Practice Plus Group

1.1...1 Health in Justice – Policy for the Management of Food and Fluid Refusal, incorporating the Refeeding Policy

Controlled document

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CONTENTS

2 1 Introduction

As defined in the Departments of Health's document 'Guidelines for the clinical management of people refusing food in immigration removal centres and prisons', food refusal in prisoners and detainee's is often used as a form of self-harm, protest against detention or deportation or to attract attention to their case/a specific cause.

It is important that careful consideration is given to identifying the underlying reasons for the food and fluid refusal, assessing and documenting capacity and regularly monitoring the nutritional status of the affected individual. Patients who are starved or severely malnourished can be at risk of Refeeding Syndrome that occurs as a result of re-starting nutrition. This document includes guidelines to ensure safe feeding in those identified at risk.
Under the Mental Capacity Act 2005 any individual over the age of 18 years has the legal right to refuse food and/or fluid. The Act assumes that a person has mental capacity to make their own decisions to refuse food and/or fluid unless it is established they lack that capacity.

3 Aim

The aim of this policy is to set out guidelines for the safest, most effective clinical management of prisoners and detainees who are refusing food or fluids in line with the NICE clinical guidelines 'Nutrition Support in adults' and PSI 64/2011 'Management of prisoners at risk of harm to self, to others and from others'

4 Malnutrition and Starvation

Malnutrition adversely affects every physical and biochemical system in the human body. This can lead to a variety of physiological vulnerabilities including increased susceptibility to infection, impaired organ functioning, depression, muscle weakness, extreme lethargy and prolonged wound healing.

Typical signs and symptoms of malnutrition

- Impaired wound healing
- Muscle wastage and weakness
- Increased susceptibility to infection and viral illness
- Lowered blood pressure
- Feeling extremely cold all the time with perpetually cold hands and feet
- Decreased liver production

Starvation can be defined as being the result of a severe or total lack of nutrients needed for the maintenance of life. The human body attempts to mitigate the effects of malnutrition by breaking down its own fat and eventually its own tissue, which affects the body's physical structure and biochemical functions.

Typical signs and symptoms of starvation

- Shrinking/gradual loss of function in vital organs (heart, lungs, ovaries, testes)
- Anaemia
- Decreased muscle mass leading to extreme weakness
- Lowered body temperature and extreme cold sensitivity leading to hypothermia
- Electrolyte depletion
- Decreased ability to digest food due to a lack of digestive acid production
- Irritability and difficulty concentrating
- Extreme immune deficiency leading to infection
- Oedema
- Reduced libido
- Anorexia and associated epidemiology

Death from starvation or malnutrition can take approximately six to eight weeks, although patients that have been severely ill prior to stopping food and fluid can die within three weeks. Patients that are also refusing hydration will experience a more rapid decline, with death likely to occur between seven and fourteen days of ceasing fluid.

Death is most likely attributable to multiple organ failure, infection and the shutting down or normal metabolic functioning rather than tissue loss.

It is important that patients are effectively communicated with in order to reconcile as much medical history as possible, recognising that other illnesses and conditions can lead to extreme weight loss including diabetes, TB, eating disorders, cancers, severe infections and gastrointestinal disorders such as Crohns and Coeliac Disease.

For every case of food and or fluid refusal in prisoners/detainee's, the possibility of mental illness (Depression, Anorexia or Psychosis) must be considered when assessing their needs and planning subsequent care. Where mental illness is suspected or confirmed, an assessment by an experienced psychiatrist is required.

5 Identification and Assessment

5.1 Identification

Early identification of an individual deliberately refusing food and or/fluids affords maximum time to work with an individual to ascertain their reasons and attempt to collaboratively agree a solution that negates the need to decline food and fluid.

IDENTIFICATION

- When it appears to any member of staff (healthcare or prison) that they intend to refuse food or fluids, monitoring must be activated and reported to HMPPS (Oscar 1) and Head/Deputy of Healthcare
    - Mealtime attendance
    - Uneaten meals
    - Intelligence from other prisoners/detainees
    - Identifying medications/illegal substances that may be suppressing appetite

ACTION REQUIRED

- Organise **MDT case review** as soon as possible to ascertain appropriate care pathway inclusive of the patient's wishes
- Patient's must be informed of the severity of their decision and likely impact on their physical and health and mental wellbeing
- **Report** to senior health professional in charge on shift and escalate to the prison governor as soon as practically possible
- **Consider whether an ACCT or ACDT is required** (dependent on circumstances, motivations, medications and personal reasons surround the refusal)
- When it appears that the patient is not regularly taking food and/or fluids (i.e. refusing food for more than three days or fluids for one day), a doctor or advanced nurse practitioner (ANP) must assess them as soon as possible.

