

Liberalized Diets for the Promotion of Overall Wellness for the Elderly

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Abstract

The American population is aging; by 2030, people over the age of 65 may comprise as much as 20% of the population (Niedert, 2006). As many as 80% of the people in this age group live with at least one chronic illness, and 4.5% of elderly persons in the United States live in nursing homes (Boyle & Holben, 2006). As individuals age into late adulthood, they may experience lessening abilities to think clearly and to move as dexterously as well as a decline in bodily functions that may inhibit their ability to perform tasks of daily living (Boyle & Holben, 2006). These experiences also hinder nutrient intake.

INTRODUCTION

The American population is aging; by 2030, people over the age of 65 may comprise as much as 20% of the population (Niedert, 2006). As many as 80% of the people in this age group live with at least one chronic illness, and 4.5% of elderly persons in the United States live in nursing homes (Boyle & Holben, 2006). As individuals age into late adulthood, they may experience lessening abilities to think clearly and to move as dexterously as well as a decline in bodily functions that may inhibit their ability to perform tasks of daily living (Boyle & Holben, 2006). These experiences also hinder nutrient intake.

NUTRITIONAL HEALTH CONCERNS IN THE ELDERLY PATIENT

RESTRICTIVE DIETS

The aging adult experiences many decreases in bodily function (Homes, 2008) including non-pathological declines in the musculoskeletal, renal, cardiovascular, endocrine, nervous, and gastrointestinal systems which affect food intake and nutrient use (Boyle & Holben, 2006; Homes, 2008). Unintentional weight loss is one of the biggest concerns for the aged population (Cluskey & Kim, 2001; Niedert, 2006). Splett, Roth-Yousey, & Vogelzang (2003) studied unintentional weight loss in newly admitted long-term care patients and found that 21.4% of the 364 patients studied lost weight in the first 90 days. Incidentally, over 50% of the participants were on therapeutic diets (Splett, Roth-Yousey, & Vogelzang, 2003). Therapeutic diets

include food items that have limited flavor which may contribute the patient's lack of interest and/or difficulty in eating the meal (American Dietetic Association (ADA) "Nutrition Assessment for underweight status," 2011; Splett, Roth-Yousey, & Vogelzang, 2003).

Splett, Roth-Yousey, & Vogelzang (2003) claimed that factors other than overly restrictive therapeutic diets, such as "lack of proper assistance and feeding devices or nutrition supplements, and lack of a positive eating environment" (p.353) can also lead to unintentional weight loss. Additional factors including age, loss of spouse, refusal of treatment (Splett, Roth-Yousey, & Vogelzang, 2003), and diseases such as dementia may also contribute to an individual having difficulty eating meals (Chang & Roberts, 2008; Homes, 2008). Cluskey & Kim (2001) found that tube-feeding, increasing the frequency of meals, allowing snacks, improving the dining setting, proper positioning of the patient, and using liquid supplements all helped residents in long-term facilities increase nutrient intake and overcome eating difficulties.

Someone who is elderly typically uses less energy and has less lean body mass, and therefore has less need for high amounts of calories (energy) in the diet, however, this does not mean an older person needs less nutrients in meals (ADA "Dietary Adjustments, 2011). In fact, it is recommended that older people have more nutrient-dense meals that include extra calcium and vitamins (Boyle & Holben, 2006) instead of energy rich meals that are high in fats and carbohydrates

(Grosvener & Smolin, 2007). Nursing homes, other long-term care facilities, and programs that provide home delivered meals seem to have a dilemma between serving more nutritious meals and serving meals that the elderly person would find preferable or familiar, despite a lesser nutritional value (Homes, 2008; Niedert, 2006).

