NUTRITION, FOOD SERVICE & DINING IN LTC

The best practices within this document are recommendations to support regulatory compliance to Ontario LTC legislation, promote optimal nutrition and hydration care and support person centered care. It is important to note, however, that residents' rights and preferences are paramount and should be respected regardless of legislation or best practice. The best practice document is based on resources and expertise from industry professionals and where applicable, are evidence-based. This is a living document that will transition with the evolution of the industry over time.

SUBJECT: PALLIATIVE & END-OF-LIFE CARE	**Revised: 2023-07-18**
ONTARIO REGULATION 246/22 made under the FIXING LONG-TERM CARE ACT, 2021	
Nutritional Care and Hydration Programs	

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1. Purpose & Scope

- This palliative and end-of-life resource was developed for the long-term care interdisciplinary team to provide a supportive and resident centered approach to the nutrition and hydration aspect of palliative care and through the end stages of each resident's life.

2. Definitions and Key Concepts

- Palliative care is a philosophy of care that aims to relieve suffering and improve the quality of living and dying.
- Palliative care is a resident centered, holistic approach that focuses on supporting the resident and the families at all stages of the illness, focusing not only on treating an illness itself, but the impact that an illness has caused.
- Although palliative care can include end-of-life care, palliative care is broader and can last longer. When resident is receiving palliative care it does not necessarily mean they are at end-of-life. Some residents may be receiving palliative care for several years. End-of-life care offers treatment and support for people who are nearing the end of their life.
- Palliative care is a unique, personal journey. Resident wishes and goals must be the center of the plan of care and can begin as early as when they begin their long-term care stay.
- Conversations and education about nutrition and hydration end-of-life issues are most helpful when initiated early with the resident in the diagnostic and treatment stages rather than waiting until the dying process has begun. Power of Attorney/Substitute Decision Maker (POA/SDM) is included if the resident wishes this, or if the resident is not capable. Refer to the resource section to review the Self-Assessment Checklist from the Palliative Care Alliance. This tool kit supports organizational change.
- Palliative and end-of-life care:
    - Ensures that care is respectful of human dignity and supports meaningful living as defined by the resident
    - Tailors care planning to meet the resident's goals of care
    - Recognizes the individual with life-limiting disease and his/her family as the unit of care
    - Supports the family to cope with loss and grief during the illness and bereavement periods.
    - Respects the resident's personal, cultural and religious values, beliefs and practices
    - Values ethical principles of autonomy, beneficence, non-maleficence, truthfulness & confidentiality

- Recognizes the resident as autonomous, who has a right to end-of-life care and to make decisions regarding his/ her care to the degree he/she desires
- Recognizes the importance of a collaborative interprofessional team approach to care, and also recognizes the efforts of non-health-care professionals (e.g.: volunteers, faith leaders)

3. Practice Recommendations

a. The Registered Dietitian's (RD) Role in Palliative and End-Of-Life Care

- The RD functions as part of the interdisciplinary care team, which includes the resident and/or POA/SDM, when formulating plans for a palliative approach to care and/or end-of-life care.
- The team must consider the cultural, social, psychological and spiritual needs and wishes of the resident.
- RDs identify intake challenges/weight changes that are unlikely to resolve and may be related to a resident's life-limiting illness that may indicate progression to the next steps of the resident's plan of care.
- RDs should also support education around palliative and end-of-life care and the physiological changes that impact nutrition and hydration, as a resident progresses to end-of-life care. Education should focus on the resident and POA/SDM and can include the interdisciplinary care team.
- Making decisions around nutrition and hydration can often cause stress for the POA/SDM and family, so it is important that the RD is available to support and answer any questions that they may have as part of their decision-making process.

b. Nutrition & Hydration Considerations During Palliative Care

- Frequent monitoring may be necessary since the resident's status and individual needs and wishes can evolve as a resident is nearing end-of-life. Follow up assessments should be prioritized if food/fluid challenges are identified.
- NPO (nothing by mouth) orders are only used in cases where oral intake is causing great risk or distress affecting symptom management at end-of-life.
- A comfort feeding approach (focusing on enjoyment and not nutrients) can enhance quality of life at any stage in a resident's palliative or end-of-life journey. This approach can include:

  - preferred food/fluid to enhance the pleasure of eating
  - smaller portions
  - meal and snack time adjustments
  - removal of diet restrictions that may impact comfort or desire to eat
  - removal of weight and/or lab monitoring
- Swallow capability (dysphagia) may fluctuate and hence food and fluid textures may need to be altered based on resident wishes for quality of life and swallow strength. Many factors can cause this fluctuation including fatigue, cachexia and muscle wasting weakening swallow coordination. Symptoms can include:
  - difficulty chewing or coughing or choking on thin fluids
  - wet sounding voice after eating or drinking
  - regurgitation
  - pocketing of foods in cheek area
  - prolonged chewing
  - delayed swallowing

- The RD can discuss benefit versus risk of feeding options for informed decision making while reducing discomfort to enhance quality of life for the resident.

