



## Symptom Management

### Introduction

#### Purpose

This resource will assist staff to provide care for the physical symptoms commonly experienced by a resident in the palliative phase of ageing. The symptoms to be covered in this resource are nausea and vomiting, bowel care, nutrition and hydration.

### Learning outcomes

#### Learning outcome 1

Implementation of planned care to achieve identified outcomes.

1. Discuss how the outcomes of a resident's care plan may change when a resident enters the palliative phase of ageing
2. Describe the difference between a care plan and an advance care plan
3. Discuss the importance of ongoing assessment in developing care plans

#### Learning outcome 2

Assist in managing physical symptoms.

1. Describe symptoms other than pain, which may affect the comfort of a resident
2. Describe how the resident's nutrition and hydration needs, appropriate to a palliative approach, can be determined by the care team in consultation with the resident and his/her family
3. Discuss how decisions about artificial feeding and hydration can be made in accordance with the resident's wishes
4. Outline how a resident's bowel care requires individually tailored treatments that take into account dignity and comfort of the resident
5. Discuss the importance of providing the resident and/or family with support and accurate information regarding symptom management
6. Describe the importance of oral care in meeting resident comfort needs

## Overview of symptom management

Residents in residential aged care facilities (RACFs) who experience physical symptoms other than pain require holistic care that focuses on detailed assessment and review. The resident's priorities and goals for treatment are central to a palliative approach. Symptom assessment needs to be an ongoing process which is supported by validated and reliable assessment tools.

Effective symptom management relies on detailed assessment. A detailed assessment includes: review of possible causes, the history of the symptoms and the impact of the symptoms on each resident's daily function.

Central principles to assessment should be ongoing, not a single event and ideally based on the self report of the resident or where this is not possible the report of an involved carer (significant other or staff). It is important that all relevant members of the aged care team provide input into assessment and provide clear documentation.

Effective symptom management focuses on the physical, psychological, social and spiritual and cultural domains in reflecting the goals of care of the resident and/or family. This management requires the use of validated assessment tools to provide a baseline of symptoms, to show effectiveness of intervention, and to provide documentation to support care planning.

RACFs already use a variety of tools to assess a resident's symptoms. Various tools that have been validated are outlined in the *Guidelines for a Palliative Approach in Residential Aged Care*, Chapter entitled: Physical Symptom Assessment and Management.

This resource contains 4 modules that will provide information on the symptoms frequently experienced by residents in RACFs requiring a palliative approach. The symptoms that will be covered include:

- Module 1 - Nausea and vomiting
- Module 2 – Bowel care
- Module 3 – Nutrition
- Module 4 – Hydration



Information on other symptoms is contained in *Guidelines for a Palliative Approach in Residential Aged Care*, Chapter entitled: Physical Symptom Assessment and Management

Therapeutic Guidelines: Palliative Care Version 2

## Effective symptom management for residents receiving a palliative approach in residential aged care facilities

Good symptom management is important in RACFs as it ensures comfort for residents as they approach the end of life. Effective care also provides reassurance to family members and significant others that their loved ones are able to remain comfortably in the facility where they live. The philosophy of aging in place supports this goal.

The *Guidelines for a Palliative Approach in Residential Aged Care* provides evidence-based information to support effective symptom management. This educational resource on symptom management utilises the *Guidelines* to assist with the provision of a palliative approach in RACFs.

You are encouraged to have access to a copy of *Guidelines for a Palliative Approach in Residential Aged Care* while completing this resource. This will be referred to as the *Guidelines*.

Note that two editions of the *Guidelines for a Palliative Approach in Residential Aged Care* exist. These are the original edition published in May 2004 and the Enhanced version published in May 2006. Users of this resource should use the guideline references that apply to the edition they have access to. The differences between the two versions are small and will significantly change

Please note the Enhanced Version May 2006 of *The Guidelines* can be assessed through [www.pallcare.org.au](http://www.pallcare.org.au).

### **Implementing the palliative approach**

Effective symptom management relies on early assessment, care planning with accurate documentation and regular review of care. Clear documentation assists the aged care team to provide quality care. It is necessary for the team to receive education and support in a palliative approach to symptom management in order to provide care that helps to maintain good quality of life for residents.

Quality assurance activities that review current practice can assist in the implementation of a palliative approach. Communication of these quality activities between RACFs can further enhance implementation.

### **Overcoming potential barriers in the implementation of a palliative approach**

Management of the symptoms related to nutrition and hydration can pose ethical issues for residents, family members and staff. The *Guidelines for a Palliative Approach in Residential Aged Care* can assist in discussions with residents and family members by providing validated information in order to assist with decision making.

Effective management of difficult symptoms poses challenges for the aged care team. Use of Chapter entitled Physical Symptom Assessment and Management in the *Guidelines for a Palliative Approach in Residential Aged Care* and consultation with palliative care teams facilitates quality aged care and promotes efficiency in resource management. Along with education, staff require adequate resources in order to provide a palliative approach to residents.

