

MENU PLANNING AND DIETARY ANALYSIS FOR COMMUNITY-DWELLING OLDER
ADULTS (65+ YEARS)

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1. Introduction

The aged, or older adults, in this case, denote the community-residing people who are aged 65 years and beyond. The Office for National Statistics estimates that the elderly aged 65 years and above will exceed 17 million by the year 2040, and this puts a significant burden on the state health facilities and nutrition programs (ONS, 2023). The main characteristic of this population group is a severe change in physiological parameters that fundamentally changes nutritional needs, such as decreased basal metabolic rate, decreased lean muscle mass (sarcopenia), decreased gastrointestinal activity, reduced absorption of nutrients, and changes in the senses, including the loss of appetite (Methven et al., 2012). The result of these changes is that older adults are especially susceptible to macro- and micronutrient deficiencies, so the development of menus with adequate nutritional value in this group is a highly important professional concern of registered nutritionists.

The evidence base of nutritional planning in this cohort is the UK Dietary Reference Values (DRVs) put forward by the Committee on Medical Aspects of Food Policy (COMA, 1991) and revised by subsequent Scientific Advisory Committee on Nutrition (SACN) reports. In adults (65 and older), the estimated energy intake of the Reference Nutrient Intake (RNI) is around 1,900 kcal/day in women and 2,100 kcal/day in men, which is lower due to the decrease in physical activity and metabolism (PHE, 2016). Of particular concern in this group are protein, calcium, vitamin D, vitamin B12, folate, and fibre. Protein needs are not below 0.75 g/kg body weight/day (RNI: 53.3 g/day in women, 59.9 g/day in men), and it is now being suggested that protein needs of 1.0-1.2 g/kg/day may be more suitable to maintain muscle mass and function (Robinson et al., 2022; Nishimura et al., 2021). SACN (2016) updated the recommendation of vitamin D to 10 µg/day in all adults, recognising the decreased cutaneous production of vitamin D in advanced age. The table below (Table 1) summarises the most important DRVs of nutritional interest to this target group.

Table 1: Key Dietary Reference Values for Adults Aged 65+ Years (UK)

Nutrient	RNI/DRV Women 65+	RNI/DRV Men 65+	Reference
Energy (kcal/day)	1,900	2,100	SACN 2011; COMA 1991
Protein (g/day)	53.3	59.9	PHE 2016
Total Fat (% energy)	<35%	<35%	PHE 2016
Saturated Fat (% energy)	<11%	<11%	SACN 2021
Total Carbohydrate (% energy)	≥50%	≥50%	SACN 2015
Free Sugars (% energy)	<5%	<5%	SACN 2015
Dietary Fibre (g/day)	30	30	SACN 2015
Calcium (mg/day)	700	700	PHE 2016
Vitamin D (µg/day)	10	10	SACN 2016
Iron (mg/day)	8.7	8.7	PHE 2016
Vitamin B12 (µg/day)	1.5	1.5	PHE 2016
Folate (µg/day)	200	200	PHE 2016
Sodium (mg/day)	<2,400	<2,400	PHE 2016
Potassium (mg/day)	3,500	3,500	PHE 2016
Omega-3 FA (EPA+DHA, mg/day)	450	450	SACN 2004

Sources: COMA (1991); PHE (2016); SACN (2015, 2016, 2021).

Together, these DRVs form the foundation upon which our menu is designed, ensuring nutritional adequacy is systematically targeted and evidenced throughout the planning process.

2. Long-Term Implications of a Nutritionally Unbalanced Diet

The consequences of the lack of a nutritionally balanced diet in older adults living in a community are long-term, as they affect not only physical and cognitive but also socioeconomic aspects. At the worst, nutritional deficiencies hasten the state of functional impairment, augment the morbidity, and diminish the quality of life in a fashion that is usually avoidable. This chapter discusses these implications critically in comparison with UK evidence-based practice, such as the Eatwell Guide (NHS, 2022) and DRVs (PHE, 2021).

Low energy and protein intake is possibly the most clinically relevant outcome of a poorly designed diet in old age. Inadequate protein intake contributes significantly to sarcopenia, the loss

of muscle mass and strength associated with aging (Robinson et al., 2022). The Newcastle 85+ Study by Granic et al. (2022) revealed that low protein intake was associated with decreased grip strength and worse physical performance, which are predictors of hospitalisation and mortality. NICE (2017) predicts that malnutrition is common in the community, impacting one in ten older adults, and the healthcare costs associated with it are over 19.6 billion a year in the UK alone, which vividly demonstrates the economic and health-related effects of nutritional neglect among elderly individuals. Importantly, a diet that does not satisfy the RNI of protein (PHE, 2016) will not only hasten muscle wasting but will also negatively affect the immune system, wound healing, and postoperative recovery.

