According to the United States Bureau of the Census Current Population Survey dated March 2000, there were 32.6 million people living in the United States who were at least 65 years old. In North Carolina, 12% of the state’s population, or an estimated 1.04 million people, were in this age group. By 2030, this figure is expected to rise to 18% of the population. North Carolina currently has 424 licensed nursing homes with a bed capacity of 42,897 residents. According to the North Carolina Department of Health and Human Services, 60% of people who live to age 65 will need long-term care sometime in their lives; 40% will need nursing home care.

Many aspects of an older adult’s life, such as degenerative diseases, functional limitations, medications, and social considerations can result in a decreased sense of independence. In addition to actual loss of independence, many residents in nursing homes experience “learned dependency” from excessive care given by those working in the nursing home setting. These factors have the potential to result in weight loss, dehydration, pressure wounds, and other negative health outcomes. According to the Minimum Data Set (MDS) information transmitted to the North Carolina Division of Facility Services from January to March 2005, 11.2% of residents had 5% or greater weight loss in the 30 days prior to their assessments.

Providing a positive dining experience to long-term care residents can be challenging. Functional limitations that range from an inability to walk to difficulty swallowing, along with chronic diseases that require therapeutic diets, make it difficult for facilities to provide the type of home-cooked meal each resident might prefer. An effort should be made to maintain each resident’s dignity and minimize the possibility of excess dependency during the dining experience.

**Rethinking the Dining Room**

The American Dietetic Association’s *Practical Interventions for the Caregivers of the Eating-Disabled Older Adult* discusses many aspects in which the dining experience can be optimized. These ideas range from mobility issues in the dining room to food presentation. The dining room layout, for example, directly affects the ease of mobility to and from meals. Long-term care facilities should arrange tables and chairs to allow easy access by residents utilizing wheelchairs and walkers. Facilities should also ensure that dining room table height is at a level that will accommodate residents seated in wheelchairs. Even if the dining room is easily accessible by residents in wheelchairs, staff should be encouraged to transfer residents into dining room chairs when possible.

The dining experience can also be enhanced if care facilities present a home-like environment by using tablecloths, cloth napkins, and seasonal centerpieces. Vibrant contrasting colors can be used for tablecloths, placemats, tableware, and/or napkins to increase the nutritive intake of residents with dementia and other patients who may have vision impairments that make it difficult to see the food on the plate.
difficult to distinguish food from table placements (i.e., plates, cups, etc.). Cloth napkins also make a better protective barrier for clothing than paper napkins do.

The dining experience can also be improved by simply offering the residents beverages and pleasant conversation while they wait for their meal. Age-appropriate music, along with proper lighting and room temperature (per resident preference), are other easy ways to make the dining experience more comfortable and interesting.

Two other ideas that improve the dining experience by promoting independence and choice involve the way meals are presented to residents. Facilities should consider presenting meals in a buffet-style setting or using family-style dining, which also promotes a home-like atmosphere. Both of these options allow residents to have increased independence by allowing residents to create their own menus and determine their own portion size.

**Eating with Sensory Loss and Chronic Disease**

Residents in North Carolina nursing facilities are admitted with different diagnoses, singly and in combination, which can influence how well they enjoy their dining experience. Sensory losses associated with glaucoma, stroke, arthritis, and other conditions affect a person’s ability to consume nutritionally-balanced meals and participate in the social aspects of dining. Many residents cannot see the food placed in front of them, manipulate the utensils very well, or hear conversations at the table. In addition to sensory impairments, chronic diseases and their treatments may contribute to loss of appetite, nausea, vomiting, early satiety, fatigue, lethargy, and decreased ability to feed oneself. In 2003, the North Carolina Long Term Care Ombudsman Program provided 441 training sessions for long-term care staff on sensitivity to sensory losses associated with aging.

Staff who received the sensitivity training did not enjoy their dining experience. Many of them wanted to retreat to a private location, felt embarrassment, or simply did not want to eat.

In addition to functional challenges, many residents are also prescribed therapeutic diets.* The MDS 2005 data show that 47% of residents received a therapeutic diet, and 42% of nursing home residents received a mechanically-altered** diet. A contributing factor to the high incidence of mechanically-altered diets is the fact that 40% of adults more than 65 years of age have no teeth, and only 2% of adults more than 65 years of age still have all of their natural teeth. Therapeutic diet orders, such as 2gm sodium diets, calorie-controlled diabetic diets, or fat-restricted diets may be too restrictive for the nursing home population and may contribute to existing medical problems through complications, such as weight loss, decreased nutritional status, and diminished quality of life. Some facilities use diet types, such as no concentrated sweets and/or no added salt with recipes for large quantities that can serve most residents in a facility. As a result, these menus can be low in calories, bland in taste, and unappealing. Therapeutic diets may be beneficial for certain disease states in the nursing home setting, but they may result in a decreased calorie intake for those whose health needs do not require as much restriction.

One approach used to combat the feeding challenges caused by chronic disease and functional decline is to provide a liberalized diet. Many nursing homes have embraced a liberalized diet plan, which allows all residents to have a regular diet, with minimal restrictions, such as elimination of a salt packet, altered sweet dessert, or other changes according to the resident’s medical condition. In 2002, the American Dietetic Association established a position statement for the support of liberalized diets in nursing facilities. The research demonstrated that therapeutic diets may not be warranted in lieu of the overall effects on a resident’s quality of life. Many nursing facilities have adopted liberalized menu plans for their residents who have therapeutic needs secondary to diabetes and other disease states, such as hypertension.