5.2 Clinical Assessment (including laboratory assessment)

Box 1: CLINICAL ASSESSMENT – Baseline observations to be recorded in patient's medical record

- **Mental capacity** (important to do this as soon as practicable, and critically before they become too weak to undergo thorough assessment)

- **Full medical assessment** (with informed consent) to include:
  - Brief medical history
  - Any current medical problems
  - Weight, height and BMI
  - Weight loss (%) over past 3-6 months

  - Observations including: Temperature, pulse, BP, respiration rate, oxygen saturations, urine dipstick, random blood glucose monitoring, ketone monitoring
  - Hydration status (for both dehydration and over-hydration)
  - Signs of muscle wastage and loss subcutaneous fat **
  - Signs of oedema **
  - Full nutritional examination to look for visible signs deficiency (mouth, hair, skin, nails)

** require patient to be examined in their underwear and in appropriate clinical surroundings

- **Investigations** (if multiple illness or non-specific deterioration)**:**
  - Chest x-ray
  - Urine microbiology
  - Blood cultures
  - Any others as appropriate

- **Blood tests (with patient consent):**
  - Full blood count
  - Urea and electrolytes, eGFR calcium, magnesium and phosphate
  - Liver function tests
  - CRP and ESR
  - Glucose

Plans must be in place to continue monitoring throughout the duration of the prisoner's/detainee's refusal to eat or take fluids

Frequency of this monitoring will depend on a variety of factors – see box 5.

5.3 Assessment of Capacity

It must be assumed that the prisoner/detainee has the mental capacity to make a decision, unless they are assessed as lacking capacity.

Capacity must be assessed in accordance with the test set out in Mental Capacity Act (MCA). Addressing each part of the test as appropriate (See Appendix 5 for guidance and examples of suggested clinical documentation)

Staff must support the prisoner/detainee to understand the severity of their decision in a calm and compassionate manner using clear and simple language with the aid of an advocate, interpreter or person trained in Makaton/BSL where appropriate. Healthcare staff must also ask if they can share information as part of the wider multidisciplinary team caring for them.

Where a prisoner refusing food and/or fluids is also refusing medical treatment at a time when a doctor judges it is becoming necessary, whether or not an advance refusal of treatment has been made, the doctor must explain the consequences of these refusals to the prisoner, in the presence of another clinical practitioner. These explanations must include the following information:

1. That the deterioration of their health will be allowed to continue without medical intervention unless they request it
2. That continuing food refusal will lead to death. This must include description of the process in terms of pain, what can be offered to help with their symptoms and the physical effects of food refusal.

The doctor must then:

1. Write a full record of what has been said in the patient's clinical record, verified by both the doctor and the second clinician to say they were both present when this advice was given. It may be advisable for the doctor to repeat this practice from time to time. See Appendix 5 for guidance on discussion and clinical documentation.
2. Inform the Duty Governor that this stage has been reached, with an indication of the likelihood of the need to transfer the prisoner to an outside hospital. (The duty governor must monitor the situation daily at this stage and sign the log accordingly).

Where food refusal continues to the extent that a prisoner's long term health is placed at risk, whatever the outcomes of the doctors own assessments, they must arrange for a second assessment to be carried out as soon as possible by a psychiatrist to give a second opinion about mental health issues and/or lack of capacity.

In the event of continuing doubt about capacity the doctor must seek legal advice from the Practice Plus Group Legal Team

5.4 Advance Decisions

Advance decisions enable the patient to refuse future medical treatment/interventions whilst they are still mentally capable to do so. Please see Practice Plus Group Advance Decision Policy and examples of appropriate clinical notes around this in Appendices 4 and 5.

6 Ongoing Care and Management

Assessments of a starving patient's mental and physical condition must be undertaken regularly and within the acceptable parameters as defined by the patient.

At present, there is no conclusive evidence regarding the level of clinical monitoring required. Therefore a common sense approach should be taken with decisions relating to frequency of monitoring based upon professional experience, the care setting and the patients response to starvation. Additionally, the following recommendations should be adhered to in the absence of more formal guidance.

- Weekly clinical assessments (such as those in box 1) should be undertaken initially with individuals refusing food but taking fluids, assuming their nutritional status was normal upon commencement of food refusal. Where an individual develops inter-current illness or rapid decline, assessments need to occur more frequently throughout the week.
- Where an individual was malnourished at commencement of food refusal, assessments should be undertaken more frequently until daily assessments are required.
- Where a patient has refused both food and fluids from the outset, daily assessments and health evaluations should be undertaken.
- Individuals refusing food should be encouraged to take a nutritionally balanced supplement and trace element such as Forceval. They should also be supported to drink adequately but without excessive liquid consumption.
- Where the patient has a live ACCT/ACDT, regular assessments should feed into the plan.
- With patient consent, weekly blood tests (as per box 1) should be undertaken to monitor potential infections and nutritional status. Where life threatening abnormalities are detected and the patient is receptive to treatment, blood tests should be undertaken daily in addition to relevant treatment such as potassium and or phosphate supplements.

