



# A palliative care approach to nutrition and hydration

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Managing the practical, ethical, and emotional issues associated with loss of appetite and weight loss in residents who have an advanced life-limiting illness can be complex and challenging for the residential aged care team. Family members often experience distress when they see their loved one eating and drinking less, losing weight, and becoming increasingly frail, and may say to care staff “*Why is this happening and can anything be done?*”, “*How will staff be able to care for my loved one when they can no longer eat or drink?*”, or “*You can’t just let them starve to death*”.

Access the PA Toolkit at:  
[www.caresearch.com.au/  
PAToolkit](http://www.caresearch.com.au/PAToolkit)

## Causes of nutritional deficiency in older people

Poor nutritional status and unintentional weight loss are common in older people with advanced life-limiting illness. The causes, which are multifactorial and not well understood, may include a decreased sense of smell and taste, reduced chewing efficiency, gastrointestinal changes, and dysphagia.<sup>1</sup> Swallowing deficits are a feature of advanced neurological disorders (e.g. Parkinson’s disease, stroke, dementia) and are due to sensory and motor disturbances in the brain as well as progressive weakness of the muscles of the face, mouth, tongue, and oropharynx. Alterations in the production of particular chemicals and hormones also impact on

nutritional intake by prolonging feelings of gastric fullness and decreasing the sensation of hunger.<sup>1,2</sup> A study of individuals receiving a palliative approach explored whether a decrease in oral intake adversely affected their quality of life; however, they reported that they did not experience hunger and remained comfortable on sips of fluid only.<sup>3</sup> While many of the factors that contribute to loss of appetite and weight loss are due to irreversible age-related physiological changes, there are other causes such as ill-fitting dentures, broken teeth, gum disease, oral thrush, poorly controlled symptoms, depression, and medications (e.g. opioids, anticholinergics), which, if identified, may be managed.<sup>3,4</sup>

## Assessment and management of oral feeding problems

Oral feeding problems can manifest as progressive weight loss, frequent coughing and spluttering, prolonged meal times, drooling, withdrawal at meal times, and respiratory problems such as chest infection caused by aspiration.<sup>1</sup> When a resident first exhibits any of the above signs it is essential that a systematic assessment is carried out by the multidisciplinary team. The PA Toolkit ‘Module 3: Clinical Care’ provides an assessment tool called ‘Meals on Wheels’ to assist the care team to identify potentially reversible causes of poor nutritional status. The resident’s nutritional care plan

should consider the resident’s prognosis and the severity of the oral feeding problem, and must be in line with the resident’s and family’s stated goals of care.

### Use of oral supplements

A systematic review found that undernourished older people may experience a small but consistent weight gain and a reduction in mortality following the introduction of oral nutritional supplements. However, the review found little evidence of improvement in functional benefit or reduction in length of hospital stay following introduction of oral supplements and concluded that further

studies are required to support their beneficial effect.<sup>5</sup> A recent prospective randomised control trial studying the effect of oral nutritional supplements in combination with physical therapies was able to demonstrate an improvement in functional independence in older, acutely ill, hospitalised patients.<sup>6</sup> There is evidence that dietary advice with or without oral nutritional supplements may decrease complications associated with undernutrition.<sup>7</sup> Early referral of residents who are showing signs of undernutrition to a dietitian has been shown to have positive outcomes.<sup>8</sup>

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For residents who are still able to tolerate oral intake there are a number of approaches that may assist with increasing nutrient intake. These include:

- providing small, frequent meals of familiar and preferred foods, and encouraging snacks
- increasing the nutrient density of meals by adding milk powder, grated cheese, margarine, or cream
- providing nourishing fluids such as milk drinks, smoothies, and juices.<sup>3,4</sup>

### Artificial nutrition and hydration

There is no quality evidence to support the benefits of PEG feeding in residents with advanced life-limiting illness. It has not been shown to be effective in improving nutrition, maintaining skin integrity, preventing aspiration pneumonia, improving functional status, or extending life.<sup>4</sup> It is considered legally and medically acceptable for a resident and/or their substitute decision maker to voluntarily choose to discontinue artificial nutrition and hydration at end of life when this treatment no longer provides benefit or contributes to quality of life.<sup>9</sup> If a resident experiences a potentially correctable cause of dehydration, such as recurrent vomiting or diarrhoea or a

delirium, rehydration should be considered and, if appropriate, instigated as a short-term measure. There is no evidence to support rehydration at end of life where a resident has lost the ability to swallow and/or is experiencing fluctuating levels of consciousness. In general, rehydration does not improve symptoms or quality of life<sup>10</sup>, and may lead to fluid overload or even prolong the dying process.<sup>4</sup>

### Comfort feeding

Some oral feeding strategies focus on providing sufficient nutrition to optimise the resident's comfort rather than specifically increasing oral intake and weight. These include: modifying food and fluid by changing the texture, consistency, and quantity; introducing manoeuvres or

exercises that can improve ability to swallow; and using positioning and postural techniques, as well as using behavioural and cognitive strategies for residents with dementia.<sup>4</sup> As the resident approaches end of life their care plan should include instructions for the continuation of careful hand feeding. This involves an experienced staff member using the strategies mentioned above to hand feed, as long as it is not causing the resident distress.<sup>11</sup> If the resident's ability to swallow is severely compromised, or their level of consciousness fluctuates, the care plan is again modified with an increased focus on continuing frequent and assiduous mouth care, good symptom management, gentle and mindful nursing care, and support for the family.

**In summary:** Families are often concerned that their loved one will experience distress associated with hunger and thirst if they are unable to eat and drink as they approach the end of life. Discussions about the impact of ageing and disease progression on nutrition and hydration should take place with the resident and their family at the earliest opportunity to give them time to make informed decisions that are in line with the resident's goals and preferences for care.

<sup>1</sup> Norman K et al. (2008) *Clinical Nutrition*. 27: 5-15. doi:10.1016/j.clnu.2007.10.007

<sup>2</sup> Ahmed T, Haboubi N (2010) *Clinical Interventions in Aging*. 5: 207-16. doi: 10.2147/CIA.S9664

<sup>3</sup> Australian Government Department of Health and Ageing (2006). Guidelines for a Palliative Approach in Residential Aged Care.

<sup>4</sup> Royal College of Physicians and British Society of Gastroenterology (2010). Oral feeding difficulties and dilemmas: A guide to practical care, particularly towards the end of life. London: Royal College of Physicians.

<sup>5</sup> Milne AC et al. (2009) *Cochrane Database of Systematic Reviews*. Issue 2, Art No.:CD003288. doi: 10.1002/14651858.CD003288.pub3

<sup>6</sup> Hegerov P et al. (2014). *Nutrition*. 31(1): 166-70. doi:10.1016/j.nut.2014.07.010

<sup>7</sup> Baldwin C, Weekes CE (2011) *Cochrane Database of Systematic Reviews*. Issue 9, Art No.:CD002008. doi:10.1002/14651858.CD002008.pub4.

<sup>8</sup> Schneyder A (2014) *Australian Prescriber*. 37(4):120-3.

<sup>9</sup> Fidelis M, Manalo C (2013) *Palliative Care: Research and Treatment*. 7:1-5. doi: 10.4137/PCRT.S10796

<sup>10</sup> Bruera E et al. (2013) *Journal of Clinical Oncology*. 31(1): 111-18. doi: 10.1200/JCO.2012.44.6518

<sup>11</sup> Palecek EJ et al. (2010) *Journal of American Geriatrics Society*. 58(3): 580-4. doi: 10.1111/j.1532-5415.2010.02740.x

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