Nutrition Care of the Older Adult

FOURTH EDITION

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eat right. Academy of Nutrition and Dietetics

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Preface

THE POPULATION OF OLDER ADULTS continues to increase as the baby boomer generation retires and grows older. This is accompanied by multiple concerns from both older adults and their loved ones on issues such as health care, housing, and transportation. For those who need additional care, there are increasing options, including nursing facilities, group homes, assisted living facilities, home health care, and aging-in-place.

These options have created increasing opportunities for nutrition practitioners to apply their expertise to improve the quality of life and care of older adults. The role of the registered dietitian nutritionist (RDN) has expanded to include the nutrition focused physical examination and order writing privileges in certain settings, and the expertise of both the RDN and the nutrition and dietetics technician, registered (NDTR), is in high demand. Staying up-to-date on both nutrition and regulatory guidelines is of the utmost importance. *Nutrition Care of the Older Adult* is designed as a handbook for RDNs and NDTRs working in the field. Every effort has been made to include practical information that reflects current research and practice.

The fourth edition of *Nutrition Care of the Older Adult* comes 26 years after the first edition was published in 1998. This edition was slightly delayed by the COVID-19 pandemic and its oversized impact on health care professionals serving older adults. We are thrilled with the completed product. This edition updates material from previous editions with new information, topics, and references. Brand new chapters include detailed information on gastrointestinal disorders, food allergies and intolerances, and neurological disorders.

Like previous editions, this hands-on reference encompasses the total perspective on person-driven nutrition care of older adults, from nutrition and disease states to regulatory compliance in health care settings. The book is organized into four sections: Introduction to Nutrition Care in Older Adults, Nutrition Assessment, Disease States and Interventions, and Standards for Compliance. Existing chapters were updated to reflect the most current information. For example, the unintended weight loss chapter is now renamed and focused on malnutrition, and the nutrition assessment chapter is even more extensive, and includes nutrition focused physical findings. The appendix includes updated sample facility planning and policy documents needed for emergency preparedness.

Nutrition Care of the Older Adult provides important guidance and the foundation for nutrition care of older adults wherever they call home—in nursing homes, assisted living facilities, group homes, prisons, or the house down the street. Designed as a handbook, it can accompany the nutrition professional on the job—in a nursing facility or a client's home—and provides RDNs and NDTRs with current useful material in this ever-changing environment.

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Chapter 1

Nutrition in Older Adults: An Overview

How old is an older adult? Individuals' beliefs about aging have a profound effect on their health and well-being. Numerous research studies report that beliefs about aging affect physical and mental health, recovery from a debilitating illness, and length of life.[1-4] Health care professionals' beliefs about aging also affect the quality and quantity of care they provide to older adults.[4-7]

Health care professionals working with older adults should consider their personal views on aging. Although their perspectives on aging may change over time, health care professionals may benefit from the following:

- Visualize older clients, older colleagues, and older friends and family members.
- Ask themselves what adjectives can be used to describe their experiences with aging.
- Ask how groups of older adults view their experiences with aging.
- Health care professionals who are older (defined by the Centers for Disease Control and Prevention as those aged 50 to 64 years[8]) can reframe these questions to target their beliefs about aging and experiences as a consumer of health care services.

When aging is considered a negative season of life, adjectives such as *decrepit, senile, demented, slow, dependent, sickly, helpless, less worthy of care,* and *hopeless* may come to mind. In many cases, individuals with a negative view of aging tend to feel greater stress in later life and are less likely to choose a healthy diet or exercise. When aging is seen as a positive season of life, adjectives such as *wise, accomplished, creative, insightful, healthy,* and *active* may come to mind. Addressing common views about aging may help improve efforts to increase preventive health behaviors among older adults.[1,2,9,10]

Ageism in Health Care

Nutrition practitioners working with older adults should consider their own beliefs about aging. Do they view older clients, colleagues, friends, and family through the lens of ageism? *Ageism* refers to discriminatory behaviors toward older adults based on their chronological age. Ageism may occur on an institutional level, reflected in its actions and policies; on an interpersonal level through social interactions; or on a personal level through internalized ageism, in which a health professional internalizes and applies ageist beliefs to themselves and others. Findings from systematic reviews indicate that ageism is widespread, affecting every aspect of health care, institutional policies, and workplace culture.[5,11]

Many health professionals are unaware of their ageist beliefs.[4-6,12] Common ways in which ageism manifests include[11]:

- using oversimplified language like "elder speak" or "baby talk" or speaking in a voice someone might use with a child,
- having inaccurate perceptions about aging that may lead to inappropriate care,
- spending less time providing care or using less effective interventions, and

- allowing personal views about aging to affect assessment and care of older adults.