## Module 1: Nausea and vomiting

Nausea is the unpleasant, subjective feeling of the need to vomit. It is sometimes prolonged and can be less easy to control than vomiting. Vomiting is the expulsion of stomach contents from the mouth caused by the forceful contraction of the abdominal muscles and diaphragm. Nausea can occur without vomiting (the reverse is also true). It is important to try to identify the cause of nausea or vomiting in order to effectively manage the symptoms.

### Causes of nausea and vomiting

- Iatrogenic – (medically induced) medications, chemotherapy, radiotherapy
- Metabolic – (process or change at a cellular level) hypercalcaemia, urinary tract infection, altered taste
- Organic – (structural alteration) constipation, bowel obstruction, gastritis
- Psychological – anxiety, anticipatory
- Other – odours from food, wounds, toxicity from some medications such as digoxin



A major cause of nausea for residents in RACFs is constipation. Other causes may also be affected by common factors such as:

- reduced fluid intake
- low fibre diet
- decreased mobility

Residents may experience nausea and vomiting from conditions associated with cardiac and renal failure and a number of other co-morbidities can impact.

Nausea and vomiting can be a learned response such as in relation to chemotherapy and can be associated with anxiety.

Some medications can have the effect of slowing gastrointestinal motility due to colonic (large bowel) slowing or gastroparesis (slowing of the upper gastrointestinal tract). Poor neuromuscular coordination can also have this effect and residents with diabetes, and those who have had a stroke and have nerve damage around the pharynx and epiglottis may be particularly susceptible to this slowing effect. Positional changes due to weight loss in the neck that affects the upper pharynx can also have an impact on gastrointestinal motility and cause nausea and vomiting.



**Writing activity**

Think about lying down and eating a meal and continuing to lie down as the food is being digested. Do you think you would be comfortable?. What affect do you think this would have on nausea and vomiting?

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**Writing activity**

What foods provide fibre in the diet?

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**Writing activity**

List medications that may cause nausea?

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## Assessment of nausea and vomiting

Performing a thorough assessment on the cause of nausea in residents in RACFs is vital. Where possible, this assessment should involve the resident and family to gain a history of the resident's eating habits and previous nutritional difficulties. The possible effect of the resident's anxiety on nausea may also require consideration.

Consideration should be given to reversing possible causes of nausea: This may include:

- a review of medication and cessation of unnecessary drugs
- relaxation and behavioural therapies for nausea arising from anxiety
- small frequent meals and small amounts of liquids to reduce external pressure on the stomach
- minimisation of cooking smells and unpleasant odours

When assessing nausea and vomiting:

- Establish the history of the symptom
- Establish whether or not the resident is vomiting
- Obtain a description of the vomiting
- Find out what brings on the nausea or vomiting
- Establish if there is a pattern?
- Find out what eases the nausea or vomiting?
- Check for constipation



### Writing activity

What questions might you ask a family member in regards to an assessment on nausea and vomiting?

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## Non pharmacological interventions



Often it is difficult to determine the cause of nausea and/or vomiting when a person is in the end stages of life. However if the causes are known, it is necessary to weigh the benefit of the treatment against the potential burden on the resident.

It is recommended practice that before the prescription of anti-emetic drugs, the resident's environment should be assessed to reduce the stimulus for nausea.

Non pharmacological interventions include:

- environmental factors – fresh air in room, elimination of odours such as cooking smells, perfume etc
- careful food presentation – small helpings which are well presented
- avoid lying resident flat before and after meals
- maintain good mouth care. Regular care with water and toothpaste on a small soft toothbrush after meals will assist in keeping the mouth healthy. If the resident has the sensation of dryness the use of artificial saliva e.g. Oral Balance will assist with comfort
- diversional therapies such as relaxation with music, massage and perhaps meditation



### Writing activity

Reflect on a resident in your facility that is experiencing nausea. What could be some of the ways that you may address this nausea?

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## Module 1: RN extension

### Pharmacological management

An appropriate anti-emetic strategy should include the following steps:

1. Determine the probable cause(s) of nausea and/or vomiting.
2. Identify contributing factors
3. Discuss with medical officer to select an appropriate anti-emetic
4. Consider the possibility of toxicity of current medications
5. Determine a suitable route of administration to ensure that the drug reaches the site of action e.g. if resident is vomiting a subcutaneous injection or continuous infusion maybe required
6. Give anti-emetic drug before meals so it has time to take effect
7. Ensure careful titration of the dose, frequent reviews of the resident and regular provision of the anti-emetic.



Read suggested steps to be taken for an appropriate anti-emetic strategy in *Guidelines for a Palliative Approach in Residential Aged Care*, Chapter entitled Physical Symptom Assessment & Management

## Specific management of nausea and vomiting

Although it is not always possible to identify or correct the cause of nausea or vomiting, different specific therapies are used.

### Gastrointestinal

If the cause is gastrointestinal, such as poor gastric emptying then a prokinetic agent (e.g. metoclopramide or domperidone) should be used.

