Quality of Life, Food Choice and Meal Patterns – Field Report of a Practitioner

Alfred T. Hoffmann

IQ-Innovative Qualifikation in der Altenpflege GmbH, Bad Arolsen, Deutschland

Abstract
Quality of life is defined as the result of combining personal resources, control of the environment, personal values, and actual living conditions. Balanced nutrition is an important condition for quality of life, health and well-being. During the course of life everyone develops his very individual biography of eating. This includes eating habits, food choice, and meal patterns. The process of aging is accompanied by hardly recognizable physiological, emotional, social, and environmental changes. Ignoring these changes can lead to malnutrition and nutrition-related problems and thus reduce health, diminish the quality of life, and overall well-being. Accordingly, it is necessary to synchronize the individual biography of eating, the physiological, emotional, social, and environmental changes to enable the aged to feel self-determined and self-confident. This presentation will describe successful examples from local homes for the aged/nursing homes. Examples will show that possibilities of food choice answer the need of the residents to control their environment, that residents can be integrated in the planning and preparation of food and how this corresponds with their need to show their knowledge and experience, that meals in residential facilities can be re-arranged to let the residents experience joy and pleasure, and that nutritional concepts in nursing homes can be changed so that the residents experience themselves as subjects of nutrition.

Introduction

As a social-gerontologist, I am interested in the process of aging. It is a great achievement of mankind that we have a good chance of reaching the age of 90 years, some of us even a hundred years, and a few even more. As we are all getting older, the question is no longer how to add years to life but how to add life to years.

Having worked in this field for more than 30 years, I have become more convinced that quality of life during the process of aging is no longer definable in general terms. Quality of life is what the elderly themselves experience as the quality of their own life – their everyday life.

The consequence is that we have to consider quality of life very individually.

People differ from each other and during the process of aging the difference gets bigger. Let me give you some examples to explain this:
there is 65-year-old Mr. Smith, a former lawyer, who needs help in all activities of daily life due to suffering a very severe stroke,

- or 72-year-old Mr. Klein, who just got married to a 39-year-old woman and who is looking forward to becoming a father in the near future,

- or 92-year-old Mrs. Miller, who is studying at the University of Dortmund and will complete her doctoral thesis end of next semester,

- or 101-year-old American Mr. Snow, who decided to move away from the retirement community in Montreux to a hotel, because there were too many elderly,

- or 88-year-old Mrs. Donald, a widow of 12 years, who has lost 3 of her 5 children, is physically severely handicapped and lives in a nursing home in a double room where she never wanted to be,

- or 96-year-old Mrs. Apple, who is severely cognitively impaired, lives in a special care unit, wanders around many kilometers per day, wears a helmet to protect her when she falls, and enjoys eating with her fingers.

I could keep describing the elderly for a long time and still that would not be enough to mention all the differences and variations of lifestyle in old age.

What do we understand from these examples?

Age in itself, as in the number of years a person has lived, is not so important. More important for our discussions is the relevance of personality, lifestyle, life experience, life expectations, health status, social environment, etc.

To conclude this introduction, we should stop trying to define quality of life in general terms and instead start talking with the elderly and let them tell us what quality of life means to them. They are the experts of aging – not us.

We should bear in mind that there are certain dimensions we should address when we try to understand what quality of life means to the elderly.

Dimensions of Quality of Life

Andreas Kruse names four dimensions or aspects which underlie quality of life.

(1) Firstly, he points out ‘the personal resources’, like skills, knowledge, health status, social contacts, self-help activities, etc.

To simplify this, it could be said that the more personal resources a person has, the better their quality of life. But this is only true when the persons see, accept, and value themselves and their personal resources. Very often elderly compare themselves with earlier stages of life and regard their actual life as less, as loss, as minor. Unfortunately, this attitude is strengthened by the very youth and young-oriented norms in our western societies. Nevertheless, the elderly should learn to accept their situation and should stop trying to adapt to these norms and values. And there is good argument for this: the aged today are biologically about 10–15 years younger than their parents’ generation when they were the same age. To overcome this traditional thinking – of aging as a process of decline – is not an easy task. Although we know that in the end everyone is responsible for his or her own view on life, we should assist the aged in accepting their aging process.

