End of Life
Nutrition and Hydration

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End of Life Nutrition and Hydration

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End of Life Nutrition and Hydration

Instructions

This inservice provides many of the tools you need to educate staff on the role of adequate nutrition in the prevention and treatment of pressure in your facility:

Slides for the Inservice:

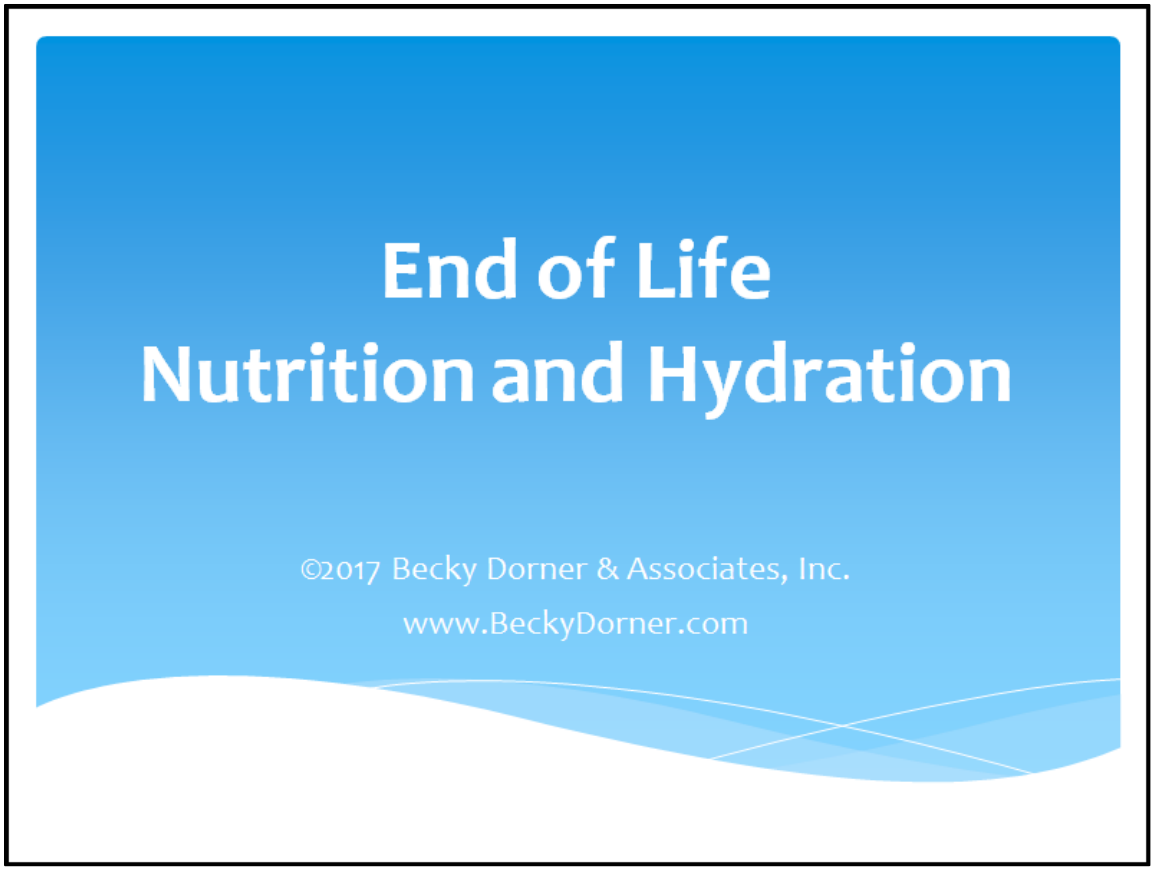
- The slides can be shown on computer or projected on a screen using a data projector.
- You can show the slides directly from the Acrobat file by simply clicking on the icon that looks like a computer screen. Or you can go to the tool bar and click on “View” and “Full Screen” to show the slides on your screen.
- Then click the down arrow button or the page down button on your keyboard.

Presenter’s Notes for the Inservice:

- Review the presenter’s notes prior to presenting the slides.
- The presenter’s notes offer additional information not included on the slides, suggestions for how to present some of the information, and activities you may want to incorporate.

Handouts for the Inservice:

- Simply copy the handouts and the pre- post-tests for participants.
- Do not provide the answer key for the pre-post tests.
- You can choose to give the test before and after the training, or just after the training to determine the effectiveness of your inservice and whether or not additional training is needed.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Slides

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Objectives

1. Obtain a basic understanding of advance directives for nutrition and hydration
2. Understand the need to continue to offer interventions even if a person is on hospice care
3. Outline some basic nutrition interventions to help manage end of life conditions (i.e. anorexia, dry mouth)

Difficult Decisions

- We are often faced with difficult questions from residents/patients and families related to nutrition and hydration at the end of life

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

Definitions

Our facility has established policies/protocols and written definitions for “do not resuscitate” (DNR), “no CPR” and “comfort measures only”

- Do Not Resuscitate
- No CPR
- Comfort Care

CMS on Advance Directives

- At end of life, a "Do not Resuscitate" does not indicate the individual is declining appropriate treatment and services
- Weight loss, pressure injuries, or dehydration may occur even if appropriate interventions are implemented (per the individual's wishes)
- The facility is expected to address the resident's concerns and offer relevant alternatives

Advance Directives

Help direct care when a person is unable to make their own decisions

1. Living Will - stipulates the type of care the individual desires to sustain life including use of feeding tubes
2. Durable Power of Attorney (DPOA) for health care – identifies the individual's surrogate or proxy, who will make health care decisions when the individual is not capable of making their own decisions

Declining Status

- A declining status alerts the IDT to conduct a comprehensive assessment, medical record review, revise interventions

- End-of-life decisions should be initiated only after the IDT is confident that all other approaches, interventions, and considerations have been examined, implemented and exhausted

Determining Whether Tube Feeding Is Appropriate

- If all interventions have been implemented and exhausted, review the advance directive documents

- If there are no advance directives for artificial nutrition and hydration (tube feeding), and these interventions are necessary to sustain life, the IDT should consult with the individual or surrogate to determine wishes

Comfort Care

- If the individual and/or surrogate are in agreement, the physician can write an order for "comfort measures only" or "palliative care"
- Hospice care may be initiated, if desired
- Honor the individual's wishes; provide care according to the physician's orders

Prior to Feeding Tube Placement

- Identify individuals at risk for malnutrition
- Provide enough assistance in eating (cue to eat, assistive devices, assist with eating, or feed if needed)
- Therapy to improve swallowing skills
- Determine cause of decreased oral intake, weight loss or malnutrition
- Follow RDN recommendations

Having the Nutrition Discussion

- Inform the individual /surrogate of the ability to implement an advance directive (including nutrition and hydration)
- IDT discusses with the individual and/or family
- The discussion includes options for nutrition and hydration based on the individual's desires

Hospice Philosophies

- Care is controlled by the individual (Person centered)
- The individual guides the decisions for ongoing care
- Caregivers provide compassionate care
- Caregivers need to change their mindset from curative and therapeutic to comfort and support
  - Managing symptoms, pain management, comfort and quality of life become the focus

Nutrition Care at the End of Life

- Promote quality of life
  - Dignity, choice, decision making, accommodate needs
- Minimize diet restrictions to help maximize food and fluid intake
- Remain flexible and make food available at any time the individual may want to eat

Make Dining as Pleasurable as Possible

- Encourage pleasure in eating by honoring food and meal/snack time preferences
- Encourage to eat and drink small amounts of preferred food and fluids when alert and awake - but do not force food or fluids
- If intake is poor, reassure the individual and family and allow the person to do what is comfortable

Chronic Pain

- Unintended weight loss and malnutrition may occur due to:
  - Chronic pain may decrease desire to eat
  - Pain can change eating patterns
- Meals may need to be timed to coincide with the person's alertness

Anorexia
(Lack or loss of appetite for food)

- Identify/address treatable causes of anorexia and cachexia (pain, depression, GI issues, cognitive impairment)
- Offer favorite foods when food is desired
- Offer nutrient dense foods/supplements
- Try 6 small meals a day, or offer food every few hours
- Monitor weight weekly if anorexia is severe

Dry Mouth

- Provide good oral care (frequent swabbing or brushing)
- Offer sips of fluids frequently
- Offer ice chips
- Sorbets, lemon ice, sherbet with meals or in between
- Lemon drops may help

Nausea

- Offer small meals, snacks
- Eat slowly/chew well
- Try “dry meals” with liquids between meals
- Do not force feed
- Avoid favorite foods when nauseated
- Remain upright for 30-60 minutes after eating
- Avoid fatty/fried foods, heavy sweets, spicy foods and foods with very strong odors
- Offer foods/fluids the person will agree to eat
- The following may help:
  - Cold foods
  - Lemon-lime soda, ginger ale
  - Peppermints or spearmints

Constipation

- Offer and encourage plenty of fluids
- Encourage activity/movement
- Offer high fiber foods: Fruits, vegetables, whole grains, bran cereal, prunes or prune juice
- Hot beverages may act as stimulants
- Increase fiber intake gradually to avoid problems with tolerance

Diarrhea

Foods/Beverages to Avoid

- Carbonated beverages, liquid with meals
- High fiber foods, greasy foods, fatty or fried foods
- Raw fruits and vegetables
- Spicy foods
- Very hot or cold items
- Limit caffeine (coffee, tea, cola, chocolate, etc.)

Try These Approaches

- Small, Frequent Feedings
- Fluid between meals
- Starches: rice, noodles, cream of wheat, white bread
- Fruits/Veg.: pureed cooked or canned; grape/apple juice, ripe bananas
- Yogurt, eggs, poultry, tender lean beef, cottage cheese

Dehydration

- Encourage fluids as tolerated
- Small frequent sips are best
- If fluids by mouth are not tolerated, an IV or tube feeding may be recommended

Fluid Overload: Symptoms

Report these symptoms to your supervisor:

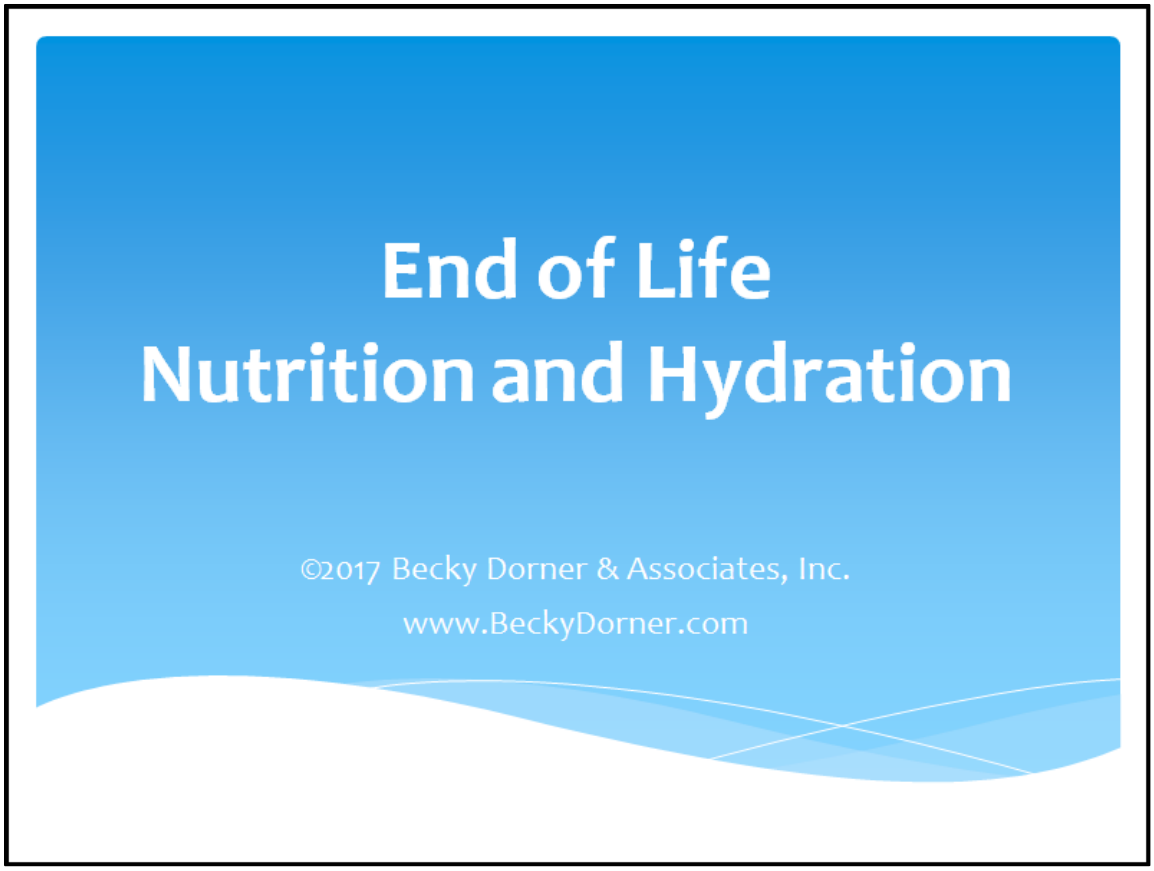
- Puffiness
- Bloating
- SOB
- Increased respirations
- Increased secretions