### Constipation

Constipation can cause nausea, although it is rare for vomiting to indicate a resident is constipated. While the underlying constipation is being managed, metoclopramide or haloperidol can be used.

Vomiting, especially if it is of a large volume or has a faecal smell can be a symptom of bowel obstruction. Referral to a medical officer for diagnosis and management is essential.



*Therapeutic Guidelines Palliative Care, Version 2, p.220*

### Hyperacidity

Hyperacidity can produce considerable nausea, heartburn, acidity or a bitter taste and has been associated with vomiting.

Treatment of hyperacidity can be accomplished by:

- non absorbable antacids (magnesium plus aluminium hydroxide preparations)
- antacids plus alginate preparations
- histamine H<sub>2</sub>-receptor antagonist (e.g. ranitidine)
- or a proton pump inhibitor (e.g. omeprazole).

### Psychological factors

Anxiety can cause nausea leading to an increase in sympathetic nervous system activity. Drug treatment with medications such as diazepam, alprazolam or lorazepam can block the physical manifestations of anxiety.

### Intracranial causes

Raised intracranial pressure related to cerebral tumour can cause nausea. Headache may or may not be present. Treatment includes the use of dexamethasone and if required, haloperidol or cyclazine.



Further information can be found in the *Therapeutic Guidelines: Palliative Care, Version 2, pp.211-216.*

### Case study - Nausea and vomiting

Frances is an 84 year old lady who has been living in your RACF for the past two years. Prior to her admission she lived at home alone until her short-term memory worsened and she was unable to care for herself. She has a supportive family but they are unable to visit her regularly.

Frances' general health is good. For the past two weeks she had been experiencing constant nausea but not vomiting. Consequently she has not been interested in food and fluids, and is refusing to enter the dining room or receive meals in her room. Staff were alerted to her nausea but as Frances was still mobile, no investigation was made. Her family was advised of the constant nausea when they made one of their weekly telephone calls, however they were not overly concerned.

Eventually Frances refused to get out of bed. She explained she was too weak to stand and complained of abdominal discomfort. The Registered Nurse was alerted to Frances' condition and a thorough assessment was performed. Through this assessment it became evident that Frances was severely constipated. The constipation was treated with laxatives and Frances was commenced on a high fibre diet and encouraged to drink more.

Consider what are the other possible causes of nausea for Frances?



#### Reflection

Reflect on the timeliness of assessment.



#### Reflection

Reflect on the treatment.

### Summary box – Nausea and vomiting

- Nausea is feeling the need to vomit. Vomiting is expulsion of stomach contents from the mouth.
- Assessment includes history of eating habits, medications and other contributing factors such as diagnosis.
- Major causes of nausea are constipation and medication side effects.
- Anti-emetic strategy – determine probable cause, suitable route of administration, titration of dose and undertake frequent reviews of resident.

## Module 2: Bowel care

Bowel symptoms such as constipation or faecal incontinence can have a negative effect on a resident's quality of life. Bowel care is a key component of a palliative approach as residents may be taking opioids, which are a major cause of constipation.

Constipation is defined as difficulty or straining on defecation of dry, hard stool. Infrequent bowel movements over an extended period of time, with the sensation of incomplete evacuation of the bowel also define constipation.

Normal colonic function requires:

- absorption of water
- a coordinated combination of segmental contractions that mix the stool
- movement of faeces over short distances
- large contractions that move waste over longer distances

Defaecation occurs with a synchronised combination of voluntary contraction of striated muscle and involuntary smooth muscle contraction.

Constipation may occur with reduced fluid intake causing:

- dry stools
- limitation to the movement of faeces through the colon
- inadequate muscle contraction

Constipation can cause abdominal pain and bloating, nausea and vomiting, overflow incontinence, faecal impaction.

There are three types of constipation:

- Primary – due to inadequate dietary fibre, dehydration, reduced mobility, reduced muscle tone, and withholding of faecal evacuation.
- Secondary – may occur as the result of partial bowel obstruction, spinal cord compression or conditions such as hypercalcaemia.
- Iatrogenic (medically induced) - constipation induced by the administration of drug therapies such as opioids, anti-inflammatory medications, anticholinergics and antidepressants, aluminium and calcium antacids, diuretics. Opioids are the main cause of medication induced constipation.

## Symptoms of constipation

- nausea and vomiting
- straining during defecation
- infrequent bowel movements
- feelings of incomplete emptying after bowel movements
- frequent small amounts of diarrhoea
- rectal pain on defecation
- stomach pain, distension or discomfort
- hard stools
- faecal incontinence

## Principles of bowel care

- ongoing assessment and documentation of findings
- prompt and individually tailored treatments
- minimisation of interventions that can cause loss of dignity



Residents in RACFs require an initial and thorough assessment of bowel habits as part of their initial care planning. After the initial care plan is developed it will be used in conjunction with a daily bowel chart.