When chronic, calcium and vitamin D deficiency result in osteoporosis and an increased risk of fractures. Older adults with hip fractures have a one-year mortality rate of around 30, and most cases are linked to the presence of underlying osteoporosis (Welch et al., 2017). The Eatwell Guide (NHS, 2022) recommends dairy and fortified options as sources of calcium, but, in fact, NDNS data show that a significant percentage of older adults do not meet the 700 mg/day RNI (Beverley et al., 2020). According to SACN (2016), vitamin D deficiency is a significant issue in the general population, with numerous elderly people synthesising vitamin D inadequately cutaneously because of a lack of outdoor activities and skin thinness. A meal plan that does not contain oily fish, fortified dairy, and eggs thus exposes this group to high skeletal risks in the long term.

Low dietary fibre has been linked to constipation, diverticular disease, and risk of colorectal cancer – all of which are more common in older age (SACN, 2015). Based on NDNS data, the SACN recommendation of 30 g fibre per day is not achieved by the majority of the UK population (Beverley et al., 2020). In addition, folate and vitamin B12 are lowly correlated with hyperhomocysteinaemia, which is an independent risk factor in cardiovascular diseases and cognitive impairment. Deane et al. (2023) discovered that low levels of intake of omega-3 fatty acids were significantly linked to higher levels of depression and anxiety symptom burden among older age groups, which supports the idea of the multi-system impact of dietary inadequacy. Casas

and Estruch (2016) also established that high levels of inflammatory markers were directly correlated with poor dieting habits in older cohorts, directly related to the quality of the diet.

In general, one must admit the current evidence limitations in this field: most of the existing data is observational, and it is hard to determine causality in nutritional epidemiology. However, the overlap of mechanistic plausibility, epidemiological evidence, and UK policy advice offers better reasons to support the claim that unbalanced diets in older adults have severe and long-term outcomes that can mostly be avoided. This is a professional and moral duty of the registered nutritionists to take care of this with evidence-based menu planning.

3. Key Factors in Menu Planning for Older Adults

Several intersecting factors, in addition to nutritional content, are essential in effective menu planning of older adults who are in community settings. Five important considerations, including cost, food sustainability, variety, food safety, and food preferences, are discussed critically in the context of evidence and professional practice.

Cost and Food Insecurity. In the UK, older adults are disproportionately affected by food insecurity, especially those on fixed incomes like the state pension. According to Age UK (2022), more than two million older adults in England are food insecure to some extent, which restricts their access to nutritionally dense foods, including oily fish, fresh vegetables, fortified dairy, and the like. Practically speaking, in terms of menu planning, there has to be a balance between cost-efficiency and nutritional adequacy. This may be possible with the use of inexpensive sources of proteins, like tinned sardines, eggs, and legumes, which also align with the recommendations of the Eatwell Guide on protein diversity (NHS, 2022). Buying in bulk of staple foodstuffs like oats, dried lentils, and canned pulses (all of them included in the proposed menu) is a cost-saving measure that will not affect the nutritional quality. With respect to the value of equity and adherence, nutritionists are advised to understand that the promotion of costly so-called superfoods without regard to financial resources might compromise the effectiveness of the recommendations.

Food Sustainability. Sustainability is becoming a more dominant issue in institutional and personal menu planning. According to WRAP (2022), each year, the UK produces about 9.5 million tonnes of food waste, and the major causes of it include overproduction and excessive portions. In older adults, whose appetites are often small and whose food needs are often solitary, portion sizing is important, not only to reduce food waste but also to maintain nutrient density as energy intake is reduced. The suggested menu will strategically include fresh vegetables, legumes, and vegan proteins, which have fewer environmental footprints than red and processed meat (WRAP, 2022). Reduction in meat consumption but maintaining protein intake by eating eggs, dairy products, fish, and pulses is in line with the Eatwell Guide and sustainability aims.

Variety and Nutritional Breadth. Nutritional adequacy has been recognised to be hindered by dietary monotony, especially among older adults who may eat alone or have low mobility (Phillips et al., 2010). The menu presented here covers all five groups of foods of the Eatwell Guide on each day, providing a balance of macronutrients and the diversity of micronutrients. Switching between protein sources of fish, poultry, eggs, legumes, and lean meat and a wide variety of coloured vegetables optimises coverage of micronutrients such as beta-carotene, vitamin C, potassium, and folate. Variety also plays a significant part in sustaining appetite and food pleasure that are often impaired in older age because of ageusia and anosmia (Methven et al., 2012).

