Nutritional Screening Assessment in Palliative Care

Standard Operating Procedure
1. **Aim**

This Standard Operating Procedure (SOP) aims to provide clear guidance for nutritional screening of palliative care patients.

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of symptoms, be they physical, psychological and spiritual (WHO 2015).

Palliative care encompasses more than the last days of life, ranging from days to years, therefore the nutritional needs of palliative patient’s may vary widely. Before carrying out nutritional screening consider if the patient is early palliative, late palliative or last few days of life (NHS Lothian 2010, Northamptonshire Healthcare NHS Foundation trust 2013):

- **Early palliative care**

  *The patient has been diagnosed with a disease or disorder that cannot be cured. Death is not likely to be imminent and the patient may have months or even years of life and quality of life might also be good.*

- **Late palliative care**

  *The patient will be experiencing a general deterioration in condition. Appetite tends to be reduced and the patient becomes increasingly fatigued. There may also be a general increase in other symptoms. Carers’ anxieties tend to increase at this time and they may become increasingly concerned about the patient’s food intake.*

- **Last days of life**

  *The patient is likely to be bed-bound, very weak and drowsy with little desire for food or fluid.*

2. **Scope**

All clinical staff that care regularly for palliative care patients

3. **Link to overarching policy**

Nutrition Policy

4. **Procedure**

**Early Palliative Care**

RDASH nutrition policy to be adhered to.
Any reasons for not completing a MUST assessment for these patients must be documented on TPP.

4. **Late Palliative Care**

Aggressive feeding may not be appropriate, especially as eating and drinking can cause discomfort and increase anxiety and stress.

**Aim:**
- Improve well-being
- Nutrition should NOT be for weight gain or reversal of malnutrition, but should be about quality of life, comfort, symptom relief and the enjoyment of food.

**Intervention:**
- MUST assessment NOT required, tick appropriate box on New TPP template ‘MUST tool not performed as not appropriate e.g. end of life’ and write free text if explanation required.
- Reassurance and support to patient and family that reduced appetite is a normal response
- Consider treating reversible symptoms
- Nourishing diet focussing on enjoyment of food and drink – do not pressure the patient to eat.
- Little and often – food and drink that the patient likes and fancies.
- Consider the ‘Food first’ approach by adding butter, cream, cheese, milk powder to enrich the nutritional value of food.
- Oral Nutritional Supplements (ONS) may be beneficial in some patients on psychological grounds. Patients should not be made to feel that they have to take these or be given false hope that these will improve nutritional status or quality of life. If ONS are felt to be beneficial and patient wishes to try them, Over the Counter (OTC) products should be the first line advice e.g. Complan or build up. **If the patient is unlikely to consistently manage at least two cartons of sip feeds per day, then they are unlikely to derive any significant benefit to the well-being or nutritional status** (Northamptonshire Healthcare NHS Foundation trust 2013).
- Dietician referral may not be appropriate, however contacting for advice is advised if you or the patient have any queries.

It is important to be aware of the potential tensions that may arise between patients and the carers concerning the patient's loss of appetite (anorexia). This is likely to become more significant as the patient moves towards late palliative care and nearing the last days of life. Patients and their carers may require support in adjusting to, and coping with anorexia.

**Last Days of Life**

Food and fluid administration beyond the specific requests of patients may play a
minimal role in providing comfort to patients in the last days of life.

**Aim:**

- Enjoyment of food (if requesting and as able)
- Quality of life in their last days

**Intervention:**

- MUST assessment NOT required, tick appropriate box on New TPP template ‘MUST tool not performed as not appropriate e.g. end of life’ and write free text if explanation required.
- Dietician referral is inappropriate
- Mouth care
- Sips of Fluid, as able
- Other food and fluid as desired by the patient
- Support for patient and family

5. **References:**


6. **Appendices**

Appendix 1 – Nutrition in Palliative Care Patients Flow Chart.
Nutrition in Palliative Care Patients

**Early Palliative Care**
The patient has been diagnosed with a disease or disorder that cannot be cured. Death is not likely to be imminent and the patient may have months or even years of life and quality of life might also be good.

**MUST assessment as per Nutrition Policy**

**Late Palliative Care**
The patient will be experiencing a general deterioration in condition. Appetite tends to be reduced and the patient becomes increasingly fatigued. There may also be a general increase in other symptoms. Carers’ anxieties tend to increase at this time and they may become increasingly concerned about the patient’s food intake.

**Last Days of Life**
The patient is likely to be bed-bound, very weak and drowsy with little desire for food or fluid.

**No MUST assessment**
Care as per guidance above Document Rationale on TPP