## Assessment

Bowel assessment involves taking a careful history of the resident's usual bowel habits and performing a physical examination. This assessment takes time and should be discussed with the resident in privacy and with sensitivity. Questions need to be clearly stated in language appropriate to the resident's understanding. Such questions to be asked should identify normal bowel movements, regularity of the bowel movements, and use of laxatives in the past.

Daily assessment of bowel function is important for residents as medications such as opioids, frequently used in a palliative approach, can increase the risk of bowel symptoms.

The history needs to identify issues such as:

- the adequacy of fluid intake and dietary fibre
- presence of desire to defecate

- level of physical mobility
- medications that may be contributing to constipation
- physical problems such as haemorrhoids or anal fissures
- skin problems due to leakage
- regularity of bowel movements
- type and frequency of laxatives used in the past
- 'normal' bowel movement



It is important for a resident's bowel habits to be assessed individually as there is considerable variation in what is considered 'normal'.

A physical examination may involve:

- checking for bowel sounds
- checking for abdominal distension
- feeling the abdomen for presence of faecal masses in colon
- visually checking for haemorrhoids or anal fissures
- rectal exam where necessary



*Guidelines for a Palliative Approach in Residential Aged Care*, Guideline 36 (Enhanced Version, 2006) or Guideline 40 (Original Version, 2004) as follows:

*Eliciting information that includes a history of residents' bowel habits and their preferences for treatment, an awareness for complimentary methods of bowel care (e.g. low-intensity exercise, abdominal massage and hot packs) and better documenting procedures, will improve bowel management and residents' well-being.*



### Writing activity

Using the above bowel assessment considerations, develop a list of questions you would ask a recently admitted resident (and/or family) as part of an initial bowel assessment.

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## Pharmacological management



Discussion between a doctor and aged care team members is important when considering the type of laxatives used in the management of constipation. The resident's preferences for treatment also need to be taken into account. It is important to address the cause of the constipation when considering pharmacological interventions.

Laxatives stimulate defaecation through their:

- Osmotic properties causing fluid retention in the colon, increasing bulk and softness of stool
- Contact on the mucosa of the bowel, decreasing water absorption through the wall of the bowel, thus softening the stool
- Stimulating effect causing increased mobility of the bowel, decreasing transit time



*Guidelines for a Palliative Approach in Residential Aged Care*, Guideline 37 (Enhanced Version, 2006) or Guideline 41 (Original Version, 2004) as follows:

*Discussion between the doctor and nursing staff about the most appropriate laxative for use with a resident will enhance management decisions regarding bowel care.*

### Osmotic laxatives

- Macrogol 3350 (Movicol):

Macrogol 3350 has an osmotic effect on the gut which induces the laxative effect. Movicol contains Macrogol 3350 and electrolytes to ensure there is virtually no loss of sodium, potassium or water. Movicol is dissolved in water and may be taken with or without food.

- Lactulose:

Lactulose draws water into the bowel in order to maintain moisture content of stool and stool volume. Disadvantages of this type of laxative can be abdominal discomfort and cramping. Lactulose should not be used in residents whose fluid intake is poor.



*Guidelines for a Palliative Approach in Residential Aged Care*, Guideline 39 as (Enhanced version, 2006) or Guideline 43 (Original Version, 2004) follows:

*Where a laxative is required, it is recommended that a cheaper laxative be trialled first and that appropriate compensatory measures should be taken to avoid dehydration and electrolyte depletion.*

## Faecal softeners and stimulant laxatives

Reduced peristalsis and inability to pass hard faeces is the most common cause of constipation and therefore the most effective laxatives will be those that increase peristalsis and soften the stool. Coloxyl with senna is an example of this type of laxative.

Coloxyl is a faecal softener which acts in the small and large intestine. It acts by facilitating penetration of the faecal mass by water and fats, thus softening the faeces.

Senna is a stimulant laxative which has a direct effect on the mucosa of the colon, stimulating the myenteric nerve plexuses. The effect of this is to alter water and electrolyte secretion so they accumulate in the intestines and stimulate motility.

## Bulk forming laxatives

### Psyllium (Metamucil), Bassorin (Granucol), unprocessed bran

The use of bulk laxatives when combined with suppositories is associated with low rates of faecal incontinence in aged care residents. However, bulk laxatives are not indicated for residents who are taking opioids, especially if they are not ambulant, because of the likely formation of hard faeces from poor fluid intake and reduced transit time through the bowel



Therapeutic Guidelines Palliative Care, Version 2, p.217

## Rectal management

The use of suppositories after bowel clearing can prevent recurrent constipation.

- Glycerin suppositories act as a softener when inserted into faecal matter.
- Coloxyl suppositories are a surface wetting agent. They soften faeces in the rectum and assist with peristalsis.
- Bisacodyl (Dulcolax) suppositories stimulate sensory endings in the colon and increase gut motility.
- Microlax enemas have a combined osmotic and surface wetting agent for evacuation of soft faeces in the rectum.

When performing rectal treatment, it is essential to carefully explain the procedure to the resident.



