativity which increase in importance when dealing with the elderly. These can play a decisive role in experiencing food and drink as an agreeable and pleasant event.