- Mealtime interventions to enhance comfort may include hand feeding when the resident is alert and in a safe body position, minimizing the risk of choking or aspiration. There is commonly a gradual decrease of food/fluid intake as end-of-life approaches.

- If the resident is coughing or has shortness of breath during feeding, staff are to be instructed to wait until normal breathing has resumed and the resident confirms that he/she is ready to restart.

- Residents may choose to “eat at risk” and tolerance of food/fluid may fluctuate. This is part of the Resident’s Bill of Rights, and the proper process should be followed for informed consent. Refer to the Consent to Treatment Best Practice for more detail. Feeding instructions should be clearly outlined in the plan of care to reduce risk of aspiration or choking.

- Good oral care is important to ensure residents’ safety and quality of life. Mouth care post meals is recommended for anyone that has difficulty clearing food after eating. Research indicates that if good mouth care occurs, residents have reduced risk of the ill effects of terminal dehydration.

- Other strategies to support the palliative care approach may include discontinuing monthly weights, vitamin/mineral supplements, and oral nutritional supplements unless these are requested to be continued by the resident or POA/SDM. The plan of care should reflect any changes to nutrition monitoring with detailed progress notes explaining the reasoning.

c. Nutrition & Hydration Considerations During End-Of-Life Care

- The physician/nurse practitioner or applicable medical team member, along with the support of the interdisciplinary care team, monitor all residents receiving palliative care for any signs of progression toward end-of-life.
- The RD is involved and reassesses the current goals of care and interventions in place during palliation and work collaboratively with the resident, POA/SDM and care team to adjust as required.
- Residents continue to receive food and fluids as they approach the end-of-life phase, with the emphasis on quality of life and symptom relief rather than active nutritional therapy or prolonging life
- The body naturally decreases food/fluid needs as a part of the natural dying process at end-of-life
- It is Best Practice to have conversations and education about nutrition and hydration end-of-life issues as early as possible after the transition to long-term-care. Once a plan of care is established, these wishes can be implemented as part of end-of-life care. This can alleviate much of the stress and burden on the POA/SDM knowing that their loved one's wishes are being honored.
- The resident'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.
- Families should be provided education around the physiological progression at end-of-life, including the natural decrease in appetite/intake and changes in swallowing ability throughout the dying process
- They should also be provided education around the misconceptions around dehydration and the dying process. Hypodermoclysis or intravenous therapy is often contraindicated at end-of-life.

d. Artificial Nutrition and Hydration at End-Of-Life

- Hydration interventions are limited as artificial hydration may lead to suffering, restricted movements and prolonged 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 as tolerated, lip balm, and moistened swabs for oral care.

- Artificial nutrition and hydration are considered when in the best interest of the person.
- 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 RD plays an important role in educating the resident, the POA/SDM and the staff on these areas to support informed decision making.

e. Education on Palliative and End-Of-Life Care

- The RD's role as an educator in palliative and end-of-life care is important to support an understand of nutrition and hydration changes as residents progress through the final stages of life.
- The RD should be involved in education for residents and POAs/SDMs, but also in more formal education for staff and the health care team as deemed necessary.
- To best support the residents and their families during these challenging times, all staff should understand the palliative approach from a clinical perspective, but also from the perspective of nutrition and hydration and the human element of meeting these needs during these times. Working collaboratively with the health care team enhances this support.
- It is recommended that this education be part of all long-term care onboarding and orientation resources for all disciplines.

4. Home Specific Policies, Roles & Responsibilities

- Policies and procedures are in place that outline the processes for managing a palliative approach to care and end-of-life care for individual residents.
- The RD should be involved in policy development for palliative and end-of-life care.
- Utilize these Best Practices to guide your home specific policies, roles, and responsibilities. Home specific polices take precedence over this document.