*Guidelines for a Palliative Approach in Residential Aged Care*, Guideline 38 (Enhanced Version, 2006) or Guideline 42 (Original version, 2004) as follows:

*The combined use of bulk laxatives and suppositories is associated with the lowest rates of faecal incontinence. The use of suppositories after bowel clearing can prevent recurrent constipation.*

## Non-pharmacological management

Residents may prefer to use non-pharmacological approaches to bowel care.

This may include:

- toileting ensuring comfort, privacy and timeliness (gastrolic reflex occurs after eating)
- encourage fluid and fibre intake
- low-intensity exercise
- abdominal massage
- hot packs



Consult with colleagues and residents on complementary methods that could be employed to assist with constipation. Note their responses.

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### Case study – Bowel care

David has been in a RACF for the past six months. He has been diagnosed with Parkinson's disease with associated dementia. Staff noticed that he was experiencing faecal incontinence. The bowel chart in the RACF stated that he had not had his bowels opened. Nursing staff, confused as to the correctness of the documentation, spent considerable time questioning the entries in the bowel chart.

The continual faecal incontinence became an issue for David and he became upset at soiling himself. This obviously had an impact on his dementia and he became more confused and agitated. The Registered Nurse was notified of the situation and was also made aware that there were concerns as to the accuracy of the bowel chart. Following assessment it was evident that David's faecal incontinence was due to constipation with overflow.



#### Reflection

Reflect on what treatment may assist David's constipation and the importance of early assessment and intervention.



#### Reflection

Reflect on measures that could be employed to prevent ongoing constipation.



For residents receiving a palliative approach, the most significant factor affecting bowel care is opioid-induced constipation.

### **Summary box – Bowel care**

- Individualised history of resident's bowel habits.
- Daily assessment of bowel function is important for residents as medications such as opioids, frequently used in a palliative approach, can increase the risk of bowel symptoms.
- Discussion with doctor and aged care team in determining laxative, taking into account patient preferences.
- Combined use of bulk laxatives & suppositories is associated with lowest rates of fecal incontinence.

## Module 3: Nutrition

The provision of nutrition to residents in RACFs is seen not just as a physiological need but also a form of fulfilling social, symbolic and often cultural needs. Family members see the provision of nutrition as a provision of care and a social act.

When residents are receiving a palliative approach, nutrition and hydration issues may develop which require involved ethical decision making for the aged care team, resident and family members.



Attention to the nutritional intake of residents in RACFs is both a clinical issue and a quality-of-life issue.

Social issues such as sharing meals, gathering of people at meal times, the time that meals are taken, what utensils are traditionally used, and personal taste preferences can also impact on the resident's desire for food and drink. Residents who eat alone may find this extremely unpleasant and actually refuse to eat. Meals offered that are not to the residents liking may be refused and residents who require additional time or assistance with meals may also refuse meals.

Good nutritional care requires an individualised approach that includes early recognition of weight loss and the identification and management of likely causes such as:

- adverse medication effects
- poor oral health
- depression

This careful attention to assessment and management of residents' nutritional requirements improves quality of life.



*Guidelines for a Palliative Approach in Residential Aged Care*, Guideline 21 (Enhanced version, 2006) or Guideline 24 (Original version, 2004) as follows:

*Good nutritional care requires an individualised approach that includes early recognition of weight loss and the identification and management of likely causes (e.g. adverse medication effects, poor oral health or depression). This careful attention to assessment and management of residents' nutritional requirements improves quality of life.*



The most common nutritional problems for residents in RACFs are weight loss and associated protein energy malnutrition.

Potential factors in the poor nutritional status of older persons are:

- advanced dementia
- apathy
- fatigue
- paranoid behaviour
- increased generalised weakness
- anorexia associated with deteriorating condition

## Potentially reversible causes of malnutrition

Some potentially reversible causes of malnutrition include:

- metabolic disorders such as hyperthyroidism
- chronic infections
- alcoholism (nutrient malabsorption or reduced nutrient intake)
- oral health factors
- use of therapeutic diets (e.g. low salt, low cholesterol diets)
- vitamin deficiencies
- depression
- adverse medication side-effects

## Oral health

There are many strategies recommend in the *Guidelines* for ensuring that oral health is maintained in residents.



*Guidelines for a Palliative Approach in Residential Aged Care*, Guidelines 31 - 33 (Enhanced version, 2006) or Guidelines 35 – 38 (Original version, 2004) as follows:

**31.** *Good oral hygiene, regular assessment, cleansing of dentures and oral fluids can reduce oral complications.*

**32.** *Oral health assessments that include the question, “How would you describe the health of your teeth and gums? Would you say it is excellent, very good, good, fair or poor?”*

*for residents who are able to respond increases accuracy in identifying residents who require further evaluation and dental treatment.*

**33.** *Rinsing the mouth with water and cleansing teeth with a soft toothbrush and toothpaste is an effective oral cleansing routine that is cost-effective and reduces the resident's risk of oral mucositis (mouth ulcers).*

## Dysphagia

Stroke patients with associated dysphagia and residents with hip fractures, COPD or Parkinsons disease may be more likely to have poor nutritional status.