Documentation

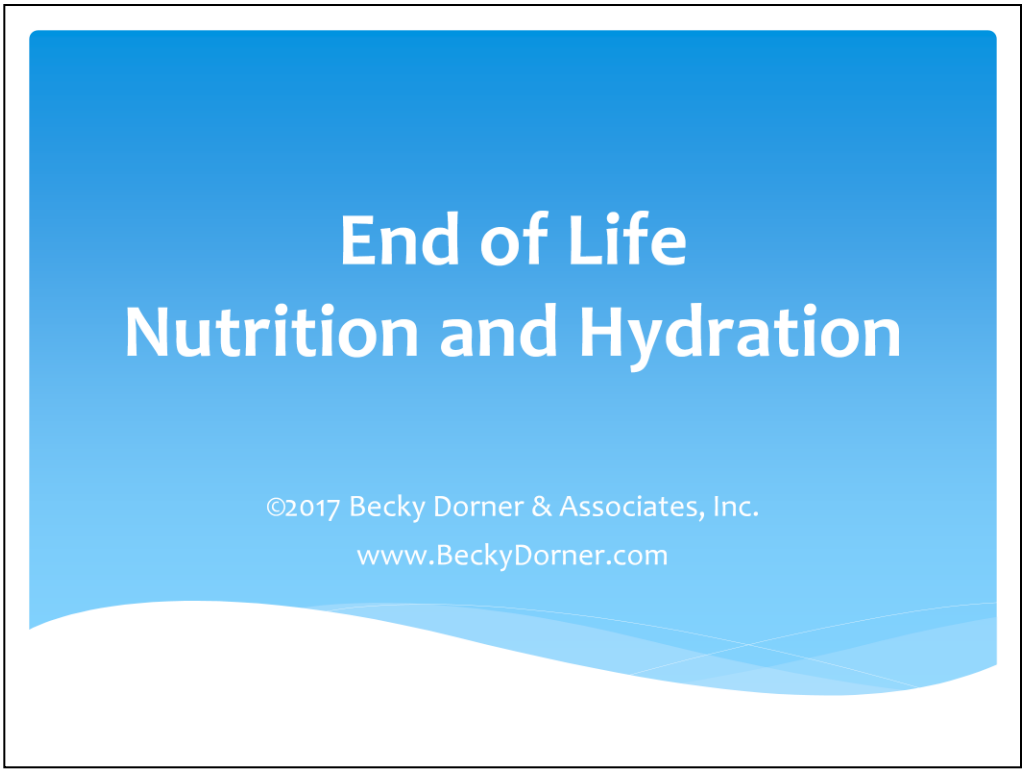
- The goal is comfort and quality of life
- Document the individual's desires
- Weight loss is expected at the end of life
  - Follow orders, change interventions as needed
- Weights and labs may not be available, so rely on:
  - Food/fluid intake records, patient/family interview
  - Adapting interventions to meet changing needs of the individual

Summary

- Provide educated and compassionate care
- Use careful and ethical decision-making
- Follow established protocols
- Involve individual /family and IDT in decision-making
  - Help the individual/family understand benefits vs. burdens of nutrition interventions
- Implement palliative interventions and revise as necessary, to maintain comfort and quality of life



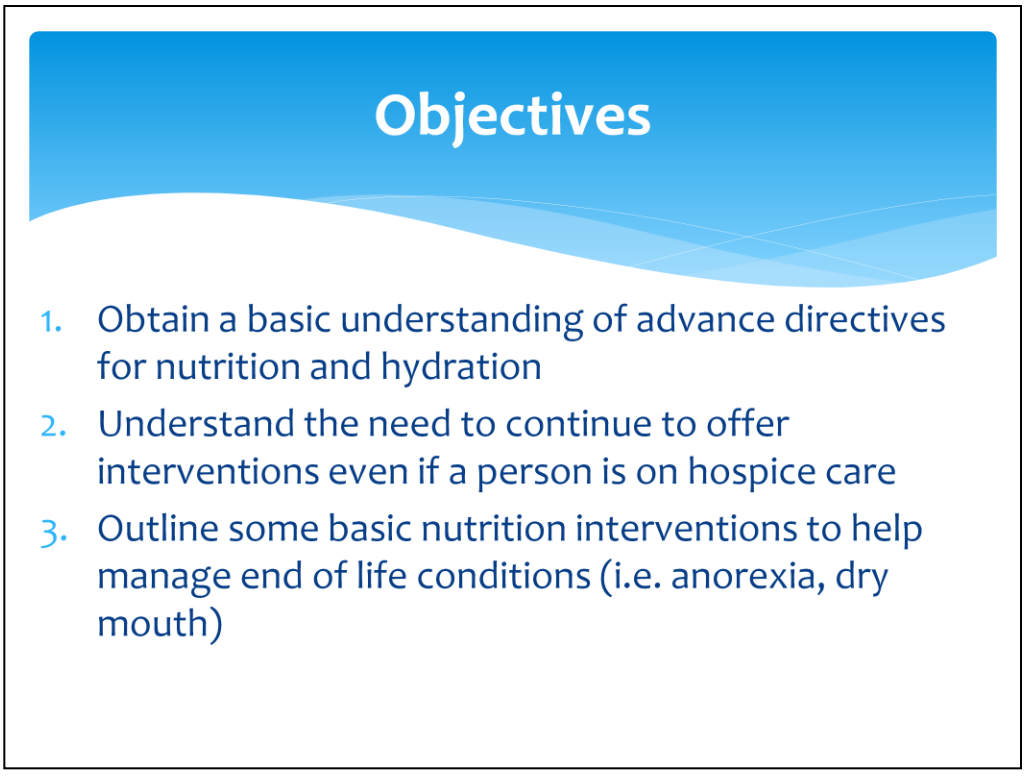
Presenter's Notes



Audience: Nursing staff, nursing assistants/aides.

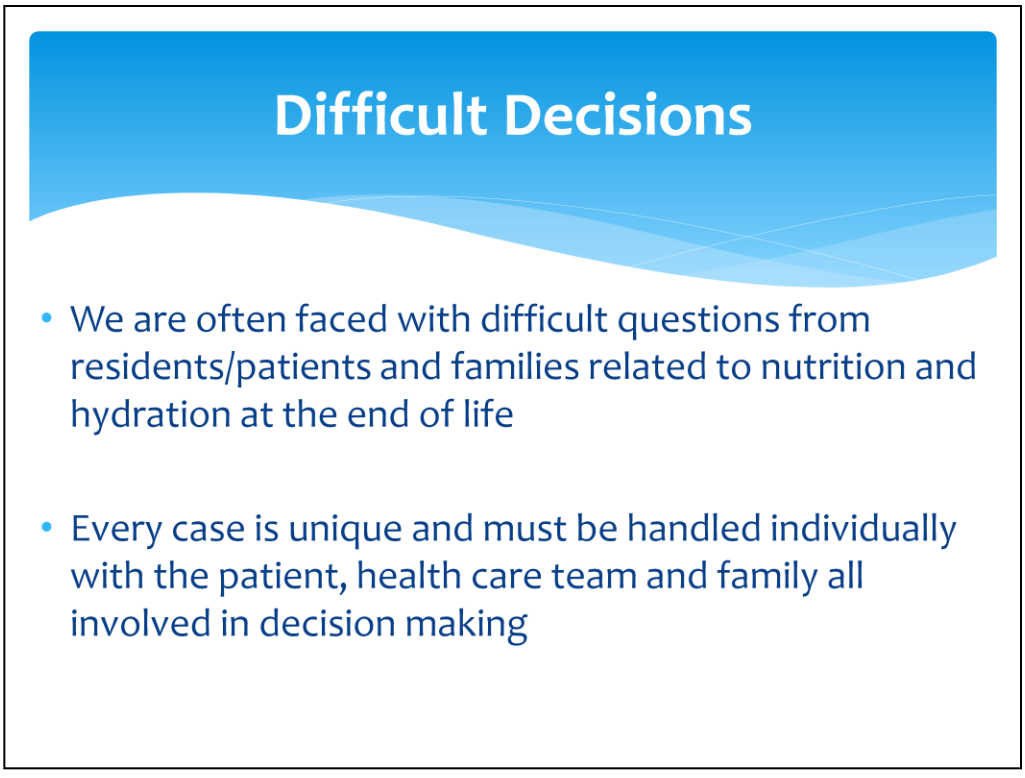
Welcome to our inservice on End of Life Nutrition and Hydration.

Presenter Note (Optional): Before we get started, let's test your knowledge with a short pre-test.



We will address a variety of topics at the end of life, however, our main objectives for today are to:

1. Obtain a basic understanding of advance directives for nutrition and hydration.
2. Understand the need to continue to offer interventions even if a person is on hospice care.
3. Outline some basic nutrition interventions to help manage end of life conditions (i.e. anorexia, dry mouth).