(2) Secondly, quality of life is more than having personal resources.

Andreas Kruse called this dimension ‘control of environment’. What does that mean? In our culture it seems that control of the environment is a very fundamental desire. We all try to influence our reality and this desire to control the environment does not stop until we die. To come back to the elderly: the more the elderly feel that they control their life and the less dependent they experience themselves, the more they enjoy a good quality of life. Control of the direct environment is important in all stages of life, during the whole course of life. People want to decide themselves where they live, with whom they live, what they think is necessary to do, etc. And this desire lasts throughout their lives. On the other hand, we should not forget that people differ very much in these desires. The degree of controlling the environment can be very low or very high and again corresponds more with personality than with age.

(3) The third dimension is ‘values’.

That means what is to be considered important, worthwhile, and valuable. Amongst the elderly there is a broad scope of values. Nevertheless, studies on this topic show that the elderly value the following criteria the most:

– independence
– privacy and companionship
– dignity
– involvement
– security.

But still there is a big variation amongst the elderly. And these values change over the course of aging. Longitudinal studies show, for example, that independence is the most important value for the young old while for the frail elderly, security becomes more and more important.
(4) The fourth and last dimension is referred to the ‘actual living conditions’.

Many elderly want to stay at home as long as possible – independent of their ability to succeed in their household chores or of their health status. Others decide to move into a retirement community and others saw no other option than to move into a nursing home. Living conditions can be very different and they are different not only between residential communities and nursing homes, but also within these facilities. I remember one lady who lived in a very upscale retirement community and told me she had never lived better and at the same time she told me that she had never felt lonelier. Another example is of an old woman who moved into a nursing home and was very frail and nearly dying. After 4 weeks, she was fine, had joined the bingo group and enjoyed her life again. To decide what suitable living conditions are is very much up to the elderly persons themselves.

When looking at these four dimensions, which underlie the concept of quality of life, we should realize that they should not be understood individually – they are interactive and interconnected. There are strong interdependencies between all four of these aspects, but all of them play an important role in the individual perception of quality of life.

What has all this to do with food, nutrition, and meals?

Firstly, there is no sole solution for a good and healthy nutrition of the elderly.

Secondly, if we want to improve the nutrition of the elderly and reduce malnutrition, we should do this by using a holistic approach, integrating the discussed four dimensions of quality of life.

As I am not an expert on nutrition, I would like to focus on the surrounding aspects of food and especially meals. My background here is retirement facilities for the aged.

Before I go a bit deeper into this topic, please let me just mention two essential points:

• As women live longer than men (4–6 years), as a result we find that the higher the age, the more women. And when we look at residential facilities, then we realize that about 80% of the residents are female. Most of them have lifelong experience in cooking and preparing meals for their children, husbands, and families. So in some ways, we can call them ‘experts on cooking’.
• Each resident has during the course of his or her life developed his or her own biography of nutrition. This biography includes taste, smells, color of food, outlook, meal preferences, mealtimes, forms of presentation, likes and dislikes, understanding of healthy and unhealthy food, importance of meals, and many more aspects. So each elderly person has a long individual history of nutrition.

Now I would like to come back to the care and nursing home.

An elderly person moving into such a facility will find that everything concerning nutrition and meals is already defined and well organized. The new resident is told at what times the meals are served, where the meals are served, what the meals will be, and with whom they will share the meals.

This means that the resident will feel excluded from this area of everyday life. Professionals have taken over all the responsibilities.

In such cases, the residents are neither seen as experts of aging or nutrition or a personal resource, nor as interested in being in control of their nutrition. They are very often reduced to the role of consumer and recipient.