Individual assessments should include a brief psychological and physical evaluation including discussions regarding their current wishes and what they would like to happen should they decline rapidly and resulting in their inability to verbally express their wishes. See Appendix 5 for guidance on key points for this discussion and clinical documentation.

6.1 Independent Assessment

Many individuals refusing food in a custodial setting may perceive their caregivers as agents of those with whom they are in dispute with. This may result in them withholding consent for important physical assessments and investigations. In these situations it may be beneficial for a Doctor or clinician independent of the prison/immigration removal centre to spend some time with the individual and sensitively support them to understand the severity of their actions and that treatment is in their best interest.

6.2 Hospital Transfers

Where an individual refusing food and/or fluid has become weak and potentially dehydrated or has significant biochemical abnormalities, it may be appropriate to transfer them to a local hospital for further assessment. This independence from prison/immigration removal centre may provide the impetus for them to reconsider their decision and allow refeeding and rehydration.

Where the individual continues to refuse treatment, the hospital may discharge them back to their custodial centre. Close liaison between prisons healthcare staff and hospital should continue throughout a period of admission and efforts made to ensure that any discharge is accompanied by full information and a clear care plan.

7 Food and Fluid Reintroduction

Individuals who decide to start eating having refused food for more than a few consecutive days are potentially at risk from re-feeding issues, further complicated if they were malnourished prior to food refusal. **Refeeding Syndrome** is a broad term for the micronutrient deficiencies, fluid and electrolyte abnormalities, disturbances of organ function and altered metabolic regulation which can occur. For clinical sequallae of altered electrolytes refer to Appendix 7. In some instances these can be life-threatening.