PSYCHOLOGICAL VERSUS PHYSICAL EFFECTS OF MEALTIME

For many elderly people, mealtimes are not just about nutrition. Mealtimes provide social connectivity, comfort, pleasure, and security (Boyle & Holben, 2006; Chang & Roberts, 2008), without which they may have little or no incentive to prepare or to eat their own meals. Meal preparation may even be a difficult task to accomplish (Boyle & Holben, 2006). Although caregivers want the best nutrition for their older patients or clients (Acreman, 2006), the older patient or customer may care more about having a meal that is enjoyable to eat and perhaps that it is eaten in good company (Boyle & Holben, 2006; Niedert, 2006). Gollub and Weddle (2004) reported that adding breakfast to the Meals on Wheels program greatly improved meal recipients' energy intake and lowered their levels of depression which suggests that increasing the frequency of meals may also improve the security and well-being of elderly people.

PROGRAMS PROVIDING MEALS TO THE ELDERLY

Nursing homes, hospices, and other long-term care facilities serve meals to their patients. There are also community based organizations that prepare and serve or deliver meals to individuals who live in their own residences (Boyle & Holben 2006), including Meals on Wheels and the Elderly Nutrition Program, which offers congregate and home delivered meals. Many adult daycares and senior centers also provide meals (Boyle & Holben, 2006; Gollub & Weddle, 2004). An important philosophy on which such programs base their care is the "person first" idea of allowing the person as much freedom and choice as possible, especially at mealtime (Eilers, Lucey, & Stein, 2007).

THE LIBERALIZED DIET

Many long-term care facilities and meal delivery programs offer special therapeutic diets when needed. For example, people with diabetes or high blood pressure may be given food prepared with less sugar or salt, respectively (ADA, "Liberalized Diets", 2011). However, many facilities and programs take into account not only the person's state of

health, physician's orders, and treatments, but also the individual's food preferences (Niedert, 2006). The term used for this approach to meals is liberalized diet. Niedert (2006) suggested that an individual may increase his or her nutrient intake on a liberalized diet that has improved palatability and texture of food. Niedert (2006) argued that the patient has a right to choose the level of his or her meal's nutritional restrictions within reason and under evaluation of a dietician in order to contribute to his or her overall wellness.

Acreman (2006) suggested that optimally nutritious meals actually aid in a patient's sense of well-being and helps "alleviate certain unpleasant side effects" (p.8). Although proper nutrition can enhance one's health and well-being, Niedert (2006) concluded that if restrictions must be placed on meal plans, a liberalized approach should be considered. Sander (2009) found that after four months of the liberalized diet trial, residents in long-term care showed improved cognitive and motor skills and a decreased risk of malnutrition.

MEAL PLANS

Creating a meal plan is not a simple process since each individual has different dietary needs. Many elderly people have dietary restrictions such as low sodium if they have renal problems, or low fat and/or low sugar if they have diabetes. The ADA Nutrition Care Manual (2011) has individual meal plans that can be used as guidelines for individual meal plans in which sugar, salt, or fat can be restricted as necessary, however, it also states that palatability is crucial for adequate food and fluid intake, and one should exercise caution when it comes to restrictions. Therefore, a liberalized meal plan is based on a dietetic professional and/or physician's assessment of the patient's dietary and medical needs, personal preferences, and rights (ADA, "Liberalized diet", 2011).

There are several ways to implement a liberalized meal plan. For example, a patient who needs low sodium could be given a "regular diet" minus the salt pack. Another example is to allow patients to choose their meals from a menu of food items that fit within the parameters of their ordered therapeutic diet (ADA, "Liberalized diet", 2011). Taking the time and the effort to construct an individual liberalized meal plan might be all it takes in some cases to improve the quality of life, promote autonomy, and decrease unintended weight loss for an aged person or long-term care patient (Niedert, 2006).

DISCUSSION

Minimizing the impact of dietary related problems among America's growing elderly population could have an impact on both their quality and quantity of life. When possible, the use of a liberalized diet approach is one technique that has demonstrated promise in meeting the unique dietary needs of this group. The use of a liberalized diet coupled with increased social interaction at meal time is worthy of further study.

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