

## section 2.1.1: the role of the multidisciplinary team

### 5. Dietetics

Palliative care patients are frequently faced with both the rigors of treatment for their disease and the impact of the disease itself. This in turn can affect their desire and ability to eat and drink and is evidenced by the high level of palliative patients noted to be at risk of malnutrition, with protein and energy malnutrition and micro-nutrient related deficiencies.<sup>1</sup>

Often these difficulties are accepted as a part of the natural progression of advanced disease, however it is important that patients receive appropriate assessment, intervention and ongoing advice and support for their intake needs. This places them in the best possible position to deal with disease and the impact of treatment. Patients themselves identify eating and appetite as important factors in contributing to their quality of life.<sup>2</sup>

Dieticians have particular skills to assist patients to optimise nutritional intake and to develop a nutritional plan which focuses on the patient's wishes. They are also able to take into account the patient's current disease context, treatment plans and overall quality of life when developing nutritional plans and education for the patient and family.

Specific interventions include:

- **assessment of nutritional requirements**
  - identifying preferred likes and dislikes and lifelong food habits
  - clarifying interventions that are consistent with advance health directives
  
- **symptom identification**
  - including swallowing and chewing problems, constipation, early satiety, nausea, dry or sore mouth or throat
  - providing practical advice regarding chewing and swallowing difficulties, in conjunction with the speech pathologist
  
- **nutritional counselling**
  - meal planning in accordance with the patient's cultural customs, preferences and swallowing ability
  - dietary strategies that assist in the management of disease and the side-effects caused by treatment or medications, including:
    - food presentation
    - food temperature
    - quick easy meals
    - ready prepared meal ideas
    - symptom management
    - modified texture diets
    - frequency of meals
    - suggestions for nourishing meals and snacks
  - answering frequently asked questions by patients and family such as "what kind of food should I be eating?" and "how important is my diet?"
  - providing advice about cost efficient access to nutritional supplements

- providing **education and support** for patients and their families in decision-making about nutritional care at the end of life, particularly when facing difficult decisions which may be sensitive and emotive.<sup>3</sup>
- development of **enteral feeding regimes** when the patient is unable to meet daily fluid and nutritional requirements and this intervention is deemed appropriate by the treating medical team
  - practical advice and education for staff, caregivers and family in managing enteral feeding in the community setting
- modified **management of chronic conditions with special diet requirements**
  - cessation of therapeutic special diets may be warranted as they can be associated with low levels of B1, B2 and C, which have been associated with cognitive dysfunction – decisions about cessation may require assessment of serum levels
  - diabetes management – the usual strict control of blood sugar levels aimed at preventing long term complications is often no longer necessary
    - management usually focuses on symptomatic management and avoidance of hypoglycaemic episodes
    - a more flexible approach to blood sugar level monitoring may be adopted

## references

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<sup>1</sup> Bennett J. Nutritional status and oral intake of palliative care patients in a Sydney palliative care unit. Presentation at the 8<sup>th</sup> Australian Palliative Care Conference (2005).

<sup>2</sup> Padilla G, Presant C, Grant M et al (1983) Quality of life index for patients with cancer. *Res Nurs Health*. 6; 117-126.

<sup>3</sup> From The end of life. *Generations: J Am Soc Aging*. 2004; 28(3): 86-91.