The effects of positive and negative attitudes toward aging among health care professionals have been studied in the context of quality of care and services provided to older adults.[6,7] Overall, researchers have concluded that medical professionals with positive attitudes toward aging are more effective in encouraging their clients to adopt health-promoting behaviors.[1,9]

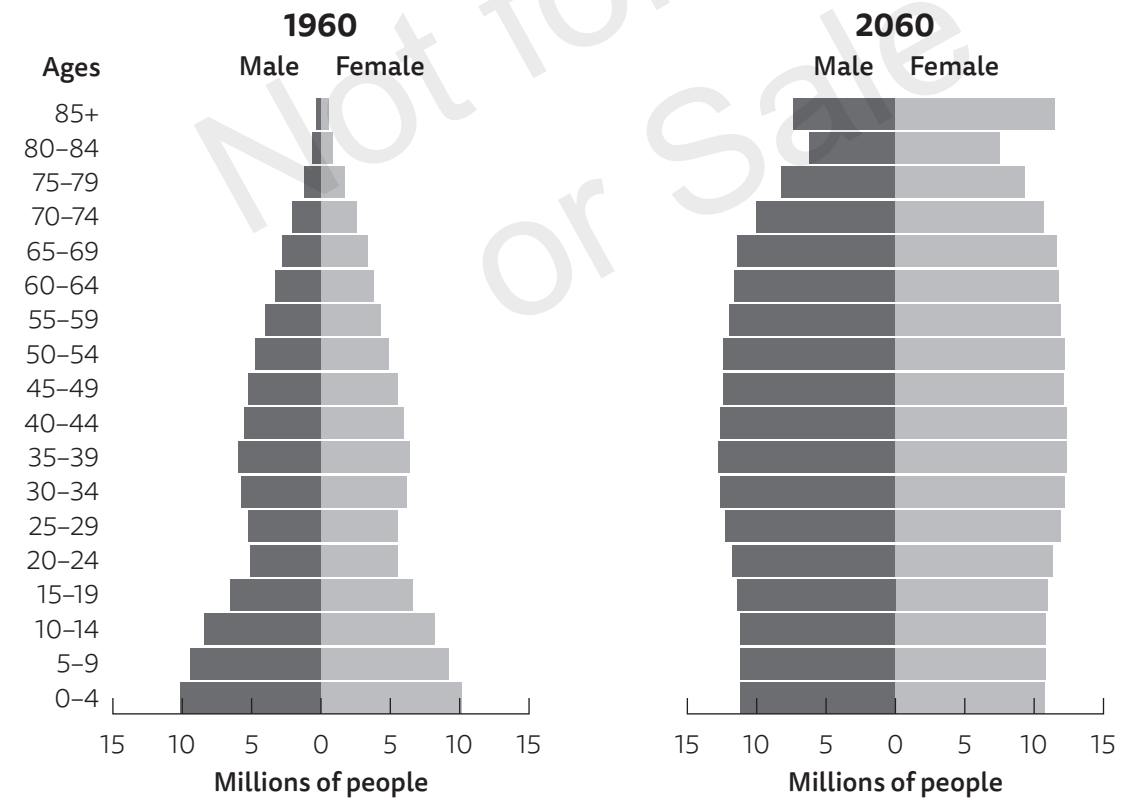
Population and Paradigm Shifts

In 2011, a "silver tsunami" reached the health care shores when the oldest members of the baby boom generation turned age 65 and started to experience notable age-related decline. Proactive health care organizations responded effectively to this first wave of baby boomers. Change triggered more change as this population grew in health care communities. Health care transformations have centered around a shift from an illness-focused care model to a paradigm of wellness.[13]

Since 1960, the US population has transitioned from a pyramid-shaped population distribution (with more children and teenagers and fewer older adults) to a pillar-shaped distribution of age groups (in which the population is distributed more evenly). In 2019, the US Census Bureau projected that older adults would outnumber children by 2024. This shift in population growth will change the number of working-age adults per older adult. In 1960, there were six working-age adults for every person aged 65 years or older. The US Census Bureau projected that this ratio would decrease to 2.4 by 2060. Figure 1.1 shows how the US population has transitioned since 1960.[14]

The National Center for Health Statistics reports that life expectancy in the United States decreased from 78.9 years in 2019 to 77.3 years in 2020, which is the lowest since 2003.[15] Moreover, the difference

Figure 1.1 **Population distribution**[14]



Adapted from US Census Bureau. Population projections. October 2019. Accessed May 19, 2022. www.census.gov/programs-surveys/popproj.html

in life expectancy of males (74.5 years) vs females (80.2 years) increased to 5.7 years in 2020.[14] These findings suggest the following:

- The shift in the older age support ratio (number of individuals aged 15–64 years [working age] to the population aged ≥ 65 years [pension age]) will likely have health care policy implications; and
- There is a growing market for health care and nutrition services for older adults, especially females.

