Enjoyable Dining: Can We Build an Evidence Base?

BY DEBRA WOOD, R.N.

Eating means more to people than simply consuming enough calories to sustain life. It's part of our culture. People cherish their right to enjoy food and have it their way, and evidence is mounting that the meaning of a meal does not change with age or infirmity. Here is a look at how providers, using an evidence base that is partly research-based and partly anecdotal, are working to make sure eating is a positive experience in long-term care.

"Eating and dining are tied to who we are," says Robin Remsburg, professor and director of the George Mason University School of Nursing and associate dean of the College of Health and Human Services in Fairfax, Va. "It's about good times, family, celebrations. Food is involved in almost everything we do in our society. It gives pleasure. It's comforting."

Yet for many nursing home residents, dining can be a less-than-pleasant experience. Food arrives on trays, as in a hospital. But more recently, providers are making the effort to improve their dining options with the help of an evidence base pointing to better ways to meet resident needs.

Consultant dietitian Gretchen Robinson, Ada, Ohio, says that the ability to make healthy food choices, socialize, interact with staff and enjoy a tasty meal provides a dignity unmatched by other services. Robinson adds that many providers have adopted an open dining philosophy with extended hours that empowers residents to make choices about what to eat.

"True choice is choice that is unique to the individual and would reflect the choice that they would make if they were still living in their own home in the community," says Linda Bump, a consultant with Action Pact in Milwaukee, Wis. That may include coffee from fresh-ground beans or a certain flavor of ice cream before bed. "True choice allows you to continue the rituals, preferences and autonomy you enjoyed before you became a resident."

A Growing Body of Evidence

Despite evidence that choice and more home-style meals can benefit long-term care residents, some providers have been slow to transition. The Commonwealth Fund 2007 National Survey of Nursing Homes reported that only 29 percent of U.S. nursing homes had "implemented initiatives to make dining less institutional," such as offering restaurant, family or buffet dining and allowing more flexibility in the times meals are served. The survey found 74 percent of nursing homes prepare meals in a central kitchen and then serve them in one or more common dining rooms, 22 percent prepare the meals in a central kitchen but serve them on the unit or household, and only two percent prepare and serve the meals on the unit.

Evidence of institutional dining's weaknesses goes back nearly 25 years, to a small Swedish study, led by S. Elmstahl at Lund University, that reported that presenting food in serving dishes and allowing residents to chose what and how much to eat led the 16 participants to increase protein and energy intake by 25 percent.

More recently, a team from Wageningen University in the Netherlands reported on findings from a six-month, randomized trial in which one cohort received family style meals and the control group the traditional pre-plated food. Residents in the family style dining increased their intake and the percentage of residents considered malnourished decreased.

Much of the research about home-style dining has taken place in Europe and Canada, Remsburg reports, something she attributes to differing values when it comes to long-term care.

"They have more flexibility to make the homes the way they think they should be, where we have lots of rules and regulations for nursing homes," Remsburg says.

While the Centers for Medicare & Medicaid Services has been receptive to dining changes, that may not hold true at the state level. Donna Yee, CEO of the Asian Community Center in Sacramento, Calif., reports that serving food family style has not been an option in California because the state surveys want all portions measured, with intake noted in addition to weight changes.

Although scant research exists, Bump questions why the field needs data about allowing resident food selection, since no evidence currently supports the idea that an institutional approach to dining on trays from a central kitchen is better than patient choice.

"Simply, all we are doing is returning dining to the resident's normal experiences at home," Bump says.

The Pioneer Network is working to bring greater clarity and ease of use to the evidence base on dining. It convened a task force with representatives from 12 national, clinical organizations to pull together all of the relevant data about nursing home dining and develop new evidence-based New Dining Practice Standards, which it released in August.

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"The standards support what the research is showing us," says Carmen Bowman, facilitator of the task force. "We also cite current thinking, which might be in advance of research," says Bowman, who is owner of Edu-Catering: Catering Education for Compliance and Culture Change, in Brighton, Colo. Each of the 10 sections includes information about what the experts' and regulators' positions are on each topic.

See the sidebar for more about the Pioneer Network's new dining practice standards.

Anecdotal Evidence

One way to improve the dining experience is to create a homier environment.

“Our memories are about food, thinking back, sitting in your grandmother’s kitchen,” says Kelly Smith Papa, director of education and consulting at the Alzheimer’s Resource Center in Plantsville, Conn., which developed its Dining with Friends program to provide more home-style meals.