5. Resources & Tools

a. Palliative and End-Of-Life Resources

- **Palliative Care Alliance. Quality Palliative Care in Long Term Care. Tools and Resources for Organizational Change – Long Term Care Tool Kit**.
  https://www.palliativealliance.ca

- **Centre for Learning, Research & Innovation in Long-Term Care (Ontario CLRI) - Provincial Palliative Care Resource Libraries**.
  https://clri-ltc.ca/resource/spc/

- **Serious Illness Conversation Guide with Substitute Decision Makers**. Vancouver Coastal Health.
  https://www.vch.ca/sites/default/files/import/documents/RPACE_serious_illness_conversation_guide_with_substitute_decision_makers.pdf

- **Dealing with Difficult Family Conversations Using SPIKES model** – Care home support
  https://www.youtube.com/watch?v=dIY74fyOod0

- **Wish-Worry-Wonder Empathic Communication Strategy** - CAPCE program – Communication Supports Framework (2020)
  http://palliativecareswo.ca/docs/Communication-Support-Tools-Framework.pdf

- **Palliative Care Resources: Pallium Canada.** To support health care professionals in being able to provide a palliative care approach to patients and families, Pallium is collaborating with partners and subject matter experts from across Canada to create and compile palliative care resources.
  https://www.pallium.ca/palliative-care-resources/

- **Hospice Palliative Care Ontario – Improving Patient Centered Conversations.**
  https://www.pcdm.ca/

- **Hospice Palliative Care Ontario – Palliative Education in Long Term Care.**
  https://www.hpco.ca/ltc/

b. **Palliative and End-Of-Life Courses**

- ***Fundamentals of Hospice Palliative Care "Core" Program.***
  https://www.palliativecareswo.ca/programs-fundamentals.html

- ***LEAP Pallium Canada Core Program***
  https://www.pallium.ca/course/leap-core/

c. Palliative and End-Of-Life Clinical Tools

- **Tools to Support Earlier Identification of Palliative Care**. Ontario Palliative Care Network. https://www.ontariopalliativecarenetwork.ca/resources/tools-support-earlier-identification

- **Article: End-of-life Nutrition**. July 2020. The Geriatric Dietitian by Katie Dodd. https://thegeriatricdietitian.com/embracing-hospice-end-of-life-nutrition/

- **B.C. Inter-Professional Palliative Symptom Management Guidelines**. BC Centre for Palliative Care. 2017. https://www.bc-cpc.ca/all-resources/hcp-resources2/?audience_role=Allied%20Health

- **Registered Nurses' Association of Ontario (RNAO) End-of-life Care During the Last Days and Hours.** Sept 2011. https://rnao.ca/bpg/guidelines/endoflife-care-during-last-days-and-hours

- **A Palliative Approach to care in the last 12 Months of Life** https://rnao.ca/sites/rnao-ca/files/bpg/PALLATIVE_CARE_FINAL_WEB_2.pdf

- **Artificial Nutrition and Hydration at End-of-life (Webinar)**; Palliative Pain and Symptom Management Consultation Service. Durham Region. June 2022 https://durham-region-ppsmc-education.constantcontactsites.com/webinars

- **Resource: When is the right time to stop tube feeding?** Canadian Virtual Hospice. https://www.virtualhospice.ca/en_US/Main+Site+Navigation/Home/Support/Support/Asked+and+Answered/Decision+Making/When+is+the+right+time+to+stop+tube+feeding_.aspx

- **Article: Palliative Care and the Elderly: Seeking Quality and Meaning over Longevity**. Breanne Drury. Canadian Society of Nutrition Management News. Spring 2019. https://seasonscare.com/palliative-care-for-the-elderly-by-breanne-drury-rd-bsc-mhsed-cand/

- **The Ontario palliative care competency framework: a reference guide for health professionals and volunteers April 2019**. https://www.ontariopalliativecarenetwork.ca/resources/palliative-care-competency-framework

6. Evidence & References

- **Ministry of Long-Term Care. Palliative Care**
  https://health.gov.on.ca/en/public/programs/palliative/palliative_questionsandanswers.aspx

- **World Health Organization.**
  https://www.who.int/news-room/fact-sheets/detail/palliative-care

- **ESPEN practical guideline: Clinical Nutrition and hydration in geriatrics** 41 (2022) 958-989.
  https://www.espen.org/files/ESPEN-Guidelines/ESPEN_practical_guideline_Clinical_nutrition_and_hydration_in_geriatrics.pdf

- **End-of-Life Care – Understanding the RD's Role**. Katie M. Dodd. Today's Dietitian The Magazine for Nutrition Professionals
  https://www.todaysdietitian.com/newarchives/0317p36.shtml

- **How dietitians address palliative care**. Caresearch. Palliative Care Knowledge Network. Government of Australia.
  https://www.caresearch.com.au/tabid/6804/Default.aspx