Nutrition Care to Optimize Healthy Aging

Health care providers can take a moment to visualize the clientele they currently serve. What is most important to the current population of older adults?

- Is longevity of life or quality of life the primary goal?
- How would older clients define healthy aging?

Healthy aging is the focus of the World Health Organization's 2015 to 2030 work in aging. The World Health Organization defines healthy aging as "the process of developing and maintaining the functional ability that enables well-being in older age."[16] *Functional ability* is defined as having the mental and physical intrinsic capacity to meet basic needs; learn, grow, and make decisions; be mobile; build and maintain relationships; and contribute to society. The level of intrinsic capacity that an older adult enjoys is influenced by the presence of chronic diseases, injuries, and age-related changes.[12] Nutrition care of the older adult strives to optimize healthy aging and move the dietetics profession toward reframing the culture around healthy aging.

Nutrition is a fundamental pillar of healthy living. Food choices contribute to social, cultural, and psychological quality of life. Healthy eating equips the body to grow and develop to its full potential. Moreover, building a robust immune system to ward off infection and chronic disease throughout the life cycle is a determinant of healthy aging.

Increasing the nutrition status of individuals is one of the most cost-effective investments for improving health outcomes and reducing health care costs. Nutrition professionals recognize the crucial role of nutrition as a determinant of health and physiological well-being. Because nutrition is a complex field, research that supports the contributions of nutrition is limited. Macronutrients and micronutrients work synergistically to nourish and sustain the body, and the role of phytonutrients and the gut microbiome in healthy aging is an emerging area of inquiry.

The 2019 Global Burden of Disease Study[17] examined the health effects of different diets in 195 countries. Researchers concluded that healthier diets could save one in five lives every year. Conversely, poor diets were associated with almost 11 million deaths annually. Illness related to poor diet was also associated with approximately 16% of disability-adjusted life years. Among diet-related deaths, 9.5 million were attributable to cardiovascular disease, more than 900,000 to cancer, and more than 300,000 to diabetes. Researchers concluded that poor diet was associated with more deaths than any other risk factor. The specific food groups and nutrients associated with diet-related deaths were high sodium intake and insufficient intake of whole grains and fruit.

Consider the current clientele of older adults, and answer the following questions:

- Are the older adults served by the clinical practice or in the health care unit experiencing healthy aging?
- Do they understand the importance of healthy eating compared with the burden of disease associated with poor diets?
- Is the nutrition care program driven by dietary restrictions or promoting wholesome foods and making healthy lifestyle choices?

Nutrition professionals working with older adults are witnessing health care reform and innovation that is both dynamic and disruptive.[13] Health professionals can use their academic training, professional continuing education, and this fourth edition of *Nutrition Care of the Older Adult* to shape and drive their practice.

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Chapter 3

Person-Driven Care

There is a difference between dining and eating. Dining is an art. When you eat to get the most out of your meal, to please the palate, just as well as to satiate the appetite, that my friend is dining. —**YUNA MER**

The practice of *person-driven*, *resident-centered care* is meant to be anticipated and enjoyed. It is not just an act to meet a need. Long-term care facilities should strive to meet this definition of person-driven, resident-centered care during dining.

History of Person-Driven Care

With the passage of the Federal Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987, nursing homes were forced to recognize the importance of the individual and that one size no longer fits all.[1] With new emphasis on residents' rights, quality standards for long-term care, and a resident-first approach, the national impetus toward person-driven care emerged and was coined *culture change*. Key principles of the culture change movement include resident-directed care and activities, a home-like environment, resident relationships (with staff, family, residents, and the community), staff empowerment, collaborative and decentralized management, and an overhaul of the nursing home quality assurance system.[2,3] (Note that the suggestion to refer to residents as guests or elders has not been the norm in most situations.) Figure 3.1 presents the framework for resident-centered care.[1]