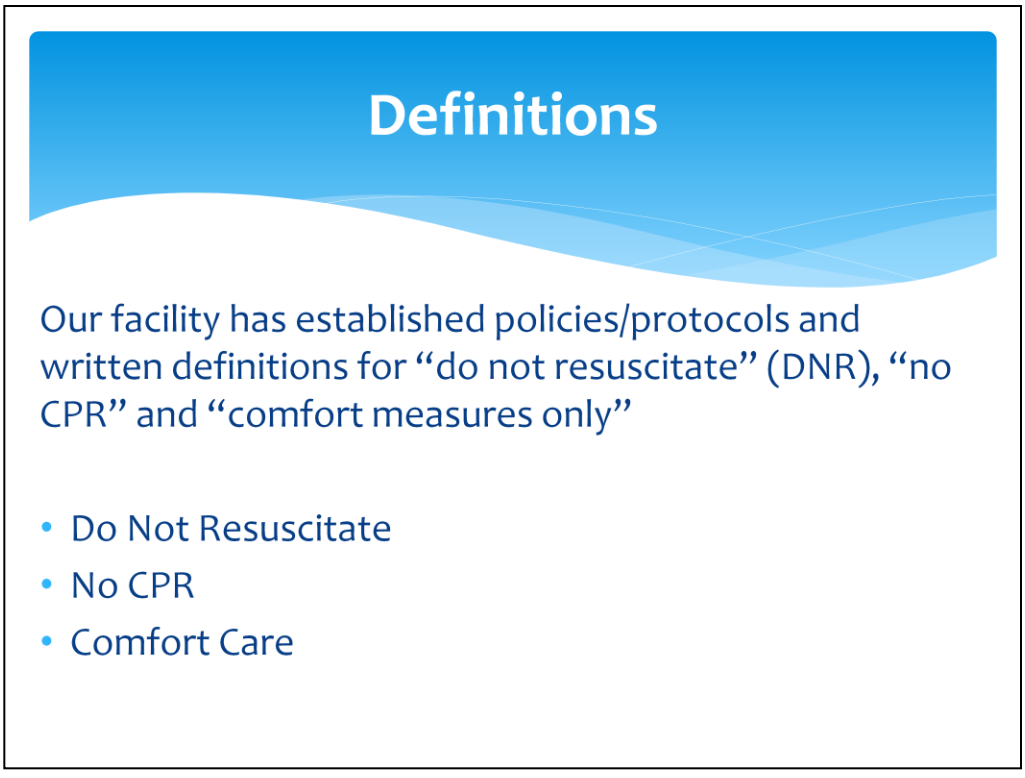
We are often faced with difficult questions from residents/patients and families related to nutrition and hydration at the end of life.

Patients/residents who are competent to make their own decisions have the right to refuse treatment, and that includes nutrition interventions such as tube feedings.

We can encourage them to eat, provide assistance, cater to their preferences, offer oral nutritional supplements, etc. But we can't force them.

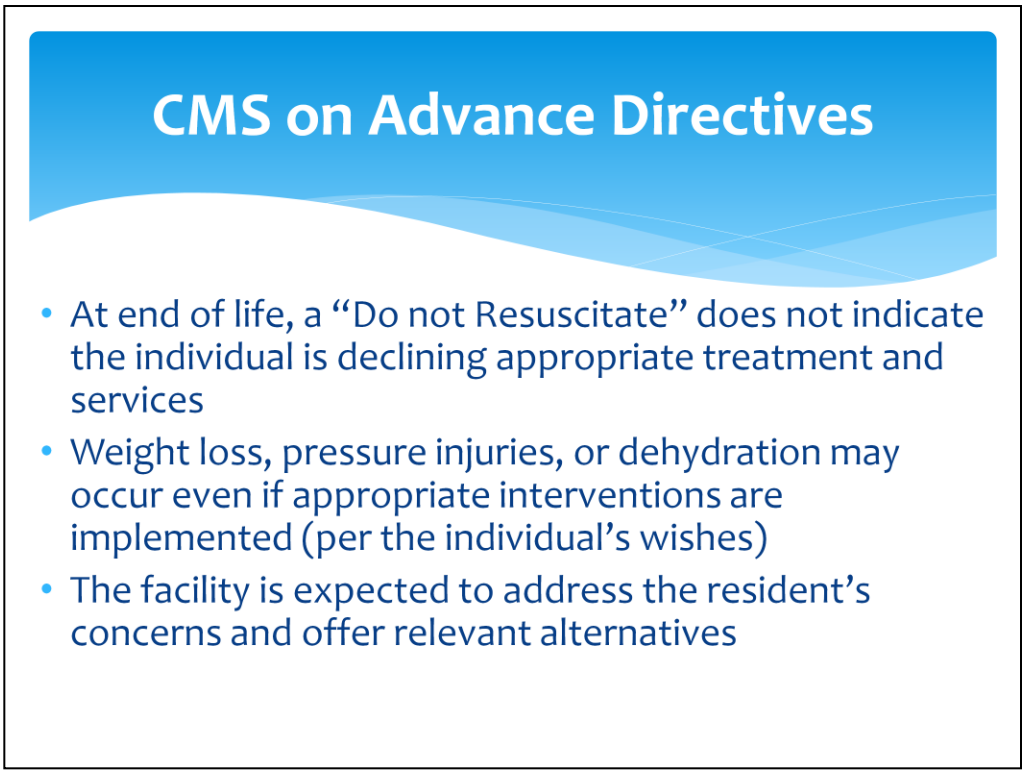
Every case is unique and must be handled individually with the patient,/resident health care team and family all involved in decision making.

There are some documents that can guide us.



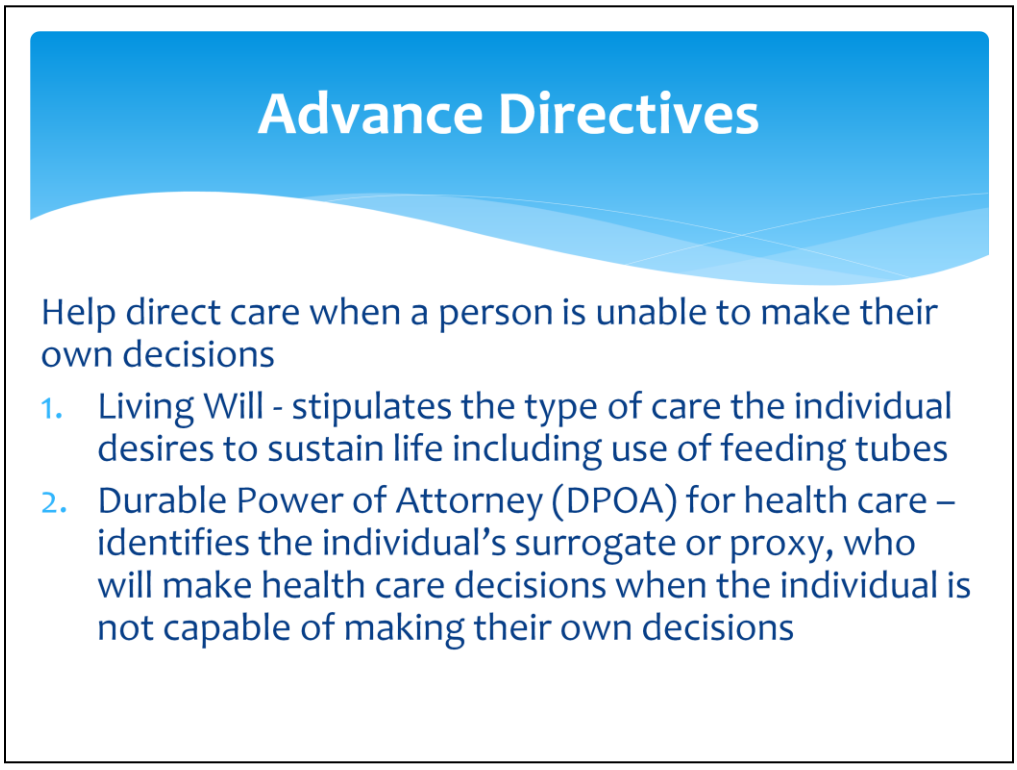
Our facility has established policies/protocols for end of life care, including written definitions for "do not resuscitate" (DNR), "no CPR" and "comfort measures only".

Presenter Note: Review your facility's definitions for "do not resuscitate", "no CPR" and "comfort care".



- At end of life, the presence of a "Do not Resuscitate" order is not sufficient to indicate the individual is declining appropriate treatment and services.
- If the facility had implemented appropriate interventions to stabilize care and treat per the resident's wishes, then the development, continuation or progression of weight loss, pressure injury, or dehydration may be consistent with regulatory requirements.
- The facility is expected to address the patient/resident's concerns and offer relevant alternatives.

It is very important that we continue to assess and intervene on nutrition and hydration issues even at the end of life. This will help promote the best quality of life possible for the time the person has left.

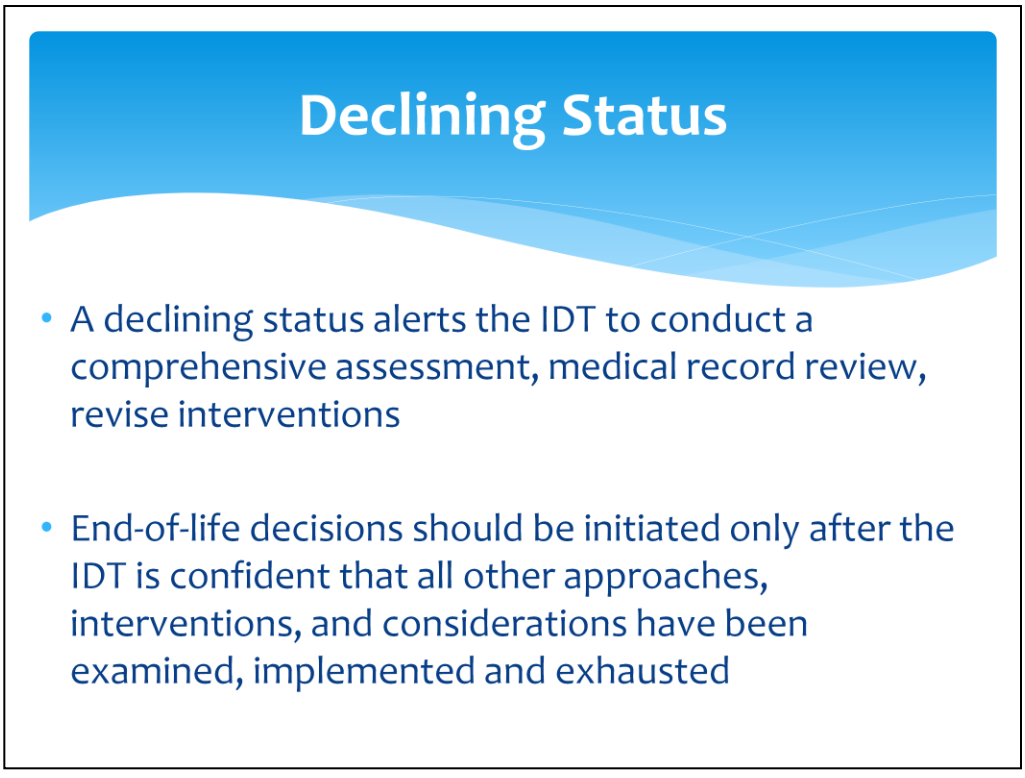


The Patient Self Determination Act of 1990 requires that individuals be informed of their right to participate in health care decisions, including their right to have an advance directive. Advance directives, living wills and durable powers of attorney are legal documents that allow individuals to convey their decisions about end of life care to family, friends and health care professionals.