Consequently, very often the residents show that they know better and can do better. How do they do that? They criticize the cook, the kitchen and the food. Very often, the professionals do not regard this as a way of positive communication and stimulation; instead they try to defend their ‘work’. This form of misunderstanding and misinterpretation can lead to the situation that residents lose their interest in and joy of food and nutrition and feel helpless.

As nutrition plays such a big role in the everyday life of residents and the care and nursing home, we developed strategies for better nourishment. We call it ‘Culture of eating’. What do we mean by that?

I will discuss some of the approaches we have done so far in residential care facilities.

First Example

As we know that residents have their very individual biography of nutrition and are experts in preparing meals, the cook meets every week with small groups of residents discussing a variety of food- and meal-related topics. The idea is that the cook gets to know each individual resident and learns about their wishes, their expectations, their skills, and their expertise. These meetings will take place at all wards or units.

Before a resident moves into the facility, the cook has gained information about his favorite meal. The resident
and his family are invited for the first meal and can enjoy the favorite together.

Within a fortnight, the cook will meet with each new resident to get to know more details about his biography and to discuss important items of nutrition.

Second Example

In Germany, we observe that more and more residential homes are offering the choice between two or three meals and buffets for breakfast and evening meals.

This is a positive development, but unfortunately residents have to make their choice a week beforehand. So what cooks should work on is to give residents a choice of foods in the dining room.

That is possible. It takes some time to develop knowledge of how many portions are required, but then it works very well.

This is one strategy to give the resident back the feeling of control.

Third Example

I already mentioned that elderly have developed their individual patterns of food intake. Unfortunately, there are still many care and nursing homes which ignore this fact and serve meals at incredible times:

- breakfast between 7.30 and 8.30 h,
- lunch at 11.30 h or
- even meals at 5.30.

And often there is a time gap between the last meal in the evening and the first meal in the morning of more than 10 h.

So what our care and nursing homes do is to offer meals over 24 h per day, so it is entirely up to the resident to decide when and where and with whom they would like to enjoy their meals.

Fourth Example

In more and more homes we are beginning to reorganize the traditional wards to special care units for up to 12 residents with their own kitchen. This family-sized community organizes everything within their group. With the assistance of nurses, care helpers, universal workers, volunteers, family members, etc., the residents do their own cleaning, washing, shopping, and cooking.

The residents are involved in all the activities of daily living as far as their physical, mental, and emotional conditions allow.

What we observe in these settings is that life becomes normal, livelier, that residents eat much better and that loneliness, helplessness, and monotony are reduced. Residents need less medicine and sleep much better.

Finally, I would like to mention some further aspects we developed within the Nutri-Senex Project; they also aim at the improvement of quality of life:

Residents should feel they are being invited to their meals. To achieve this, the dining room and its atmosphere including the setting of the table and the choice of the table should be created in a way that one feels invited.

A positive, relaxed, and family-like atmosphere during mealtimes should be secured by good organization.

Cooks should be encouraged to stimulate the reduced senses of the residents and to enhance their appetite.

A regular presence of the cook in the dining room and the dining facilities at the wards is self-evident.

To present a meal is much more than a delivery. The presentation of meals shows the resident how he is regarded by the home and the staff.

To make life in residential homes for the elderly more lively, the kitchen should get itself engaged in banquets, special events, creative activities, and many different projects.

Conclusions

The general idea of all the above-mentioned strategies is to improve quality of life by giving the resident more responsibilities and by giving assistance only where necessary.

And what we should accept is that we are still in the phase of observing, listening, and learning what life and quality of life means to people who have one experience more than we have: the experience of aging and reaching an age they had never dreamed of.

In the past we have emphasized the aspects of care and nursing too much. It is not questionable that care and nursing play an important role in preparing the resident for everyday life at the home. What we now need is an enrichment of that life. Here nutrition plays a central role and I am amazed what nutrition can achieve when we integrate the residents and when we get them involved according to their capabilities.

Nutrition is much more than just food intake!
Disclosure Statement

A.T.H. functioned as a member of the board of Nutri-Senex.

Further Reading