

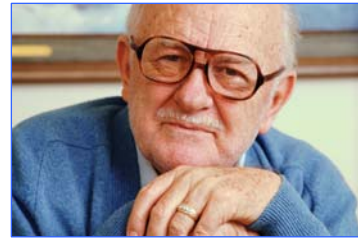
Palliative Nutrition and Hydration—Part 1

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Health care professionals are often faced with difficult questions from loved ones related to nutrition and hydration at the end of life. End of life situations may also bring potential liability issues and ethical dilemmas. At the end of life, with palliative care patients, there may be complex social, psychological, or physical issues that must be addressed in addition to providing basic medical nutrition therapy (MNT).

Advance Directives

Advance directives are written documents that help to direct care when a person becomes incompetent to make their own decisions. There are two types of advance directives: The living will states the person's desires for care in the event they are unable to make their own decisions. The durable power of attorney (DPOA) for health care allows another designated person to make decisions on the individual's behalf should they become unable to make decisions for themselves. In both the Living Will and the DPOA, individuals may specify the medical care they wish to receive and the care or treatment they would wish to have withheld or withdrawn under certain circumstances.



Unfortunately, these documents are often unclear on nutrition and hydration wishes. If statements are included, they are often vague and hard to interpret. In addition, each state has its own living will laws, so it is important to be familiar with the laws in your state. Some states have living will statutes that permit individuals to refuse artificial nutrition and hydration through their living wills, and some permit health care agents to order withholding or withdrawal of artificial nutrition and hydration.

At end of life, if an individual is competent to make their own decisions, health care providers must abide by them. If an individual is unable to make their own decisions, review the advance directive or living will; if those are not available, rely on the durable power of attorney or legal guardian. The care team should work together to make the best decisions for each individual. The care team should include the resident, family, physician, key nursing staff, dietetics professional, social services, chaplain, and other pertinent staff involved in daily care. The facility should have established policies and protocols for end of life nutrition and hydration care, including written definitions for “do not resuscitate” (DNR), “no CPR” and “comfort measures only”.

Every case is unique and must be handled individually with the patient, health care team and family all involved in decision making.

Palliative Care

Palliative care (sometimes called comfort care) is focused on the individual who is dying. It allows the individual to guide the care, focuses on relief of symptoms and pain management, and promotes the highest possible quality of life for the individual. The

focus is not on death, but rather on promoting the most compassionate and positive experience for the living: for the individual, family and loved ones who are sharing in the experience.

The health care team's role includes a team approach in which the patient is the center of care. The team must learn to handle family dynamics, spiritual beliefs and issues, feelings about "food supports life", feelings of anger, frustration, helplessness, hopelessness and grief as the reality hits both the individual and the family that the loved one is actually dying.

Palliative care and hospice philosophies include: providing the patient with as much or as little information as they want; care controlled by the patient with a focus is on increased comfort (physical/pain management, emotional, social, spiritual); the healthcare provider's role is to listen and understand, teach and share information. There are many social and psychological needs of patients and families at the end of life. Often times the messages received from patients and families are unclear. Knowing how to ask the right questions helps providers understand and provide for the needs and wishes of the dying patient and their loved ones.

Nutrition at the End of Life



"It is the position of the American Dietetic Association that the development of clinical and ethical criteria for the nutrition and hydration of persons through the life span should be established by members of the health care team. Registered dietitians should work collaboratively to make nutrition, hydration, and feeding recommendations individual cases." (J Am Diet Assoc)

Dietitians have the responsibility to provide emotional support and professional advice on how to achieve each individual's goals within legal parameters. This requires frequent assessments and may involve changing interventions and offering suggestions on a daily basis to cope with the changing needs of the dying patient.

Diets should be liberalized to eliminate restrictions and encourage eating. In some cases, diet may actually help to decrease discomfort. If this is the case, a therapeutic diet may actually be helpful. (i.e. If a low sodium diet reduces fluid overload, then it may be worthwhile.) However, in most cases, the dying individual is not interested in eating and drinking, so the small amounts of foods and fluids taken should be enjoyed. Cater to preferences as much as possible and make mealtime as pleasant as possible. If person does not eat well, reassure the individual and the family that this is normal and allow the individual to do what is comfortable. The family will need support and education. It is difficult for loved ones to watch the patient refusing to eat or drink, knowing that this will eventually lead to death. Families need to understand that it is actually the disease process that will lead to death and that lack of interest in food and fluid is a normal part of the dying process.

Chronic pain may decrease the desire to eat, leading to the potential for weight loss and malnutrition. (Weiner) When pain interferes with sleep, mood, or appetite, it can affect

all aspects of life. Pain can change eating patterns and cause weight gain or loss. The timing of meals may need to be timed with the person's alertness (which may be based on timing of pain medications.) It may also be necessary to reevaluate medications or timing of medications. It is important to remain flexible and make food available at any time the individual may want to eat.

There are many symptoms that may affect a person's ability or desire to eat (anorexia, nausea, distension, constipation, dry mouth, taste/smell alterations, etc.).

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End of Life and Pain Management Symptoms that Affect Nutritional Care

Anorexia/Loss of Appetite	<ul style="list-style-type: none"> • Major side affect of pain and pain medications • Offer favorite foods (or whatever sounds good to the resident at the time) • Offer nutrient dense foods/supplements • Try 6 small meals/snacks a day, or offer food every few hours • Monitor weight weekly if severe
Taste/Smell Alterations	<ul style="list-style-type: none"> • Offer anything that the resident thinks they may like • Try spicy/more flavorful foods if tolerated • Reassess medications if severe • Decreased sense of smell can decrease taste sensations • If sense of smell is heightened, and if it triggers nausea, keep resident away from food preparation areas
Dry Mouth	<ul style="list-style-type: none"> • Provide good mouth care (frequent swabbing or brushing) • Offer sips of fluids frequently • Offer ice chips • Sorbets, lemon ice, sherbet with meals or in between may be helpful • Lemon drops may help
Sore Mouth	<ul style="list-style-type: none"> • Provide good mouth care • If severe, refer to physician for treatment • Avoid acidic and spicy foods • Offer mild, bland flavored foods • Encourage fluids—keep well hydrated • Offer soft, chopped or ground foods if needed to ease chewing and formation of bolus
Weight Gain	<ul style="list-style-type: none"> • Nutritional assessment to determine reason for weight gain • Assess medication side affects • Assess for overhydration • Monitor weights weekly if needed • Counsel on well balanced diet, offer other suggestions to reduce pain, anxiety, frustration (if appropriate)
Dehydration	<p>If fluids by mouth are not tolerated, an IV or tube feeding may be recommended, and if put in place, appropriate fluids will be provided through the IV or tube. The dietetics professional should assess IV or tube feeding and flush recommendations, and monitor and reevaluate as needed.</p>
Fluid Overload Symptoms	<ul style="list-style-type: none"> • Puffiness • Bloating • SOB • Increased respirations • Increased secretions • CHF