The management of residents with dysphagia requires appropriate assessment and management. Guidelines 31-33 (Enhanced version, 2006) or Guideline 35 – 38 (Original version, 2004) refers to the appropriate care of these residents. This includes a multidisciplinary approach including input from a speech pathologist who will prescribe the type of fluid and food including texture and consistency. The resident can be safely fed using specific methods recommended by the speech pathologist.

## Intervention

A palliative approach attempts to encourage residents, family members and aged care team members to discuss, earlier rather than later, what the resident's wishes are regarding intervention and possible options to provide nutrition.

## Assessment

It is important to recognise that there are varied risk factors for poor nutritional status in order to implement successful assessment and management strategies.

An assessment of potential causes should be made in order to identify malnutrition.



*Guidelines for a Palliative Approach in Residential Aged Care*, Chapter entitled, Physical Symptom Assessment and Management, Table 11 (Enhanced version, 2006) or Chapter 5.4 (Original version, 2004).



### Writing activity

Using the *Meals on Wheels* mnemonic, explore possible causes of malnutrition in a resident in your facility. If you have identified a possible treatable cause(s), identify what nursing considerations and interventions you could employ.

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## Nutritional management

Three basic components:

1. Information on options and outcomes are available to resident and family members.
2. Steps to decision making that are based on the resident's preferences, personal values and clinical situation are employed.
3. A documented treatment plan with regular review is designed to put these steps into operation.

## Pharmacological management

Some residents may receive nutritional supplementation of oral protein and energy feeds to assist with malnutrition however not all residents are willing to consume these supplements. The wishes of the resident must be observed and efforts of staff to encourage residents to eat for comfort and enjoyment is considered best practice.



Oral nutrition rather than nasogastric enteral feeds is best practice management for older persons. This requires a diligent hand feeding program. Assessment of dysphagia should first be undertaken.



*Guidelines for a Palliative Approach in Residential Aged Care*, Guideline 22 (Enhanced version, 2006) or Guideline 25 (Original version, 2004) as follows:

**22:** *Giving residents oral food and fluid, even in small amounts, is preferable to using more invasive enteral (e.g. nasogastric or PEG) feeding methods. However, a dysphagia assessment is essential to provide direction for oral feeding.*

## Non pharmacological management

There have been benefits noted for some residents from non-pharmacological management such as walking. Walking enhances appetite, improves bowel function and decreased likelihood of glucose intolerance.

Other considerations may include the provision of customs such as alcohol to be offered prior to meals to assist with improving the appetite.

Food preferences can be obtained from the resident or their family and help guide the dietician in planning meals that are enjoyable and suit the resident's swallowing ability.



When assisting with feeding it is important for the aged care team member to be seated at eye-level with the resident. Creating a relaxing atmosphere may enhance the resident's nutritional intake and improve well-being.



*Guidelines for a Palliative Approach in Residential Aged Care*, Guideline 23 (Enhanced version, 2006 – when the Guidelines were updated in 2006, this Guideline was added, therefore there is no equivalent guideline in the original version) as follows:

**23:** *The aged care team member assisting with feeding should be seated at eye level with the resident and take time to establish and maintain a relationship with the resident to create an atmosphere that is conducive to relaxing the resident. This approach to feeding enhances the resident's nutritional intake and improves his/her social well-being.*

## Management of nutrition issues at end-of-life

Please also see resource entitled End of life care on PCA website [www.pallcare.org.au](http://www.pallcare.org.au).

Eating and drinking may no longer be of interest to the resident entering the end-of-life phase. A palliative approach indicates that the resident should not be forced to receive food or fluids.

To ensure quality of life the provision of oral fluid either as sips of water or chips of ice to maintain comfort is recommended.



The provision of artificial nutrition and hydration, although stemming from the belief that dehydration in a person close to death is distressing, may be detrimental to the dying person.

Discussion with family members providing sound information can assist with decision making towards the resident's end-of-life. This can also alleviate some of the social and psychological distress often experienced.



Discuss with colleagues the pros and cons of artificial feeding and hydration and how you might deal with family members. Note the responses.

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## Tube feeding

One of the hardest issues for aged care team members to deal with are the different views on rights and appropriateness of artificial nutrition interventions. Many families may request that all possible interventions be considered to ensure that the resident receives nutrition. Family members may request treatment that the team considers invasive or potentially burdensome.

Percutaneous endoscopic gastrostomy (PEG) feeding is an option available to supply nutrition to a resident artificially. Many family members will consider this option and the trajectory for the resident may impact on the family's ultimate decision. When a family is considering whether to institute PEG feeding, benefits and possible burdens should be highlighted by the aged care team. Family members should feel supported in their decision and be given ample and accurate information.