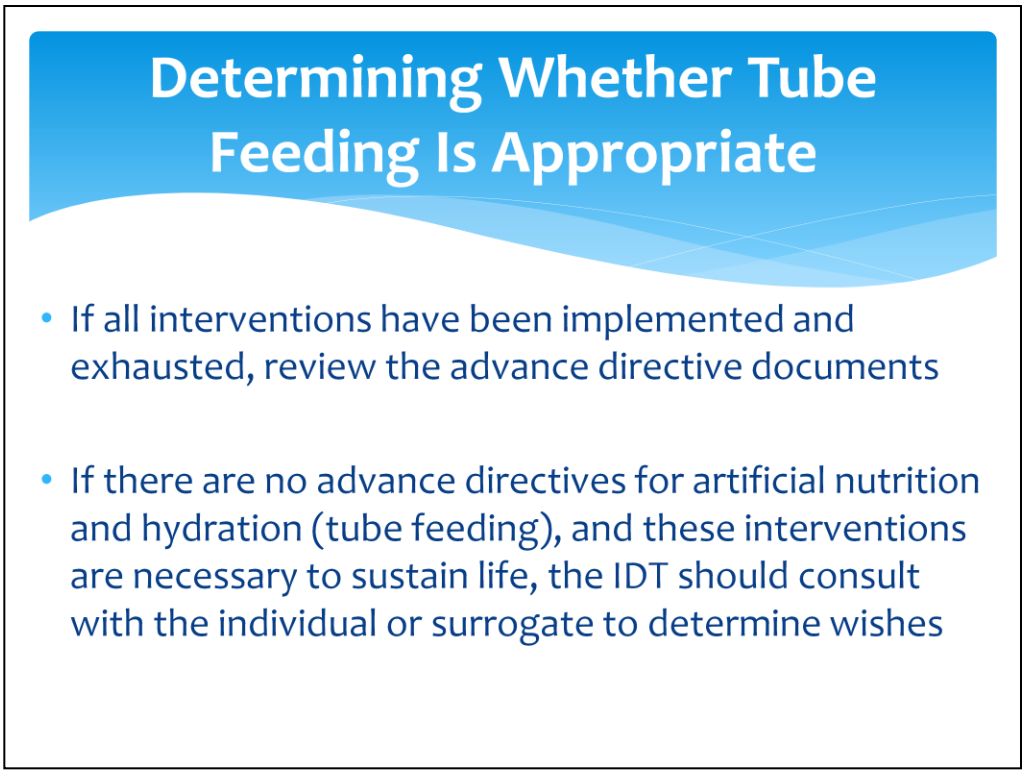
- A competent individual is someone who is informed and able to make their own healthcare decisions. They can change or cancel their advance directive at any time.
- A surrogate is someone who is an authorized proxy that will act in the individual's place if they lose the ability to make their own decisions about healthcare.

1. Living Will - stipulates the type of care the individual desires to sustain life including the use of feeding tubes
2. Durable Power of Attorney (DPOA) for health care – identifies the individual's surrogate or proxy, who will make health care decisions when the individual is not capable of making their own decisions. DPOAs allow the decision-maker to use current information about the individual's condition at the time a decision is needed.

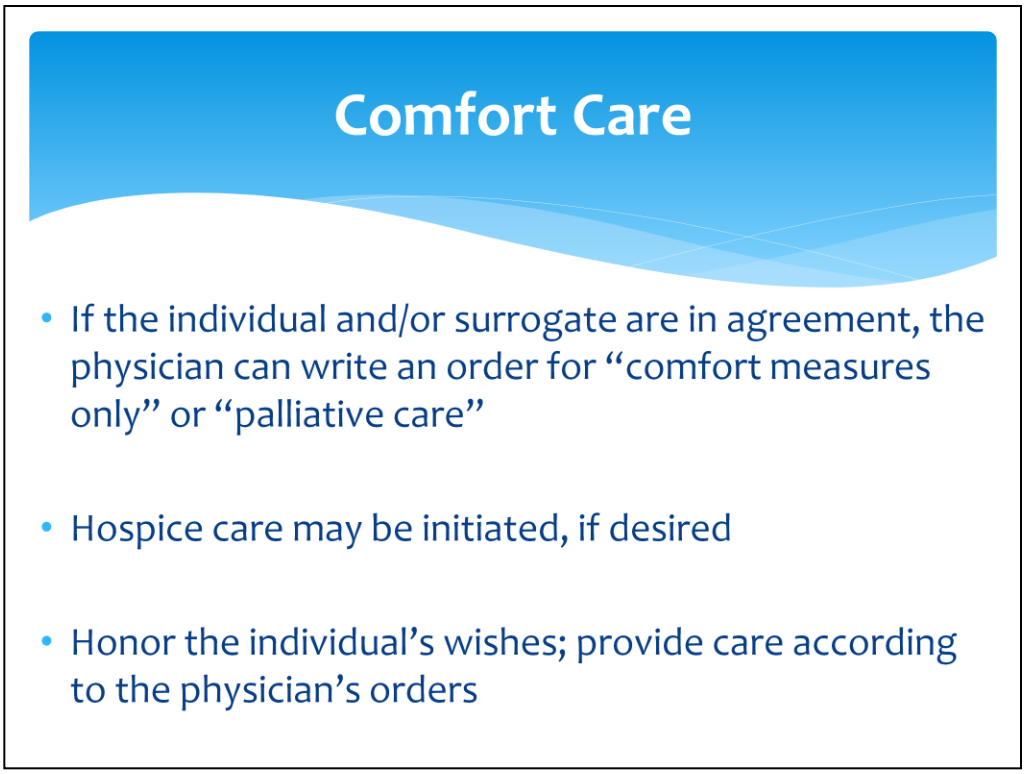
Unfortunately, advance directives frequently do not specify whether interventions such as tube feeding or IV fluids are desired.



- When a decline in status is observed, the individual's plan of care will usually change. The following guidelines can help the interdisciplinary team (IDT) determine whether enteral nutrition (EN) is appropriate for each individual.
- The IDT should initiate an accurate and complete assessment, review the medical record, and determine if the care plan was implemented correctly and appropriately by qualified staff. Interventions should be evaluated. Interventions can be revised to maintain the desires of the individual patient/resident.
- End-of-life decisions should be initiated only after the IDT is confident that all other approaches, interventions, and considerations have been examined, implemented and exhausted.

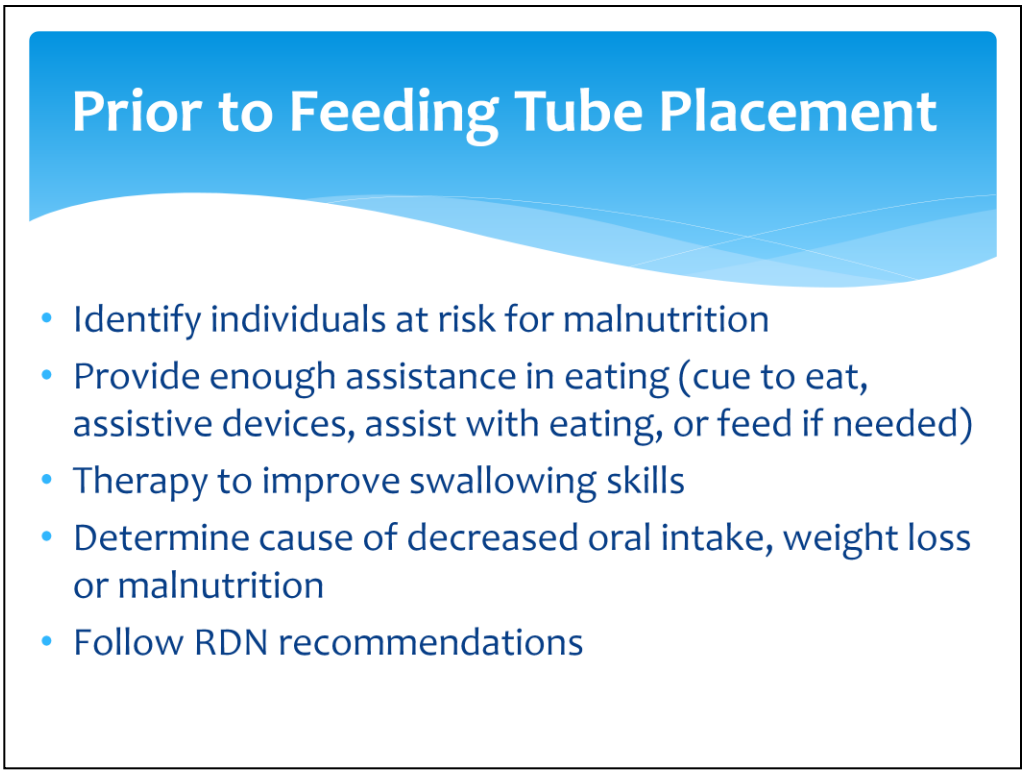


- The medical record should contain the individual's advance directive documents such as the Living Will and/or Durable Power of Healthcare/Medical Attorney to indicate the individual's end of life desires. These documents should be revisited with the individual and/or representative to assure they are still appropriate.
- If no advance directives regarding artificial nutrition and hydration (tube feeding) are on file, and it appears necessary to initiate such interventions to sustain life, the IDT should consult with the patient/resident or surrogate/proxy to determine the individual's desires and wishes. The individual's choices for end of life care should be documented in the medical record.
- There are cases in which enteral feeding may be beneficial. If the choice is made to place a tube feeding, the physician will order the feeding and nursing will follow those orders. The IDT and RDN will continually monitor and evaluate formula administration, feeding tolerance, nutritional status, overall physical health and quality of life.



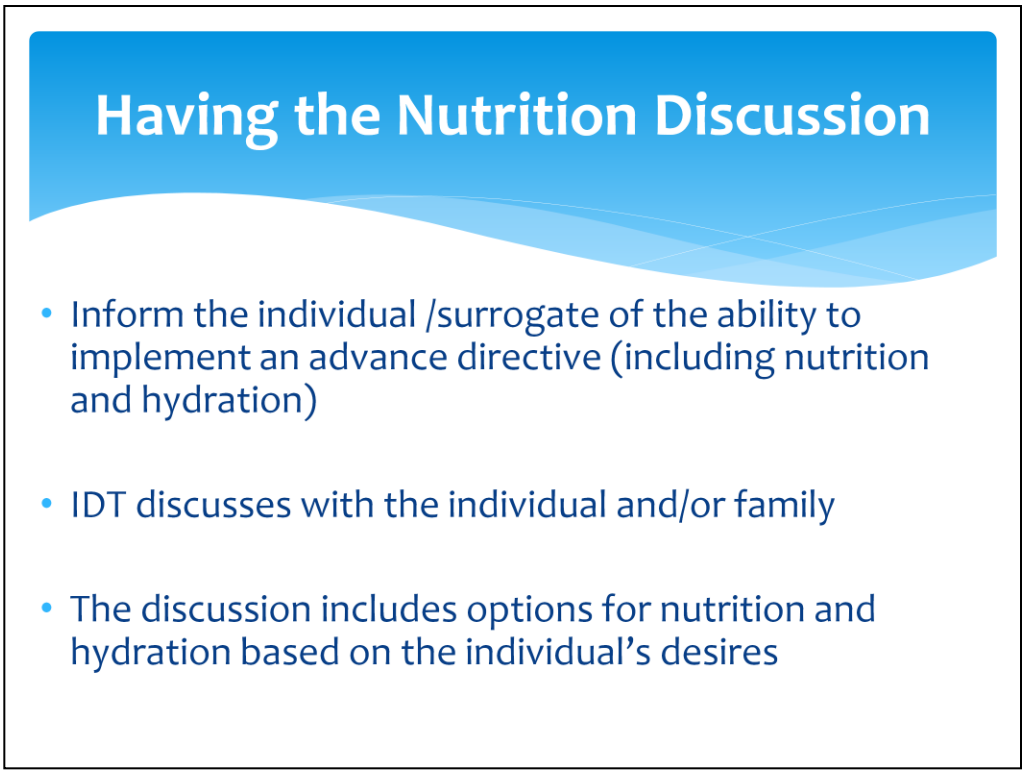
- If the individual and/or surrogate are in agreement, the physician should write an order for "comfort measures only" or "palliative care" (depending on facility protocols) and follow orders based on the facility's definitions.
- Hospice care may be initiated, if desired.
- Facility staff should honor the individual's wishes and provide care according to the physician's orders.

The care plan should be updated to reflect the end of life decisions made by the individual or the individual's surrogate. All palliative interventions as described in the care plan should be implemented and revised as necessary to reflect the individual's needs and choices to provide the highest quality of life possible.



