Nutrition in palliative care/towards the end of life

Information and advice for healthcare professionals, carers and patients

Nutrition and Dietetics

As this group of patients have varied needs, their dietary/supplement requirements should be assessed on an individual basis and may need multi-disciplinary input. **Overall priority should be given to the enjoyment of nourishing food and drinks to enhance quality of life.** As always, the patient should remain the focus, with carers giving support where able.

Loss of appetite is often a further source of stress or anxiety to all. It must be highlighted to the patient, the carers and family that loss of appetite is an expected common change as people approach end of life. They can be reassured that care will be adjusted appropriately, with the main focus on enabling comfort and quality of life.

Speech and language therapy may be involved to offer advice for eating and drinking at the end of life for comfort. Eating and drinking with acknowledged risk (EDAR) means acknowledging and accepting the risks that someone with swallowing difficulties has when eating and drinking by mouth. The main risk is around food and drink going the wrong way down towards the lungs. This can cause coughing, choking and chest infections. By accepting this risk, the individual continues to be provided with food and drink for comfort.

Stage 1: Early palliative / end of life care nutritional management

Although the patient has been diagnosed with a terminal illness, they may still have months or years to live and be having treatment to help improve quality of life. **Nutritional screening and assessment is a priority, as early intervention could help improve response to treatment and in some cases reduce potential complications. Any prescribed oral nutritional supplements (ONS) need to be taken consistently, as per prescription instructions, to benefit nutritional status and well-being.**

Stage 2: Late palliative care / end of life nutritional management

Symptoms such as pain, weakness, nausea, and poor appetite are likely to increase. **Patients should be encouraged to eat and drink the foods and fluids they enjoy.** Nutritional content of meals is not a priority, and the main emphasis should be put on addressing problematic symptoms and encouraging the patient to take foods they desire or find comforting. Nutritional goals should not be based on weight gain/maintenance or avoiding malnutrition (as this may not be possible), but on improving quality of life as best able. **At this stage nutritional screening and initiation of prescribed supplements is NOT recommended and aggressive feeding interventions can lead to discomfort and anxiety not only to the patient, but also the carers or family.** Do not feel the need to prescribe supplements for the sake of providing some form of intervention when other dietary recommendations have not been successful.

Stage 3: Very end stage / last days nutritional management

At this stage a patient is unlikely to have a desire for food or fluid, and may feel very weak. **Providing comfort for the patient should take precedence**, with food and/or fluid given as desired/tolerated, and regular mouth care provided.

Adapted from Palliative Care and ONS Prescribing Guidelines, Castle Point and Rochford Clinic Commissioning Group (2014) and Nutritional Management for Palliative Care Guidelines, Corby Clinical Commissioning Group, both of which have sourced their information from Macmillan Durham Cachexia Pack (2007).

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