**A Team Approach**

In addition to providing more liberalized diets, facilities can improve resident dining satisfaction and nutritional health through interdisciplinary care team coordination and communication. Members of the interdisciplinary team include the physician, registered dietitian, physical therapist, occupational therapist, speech therapist, pharmacist, social worker, nursing staff (including registered nurses, licensed practical nurses, and nurse aides), and the activity department. Family and resident involvement in the care planning process is also important. As an example of care team coordination, the registered dietitian

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* Therapeutic diets are used to help treat/manage certain chronic diseases (e.g., diabetes and hypertension).
** A mechanically altered diet includes foods that may be pureed or softened to help patients who have trouble chewing and/or swallowing.
can monitor the consumption of meals for all residents or target those who have a higher risk for malnutrition, dehydration, and other nutrition-related outcomes. The registered dietitian can determine if a resident’s decreased intake is secondary to drug-nutrient interactions, changes in preferences, or changes in disease state. If drug-nutrient interactions occur, the dietitian may inform the pharmacist who can recommend medications and/or order appetite stimulants to counteract the possible negative outcomes produced by the interactions. Speech therapists can evaluate tolerance to current diet textures and fluid consistencies. As a result of this team approach, a meal can be presented that is individualized to the resident’s needs and food preferences.

Dietary and activity team members can play a crucial role in making the dining experience personal for each resident. These departments can create theme/holiday meals, “meal-of-the-month” menus, and other special events. Residents also have the right to consult with the dietary department to design facility menus that express their religious, cultural, and preferred food choices. Facilities should use this information along with Dietary Guidelines for Americans, My Food Pyramid, and the Dietary Reference Intakes to create a nutritious menu. To carry out the provision of nutritionally balanced menus, a facility may spend 7-10% of its total budgeted expenses on food service-related costs.

Self- and Assisted-Feeding

Feeding difficulties occur in 87% of the elderly population. It is the duty of the direct care staff to inform the rehabilitation department when someone is having trouble. Occupational therapists can evaluate a resident’s need for adaptive equipment and individualized needs, such as proper positioning. Proper positioning (in a chair or bed) is one of the most useful ways to increased independence and, therefore, should be used during all dining experiences. Improper positioning can increase difficulty in self-feeding or swallowing, increase frustration, fatigue, and decrease the resident’s motivation to eat enough food. For residents with functional limitations, self-feeding is a challenge and may decrease socialization at mealtime. Adaptive equipment may minimize the energy required for self-feeding and, in turn, may improve the residents’ ability to socialize. An occupational therapist can develop a plan of care for positioning and train direct care staff.

Other feeding difficulties may be related to visual impairment and/or blindness. Residents with these deficits benefit from standardized placement of food, beverages, and service ware on their trays. The positional “clock system” can be used to inform the resident of the physical placement of specific foods in relation to their tray set-up.

Physical therapists can also be an asset by spearheading programs such as a “Walk to Dine” program. In this program, nurse aides and nurses work with physical therapists to assist residents with transfers from their wheelchairs into dining room chairs and work with occupational therapists on proper positioning of residents. Perry Gains, CNA, in Restorative Nursing at Charlotte Health Care Center, notes that minimizing chaos in the dining room by transferring residents into dining room chairs, and thus decreasing the number of wheelchairs in the room, can help achieve a positive dining experience for everyone. This process decreases the risk of aspiration by allowing optimal positioning and provides an increase in resident dignity during dining. To further increase dignity during dining, residents with similar cognition and table manners or those affected by disease states such as dementia should be seated together. Thus, a resident can socialize with other residents who have similar habits and communication skills. Hearing-impaired residents may be reluctant to eat in noisy, crowded dining rooms because they are unable to hear mealtime conversation, which results in a feeling of isolation. Nursing facilities can limit unnecessary staff conversations, use sound-absorbing materials in the design and décor of the dining room, and ask residents for their individual suggestions on how to address noise reduction.

Improving the social aspect of dining is another way to achieve a positive dining experience. A program entitled “Dining with Dignity” was created to use socialization to increase the intake and independence of residents during meals. The program is based on the enjoyment of meals with friends and families. It targets individuals at risk for malnutrition, dehydration, and pressure wounds and provides them with companionship at meals. Specifically, family members and “volunteer meal companions” are trained to appropriately assist residents during meals. The program trains the volunteers on concepts such as cueing, “hand-over-hand” assistance, the “power of touch,” and the importance of pleasant conversation. Residents who receive assistance from families or companions during meals consume a larger portion of their meals and decrease their risk of malnutrition, dehydration, and pressure wounds. This supports the concept that nursing staff, families, and feeding companions should be an important part of the interdisciplinary team. One nursing home resident involved in the “Dining with Dignity” program summarized her reaction to the program in this way, “I socialize with different people and get to meet new people everyday. We have become a big circle of friends.” This statement demonstrates how important the dining experience can be for a resident’s total long-term residential care.

Summary

The dining experience is an opportunity for residents to experience the independence they once knew and still desire. Through appropriate meal consistencies an optimal dining room setting, and coordination of the total healthcare team, these desires can be reached. The resident benefits from this emphasis on the dining experience, while the interdisciplinary team members gain more insight into the individual needs of residents. The dining experience can be an important part of the clinical care of the resident by assuring appropriate nutritional and fluid intake, and it can help assure a desirable quality of life even while residing in a long-term care facility.
REFERENCES

17 Personal communication with Ron Covington, Vice President of Medical Facilities of North Carolina, Department of Health and Human Services. June 28, 2005.