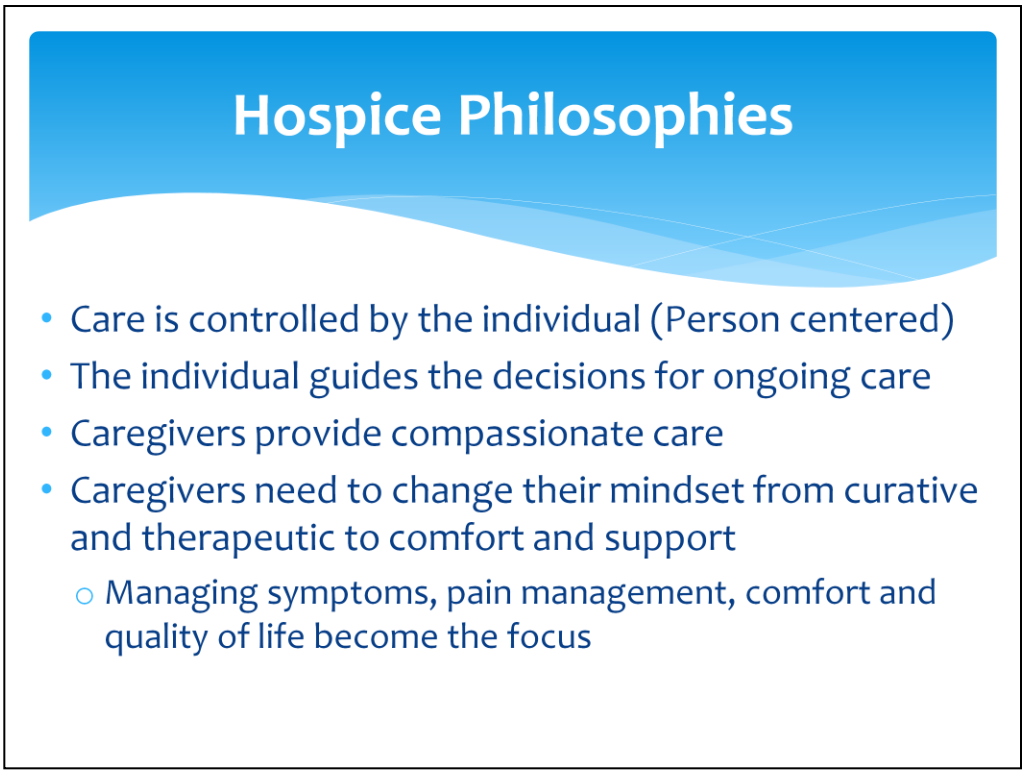
We must be sure we have done all of these things prior to placing a feeding tube. Because if a feeding tube is placed, CMS will review the following (For residents who did not have TF on admission, but now have TF placed):

- Did the facility identify the resident at risk for malnutrition?
- What did the facility do to maintain oral feeding, prior to inserting a feeding tube?
- Did staff provide enough assistance in eating?
- Did staff cue resident as needed, provide assistive devices, assist with eating, or feed the resident, if necessary?
- Is the resident receiving therapy to improve or enhance swallowing skills, as needed?
- Was an assessment done to determine the cause of decreased oral intake, weight loss or malnutrition?
- If there was a dietitian consultation, were recommendations followed?

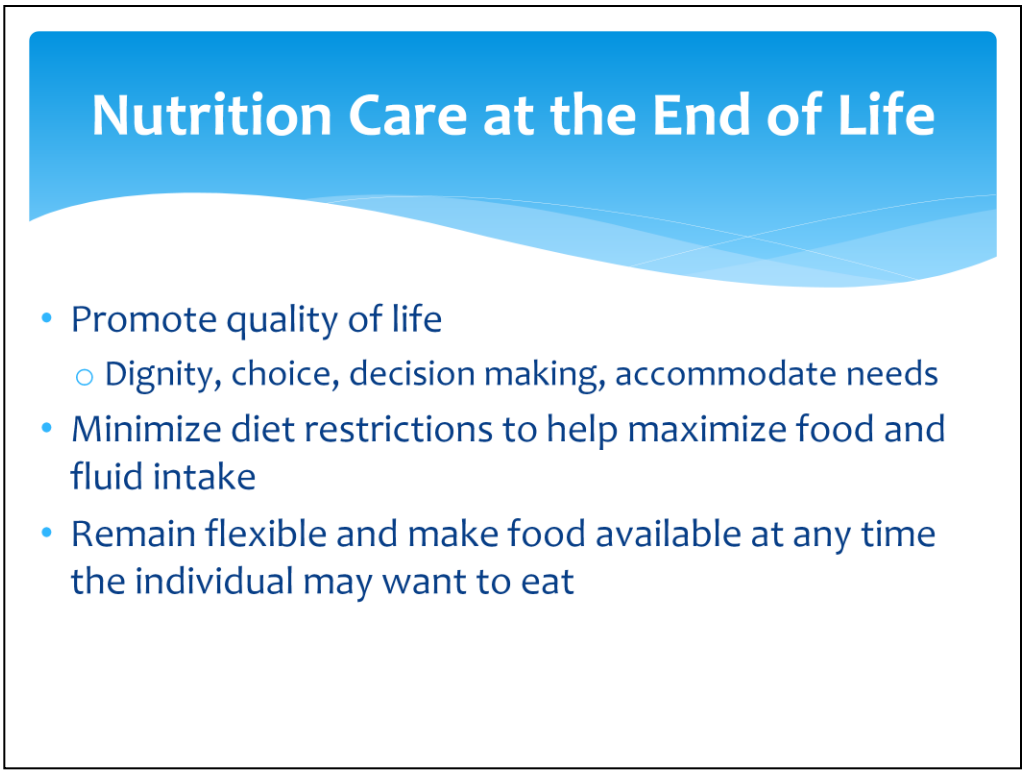


- Inform the individual and/or surrogate of the ability to implement an advance directive (including nutrition and hydration).
- The IDT determines when the discussion will take place with the individual and or family and who will lead the discussion.
- Follow appropriate protocols for weight loss, malnutrition and dehydration—be sure all interventions have been tried.
- The discussion should include options for nutrition and hydration based on the individual's desires.

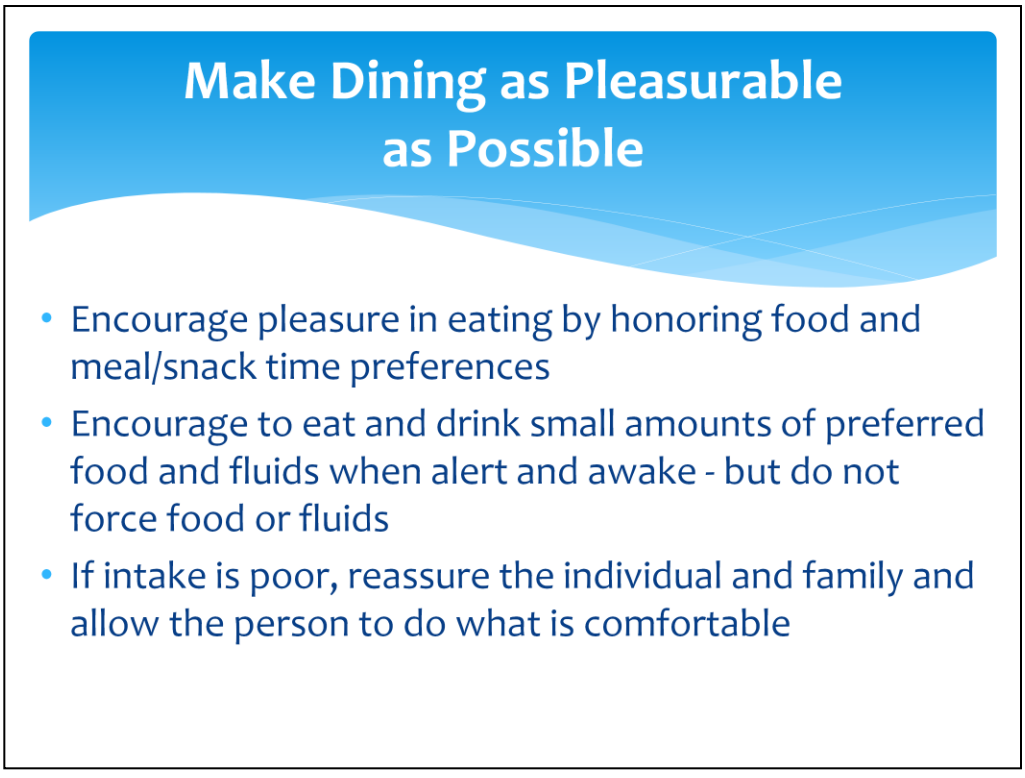
Presenter Note: Review the facility's protocol as appropriate.



- Health care professionals may not be able to prolong life for the dying, but can play an important role and help to make the person's final days more comfortable. Providing emotional support and professional advice on how to achieve each individual's goals within legal parameters is also an important role. This may require frequent assessments, changing interventions and offering suggestions to cope with the changing needs of the dying person.
- Care is controlled by the dying person (person centered). The individual guides the decisions for ongoing care and interventions. Caregivers need to provide compassionate care for the individual and their loved ones.
- Caregivers need to change their mindset from curative and therapeutic to comfort and support, and understand that unintended weight loss, malnutrition and/or dehydration may by be expected outcomes.
- Management of symptoms, pain management, comfort and quality of life become the focus. (Caregivers can provide emotional, social, spiritual comfort).



- Promote quality of life. This includes maintaining a person's dignity, providing them with choices, allowing them to make decisions, and accommodating their needs.
- If diet restrictions are contributing to decreased food/fluid intake, request that diet restrictions be minimized or eliminated to help maximize food and fluid intake. (Refer to the registered dietitian nutritionist)
    - Promote food first – before oral nutritional supplements!
    - Cater to the individual's food preferences.
- Remain flexible and make food available at any time the individual may want to eat.

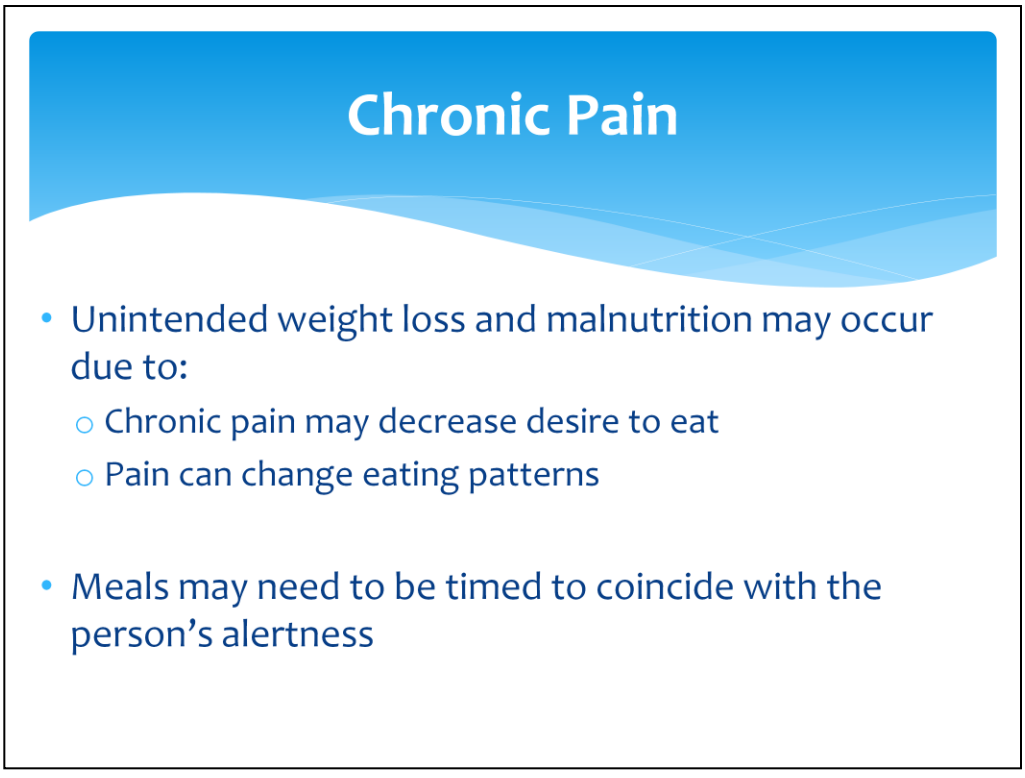


Often the dying person is not interested in eating/drinking.

