

# Applying the American Diabetes Association's Nutrition Recommendations to Health Care Institutions

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The American Diabetes Association (ADA) position statement titled "Nutrition Recommendations and Principles for People with Diabetes Mellitus"<sup>1</sup> was developed to offer guidance for people able to live independently and who have the functional, emotional, cognitive, and economic resources necessary to meet their basic nutritional needs. The ADA position statement titled "Translation of the Diabetes Nutrition Recommendations for Health Care Institutions,"<sup>2</sup> which is reprinted in this issue (p. 39), and its accompanying technical review<sup>3</sup> were initially published in 1997,<sup>4</sup> and the statement has been only slightly modified since then.

This translation document accurately reflects the fact that the bulk of diabetes teaching now occurs in ambulatory care settings, the increased severity and complexity of illness that patients with diabetes bring to the hospital on admission, and their increasingly shorter lengths of stay. The importance of basic nutrition education of all health professionals involved in diabetes management cannot be overemphasized. The discussion of special nutrition issues provides a brief overview of recommendations related to liquid diets, diets post-surgery and in-patients who experience catabolic stress, and parenteral and enteral support.

Additional issues that the position statement does not address but that nonetheless merit consideration include the limited significance of meals served over the course of a 1- to 2-day stay in the hospital in relation to the entire course of diabetes management, and the dramatic changes in institutional feeding

that have occurred during the past 6 years.

The remainder of this commentary is meant to be thought-provoking and asks those who provide medical nutrition therapy and are responsible for institutional food services for patients to consider the impact that changes in food service delivery systems may have on diabetes care.

Many acute care institutions have adopted a room-service approach to feeding that allows patients to access food 24 hours a day based on their appetite and mood.<sup>5</sup> Food choice options, portion size, and meal timing may vary widely for individual patients from day to day and meal to meal. Nutrition education services and assistance with food selection may not be as readily available during evening or early morning hours, when patients are awake and ready to make food choices and eat, but the diabetes education/dietetics staff is not on site.

Increased numbers of franchised food service operations (i.e., Pizza Hut, Taco Bell, and McDonalds) are housed in or offered as a replacement for standard hospital cafeteria fare.<sup>6</sup> Patients have increasingly easy access to high-fat, high-calorie, less nutrient-dense foods. Coffee carts, hospitality carts, and so forth abound in strategic, high-traffic areas in acute care environments.<sup>7</sup> In some institutions, these carts are wheeled into patient care areas and snack foods and beverages are sold, making adherence to a structured carbohydrate and nutrient intake more difficult.

We should insist, at a minimum, that nutrition information for fast foods and

snacks be posted at the point of purchase or that nutrition information posted on institutional foodservice Web sites or fact sheets be readily available to patients and their families to so that they can make informed choices if they so desire. Our society has become increasingly litigious regarding the food industry.<sup>8</sup> Does housing one or more fast-food establishments within a health care institution imply sanction of the food they offer for patients as well as family members and visitors? Might health care institutions offering these types of food services be held accountable as contributors to the obesity epidemic and, indirectly, to the increased incidence of diabetes among our nation's youth and adults?

In long-term care facilities, group dining is encouraged with cafeteria-line or family-style meal service arrangements becoming increasingly common.<sup>9-11</sup> Portion control in this type of setting is determined by patients and may not be easy to monitor or control. Nutrition education in long-term care settings may be needed to teach frontline caregivers how to help residents make appropriate food choices. In long-term care settings, greater numbers of patients require feeding assistance. Adequate time for feeding is of concern.<sup>12</sup> Medication regimens must be closely matched to each patient's ability to consume carbohydrate and calories on any given day, at any given meal, in the time allotted for feeding assistance per patient.

Assisted living environments and group homes for individuals with functional or cognitive impairment or developmental delay pose additional challenges. Should caregivers of cognitively

impaired children and adults be encouraged to implement regimens that provide healthful eating patterns for these individuals irrespective of the cognitively impaired clients' wishes? Many of these clients have weight-associated diseases including diabetes that make health maintenance difficult. Where do patients' rights and patients' health concerns intersect?

Similarly, the nutritional needs of prison populations deserve a more in-depth consideration. Correctional institutions house a significant number of individuals with weight-related disease including diabetes. Further, they might legitimately be viewed as "health care" institutions given that they frequently contain in-house clinic/hospitals and health care providers. Also, inmates are a captive population that has no option to seek food independently. Nutrition recommendations are only briefly addressed in the ADA's position statement titled "Management of Diabetes in Correctional Institutions."<sup>13</sup> Current feeding regimens, particularly for women in prison, promote rather than prevent weight gain and concomitant disease.<sup>14</sup>

These are some of the additional issues that we believe diabetes care pro-

fessionals in institutional settings must address to provide adequate nutritional services for people with diabetes within their specific populations.

## REFERENCES

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