In 1997, a group of interdisciplinary health care workers, including social workers, registered nurses, registered dietitian nutritionists, and others in long-term care, joined forces with the common goal to facilitate person-centered care. They adopted the term *pioneers* in identifying their common quest for this new level and different type of care for older adults residing in health care facilities. The group called themselves the Pioneer Network. They used culture change as the basis and encouraged focus on the resident and the process of person-driven care.[4]

Since its initiation, the culture change movement has continued to attempt to transition nursing homes from medical models to person-driven homes. The adoption of culture change has continued, although much slower than originally anticipated. However, barriers to adoption persist, which may be attributable, in part, to challenges related to limited financial and staffing resources in nursing facilities.[2,5] These financial and staffing constraints have affected dining and food and nutrition services. Given the delay by senior living communities in implementing culture change and the lack of focus on resident preferences, long-term care food service continues to receive underwhelming satisfaction scores. Although some questions remain regarding the reliability and validity of studies available to date, resident satisfaction is still deemed low.[6] Use of unreliable satisfaction data may mean that nursing facilities are not accurately able to

Figure 3.1 **Resident-centered care**[1]

Adapted with permission from Centers for Medicare and Medicaid Services. The Omnibus Budget Reconciliation Act of 1987. Accessed April 18, 2023. https://qsep.cms.gov/BHFS/M4/M4S1_40.aspx

understand the true impact of their changes within the system on resident or stakeholder satisfaction. Because food service quality affects the nutritional status of older adults, those dissatisfied with food service may suffer nutritionally. This dissatisfaction with food service may also increase the risk of malnutrition.[7,8]

Culture Change

Culture change continues to be the common name for a global initiative focused on transforming care for individuals living with frailty and various cognitive, developmental, psychological, and physical disabilities. Culture change focuses on personalized choice in decision-making regarding the resident's daily life. It also focuses on staff and caregivers treating the resident with dignity, respect, self-determination, and purposeful living. Culture change intends to transform the long-term care medical model to one that both nurtures and caters to the individual while also focusing on medical needs. However, health care practitioners should not assume that culture change alone will substantially improve residents' quality of life. Many potential limitations may constrain quality improvement, even in facilities that have focused on culture change.[9,10]

The Institute for Caregiver Education defined five core principles in its Foundations of Culture Change: respect, empowerment, choice, relationships, and community. Each is reviewed in Box 3.1 on page 28.[11]

Box 3.1 Foundations of Culture Change[11]

Emphasis	Definition
Respect	Each member of the community, regardless of position (resident or staff member), has the right to voice views, ideas, and opinions without fear. Each person's view should then be considered prior to making a decision.
Empowerment	Everyone, including staff, residents, and family members, needs to feel as though they make a difference and should be recognized as valued, contributing members of the community.
Choice	Everyone in the community should be given a range of options that reflect personal preference, allowing for flexibility.
Relationships	Bonds among residents, among staff, and between residents and staff should be an ongoing focus.
Community	Social, emotional, spiritual, cognitive, and cultural needs should receive as much attention as medical care.

All proponents of culture change focus on older adults feeling at home in whatever setting they reside. "Feeling at home" includes all of the choices and individual responsibilities that come with living at home. Commitment to this type of culture change mandates that modifications be made in many areas. Practitioners should remember the following:

- Language is powerful and can create a sense of team or, conversely, of "us vs them."
- All staff need to be intentional in how they interact with older adults.
- Language should be based on people and relationships, not tasks.
- All life should be looked at in the context of the home, not the facility or institution.
- Staff should find ways to say "no" less often.
- Older adults should make decisions every day about their routines and care.
- Staff should adjust their routines to meet the older adult needs, not the older adult adjusting to accommodate staff or facility routines.

Person-first language changes related to dining are listed in Box 3.2.

The Pioneer Network is committed to changing the culture in long-term care facilities. The organization's dining standards, developed over a decade ago, are still being used in the transition to person-centered care. These dining practice standards continue to emphasize the importance of the following[12]:

- informing the resident of choices in all areas, not just dining;
- determining the diet based on the goals and preferences of the resident, not just on the diagnoses;
- basing decisions on quality-of-life issues;
- utilizing the regular diet whenever possible unless a medical condition dictates that modifications must be made;
- individualizing the plan of care based on resident preferences, wants, and needs, which includes identifying cultural, religious, and ethnic preferences with the resident;
- informing the physician and pharmacist of the residents' wishes concerning diet so that medical issues, medication dosages, and timing that can impact appetite are adjusted, if possible;
- providing appropriate education to allow the resident to make informed decisions;
- mitigating nutritional risks as much as possible; and
- remembering that decisions should default to the resident whenever possible.