Food is sent to the residents’ communities from a central kitchen, and the staff cooks something there to add aroma and stimulate appetites. Residents eat off colored plates and from regular glasses. They wear a “dining scarf” rather than a bib, and they tell their stories to each other and staff who sit with them.

“This is a way of bringing an element of life into their day,” Papa says.

When the community opened 19 years ago, dietary staff began developing recipes for pureed foods that look like and taste like regular entrees. Staff members often make suggestions for new items. Preparing food this way has anecdotally improved nutrition and eliminated waste. Papa says residents sleep better and develop fewer wounds.

The Asian Community Center Nursing Home in Sacramento uses molds to make pureed food appear to resemble traditional foods. Meals are served on china and glasses, restaurant style. Residents eat at tables of four, which Yee says supports socialization. Family members often join residents. ACC spiffed up the dining room, removed the medication cart, and added dietary staff for supervision.

“We have had better intake,” Yee says. “We’ve reduced the use of supplements. They are eating real food. Our meals are part of a concerted period when the residents are up and active, which then has a positive effect on bowel and bladder care needs.”

Robinson says she prefers restaurant-style dining, with a selection of food options, such as cook-to-order, tableside cooking and pasta bars. Lighted chandeliers and fine china may be used. Whether upscale or down home or in-between, she says the dining room is always warm, friendly and attended by knowledgeable staff.

“We have less weight loss, and residents have fewer complaints about food service,” Robinson says. “They are better nourished, and there’s an increase in family involvement. And it doesn’t add to the cost, because residents are getting what they like. There is less waste.”

Pioneer Network Releases Food and Dining Standards

The Pioneer Network, with support from the Chicago-based Hulda B. and Maurice L. Rothschild Foundation, has released a set of 10 evidence-based food and dining standards of practice, supporting individualized care and self-directed living. In addition to general recommendations about honoring

choice and diet liberalization, sections address tube feeding and diabetic/calorie controlled, low-sodium, cardiac and altered-consistency diets.

More

Offering Choice

In 1999, Remsburg and colleagues conducted a study of buffet dining, in a dining room decorated to appear more homelike, with tablecloths and glasses rather than cartons. Administrators worried that changing from delivering trays with the appropriate nutrients would lead to eating less.

“There was a great fear about giving over control,” Remsburg says. “But we know in our own homes or in a restaurant, we have our own responsibility for our dining and eating.”

Remsburg was able to demonstrate that when offering at least two choices for all hot and cold food items, the residents ate as many calories and nutrients as when given pre-plated food. However, they did not increase intake, in part, she suspects, because residents cut back consumption at breakfast and lunch, which were still served on trays, to save room to eat what they wanted in the evening. Resident and staff satisfaction increased. Family members often joined their loved ones for dinner.

“It was amazing; some residents who often were fed, would pick up a fork and try to eat or drink,” Remsburg says. “Residents were a little more independent in their eating.”

In addition, the costs were similar. Upfront investments included some beverage glasses and set-up of the steam table. After one menu cycle, the dietary staff could accurately estimate how much food would be needed. She suspects the facility threw out less food, and residents needed fewer supplements.

Liberalizing Diets

Liberalized diets are another component of dining choice.

When a person chooses not to eat his or her prescribed diet, and instead does not eat anything, it impairs quality of life, according to Bowman. She adds, however, “What are the negative outcomes from being told you cannot eat or have something for years on end?”

When people do not like the food, they will not eat it and may lose weight. The American Dietetic Association’s 2005 position paper on the liberalization of diets in long-term care states that food is an essential component of quality of life and unacceptable diets can lead to a spiral of negative health effects.

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The American Medical Directors Association clinical practice guidelines recommend limiting the use of therapeutic diets in long-term care settings.

Remsburg adds, “Eating may be one of the last things a resident can control or have some say in.” Therefore, they may use food and dining to maintain their independence.

Bump points out the lack of evidence that strict therapeutic diets make a positive difference for people in the final years of life. She asks: At 85 years, does forbidding someone to eat a bowl of ice cream make sense, especially when residents are supposed to retain the same rights they had before entering the home?

“People in community living retain the inherent right to make good and bad choices on food,” Bump says. “But it’s hard for health care professionals to let go of using food as a treatment and to instead see true choice in dining as an important element of quality of life as each of us individually defines it.”

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