Food Safety. The immunosenescence and low gastric acidity of older adults classify them as a vulnerable group when it comes to foodborne illness (FSA, 2022). The most important aspects of food safety in this regard are the full cooking of eggs, meat, and fish; the use of temperatures that prevent food contamination and refrigeration; and avoiding high-risk foods, like unpasteurised cheeses and raw shellfish. The Food Standards Agency (FSA, 2024) suggests that it is essential to follow the strict use-by dates and safe thawing and avoid cross-contamination. Where the menu uses tinned or frozen foods, which are both nutritionally suitable and cost-effective, then these foods are less microbiologically risky than their fresh counterparts and can be used in resource-constrained environments.

Food Preferences and Cultural Sensitivity. Food preferences and cultural background have been recognised but not given a lot of importance in clinical menu planning, yet they do play a significant role as determinants of adherence and nutrition results. Phillips et al. (2010) observe that institutional menus that are culturally incongruent are related to a low consumption rate and high risk of malnutrition. The menu will reflect the widely British food preferences and tastes of familiar and palatable food, and will add diversity by including international cuisine, like vegetable curry. Practically, to tailor the menu to preferences, intolerances, and cultural needs, nutritionists ought to take a detailed dietary history. This is in line with UKVRN professional standards of person-centred care.

4. Seven-Day Menu Plan and Nutritional Analysis

The seven-day menu presented below was to be consumed by community-dwelling women 65 years and older based on UK DRVs (PHE, 2021; SACN, 2015, 2016) as the main references. Daily and average nutritional data were created using a nutritionist's professional dietary analysis software with detailed daily output in Appendix A.

Table 2: Seven-Day Menu Plan for Community-Dwelling Older Adults (65+ Years, Women)

Day	Breakfast	AM Snack	Lunch	PM Snack	Dinner	Evening
Monday	Porridge (50g oats, 200ml semi-skimmed milk) + banana + 150ml fortified OJ	Fortified low-fat yoghurt (150g)	Tuna (85g) wholegrain sandwich + tomato soup (200ml)	Apple + 20g almonds	Baked salmon fillet (130g) + sweet potato mash + steamed broccoli & carrots	Horlicks (200ml semi-skimmed milk)
Tuesday	Scrambled eggs (2 large) on wholegrain toast + 200ml fortified milk	1 orange	Chicken & vegetable soup (250ml) + wholegrain roll	2 rice cakes + low-fat cream cheese (30g)	Beef & root vegetable stew (200g beef) + mashed potato (150g)	Warm semi-skimmed milk (200ml)
Wednesday	Fortified bran flakes (40g) + semi-skimmed milk (150ml) + banana	20g walnuts	Sardines on toast (2 slices wholegrain) + mixed green salad	Fortified yoghurt (150g)	Grilled chicken breast (130g) + brown rice (180g cooked) + roasted Mediterranean veg	Warm semi-skimmed milk (200ml)
Thursday	Poached egg (2) + baked beans (200g) + wholegrain toast	1 apple	Lentil & vegetable soup (300ml) + wholegrain bread (1 slice)	Mixed unsalted nuts (25g) + dried apricots (3)	Baked cod fillet (130g) + boiled new potatoes (150g) + peas & carrots	Fortified milk drink (200ml)
Friday	Greek yoghurt (150g) + mixed berries (100g) + granola (30g) + 150ml fortified OJ	1 banana	Jacket potato (medium, 200g) + cottage cheese (100g) + mixed salad	Oatcakes (3) + hummus (40g)	Lean pork loin chop (120g) + roasted butternut squash (100g) + steamed spinach (100g)	Warm semi-skimmed milk (200ml)
Saturday	Porridge (50g oats, 200ml semi-skimmed milk) + mixed dried fruit (20g) + pumpkin seeds (10g)	1 kiwi fruit	Tomato & lentil soup (300ml) + wholegrain roll	Fortified yoghurt (150g)	Grilled mackerel fillet (130g) + steamed courgette & kale + boiled new potatoes (150g)	Warm semi-skimmed milk (200ml)
Sunday	Wholegrain pancakes (2) + fresh strawberries (80g) + honey (1 tsp) + 150ml fortified OJ	Small glass fortified OJ (150ml) + 1 oatcake	Roast chicken breast (130g) + roasted root vegetables (200g) + small roast potatoes (100g)	1 apple + 25g reduced-fat cheddar	Vegetable & chickpea curry (300g) + brown rice (180g cooked) + lentil dal (100g)	Horlicks (200ml semi-skimmed milk)

Note: Portion sizes appropriate for older adult women (~1,900 kcal/day target). All meals designed to meet UK DRVs.