Person-driven care is gradual, is based on core values, involves everyone, and is meaningful. Older adults should continue to pursue their interests and hobbies. Sense of purpose is central. Effective practices empower staff, and dining involves resident preferences. The community is meant to accommodate the older adult and the older adult is encouraged to be as self-sufficient as possible.

Box 3.2 Person-First Language Related to Dining

Old term	New term
Facility, unit, dayroom	Home, community, living room
Resident	Elder, guest
Feeder	Person who needs assistance with eating
Complainer	Person with concerns
Picky eater	Person with known food preferences
Allow residents to eat what they want	Support residents in their dining choices
Diabetic	Person with diabetes
Dietary, food service	Dining services
Nourishment, supplement	Snack

Models of Culture Change and Advocacy

Research suggests that to substantially improve resident psychosocial well-being, traditional-model nursing homes should be redesigned as small, home-like "households" and should comprehensively adopt other aspects of culture change.[13,14] Prevalent culture-change models include the Eden Alternative, the Green House Project, the Pioneer Network, and Planetree.

Eden Alternative

The Eden Alternative is a not-for-profit organization founded by Bill Thomas, MD, and his partner Jude Thomas, with the philosophy "that aging should be a continued stage of development and growth, rather than a period of decline."[15] As a comprehensive culture change model, the Eden Alternative focuses on creating older adult–centered communities that thrive on close and continuing relationships, meaningful interactions, opportunities to give as well as receive, and rich and diverse daily life.[16] The organization focuses on partnering with nursing homes to move away from the institutional hierarchical (medical) model of care into a constructive culture of "home" where older individuals direct their own lives. The Eden Alternative philosophy is focused on the care of both the human spirit and the human body. Bill Thomas's idea was expanded to encompass the physical layout of long-term care facilities called Green Houses.[17]

Green House Project

With support from the Robert Wood Johnson Foundation, Bill Thomas's concept of the Eden Alternative evolved into the Green House Project: small homes that return control, dignity, and a sense of well-being to older adults, while providing high-quality, personalized care. Older adults live independently in a self-contained home for 10 to 12 people that is designed to look like a private residence in the surrounding community.[18] In 2018, the Robert Wood Johnson Foundation ceased funding the Green House Project, which has since advanced to Green House 2.0.[19] The project describes its homes as "typically licensed as skilled nursing facilities and meet all applicable federal and state regulatory requirements. Each person who lives in a Green House has a private bedroom and full bathroom, opening to a central hearth/living area and an open kitchen and dining area."[20]

Each Green House home is staffed by a team of universal workers, known as Shahbazim. Instead of providing specialized care tasks, such as showering or feeding assistance, the Shahbazim provide all of the older adult's direct care needs.[21] The pleasure that accompanies sharing good food with good company is encouraged through older adults sharing meals at a common table. In addition, family members, friends, and staff are welcome to join the community at mealtimes and for other activities.

Pioneer Network

The Pioneer Network encourages research that supports culture change, hosts national conferences, and creates strategic partnerships with leading organizations. Many states also have coalitions working for culture change and person-directed care (contacts are listed on the Pioneer Network website, www.pioneernetwork.net)

The Pioneer Network focuses on caregivers developing relationships with each older adult, knowing the individual older adult, and promoting the growth and development of all to change the culture of aging.[4] The Pioneer Network created a task force to develop dining practice standards (described earlier) that were approved by 12 professional organizations, including the Academy of Nutrition and Dietetics. These standards remain current today. A toolkit for nursing homes to implement these practices was also developed.[12]

Planetree

Planetree was developed under the direction of Angelica Thieriot and is a person-centered (person-driven) model of care used in hospitals.[22,23] Based on growing evidence and experience partnering with organizations and patient advocates around the world, Planetree affirms that person-centered care is more than just the best approach for improving health care outcomes. Planetree affiliates focus on providing comfort foods by creating kitchens in patient care areas where families can prepare their loved one's favorite foods. In addition, they never turn down a request for food at any time, day or night.

Implementation of Culture Change

It is difficult for researchers to evaluate how culture change is implemented from facility to facility. The Pioneer Network's *Artifacts of Culture Change 2.0* is a downloadable, internal implementation and self-assessment tool that nursing homes can use on their culture change journey.[24] The tool lists a variety of beneficial changes that nursing facilities can make to increase resident autonomy, rights, and choices and decrease institutional practices. The *Artifacts of Culture Change 2.0* can help facilities become aware of concrete changes that leading homes have made to their policies, practices, and environment because of their commitment to culture change principles. The nursing facility can also use this tool to note their progress toward changing institutional culture over time.

