NUTRITION, FOOD SERVICE & DINING IN LTC

The best practices within this document are recommendations to support regulatory compliance to Ontario LTC legislation, promote optimal nutrition and hydration care and support person centered care. It is important to note, however, that residents' rights and preferences are paramount and should be respected regardless of legislation or best practice. The best practice document is based on resources and expertise from industry professionals and where applicable, are evidence-based. This is a living document that will transition with the evolution of the industry over time.

SUBJECT: DEMENTIA & RESPONSIVE BEHAVIOURS	**Revised: 2023-02-06**
ONTARIO REGULATION 246/22 made under the FIXING LONG-TERM CARE ACT, 2021	
Nutritional Care and Hydration Programs	

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1. Purpose & Scope

- As dementia progresses, difficulties in communication and thought processes become increasingly prevalent and may result in responsive behaviours. These responsive behaviours, or verbal/non-verbal expressions, show residents unmet needs.
- Dementia and responsive behaviours can affect food and fluid intake. Calm and comfortable meal and snack times increase food and fluid intake.

2. Key Concepts

- Dementia may affect memory, judgment, orientation, communication, mood, and behaviour. These may display as agitation, wandering, pacing, sun-downing, and apathy. All these responsive behaviours will impact food and fluid intake during meals and snacks.
- In the dining room, the interdisciplinary care team needs to be alert to changes in appetite, difficulty with self-feeding or the need for assistance and/or complete unawareness of food when being served.
- Congregate dining in and of itself may pose and create responsive behaviours and may need to be managed.
- Poor food intake due to dementia and responsive behaviours can lead to malnutrition, weight loss, dehydration, falls, wounds, and other negative health impacts.

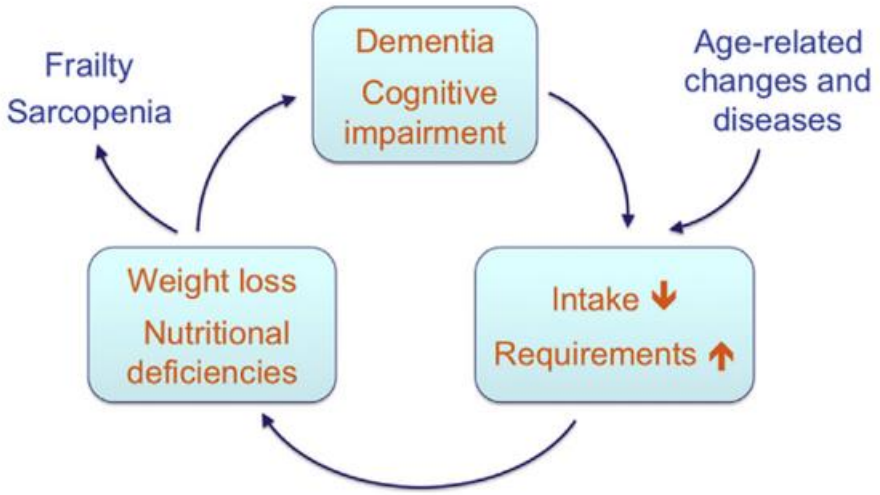

Fig. 1. Vicious circle of malnutrition and dementia.

**** ESPEN guidelines on nutrition in dementia***

3. Practice Recommendations

a. Assessment & Monitoring

- Dementia and personal expressions are discussed and documented as part of the initial assessment and ongoing nutrition assessment.
- As dementia and stages of dementia progress, so will the need for ongoing assessment and review of interventions.
- Consider factors that influence oral intake in residents with dementia:
  - Inadequate intake. Anorexia usually occurs in the final stages of the disease, contributing to weight loss.
  - Changes in smell and taste.
  - Neuropsychiatric disturbances such as memory loss, impaired judgement, changes in eating habits, or presence of dysphagia.
  - Increased nutrient requirements. Energy consumption may rise with increased physical activity due to agitation, or a hypercatabolic state.
- Brain atrophy: residents with dementia have significant atrophy which plays an essential role in eating behaviour and in the regulation of memory and emotion.
- Food and fluid intake are monitored for all residents and interventions put into place as needed.
- Monitor meal and snack intake records and monthly weights.
- Connect with families, power of attorney (POA) and/or substitute decision maker (SDM) to learn about foods that residents have enjoyed in the past.