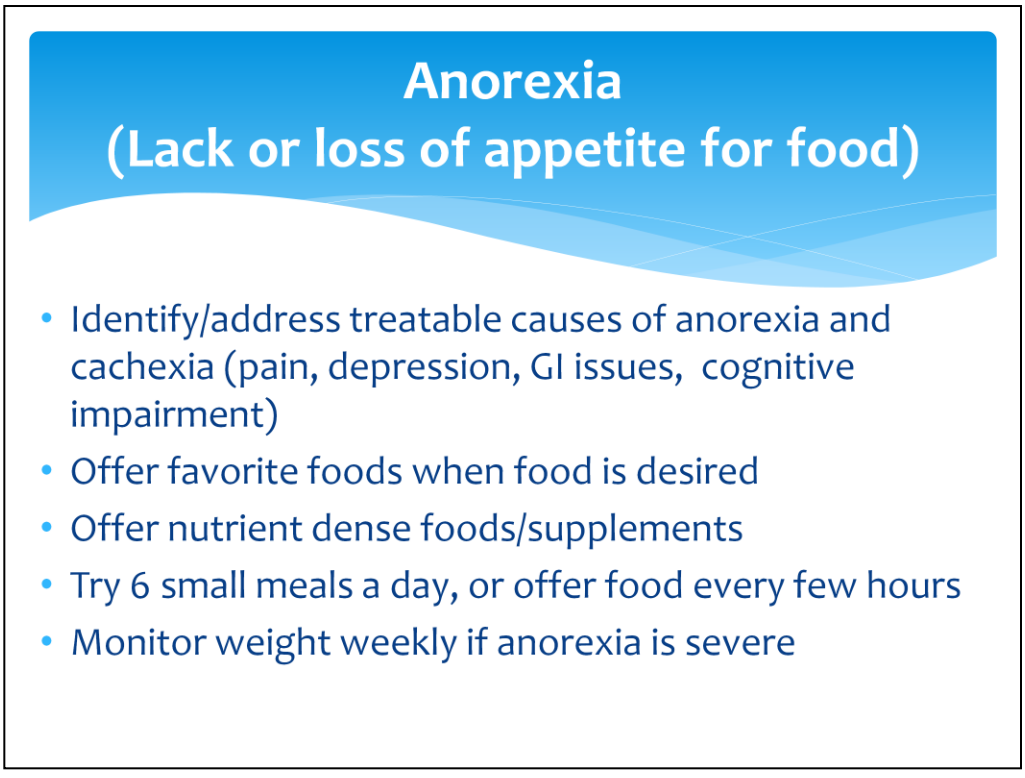
- Encourage pleasure in eating by honoring food and meal/snack time preferences.
- Encourage the individual to eat and drink small amounts of preferred food and fluids when alert and awake - but do not force food or fluids.
- If intake is poor, reassure the individual and family that this is normal and allow the person to do what is comfortable.

Refer to nursing who can support and educate the family to understand that lack of interest in food and fluid is a normal part of the dying process and part of the progression of many disease states.

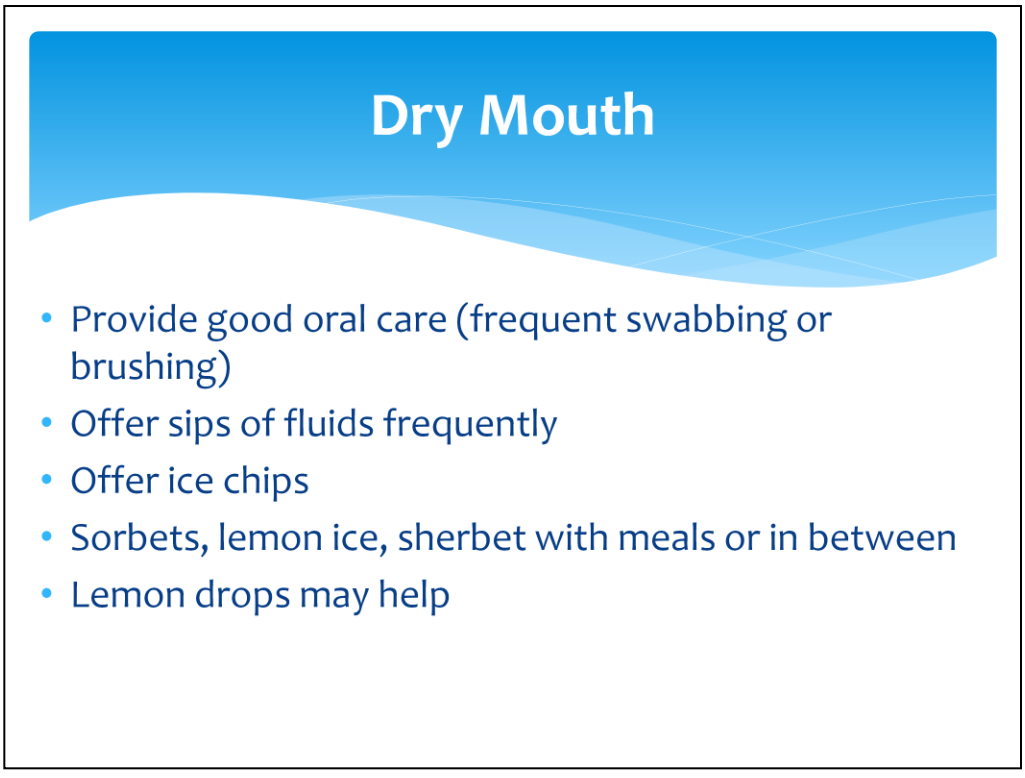
There are many symptoms that may affect a person's ability or desire to eat. Let's review some of the symptoms we can try to manage through food/fluid/nutrition interventions.



- Unintended weight loss and malnutrition may occur due to:
  - Chronic pain which may decrease desire to eat
  - Pain can change eating patterns
- Meals may need to be timed to coincide with the person's alertness (which may be based on timing of pain medications and sleep/wake cycles.)
- It may be necessary to reevaluate medications or timing of medications.



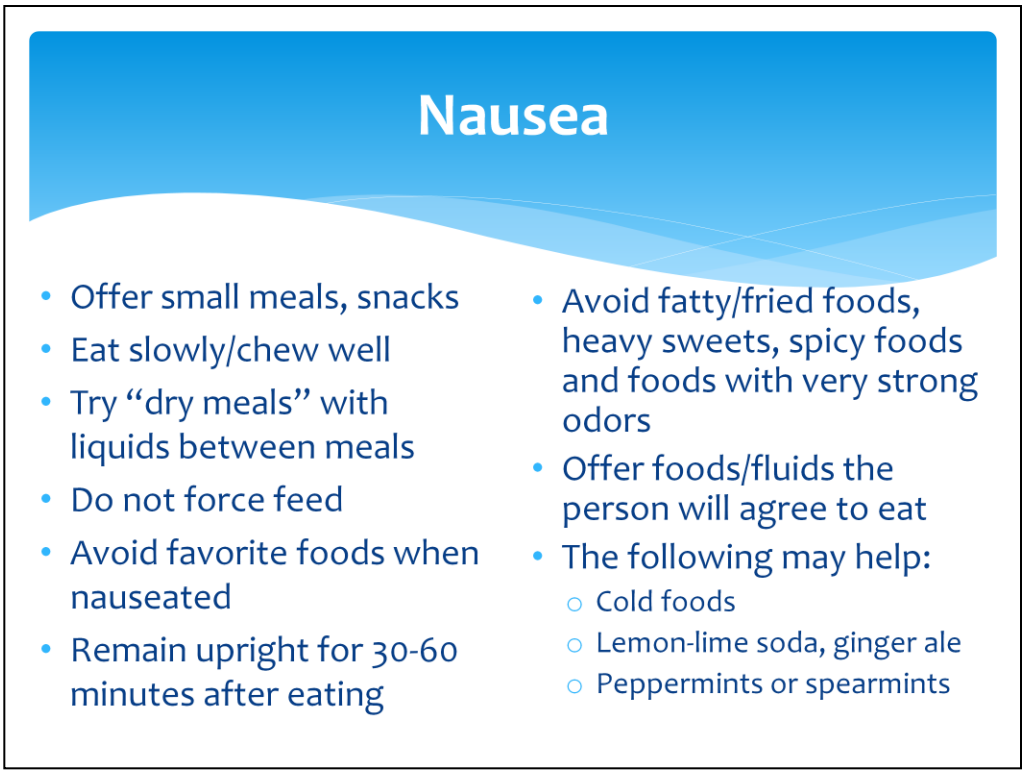
- Anorexia (lack or loss of appetite for food) is a major issue at the end of life. It can be a side effect of pain and pain medications.
- But there are things we can do to help.
- Identify and address treatable causes of anorexia (pain, depression, medications, GI tract dysfunction, and cognitive impairment).
- Offer favorite foods when the person has a desire to eat.
- Offer nutrient dense foods/supplements.
- Try 6 small meals/snacks a day, or offer food every few hours.
- Monitor weight weekly if anorexia is severe (and if this is desired by the individual).



Dry mouth can be a side affect of medications, or a result of poor oral fluid intake.

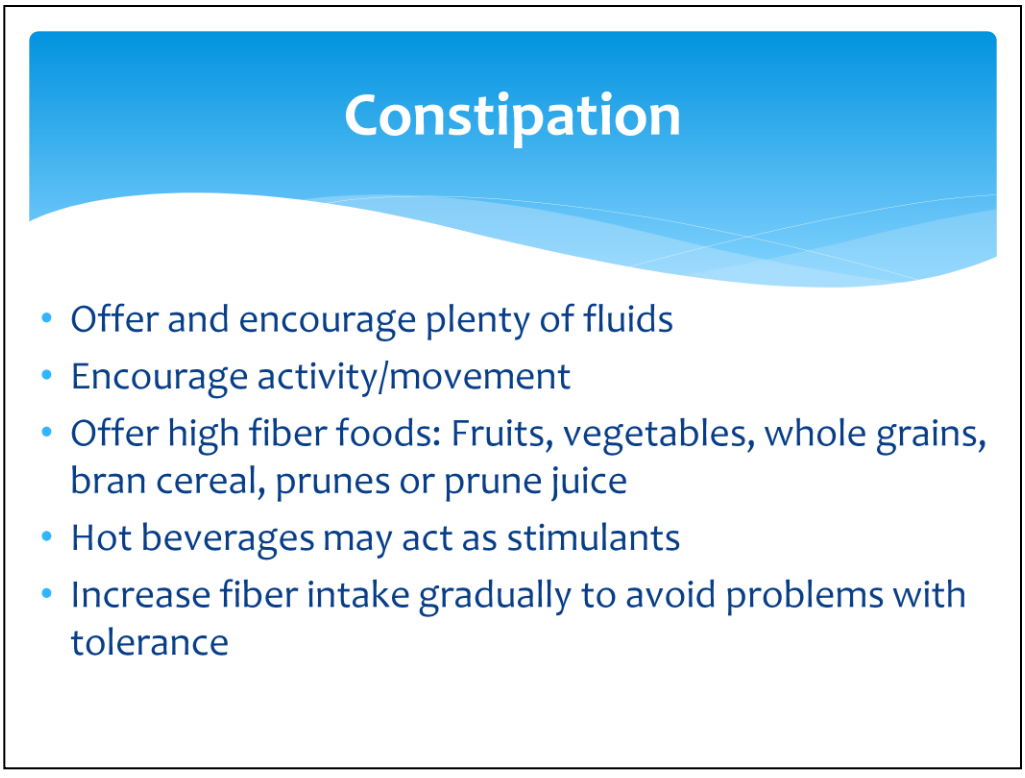
Here are some steps you can take to provide relief include:

- Provide good oral 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.