The aged care team needs to initiate discussions with residents and their families about the pros and cons of artificial feeding and hydration. It will be important for the family to be supported by the team when they are making such decisions on their relative's behalf.



Reviewing the benefits of this feeding against the potential burden should be discussed with the resident, their family and medical officer. The resident's best interests and preferences guide the decision-making. Where they are unable to speak for themselves, as much information as possible should be sought from family members.



Continuing percutaneous endoscopic gastrostomy (PEG) feeding at end-of-life may pose a burden on the dying person.

The dilemma for families may be the decision to discontinue PEG feeds after it has been started. It is important for people involved in such decision –making to understand that withholding or withdrawing treatments is legally and ethically sound if the decision is based on fully informed consent.



Tube feeding decision aid - *Guidelines for a Palliative Approach in Residential Aged Care*, Chapter Entitled, Physical Symptom Assessment and Management, Table 12 (Enhanced version, 2006) or Table 7 (Original version, 2004)



### Writing activity

Review the table and develop strategies that could be used in your RACF to ensure the steps to decision making are observed. Consider the use of a flow chart.

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### Case study – Nutrition

Harry has been a resident at the RACF since his wife died several years ago. He is very frail and has dementia. Recently Harry's condition has deteriorated and he no longer wants to eat or drink. His children are concerned that he has not been able to communicate his wishes to them.

Staff encourage him with his favourite foods and his children often visit at meal times to feed him. However, his family are becoming concerned about the small amounts that he manages to eat and drink and have requested supplementary feeding with protein drinks. Harry does not like the taste of the drinks and now becomes distressed when he is offered them.

Harry's children ask the aged care team about tube feeding and following careful discussion with the team about the risks and benefits of such treatment, his children decide against this option. The team and his children decide to continue with hand feeding. Staff also suggest discontinuing the protein supplements due to Harry's distress.



#### Reflection

Reflect on the decisions that Harry's children have had to make regarding his care. What information do you think they might use to consider what he would want?

Reflect on the benefits to Harry's nutrition of the protein supplements versus the burden on Harry because of his dislike of the taste.

### Summary box – Nutrition

- Good nutrition requires an individual approach. A palliative approach attempts to encourage residents, family members and aged care team members to discuss, earlier rather than later, what the resident's wishes are regarding intervention and possible options to provide nutrition.
- Early assessment and management.
- Giving oral foods and fluids is preferable to using more invasive feeding methods.

## Module 4: Hydration

Also see resource entitled End of Life care on PCA website.

When considering a palliative approach to care for the resident who can no longer maintain optimal hydration, the wishes of the resident and their family are paramount. Artificial hydration will not necessarily increase comfort or quality of life especially in the last stage of life.

The definition of dehydration is the loss of normal body water. Dehydration should not be confused with thirst.

Thirst can be treated through good nutrition and does not require medical intervention. Thirst is best treated by small amounts of fluid and ice chips offered frequently. The focus is on keeping the resident's mouth and lips moist. Effective oral hygiene using a soft toothbrush, water and toothpaste to cleanse teeth can reduce the resident's sensation of thirst. The use of oral lubricants such as Oral Balance may also assist with comfort. Oral hygiene is also a task that family members or significant others may wish to attend with or for the resident.

Current research reported in the *Guidelines for a Palliative Approach in Residential Aged Care* suggests that artificial hydration may be pointless in people at the end of life. The benefits of treatment need to be weighted against the burden on the resident and their family.



*Guidelines for a Palliative Approach in Residential Aged Care*, Chapter entitled, Physical Symptom Assessment and Management

### Assessment of hydration

Early assessment of hydration is important in the prevention of correctable dehydration.

There are several clinical signs that can be used when assessing for dehydration. These include:

- Dry skin and mucous membranes
- Thickened oral secretions
- Decreased urine output
- Postural hypotension
- Headaches
- Cramps
- Irritability
- Drowsiness
- Constipation
- Weight loss

- Disorientation
- Changes in blood pressure due to postural change (orthostatic hypotension)

If several of these signs appear simultaneously or are different to the resident's usual presentation, dehydration maybe the cause.

Aged care workers should be mindful that clinical signs may appear when hydration is far advanced.



*Guidelines for a Palliative Approach in Residential Aged Care*, Guideline 24 (Enhanced version, 2006) or Guideline 27(Original version, 2004) as follows:

*Recommendations regarding fluid therapy that are based on an ongoing assessment of each resident's circumstances, including the resident's and family's treatment preferences, improve the resident's and family's satisfaction with the care that is provided.*

## Deciding on hydration



*Guidelines for a Palliative Approach in Residential Aged Care*, Chapter entitled, Physical Symptom Assessment and Management

Therapeutic Guidelines in Palliative Care Version 2, p.22

Both sections reflect on the provision of artificial hydration and nutrition.