The lack of a common definition or nomenclature to describe the culture-change process has resulted in the proposal of two models: the stage model of culture change in nursing facilities by Grant and Norton[25] and the continuum of person-directed culture by Misiorski and Rader.[26] Facilities may follow one of these models or use a combination when implementing culture change.

Stage Model of Culture Change in Nursing Facilities

In 2003, the creators of the stage model of culture change categorized culture change into four stages[25]:

1. institutional (traditional, no change)
2. transformational (beginning stages of change)
3. neighborhood (smaller resident-centered living areas within a larger whole)
4. household (small self-contained living areas)

As organizations move from stage 1 to 4, innovation occurs in five organizational systems: decision-making staff roles, physical environment, organization design, and leadership practices. This model is still used today. Box 3.3 provides an overview.[25]

Box 3.3 Stage Model of Culture Change[25]

Stage 1: Institutional	Traditional medical model organized around a nursing unit without permanent staff assignments
Stage 2: Transformational	Characteristics include permanent staff assignments, a physical environment that is less institutional, and awareness and knowledge of cultures spread among direct care workers and the leadership team
Stage 3: Neighborhood	Breaks up traditional nursing units into smaller functional areas and introduces resident-centered dining; gives neighborhoods unique identifiers or names
Stage 4: Household	Consists of self-contained living areas with their own full kitchen, living room, and dining room and cross-trained staff

Continuum of Person-Directed Culture

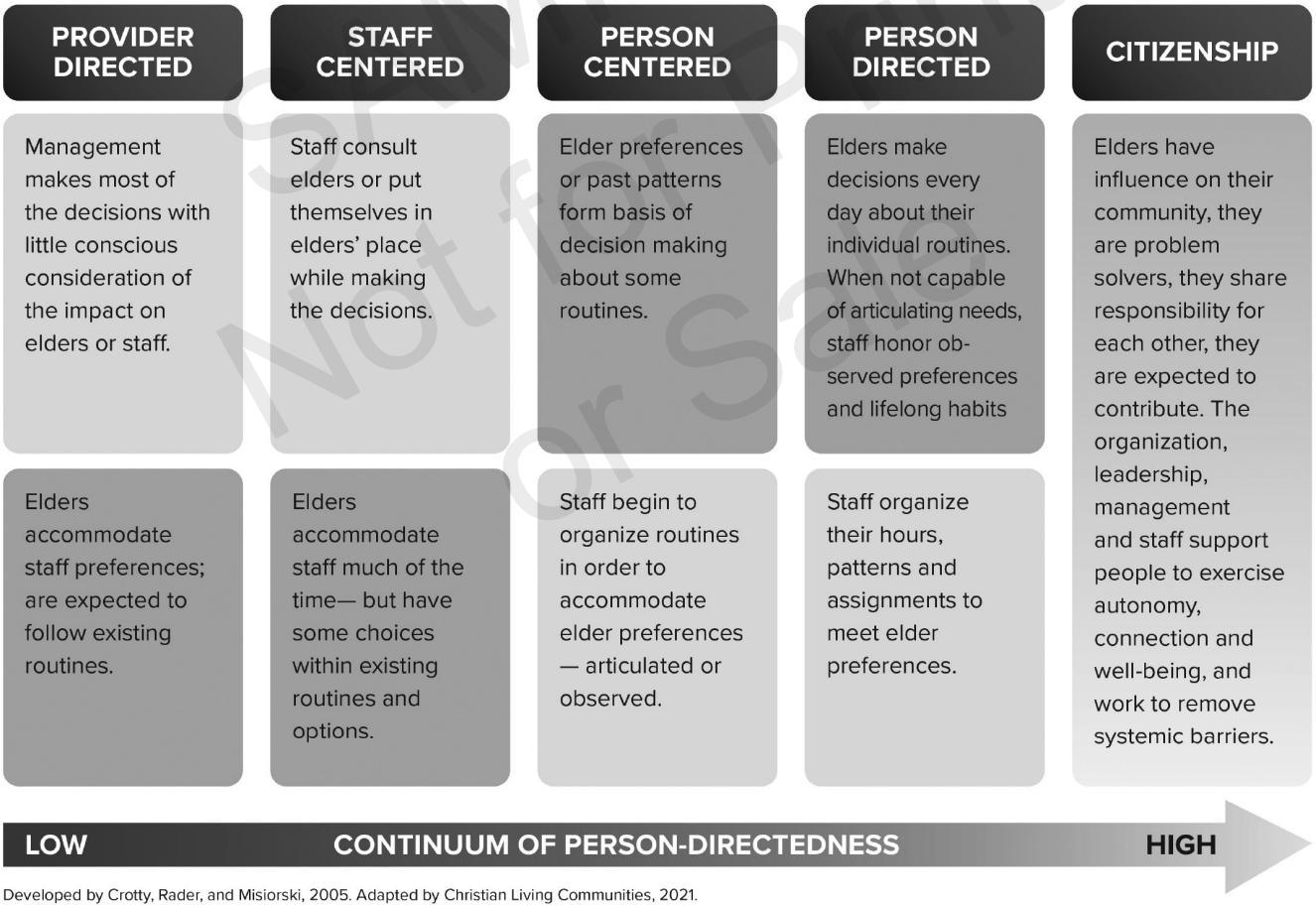
Misiorski and Rader developed the Continuum of Person-Directed Culture in 2005, illustrating the degree of change from physician-directed care through the continuum to person-directed care. This continuum focuses on the person or persons in charge of decision-making and delineates examples of specific practices (eg, care assignments, dining, bathing, moving in, nighttime assistance, medication administration, and handling of death) throughout culture change. The Pioneer Network added another stage to the continuum: citizenship. The five phases are summarized in Figure 3.2.[26]

