

DEMENTIA IN LONG-TERM CARE MEALS AND MEAL PREPARATION

1. Good nutritional intake is vital. Poor intake leads not only to physical but also cognitive changes. Adequate amounts of fluids are necessary to prevent dehydration.
2. Elderly residents do not get thirsty as they did when younger. Even when their body needs fluids they don't get the message to drink. Encourage drinking fluids, especially water, throughout the day.
3. Poor intake has many causes. Nausea commonly occurs and medical issues or medications can be the cause. Be aware of any new medications and the development of loss of appetite.
4. Alzheimer's patients lose their sense of smell, which makes the taste of food bland. Increasing the seasoning of food may help with this issue.
5. Carbohydrate craving also can occur in dementia. Residents may simply want to eat bread, cookies, and candy rather than a balanced diet.
6. Smelling food being prepared is a means to enhance the appetite of residents. Whether for meals or when baking is an activity the aroma of the kitchen is a powerful appetite enhancer.
7. Constipation can be a cause of poor oral intake.
8. Mechanical issues, such as loose-fitting dentures, trouble swallowing, and an inability to use utensils need to be assessed for when poor intake occurs.
9. Loose-fitting dentures or painful teeth can lead to a decline in eating meals. A dental evaluation is called for in these cases.
10. Swallowing problems should be documented (coughing, especially) so the provider can arrange a swallowing evaluation. This may require a change in diet to another consistency to prevent aspiration.
11. Lack of ability to manipulate utensils can lead to poor oral intake and embarrassment. Heavier or larger handles on forks and spoons, no-spill cups, and reliance on finger foods may enhance the resident's oral intake. Occupational therapy may help with this issue.
12. Some residents may be overwhelmed by three large meals and you may find that their intake improves with many small meals or snacks during the day.
13. Stimulation from the dining room may prove to be too much for a resident so a calmer, less noisy area to dine, even their room may improve their appetite.
14. Make sure the resident is comfortable with tablemates. This could make the dining experience hard to bear and lead to a refusal of meals to avoid certain people.
15. Make sure lighting is adequate for residents to see their food. In addition, the contrast between food and plates, bowls, and cups can allow the meal to be more readily identified.
16. Find out from family traditional likes and dislikes. Make sure that the food is identifiable to the resident, as some meals may not be foods they traditionally ate, or the food is prepared in a manner the resident is unfamiliar with.
17. Weight gain can be prevented as it leads to more physical difficulties, such as with diabetes, cholesterol, breathing and ambulation. Proper documentation of intake (especially food brought in from family, friends) and weights is necessary.

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18. Patients with frontal lobe deficits have difficulty limiting intake and may eat much more than expected, leading to weight gain.
19. Some demented residents get forgetful about whether they have eaten or not. If adamant that they have been to a meal when they haven't simply tried again later to encourage a small plate of food or a snack.
20. Those patients who have significant changes in their wake-sleep cycle may need meals at night, when awake, rather than during the day, when they sleep.

Video Links

[Feeding Tips for Dementia](#) (3min09sec)

[How to Help a Family Member with Alzheimer's or Dementia with Eating](#) (1min30sec)

[Eating and Feeding Issues in Older Adults with Dementia](#) (38min05sec)

[Dementia, Dining & Dignity at the Dinner Table](#) (4min46sec)

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