Nausea may be a side affect of medications, or progression of the disease state. Here are things we can do to help:

- Offer small meals and snacks.
- Encourage the person to eat slowly and chew food thoroughly.
- Try "dry meals" with liquids given between meals (one hour before or after); offer cool, clear liquids, and encourage to drink slowly.
- Do not force the person to eat (it may cause a permanent dislike for the foods that are forced); encourage to avoid favorite foods during bouts of nausea to avoid developing aversion to favorite foods.
- Encourage to rest calmly but to remain upright for 30 to 60 minutes after eating, with head of bed elevated. Be sure clothes are loose and comfortable.
- Cold foods may be more appealing.
- Avoid fatty and fried foods, heavy sweets, spicy foods and foods with very strong odors.
- Offer whatever foods/fluids the person suggests he/she will try to eat.
- Avoid any odors (including food) that may be unpleasant to the individual.
- Give medications as instructed. (Some need to be given with food and this may help to alleviate nausea).
- Carbonated beverages such as lemon-lime soda or ginger ale may be helpful.
- Peppermints or spearmints may be helpful if tolerated.
- Remove plate cover away from person, allow odors to dissipate before serving.



Constipation is a major side effect of pain medications. Food/fluid and activity interventions sometimes help. Providing adequate fluid is essential. Here are a few suggestions. (However, many people will need laxatives, stool softeners).

- Offer and encourage plenty of fluids.
- Encourage activity. The physical therapist may be able to give some suggestions.
- Offer high fiber foods such as fruit and vegetables, whole grains (breads and cereals, brown rice and other grains), bran cereals, prunes, prune juice.
- Hot beverages may act as stimulants.
- Increase fiber intake gradually to avoid problems with tolerance.

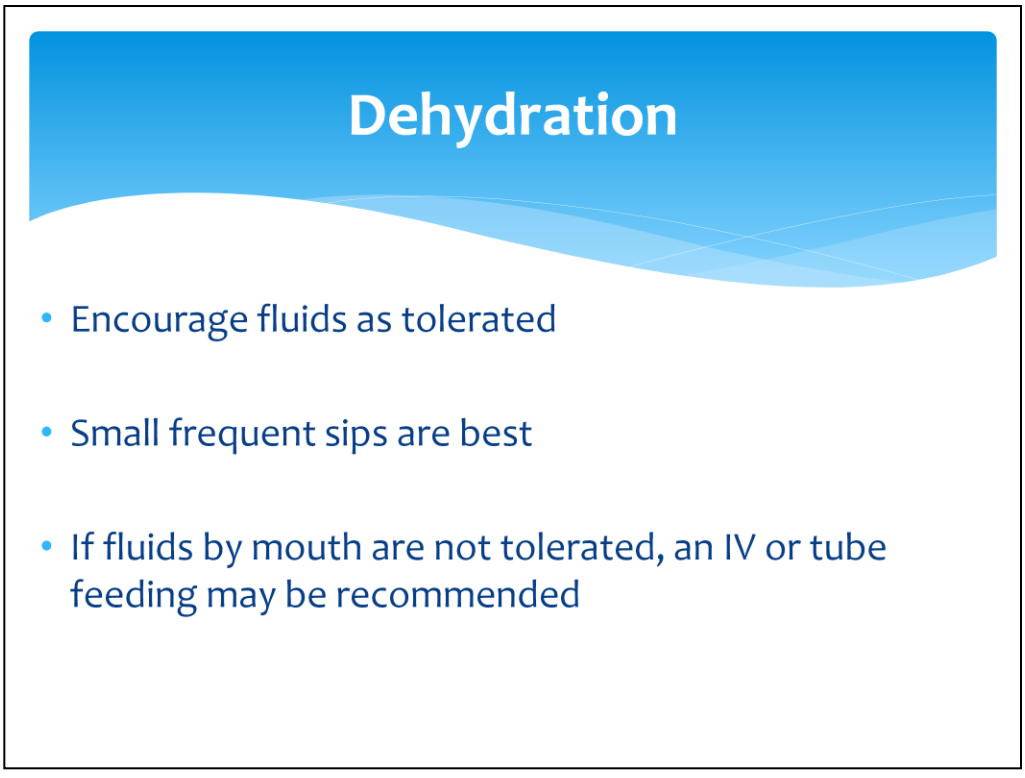
If diarrhea persists, it may lead to dehydration and contribute to malnutrition. Anti-diarrheal medications may be needed if severe or persistent.

Foods/Beverages to Avoid:

- Carbonated beverages, liquid with meals, high fiber foods, greasy foods, fatty or fried foods
- Raw fruits and vegetables
- Spicy foods
- Very hot or cold foods /beverages
- Limit caffeine (coffee, tea, cola, chocolate, etc.)

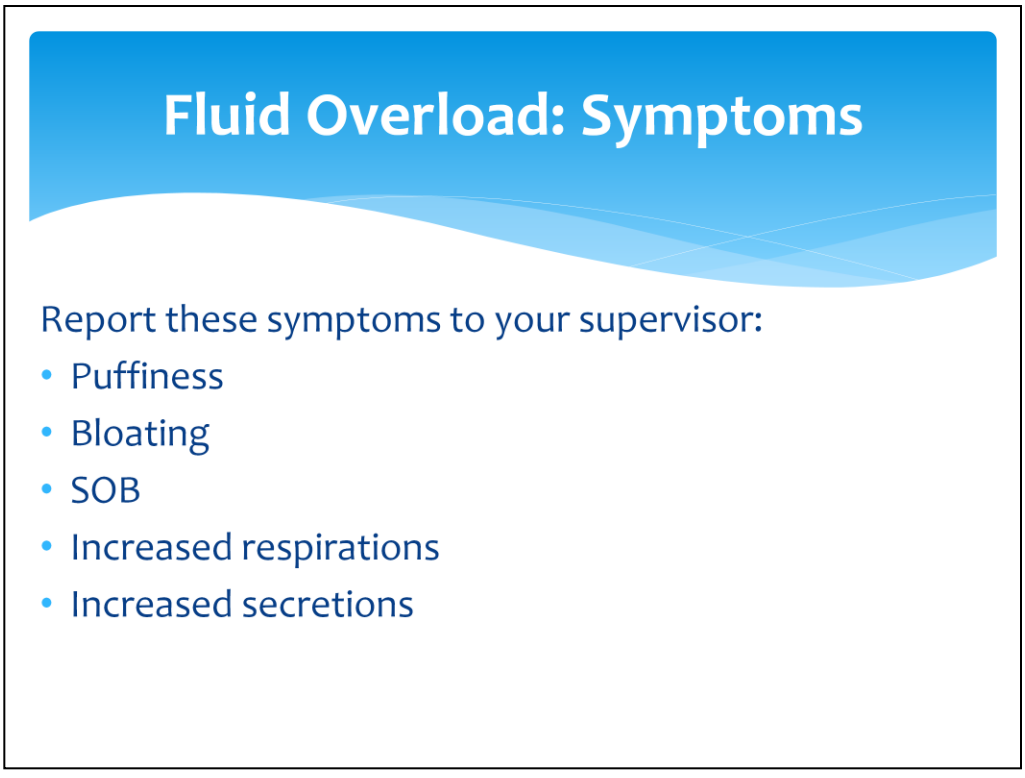
Encourage small, frequent feedings with fluid between meals. These foods may be better tolerated:

- Starches: rice, noodles, cream of wheat or farina, white bread
- Fruits/Vegetables: pureed cooked vegetables, applesauce, grape or apple juice, ripe bananas, canned or cooked fruit without skin
- Protein Foods: yogurt, eggs (not fried), smooth peanut butter, chicken, turkey, tender lean beef, low-fat beef, cottage cheese
- Offer salty foods or salt at the table (if permitted) to replace lost sodium; Offer foods high in potassium; bananas, potatoes, apricot nectar
- Investigate potential food intolerances – especially lactose intolerance



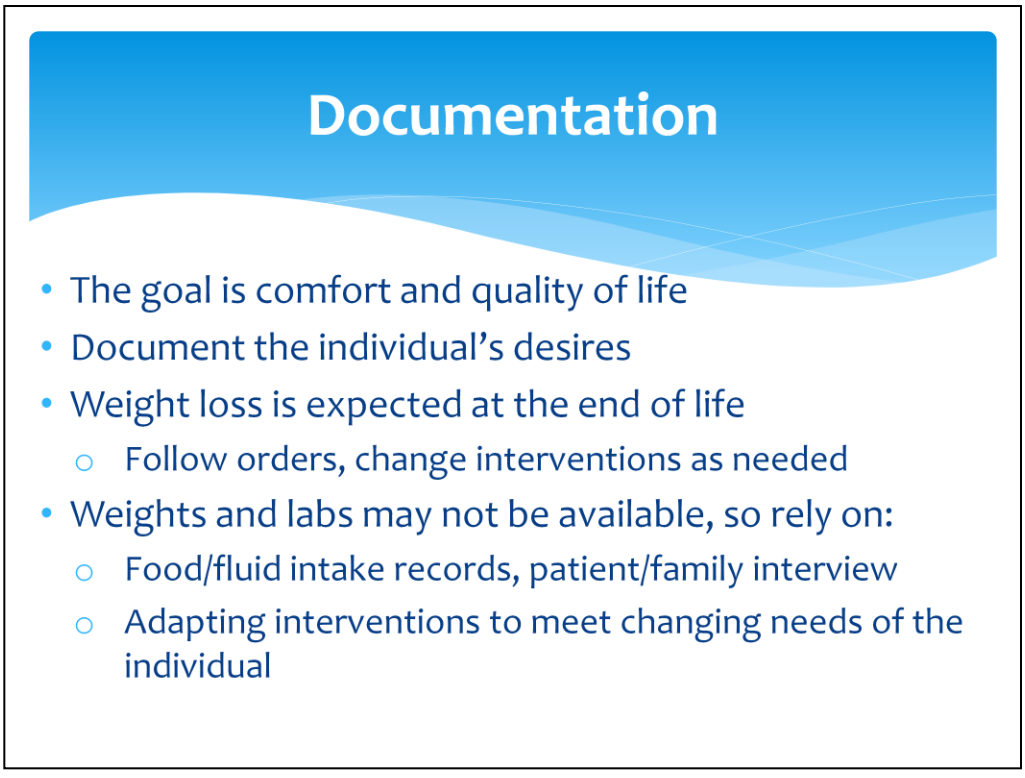
Encourage fluids as tolerated. Small frequent sips are best.

If fluids by mouth are not tolerated, an IV or tube feeding may be recommended.



These signs may be symptoms of dangerous fluid overload. Nursing assistants should report this to a supervisor:

- Puffiness
- Bloating
- SOB (Shortness of breath)
- Increased respirations
- Increased secretions



Documentation for Palliative Care

Remember that the goal is comfort (for the individual first, and also for the family). However, accurate and timely documentation of the individual's desires is important. Discussions with the individual and/or surrogate, IDT and ethics committee should be documented in the medical record. Develop a detailed care plan to address the needs/preferences of the individual and the expected outcomes of care.

