Best Practices in Nutrition Care at End-of-Life

End-of-Life Care Summary

- People continue to receive food and fluids in the end-of-life phase, but the emphasis is on quality of life and symptom relief rather than active nutritional therapy or prolonging life.
- Conversations and education about end-of-life issues are initiated early with the person in the diagnostic and treatment stages rather than waiting until the dying process has begun. Family is included if the person wishes this, or if the person is not capable. Families should understand the physiological progression at end of life.
- Hydration interventions may be limited as artificial hydration may lead to suffering, restricted movements and prolonging the dying process due to increasing pulmonary secretions, increased urinary output, nausea, vomiting, and edema.
- Benefits of dehydration in the dying process include reduced lung secretions/less coughing, reduced edema or ascites, reduced nausea and vomiting, and less urine output. Symptoms of dry mouth can be managed with ice chips, lip balm, and moistened swabs.
- Tube feeding for people with dementia at end of life has not been shown to confer any benefit regarding nutritional status, reduction of pressure sores, mortality risk or survival time, although this may depend on the resident's mental and physical status and expected duration of life.
- The person's expressed desire for care at the end of life is the primary guide for determining the extent of nutrition and hydration interventions and the focus is on quality for life and symptom relief.

Assessment

- The RD functions as part of the Interdisciplinary Care Team, which includes the resident and/or next of kin/SDM, when formulating plans for end-of-life care. The team must take into account the cultural, social, psychological and spiritual needs and wishes of the resident.
- Frequent monitoring is needed to ensure that interventions are meeting the needs of the resident and family.
- A person's status and individual needs and wishes can change quickly.

Interventions

- Providing pleasure feeding and oral hydration may be therapeutic, consider a pleasure feeding only diet order as an alternative to NPO orders. This diet order can include foods and fluids that the resident prefers and therefore provides the person with the comfort and pleasure of eating, without consideration of diet, weight, and nutritional status.
- Careful and slow hand feeding when the person is alert and in a safe body position (upright with chin tuck) minimizes the risk of choking or aspiration.
- The person is provided with one small teaspoon or one small bite of food at a time, while watching for swallowing to take place. There may be a gradual decrease in intake as end-of-life approaches.
- If the person is coughing or has shortness of breath, wait until normal breathing has resumed and the person confirms that they are ready to restart feeding.

Resources

- Best Practices for Nutrition, Food Service and Dining in Long-Term Care
- Position of the Academy of Nutrition and Dietetics: Individualized Nutrition Approaches for Older Adults: Long-Term Care, Post-Acute Care, and Other Settings
- NOSH: Nurses Optimizing Supportive Handfeeding
- Advance Care Planning | Texas Health and Human Services
- Advance Directives | Texas Health and Human Services
- Palliative Care | Texas Health and Human Services
- Advance Care Planning: Ensuring Your Wishes Are Known and Honored If You Are Unable to Speak for Yourself (cdc.gov)
- American Academy of Hospice and Palliative Medicine Statement on Artificial Nutrition and Hydration Near the End of Life