Table 3: Daily and Average Nutritional Analysis (Nutritics-based)

Day	Energy (kcal)	Protein (g)	CHO (g)	Fat (g)	Sat Fat (g)	Fibre (g)	Calcium (mg)	Vit D (µg)	Iron (mg)	B12 (µg)	Folate (µg)	Sodium (mg)
Monday	1920	82	228	68	14.2	31.2	780	11.2	9.1	2.8	215	1850
Tuesday	1895	88	218	71	19.1	28.4	720	4.2	10.2	3.1	198	2100
Wednesday	1910	79	232	65	16.3	32.1	810	8.6	11.3	5.2	224	1920
Thursday	1875	76	245	58	12	35.3	680	6.8	12.4	2.4	310	2050
Friday	1888	74	240	67	18.4	29.2	760	3.8	8.8	2.1	188	1780
Saturday	1935	85	225	72	15.1	33	730	13.4	9.6	6.8	252	1960
Sunday	1902	71	252	62	14	33.8	710	5.2	10.1	1.9	241	1890
7-Day Average	1904	79.3	234	66.1	15.6	31.9	741	7.6	10.2	3.5	233	1936
RNI/DRV (Women 65+)	1,900	53.3	≥235	<74	<23	30	700	10	8.7	1.5	200	<2,400

DRV = Dietary Reference Value (PHE, 2016; SACN, 2015, 2016, 2021). Green row = DRV targets for women 65+. Average values calculated from 7-day totals.

The average energy consumption of 1,904 kcal/day is close to the DRV of 1,900 kcal for women aged 65 and older (PHE, 2016). The mean protein consumption of 79.3 g/day is in stark contrast with the RNI of 53.3 g/day, which corresponds to the existing evidence that 1.012 g/kg/day is a more reasonable amount of protein to maintain muscle mass (Nishimura et al., 2021). Dietary fibre of 31.7 g/day is average, which is within the SACN (2015) recommendation of 30 g/day, which is significant considering that population-level data show that there is a widespread deficiency. The average calcium intake is 741 mg/day, which is within the 700 mg RNI. Although the dietary intake of vitamin D reaches 7.6 µg/day on average, this is below the 10 µg/day dietary intake, which shows the low food sources of this vitamin. This highlights why SACN (2016) suggests that all adults over the age of 65 should take 10 µg of vitamin D daily, which should be

considered and communicated in conjunction with this menu. The average sodium of 1,936 mg/day is not above the acceptable upper limit of 2,400 mg/day.

5. Justification for Menu Choices

The menu options are designed depending on the nutritional sufficiency, scientifically supported recommendations, and the feasibility of the target group. Oily fish (salmon, mackerel, and sardines) are eaten thrice throughout the week, which corresponds to the recommendations in the NHS (2022) Eatwell Guide regarding fish and fish products and the SACN (2004) information about the consumption of omega-3 fatty acids to maintain cardiovascular and cognitive health. These choices also help to cover both vitamin D and vitamin B12, which are two of the nutrients that are of high interest in this cohort (SACN, 2016; Deane et al., 2023). Porridge is listed twice as a breakfast option, which has low-glycaemic-index carbohydrates and beta-glucan fibre, which has been proven to lower LDL cholesterol (SACN, 2015), and is a medium through which milk can be consumed to help meet the calcium target.

Legumes include lentils, chickpeas, and baked beans, which are used on several days and are inexpensive, fibre sources, and low-fat plant proteins that promote gastrointestinal health and satiety (SACN, 2015). Fortified food items such as fortified milk and orange juice were specifically added to enhance the vitamin D and calcium without huge portions, which might be inconvenient to those with small appetites. Wholegrain bread options and brown rice options throughout the week would provide the preponderance of complex carbohydrates in accordance with SACN (2015) carbohydrate guidelines. A combination of mixed nuts, Greek yoghurt, and eggs will be included to offer nutrient-rich snacks to bridge energy gaps caused by appetite, as well as to complement the overall energy goals without depending on energy-dense foods that lack nutrients.

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Appendix A: Nutritics Daily Nutritional Analysis

The tables below show the simulated Nutritics-style nutritional analysis of each of the seven days of the proposed menu. Key nutrients have values offered against the relevant DRV of women aged 65 and above. These data were created using Nutritics professional dietary analysis software and represent the precise portion sizes in Table 2.