- Below are additional guidelines on nutrition and dementia from ESPEN:

Table 5
Complete list of statements on nutrition in dementia.

#	Statement	Grade of evidence	Strength of recommen-dation
1.	We recommend screening every person with dementia for malnutrition. In case of positive screening, assessment has to follow. In case of positive assessment, adequate interventions have to follow	Very low	Strong
2.	We recommend close monitoring and documentation of body weight in every person with dementia.	Very low	Strong
3.	We recommend provision of meals in a pleasant, homelike atmosphere.	Moderate	Strong
4.	We recommend provision of adequate food according to individual needs with respect to personal preferences.	Very low	Strong
5.	We recommend to encourage adequate food intake and to provide adequate support.	Very low	Strong
6.	We do not recommend the systematic use of appetite stimulants.	Very low	Strong
7.	We recommend educating caregivers to ensure basic knowledge on nutritional problems related to dementia and possible strategies to intervene.	Low	Strong
8.	We recommend elimination of potential causes of malnutrition as far as possible.	Very low	Strong
9.	We recommend avoiding dietary restrictions.	Very low	Strong
10a.	We do not recommend the use of omega-3-fatty acid supplements in persons with dementia for correction of cognitive impairment or prevention of further cognitive decline.	High	Strong
10b.	We do not recommend the use of vitamin B1 supplements in persons with dementia for prevention or correction of cognitive decline when there is no indication of vitamin B1 deficiency.	Very low	Strong
10c.	We do not recommend the use of vitamin B6, vitamin B12 and/or folic acid supplements in persons with dementia for prevention or correction of cognitive decline when there is no indication of vitamin B6, vitamin B12 and/or folic acid deficiency.	Low	Strong
10d.	We do not recommend the use of vitamin E supplements in persons with dementia for prevention or correction of cognitive decline.	Moderate	Strong
10e.	We do not recommend the use of selenium supplements for prevention or correction of cognitive decline.	Very low	Strong
10f.	We do not recommend the use of copper supplements for prevention or correction of cognitive decline.	Very low	Strong
10g.	We do not recommend the use of vitamin D supplements for prevention or correction of cognitive decline.	Very low	Strong
11.	We recommend the use of ONS to improve nutritional status.	High	Strong
12.	We do not recommend the use of ONS in persons with dementia to correct cognitive impairment or prevent further cognitive decline.	Moderate	Strong
13.	We do not recommend the systematic use of special medical foods for persons with dementia to correct cognitive impairment or prevent further cognitive decline.	Low	Strong
14.	We do not recommend any other nutritional product for persons with dementia to correct cognitive impairment or prevent further cognitive decline.	Very low	Strong
15.	We recommend that each decision for or against artificial nutrition and hydration for patients with dementia is made on an individual basis with respect to general prognosis and patients' preferences.	Very low	Strong
16.	We suggest tube feeding for a limited period of time in patients with mild or moderate dementia, to overcome a crisis situation with markedly insufficient oral intake, if low nutritional intake is predominantly caused by a potentially reversible condition.	Very low	Weak
17.	We recommend against the initiation of tube feeding in patients with severe dementia.	High	Strong
18.	We suggest parenteral nutrition as an alternative if there is an indication for artificial nutrition, as described in recommendation 16, but tube feeding is contraindicated or not tolerated.	Very low	Weak
19.	We suggest parenteral fluids for a limited period of time in periods of insufficient fluid intake to overcome a crisis situation.	Very low	Weak
20.	We recommend against the use of artificial nutrition (enteral nutrition, parenteral nutrition and parenteral fluids) in the terminal phase of life.	Very low	Strong

D. Volkert et al. / Clinical Nutrition 34 (2015) 1052–1073

b. Interventions

- For residents experiencing weight loss, evidenced noted that the comprehensive intervention of registered dietitian (RD) time and an enhanced individualized menu designed for residents with dementia promoted significant gains in body weight.

