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The Nutrition Needs of Patients With Chronic Kidney Disease in Health Care Community Settings

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WHEN INITIALLY CONSIDERED, the average person may be quick to conclude that diets are better managed in health care communities than at home. By definition, health care communities are living environments for persons with chronic conditions, functional limitations, or need for supervision or assistance.[1] Skilled nursing facilities and assisted living facilities are examples of health care communities.[1] One reason for the assumption that diets may be better managed in health care communities is that these environments are usually controlled and therefore should result in better control of nutrition intake. It is sometimes assumed that the nutritional quality should be superior in this setting because the type and amount of food provided are closely monitored by a qualified staff. Ironically, it is this control—such as structured meal times and restricted portion sizes—that may have a more negative versus positive effect on residents' nutritional status. A lack of individualization and flexibility with nutrition intake and diets may exacerbate this negative effect. Inadequate food and fluid intake leading to unintended weight loss and undernutrition is a significant problem in health care communities.[2] Other factors contributing to decreased food and fluid intake in health care communities may be: (1) the normal "anorexia of aging" phenomenon, (2) overmedicated residents who are too sleepy to eat, (3) depression, (4) residents unable to feed themselves coupled with staff shortages, (5) dentition and dysphasia problems resulting in reduced food and fluid options, and (6) limited menu items and repetitive menus.[2]

Health care community residents with complicated nutrition needs such as chronic kidney disease (CKD) patients are at risk for decreased food and fluid intake and may be increasingly affected by overly controlled and template-type disease-specific diets. With a focus on so many restrictions, CKD patients are often left with a limited amount of foods that they can actually eat.[3] In addition to being at risk of undernutrition, CKD patients may also face different nutrition-related challenges in the health care community setting (Appendix). For example, commonly prescribed phosphorus binder medications are often not given correctly with food or in a timely manner, thus making the medication less effective at controlling serum phosphorus.[8] Another nutrition-related challenge might be a limited supplement formulary that offers only higher potassium options. Of note, early-stage CKD patients and dialysis patients living in health care communities typically have different nutrition requirements and issues because of the stage of disease progression. Therefore, a one-size-fits-all CKD nutrition and diet order may be inappropriate, and alternatively, CKD nutrition intake and diets should be individualized.[4]

Nephrology dietitians must work together with the health care community staff to ensure the integration of nutrition intake goals and continuity of nutrition care for CKD patients. Offering CKD nutrition education to health care community staff may be helpful. Education may consist of written CKD nutrition intake guidelines and/or assistance with staff in services. It is also important to listen and obtain input from the health care community staff. Coordinating nutrition care for CKD patients is an ongoing, team effort dependent on consistent communication and participation between both nephrology caregivers and the health care community. Although communication and participation are ideal in theory, it can be difficult to achieve with overworked staff and busy schedules. Prescribing providers in health care communities may be uncomfortable easing up on residents' nutrition intake restrictions. Tension may arise if criticism is present and goals fail to align. However, maintaining a broad view of each other's perspective and placing the CKD patient first will lead to better outcomes and improved integration and continuity of nutrition care.

The following is a list of potential nutrition- and diet-related challenges faced by CKD patients living in health care communities (listed in no particular order):

- One general "CKD diet" order exists.
- Special diets or nutrition restrictions may not be available for use by staff.
- Meal times may not be flexible.

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- Meals may be missed and not well compensated for during hemodialysis treatment days.
- Daily protein requirements may not coincide with protein content of meals.
- Food quality (in particular, protein food) may be mediocre.
- Nutritional supplement formulary may be limited.
- Substitutions for entrées and other meal items may not be optimal.
- Phosphorus binders may not be administered for optimal outcomes.
- Nutrition label information may not be easily accessible for identifying phosphorus additives.
- Reduced sodium products included in menu items may contain potassium.
- Orange juice may be used to raise low blood glucose levels.
- Milk of magnesia and prune juice may be used for bowel management.
- Extra fluid intake opportunities exist.
- Body weight fluctuations complicate accurate assessment.

Solutions to these listed challenges do exist (please refer to Appendix). As briefly mentioned, nephrology dietitians establishing and maintaining good relationships with health care community staff is critical and is directly related to resolving these challenges. Within the health care community setting, nephrology dietitians should seek relationships with not only the covering dietitian but also the kitchen manager and lead nurses on the patient's floor. The involvement of the nephrologists can also strengthen efforts made by the nephrology dietitian. The nephrologists' orders or notes may be necessary for nutrition and diet suggestions to materialize. Worth mentioning, the Nursing Home Reform Act established in 1987 requires a nursing home to make reasonable adjustments to meet resident needs and preferences.[9–11] Under this law, one may assume that a nursing home must assist a resident in maintaining his/her ability to eat. This may include providing an environment conducive to eating, for example, ensuring meals are scheduled at an appropriate time to optimize nutritional intake.

As discussed, CKD patients living in health care communities may be negatively affected by overly restrictive, template disease-specific diets. CKD patients may also face other nutrition-related challenges in the health care community setting. These challenges may be overcome and the nutrition needs of CKD patients met if nephrology dietitians and health care community staff work together to provide individualized nutrition intervention and promote continuity of care.

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