Culture Change in Food Service

Culture change affects all aspects of the physical facility, including staffing, medication administration, activities of daily living, schedules, and dining practices. This section focuses on culture change and the dining experience, during which the resident is allowed to make choices of when, where, and how to eat and the facility and staff organize around the resident's preferences.

Facilities should consider the resident's Five Rights of Dining (outlined in Box 3.4 on page 32) when moving toward person-driven care.[27]

Figure 3.2 Continuum of person-directed culture[26]



Developed by Crotty, Rader, and Misiorski, 2005. Adapted by Christian Living Communities, 2021.

Box 3.4 The Five Rights of Dining[27]

The right food: the resident's preferences

The right setting: where the resident likes to eat

The right preparation: how the resident likes the food made

The right time: when the resident wants the food

The right to choose: the resident's choices are honored

Research and literature reviews regarding the effects and implementation of culture change on the dining experience are abundant.[28,29] Mealtimes are a source of pleasure from both the foods consumed and the social interaction experienced. However, the pleasure associated with eating can often be lost for older adults after moving into a nursing facility. Mealtimes are frequent events within a facility. The large number of nutrition care quality initiatives in both hospitals and nursing homes indicates the high interest in and importance of better nutrition care provision for older adults.[30] The following have become necessary in the person-first environment:

- identifying each person's daily food or dining pleasures,
- determining how these pleasures can be provided,
- educating staff about residents' needs and expectations, and
- monitoring and following up to ensure individual requests are being met.

Changes to dining practices can be as small as the addition of a selective menu or as large as a full-scale dining service change, including staffing, equipment, facility design, and dining atmosphere. Among dining style practice studies, restaurant style has continued to be a popular theme.[31] In one facility, 24-hour dining was initiated after the owner was delivering breakfast trays, noted that several residents were sleeping, and thought it ridiculous to wake them to eat.[32] Another facility started with a continental breakfast buffet and worked its way up to a trayless buffet for all three meals.[33] Box 3.5 summarizes additional culture change ideas for dining experiences that have been used successfully.

Box 3.5 Examples of Culture Change Implementation

Food service methods

Specialty stations: omelet, soup, pasta, and salad bar; pizza; grills

Open dining: extended hours, 24-hour dining

Room service, buffet-style dining, restaurant-style dining

Resident involvement

Preparation of a favorite recipe

Culinary school demonstrations

Menu development committees

Open dining

Kosher café open to residents, families, staff, and the public

Cocktail or coffee shop open to residents and families

Mealtime activities

Aromas of baked goods in the dining rooms and hallways

Residents sharing in meal preparation, as desired

Staff sitting and sharing meals with residents

Benefits of Culture Change

Culture change results in many benefits. Most facilities that have implemented a culture change boast resident-reported improvements in quality of life, emotional well-being, and behavioral measures. Other benefits include decreases in the number of residents requiring a therapeutic diet, those with unintentional weight loss, and those with nonhealing pressure injuries.[32] Although administrators assume that a commitment to culture change would have tremendous financial impact, studies have shown an offset to costs in savings. Examples of these savings include decreased plate waste, decreased employee turnover and training, decreased costs for unintentional weight loss and pressure injury intervention, and decreased supplement expenses.[25,33]