Current research reviewed in the *Guidelines for a Palliative Approach in Residential Aged Care* has identified several issues that can be of assistance when making decisions regarding hydration. These issues include:

- assess each person's individual circumstances (this takes into account the resident's and family's wishes)
- there is no evidence that rehydration makes people more comfortable although it may reduce the risk of ulcers and constipation
- rehydration may also have a negative effect on cognition
- intravenous hydration may have negative psychological effects (it maybe seen as a barrier between the person and their family and causes difficulty when family members may want to embrace their loved one). This intervention also requires admission to an acute care facility.
- an indication for rehydration is that the resident reports that their mouth feels dry despite good mouth care.



### Writing activity

Refer to the *Guidelines for a Palliative Approach in Residential Aged Care*, Chapter entitled, Physical Symptom Assessment and Management, Table 13, (Enhanced version, 2006) or Table 8 (Original version, 2004) and reflect and make notes on the principles to guide decisions regarding hydration.

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## Management of hydration



The management of providing hydration to residents must always focus on the comfort of the resident. This is the primary goal rather than providing optimal hydration.

The principle to ensure adequate hydration is to offer oral fluids to bed ridden older people regularly.

## Artificial hydration

Depending on the illness trajectory artificial hydration should be considered in the palliative approach where dehydration results from potentially correctable causes such as:

- over treatment of diuretics and sedation
- recurrent vomiting
- diarrhoea
- hypercalcaemia



*Guidelines for a Palliative Approach in Residential Aged Care*, Guideline 25 (Enhanced version, 2006 – when the Guidelines were updated in 2006, this Guideline was added, therefore there is no equivalent guideline in the original version) as follows:

*Regular presentation of fluids that include strategies such as a colourful beverage cart, verbal prompting or complying with residents preferences will increase the amount of oral fluid intake for those residents able to have oral hydration.*



### Writing activity

Reflect on the US study highlighted in the *Guidelines for a Palliative Approach in Residential Aged Care*, Chapter entitled, Physical Symptom Assessment and Management, about an intervention to increase consumption of oral hydration. The intervention was the use of two colourful beverage carts which contained a variety of cold and hot beverages that were dispensed in colourful plastic cups. What were the results of this intervention?

Can you think of an intervention that could be adopted by your aged care facility that could increase oral fluid consumption?

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## Management of hydration issues at end-of-life



Dehydration in the end-of-life stage has not been found to produce distressing symptoms or to shorten life span and may in fact be beneficial to the dying resident.

### Benefits of dehydration at end-of-life may include:

- the production of a natural analgesia – endorphins and dynorphins
- ketoacidosis takes away the feeling of hunger and results in further analgesia
- decrease in urinary output and diminished respiratory secretions

Residents who are entering the final stages of life may have thirst or dry mouth caused by: medication, mouth breathing or oral thrush. Artificial hydration is unlikely to alleviate this symptom. Good mouth care and reassessment of medication are the most appropriate considerations.

A fluid deficit will develop in the days prior to death due to the resident's diminished energy, emotional withdrawal from daily activities of living and eventually a reduced level of consciousness. Symptoms such as dysphagia, nausea and anorexia can also result in a reduced fluid intake.

### Adverse effects of fluid accumulation caused by artificial hydration

- Increased urinary output possibly necessitating an IDC
- Increased fluid in GI tract which may result in vomiting
- Development of pulmonary oedema or pneumonia
- Increase in respiratory tract secretions leading to noisy respiration



*Guidelines for a Palliative Approach in Residential Aged Care, Guideline 26 (Enhanced version, 2006) or Guideline 28(Original version, 2004) as follows:*

*Frequent small sips of fluids and adequate mouth care can reduce the resident's sensation of thirst and oral discomfort that is associated with dehydration.*

### **Case study – Hydration**

Dulcie has been living in a RACF for three years and was well adapted to the environment despite being diagnosed with dementia prior to her admission. She developed a urinary tract infection and became acutely confused. In conjunction with her confusion she demonstrated challenging behaviour. As well as being treated for her urinary tract infection, her GP in consultation with nursing staff and family members, prescribed medication to manage her challenging behaviour. With the increase in medication, Dulcie became nauseated and refused to eat or drink. When she developed a second urinary tract infection her general health deteriorated. Finally an assessment of her fluid intake was performed and it was apparent that she was dehydrated. She was given small sips of fluids and ice chips to such regularly. Dulcie's condition improved and she was offered sips more regularly and beverages that she enjoyed. Her fluid intake improved and her recurrent urinary tract Infections resolved.



#### **Reflection**

Reflect on the need for early assessment and how it can prevent ongoing complications.



#### **Reflection**

Reflect on the response to good nursing care, by providing small sips of fluids regularly.

### **Summary box – Hydration**

- Ongoing assessment of hydration with reflection on family and resident wishes.
- Frequent small sips of fluids to reduce resident's sensation of thirst and oral discomfort.
- Dehydration at end-of-life does not produce distressing symptoms or shorten life span.

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CareSearch – [www.caresearch.com.au](http://www.caresearch.com.au)

This contains resources on palliative care.

Video – The Essence of Care. A Guide for the Practice of Gerontology and Palliative Care.