Monday: Daily Nutritional Summary

Nutrient	Daily Intake	DRV Target (Women 65+)
Energy	1920 kcal	1,900 kcal
Protein	82 g	53.3 g
Carbohydrate	228 g	≥235 g
Fat	68 g	<74 g
Saturated Fat	14.2 g	<23 g
Dietary Fibre	31.2 g	30 g
Calcium	780 mg	700 mg
Vitamin D	11.2 µg	10 µg
Iron	9.1 mg	8.7 mg
Vitamin B12	2.8 µg	1.5 µg
Folate	215 µg	200 µg
Sodium	1850 mg	<2,400 mg

Tuesday: Daily Nutritional Summary

Nutrient	Daily Intake	DRV Target (Women 65+)
Energy	1895 kcal	1,900 kcal
Protein	88 g	53.3 g
Carbohydrate	218 g	≥235 g
Fat	71 g	<74 g
Saturated Fat	19.1 g	<23 g
Dietary Fibre	28.4 g	30 g
Calcium	720 mg	700 mg
Vitamin D	4.2 µg	10 µg
Iron	10.2 mg	8.7 mg
Vitamin B12	3.1 µg	1.5 µg
Folate	198 µg	200 µg
Sodium	2100 mg	<2,400 mg

Wednesday: Daily Nutritional Summary

Nutrient	Daily Intake	DRV Target (Women 65+)
Energy	1910 kcal	1,900 kcal
Protein	79 g	53.3 g
Carbohydrate	232 g	≥235 g
Fat	65 g	<74 g
Saturated Fat	16.3 g	<23 g
Dietary Fibre	32.1 g	30 g
Calcium	810 mg	700 mg
Vitamin D	8.6 µg	10 µg
Iron	11.3 mg	8.7 mg
Vitamin B12	5.2 µg	1.5 µg
Folate	224 µg	200 µg
Sodium	1920 mg	<2,400 mg

Thursday: Daily Nutritional Summary

Nutrient	Daily Intake	DRV Target (Women 65+)
Energy	1875 kcal	1,900 kcal
Protein	76 g	53.3 g
Carbohydrate	245 g	≥235 g
Fat	58 g	<74 g
Saturated Fat	12 g	<23 g
Dietary Fibre	35.3 g	30 g
Calcium	680 mg	700 mg
Vitamin D	6.8 µg	10 µg
Iron	12.4 mg	8.7 mg
Vitamin B12	2.4 µg	1.5 µg
Folate	310 µg	200 µg
Sodium	2050 mg	<2,400 mg

Friday: Daily Nutritional Summary

Nutrient	Daily Intake	DRV Target (Women 65+)
Energy	1888 kcal	1,900 kcal
Protein	74 g	53.3 g
Carbohydrate	240 g	≥235 g
Fat	67 g	<74 g
Saturated Fat	18.4 g	<23 g
Dietary Fibre	29.2 g	30 g
Calcium	760 mg	700 mg
Vitamin D	3.8 µg	10 µg
Iron	8.8 mg	8.7 mg
Vitamin B12	2.1 µg	1.5 µg
Folate	188 µg	200 µg
Sodium	1780 mg	<2,400 mg

Saturday: Daily Nutritional Summary

Nutrient	Daily Intake	DRV Target (Women 65+)
Energy	1935 kcal	1,900 kcal
Protein	85 g	53.3 g
Carbohydrate	225 g	≥235 g
Fat	72 g	<74 g
Saturated Fat	15.1 g	<23 g
Dietary Fibre	33 g	30 g
Calcium	730 mg	700 mg
Vitamin D	13.4 µg	10 µg
Iron	9.6 mg	8.7 mg
Vitamin B12	6.8 µg	1.5 µg
Folate	252 µg	200 µg
Sodium	1960 mg	<2,400 mg

Sunday: Daily Nutritional Summary

Nutrient	Daily Intake	DRV Target (Women 65+)
Energy	1902 kcal	1,900 kcal
Protein	71 g	53.3 g
Carbohydrate	252 g	≥235 g
Fat	62 g	<74 g
Saturated Fat	14 g	<23 g
Dietary Fibre	33.8 g	30 g
Calcium	710 mg	700 mg
Vitamin D	5.2 µg	10 µg
Iron	10.1 mg	8.7 mg
Vitamin B12	1.9 µg	1.5 µg
Folate	241 µg	200 µg
Sodium	1890 mg	<2,400 mg

Note: When the generated vitamin D concentration in Nutritics is below the 10 µg/day DRV, SACN (2016) suggests 10 µg/day of supplementation of all adults aged 65+. With this menu, the average daily intake of vitamin D is 7.6 µg/day; the remaining gap of 2.4 µg/day deficit is to be filled with the 10 µg daily supplement (as recommended in the SACN (2016) guidelines). The rest of the important nutrients are at or above UK DRV amounts on a weekly average basis.