The Regulatory Process and Culture Change

The Centers for Medicare and Medicaid Services (CMS) has continued to update federal regulations for long-term care providers. These regulations reinforce person-driven care through multiple regulatory statements, beginning with resident rights. As noted in CMS regulation F561 (Self Determination and Participation), 483.10 (F)(2), "The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident." The CMS additionally defines person-driven care to "focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives."[34]

CMS regulation F561 includes language that gives the resident the right to "exercise his or her autonomy regarding those things that are important in his or her life. This includes the residents' interests and preferences." Residents have the right to choose schedules for waking, eating, bathing, and sleeping that are consistent with their interests, assessments, and care plans. The CMS offers clarification that clearly promotes a resident's right to exercise their autonomy. It also provides nursing home providers with assurances that the regulations and regulatory agencies are supportive of individualized, resident-centered care that provides options for resident choice.[34]

The regulatory interpretive guidelines for Federal Nursing Facility regulation F675 (Quality of Life) state the following[34]:

> The intention of this requirement is to specify the facility's responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by:
>
> - ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and
> - ensuring that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values, and beliefs.

Resident Expectations

Researchers have found that older people want, but do not get, the same chance that younger people have to choose autonomy when it comes to long-term care, including control, individuality, and continuity of a meaningful personal life.[35] Older adults want to live in a setting that is home-like and allows them to make the decisions they are accustomed to making for themselves.

In 2005, Linda Bump, MPH, RD, NHA, Pioneer Network member and culture change leader with Action Pact, emphasized resident-centered dining and encouraged "excellence in individualization." She indicated that to accomplish such excellence, each facility must provide choice, accessibility, individualization, liberalized diets, food first, quality services, and responsiveness, as defined below.[36]

Choice is the choice of what, when, and where to eat; whom to eat with; and how leisurely to eat. Choice should be true choice, not token choice—that is, choice of what the resident wants without facility-imposed limitations.

Accessibility is the access to foods of choice available when hungry or when just longing for a specific food. Food should be available 24 hours a day, 7 days a week, and someone should be available to help prepare it.

Individualization is specific attention to older adults' favorite foods, comfort foods, ethnic foods, foods prepared from their own favorite recipes, and foods they choose to eat in their own home. The foods offered should make older adults look forward to the day, warm their heart and soul, and nourish their bodies.[37]

Liberalized diets should include the older adult's right to choose whether to follow a restrictive diet. The diet should not be based solely on diagnosis but on the individual.

Food first is the ability to choose food before supplements and medication. This is a natural decision and should be fostered.

Quality service focuses on relationships that are the key to quality caregiving and quality service in dining. Knowing older adults, their choices, their

preferences, and their daily pleasures in dining results in quality service that encourages optimal intake.

Responsiveness refers to relationship-based services, resident access to the refrigerator whenever desired, and quiet attention to every need.

Regardless of the delivery method, Bump concluded that "food is the heart of the home. The ideal is to have what the residents want to eat available 24 hours a day, 7 days a week, with the opportunity to eat with whom they wish, in places they choose to be."[36]

Summary

For culture change to be successful, health care professionals should determine the true wants and needs of the resident before changes are made. Challenges to implementation include inadequate staffing levels and lack of appropriate financial support, buy-in at all levels, and time. Successful transformation does not occur quickly and is most effective when driven by the entire team, including residents, family members, all staff levels, and all other stakeholders. The baby boomer generation that will continue to age over the next several years is accustomed to greater food variety, entertainment, and culture. These lifestyle criteria and wants will continue to enhance the evolution of resident-centered or person-driven care.

Part of culture change is adjusting practices as the resident population changes. Processes enacted today may not work a year from now because of changes in the resident population and their cognitive abilities, overall general health, and functional status. Additionally, health care professionals should continually revisit the concept of a home-like environment, especially because many nursing facilities are evolving into short-stay rehabilitation centers. These older adults may have different expectations, including facilities that resemble a rehabilitation hotel.

Culture change should be home-like, person driven, and resident centered. It should focus on improvements in quality of life. Food is integral to overall resident satisfaction with the facility. Further research is needed to determine resident home practices and assess their preferences for dining style in skilled nursing facilities. These data could then be generalized to the larger population, and facilities could merge culture change and resident choices regarding the dining experience. Culture change must be defined by the customer (ie, the resident of the skilled nursing facility) for it to be successful.

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