Document that weight loss is expected and unavoidable at the end of life, and provide continual assessment/reassessment of symptoms and nutrition/hydration status. Outline interventions ordered, reassess status, and change interventions as needed. Food and fluid intake and acceptance of interventions should be included in periodic progress notes and/or changes to the care plan.

Weights and labs may be discontinued in an attempt to keep the individual comfortable, so rely on other information for documentation: food/fluid intake records, patient/family interview. Note how interventions are being adapted to meet the changing needs of the individual, etc.

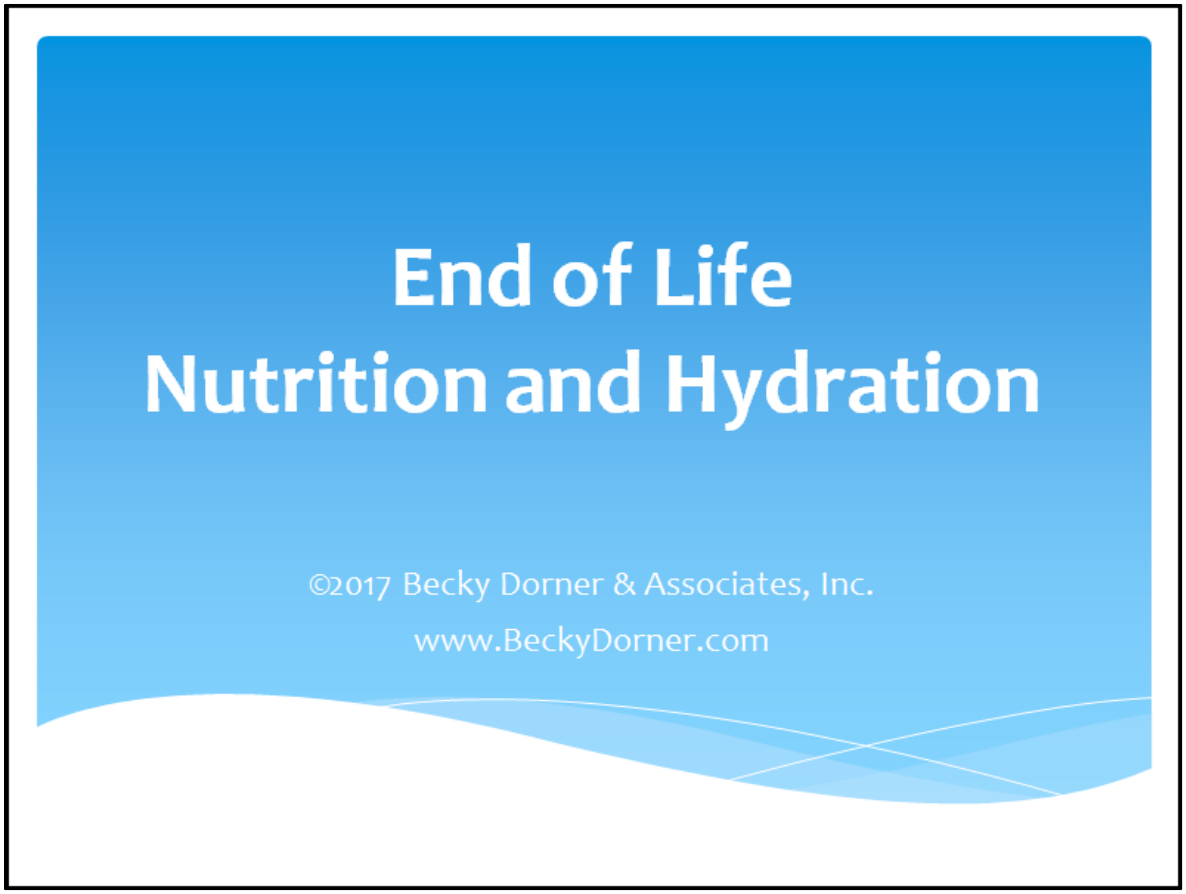
Our role is to:

- Provide educated and compassionate care.
- Use careful and ethical decision-making.
- Follow established protocols.
- Involve individual/family and care team in decision-making.
- Help individual/family understand benefits vs. burdens of nutrition interventions.
- Implement palliative interventions and revise as necessary, to meet the individual's needs/choices to maintain comfort and quality of life.

Presenter Notes:

Questions and Answers.

Optional: Post-test.


End of Life
Nutrition and Hydration
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Handouts

End of Life Nutrition and Hydration

Objectives

1. Obtain a basic understanding of advance directives for nutrition and hydration
2. Understand the need to continue to offer interventions even if a person is on hospice care
3. Outline some basic nutrition interventions to help manage end of life conditions (i.e. anorexia, dry mouth)

Difficult Decisions

- We are often faced with difficult questions from residents/patients and families related to nutrition and hydration at the end of life
- Every case is unique and must be handled individually with the patient, health care team and family all involved in decision making

Definitions

Our facility has established policies/protocols and written definitions for "do not resuscitate" (DNR), "no CPR" and "comfort measures only"

- Do Not Resuscitate
- No CPR
- Comfort Care

CMS on Advance Directives

- At end of life, a "Do not Resuscitate" does not indicate the individual is declining appropriate treatment and services
- Weight loss, pressure injuries, or dehydration may occur even if appropriate interventions are implemented (per the individual's wishes)
- The facility is expected to address the resident's concerns and offer relevant alternatives

Advance Directives

Help direct care when a person is unable to make their own decisions

1. Living Will - stipulates the type of care the individual desires to sustain life including use of feeding tubes
2. Durable Power of Attorney (DPOA) for health care – identifies the individual's surrogate or proxy, who will make health care decisions when the individual is not capable of making their own decisions

Declining Status

- A declining status alerts the IDT to conduct a comprehensive assessment, medical record review, revise interventions
- End-of-life decisions should be initiated only after the IDT is confident that all other approaches, interventions, and considerations have been examined, implemented and exhausted

Determining Whether Tube Feeding Is Appropriate

- If all interventions have been implemented and exhausted, review the advance directive documents
- If there are no advance directives for artificial nutrition and hydration (tube feeding), and these interventions are necessary to sustain life, the IDT should consult with the individual or surrogate to determine wishes

Comfort Care

- If the individual and/or surrogate are in agreement, the physician can write an order for "comfort measures only" or "palliative care"
- Hospice care may be initiated, if desired
- Honor the individual's wishes; provide care according to the physician's orders

Prior to Feeding Tube Placement

- Identify individuals at risk for malnutrition
- Provide enough assistance in eating (cue to eat, assistive devices, assist with eating, or feed if needed)
- Therapy to improve swallowing skills
- Determine cause of decreased oral intake, weight loss or malnutrition
- Follow RDN recommendations

Having the Nutrition Discussion

- Inform the individual /surrogate of the ability to implement an advance directive (including nutrition and hydration)
- IDT discusses with the individual and/or family
- The discussion includes options for nutrition and hydration based on the individual's desires

Hospice Philosophies

- Care is controlled by the individual (Person centered)
- The individual guides the decisions for ongoing care
- Caregivers provide compassionate care
- Caregivers need to change their mindset from curative and therapeutic to comfort and support
  - Managing symptoms, pain management, comfort and quality of life become the focus

Nutrition Care at the End of Life

- Promote quality of life
  - Dignity, choice, decision making, accommodate needs
- Minimize diet restrictions to help maximize food and fluid intake
- Remain flexible and make food available at any time the individual may want to eat

Make Dining as Pleasurable as Possible

- Encourage pleasure in eating by honoring food and meal/snack time preferences
- Encourage to eat and drink small amounts of preferred food and fluids when alert and awake - but do not force food or fluids
- If intake is poor, reassure the individual and family and allow the person to do what is comfortable

Chronic Pain

- Unintended weight loss and malnutrition may occur due to:
  - Chronic pain may decrease desire to eat
  - Pain can change eating patterns
- Meals may need to be timed to coincide with the person's alertness

Anorexia (Lack or loss of appetite for food)

- Identify/address treatable causes of anorexia and cachexia (pain, depression, GI issues, cognitive impairment)
- Offer favorite foods when food is desired
- Offer nutrient dense foods/supplements
- Try 6 small meals a day, or offer food every few hours
- Monitor weight weekly if anorexia is severe

Dry Mouth

- Provide good oral care (frequent swabbing or brushing)
- Offer sips of fluids frequently
- Offer ice chips
- Sorbets, lemon ice, sherbet with meals or in between
- Lemon drops may help

Nausea

- Offer small meals, snacks
- Eat slowly/chew well
- Try "dry meals" with liquids between meals
- Do not force feed
- Avoid favorite foods when nauseated
- Remain upright for 30-60 minutes after eating
- Avoid fatty/fried foods, heavy sweets, spicy foods and foods with very strong odors
- Offer foods/fluids the person will agree to eat
- The following may help:
  - Cold foods
  - Lemon-lime soda, ginger ale
  - Peppermints or spearmints

Constipation

- Offer and encourage plenty of fluids
- Encourage activity/movement
- Offer high fiber foods: Fruits, vegetables, whole grains, bran cereal, prunes or prune juice
- Hot beverages may act as stimulants
- Increase fiber intake gradually to avoid problems with tolerance

Diarrhea

Foods/Beverages to Avoid
- Carbonated beverages, liquid with meals
- High fiber foods, greasy foods, fatty or fried foods
- Raw fruits and vegetables
- Spicy foods
- Very hot or cold items
- Limit caffeine (coffee, tea, cola, chocolate, etc.)

Try These Approaches
- Small, Frequent Feedings
- Fluid between meals
- Starches: rice, noodles, cream of wheat, white bread
- Fruits/Veg.: pureed cooked or canned; grape/apple juice, ripe bananas
- Yogurt, eggs, poultry, tender lean beef, cottage cheese

Dehydration

- Encourage fluids as tolerated
- Small frequent sips are best
- If fluids by mouth are not tolerated, an IV or tube feeding may be recommended

Fluid Overload: Symptoms

Report these symptoms to your supervisor:
- Puffiness
- Bloating
- SOB
- Increased respirations
- Increased secretions

Documentation

- The goal is comfort and quality of life
- Document the individual's desires
- Weight loss is expected at the end of life
  - Follow orders, change interventions as needed
- Weights and labs may not be available, so rely on:
  - Food/fluid intake records, patient/family interview
  - Adapting interventions to meet changing needs of the individual

Summary

- Provide educated and compassionate care
- Use careful and ethical decision-making
- Follow established protocols
- Involve individual /family and IDT in decision-making
  - Help the individual/family understand benefits vs. burdens of nutrition interventions
- Implement palliative interventions and revise as necessary, to maintain comfort and quality of life

Pre/Post Test

True/False ***(Circle your choice)***

1. At end of life, the presence of a "Do not Resuscitate" order is not sufficient to indicate the resident is declining appropriate treatment and services.
   True **False**

2. The facility is expected to address the individual's concerns and offer relevant alternatives.
   True **False**

3. The physician is the most important decision maker when it comes to end of life nutrition and hydration care.
   True **False**

4. Unintended weight loss, malnutrition and/or dehydration may by be expected outcomes.
   True **False**

5. It is important to continue all dietary restrictions to help maximize food and fluid intake.
   True **False**

6. If intake is poor, tell the family to try encourage the individual to eat and drink at least 50% of all meals/snacks.
   True **False**

7. Anorexia is a lack or loss of appetite for food that we cannot do anything about.
   True **False**

8. Providing good oral care can help people with dry mouth.
   True **False**

9. We should encourage small sips of fluid often as tolerated.
   True **False**

10. We should implement interventions to meet the individual's needs/choices to maintain comfort and quality of life.
    True **False**

Pre/Post Test Answer Key

1. **True**
2. **True**
3. **False**
4. **True**
5. **False**
6. **False**
7. **False**
8. **True**
9. **True**
10. **True**