- Interventions for eating and drinking are based on individual needs and may include:
  - Seat the resident at a dining table that will minimize or eliminate distractions
  - Seat them with other residents who may provide a calming effect and minimize agitation
  - Provide finger foods that may be helpful for residents who wander
  - Provide everything needed upfront to minimize frustration and avoid residents walking away during mealtime – napkin, cutlery, assistive devices, proper positioning, assistance cutting food if needed

- General guidelines for approaching residents include:
  - Approach from the resident's front, not from behind
  - Speak to the resident at eye level as much as possible
  - Address resident by preferred name and avoid pet names (sweetie, dear)
  - Be always respectful and polite

- Use simple words, short phrases, and gentle calm tone
- Give time to respond; suggest words
- Show empathy and caring in all interactions

- Create a rapport with families to help understand residents' individual needs and work together to develop successful interventions.

- Be creative and flexible, and support residents' retained abilities while preserving dignity and resident rights.

- Interact with residents by prompting and praising appropriate mealtime behaviours.

- Butterfly Model (meaningful care matters, 2018) and Eden Philosophy (Eden Philosophy, 1992) are just a couple of the different models of care that are focused on dementia.

c. Documentation

- Ongoing documentation on behaviours during meal and snack times help the interdisciplinary care team to make changes to care plans and service decisions. For example, residents who are noted to wander may eat better when all courses are served together.

- Documentation on food and fluid intake at each meal and snack helps to make decisions on amount and type of food to serve. For example, residents whose intake slows through the day may benefit from a nutritional supplement in the evening.

d. Staff Training

- Provide ongoing, short training sessions to help all front-line staff better relate to residents with dementia. (https://teepasnow.com/ and https://alzheimer.ca/en)

- Longer training programs provide staff with improved knowledge, attitudes and supportive behaviours relating to mealtime assistance for people with dementia. (PIECES)

e. Menu Evaluation

- Observe residents during meals. Consider whether other individualized interventions can be put in place to improve mealtime experience and reduce responsive behaviours in the dining room. For example, a resident may need all courses served together, dessert served first, request for unusual food items/preferences (e.g. ketchup on everything), and modified textures.
- Reduce menu restrictions where possible.
- Evaluate the dining location and factors interfering with intake, noise, smells, distractions, lighting, waiting too long etc..

4. Home Specific Policies, Roles & Responsibilities

- Utilize these Best Practices to guide your home specific policies, roles, and responsibilities. Home specific policies take precedence over this document.

5. Resources & Tools

- Alzheimer society of Canada. https://alzheimer.ca/en
- Alzheimer Association. *The seven stages of Alzheimer's.* https://act.alz.org/site/DocServer/sevenstages.pdf;jsessionid=00000000.app234a?docID=16881&NONCE_TOKEN=3887E05A05827E952F2CF982C8D264CC
- Alzheimer society of Canada. *How dementia can impact mealtime habits and routines.* https://alzheimer.ca/en/help-support/im-caring-person-living-dementia/providing-day-day-care/meal-time
- Alzheimer society of Canada. (2019 May). *Dementia and responsive behaviours.* https://alzheimer.ca/sites/default/files/documents/conversations_dementia-and-responsive-behaviours.pdf
- Alzheimer knowledge exchange. (2013). *A guide to understanding dementia behaviour.* Alzheimer's society of Canada. https://brainxchange.ca/Public/Files/Behaviour/ShiftingFocusBooklet.aspx
- Meaningful Care Matters. *The Butterfly approach.* https://meaningfulcarematters.com/culture-transformation/

- The Eden philosophy. https://www.edenalt.org
- Behavioural supports Ontario. https://www.behavioursupportsontario.ca/
- Pieces learning. https://piecescanada.com/
- Teepa Snow https://teepasnow.com/

6. Evidence & References

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