7.1 Identifying patients at risk of developing Refeeding Syndrome

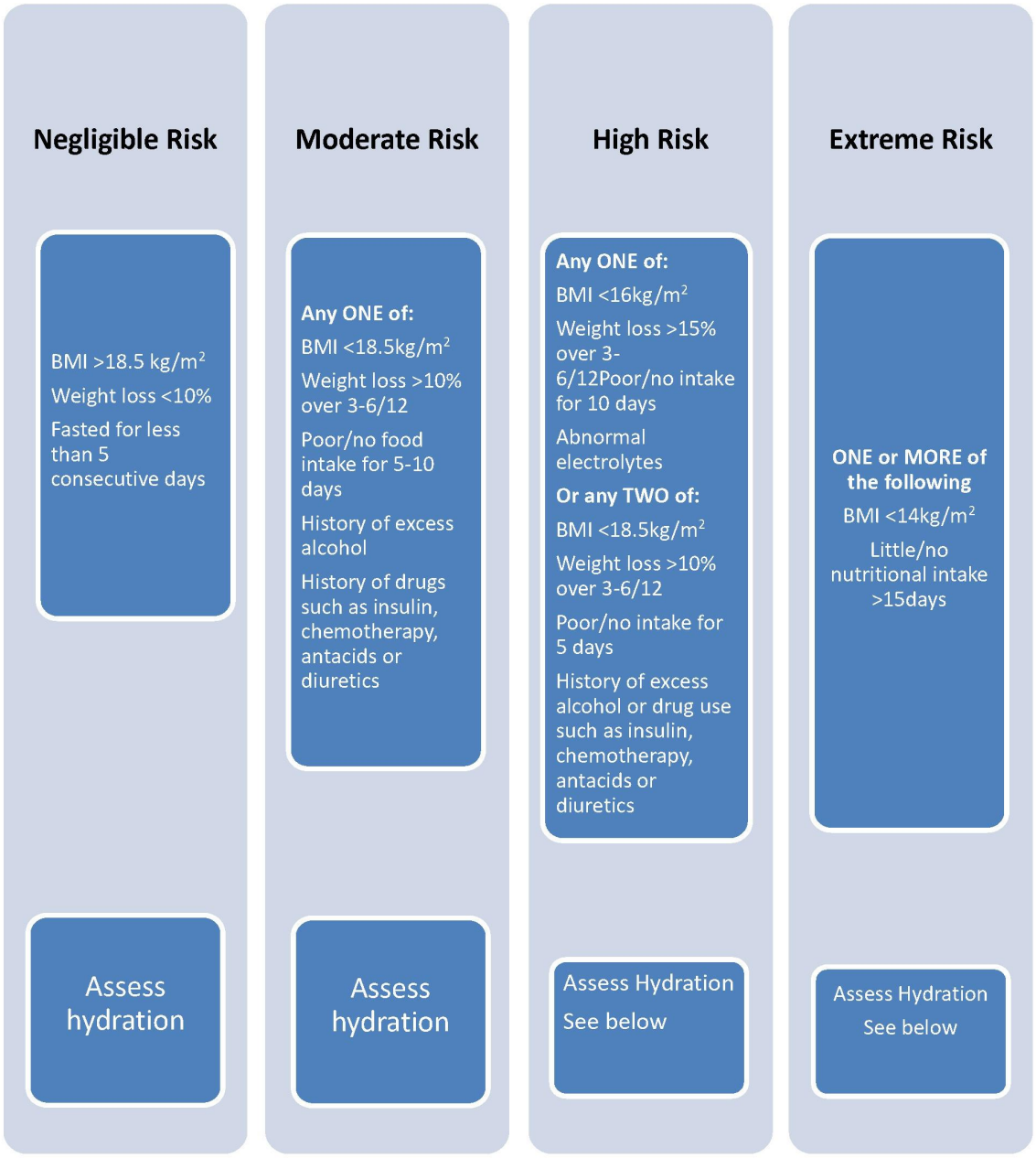
Box 2: CLINICAL ASSESSMENT

- History
  - Period of time with little/no nutritional intake
  - Recent history of alcohol or medicines that affect electrolyte balance such as insulin, chemotherapy, antacids, diuretics, methamphetamine, Heroin and other mood-altering substances
- Examination
  - Weight, height, BMI
  - Weight loss (%) over past 3-6 months
  - Blood pressure, respiration rate, oxygen saturations, temperature, pulse, urine dipstick, random blood glucose monitoring, ketone monitoring
  - Fluid balance
- Blood tests
  - Full blood count
  - CRP, ESR
  - Urea and electrolytes, eGFR
  - Liver function tests
  - Magnesium, calcium, phosphate
  - Glucose
- Additional considerations:
  - If oral route can be used (if not, admit to hospital for assessment and initiation of artificial nutrition support, not covered in the scope of this guidance)

7.2 Establishing level of risk of developing Refeeding Syndrome

With the information from Box 2, a level of risk of developing Refeeding Syndrome can be established using the chart below (adapted from NICE CG32 2017, BAPEN 2012 and DH 2010)

Re-feeding risk assessments should be taken on a case by case basis with food reintroduced dependent on the individual's level of risk recognising that re-feeding syndrome can be fatal. In all 'at risk' cases, blood tests for biochemical or haematological abnormalities should be taken prior to re-feeding. Abnormalities reflecting starvation changes should lead to the category of risk being reassessed. Where an individual develops an intercurrent illness or have an existing comorbidity, the category of risk should also be promptly reassessed.



For patients at HIGH or EXTREME RISK:

- Refer immediately to the dietitian and/or nutrition team
- Ensure adequate Thiamine and B Vitamins before and during feeding: high dose thiamine (200-300 mg/day) and Vit B Co-Strong (1-2 tablets, 3 times per day)
- Seek assistance from pharmacist and dieticians
- Include a balanced multivitamin and travel element (eg Forceval) daily

7.3 Management of risk and starting to feed safely

6.3.1 **Negligible Risk**

Due to low risk of refeeding can eat and drink freely but may need careful monitoring of hydration/renal function if required.

6.3.2 **Moderate Risk**

ASSESSMENT
Daily nursing assessment and observations for first two days including:

- Nursing assessment and observations including:
    - Vital signs: BP, pulse, respiratory rate, random blood glucose monitoring, ketone monitoring, oxygen saturations, temperature
    - Weight
    - Food/fluid reported intake
    - Urine dipstick
    - Bowels
    - Any other signs of fluid overload, general infection or deterioration
- Blood tests daily for first two days:
    - Urea and Electrolytes, eGFR
    - Glucose
    - Magnesium, calcium and phosphate.

CARE PLAN

- Encouragement to eat a balanced diet from the menu
- < 30kcal/kg/day for first two days (See Food Plans Appendix 1)
- 30ml/kg/day fluid unless clinically dehydrated
- Balanced vitamin and mineral supplement i.e. Forceval (one daily for 10 days)
- If demonstrates any electrolyte indicators of Refeeding Syndrome i.e. decrease in serum phosphate, magnesium or potassium by 10-20% (mild); 20-30% (moderate), >30% (severe), discuss with GP and treat as High Risk instead.
- If no problems and electrolytes normal, can build up intake to eat freely by day 5

6.3.3 **High Risk**

ASSESSMENT

- Nursing assessment and observations including:
    - Vital signs: BP, pulse, respiratory rate, random blood glucose monitoring, ketone monitoring, oxygen saturations, temperature
    - Weight
    - Food/fluid reported intake
    - Urine dipstick
    - Bowels
    - Any other signs of fluid overload, general infection or deterioration
- Blood tests daily for first two days:
    - Urea and Electrolytes, eGFR
    - CRP and ESR
    - Glucose

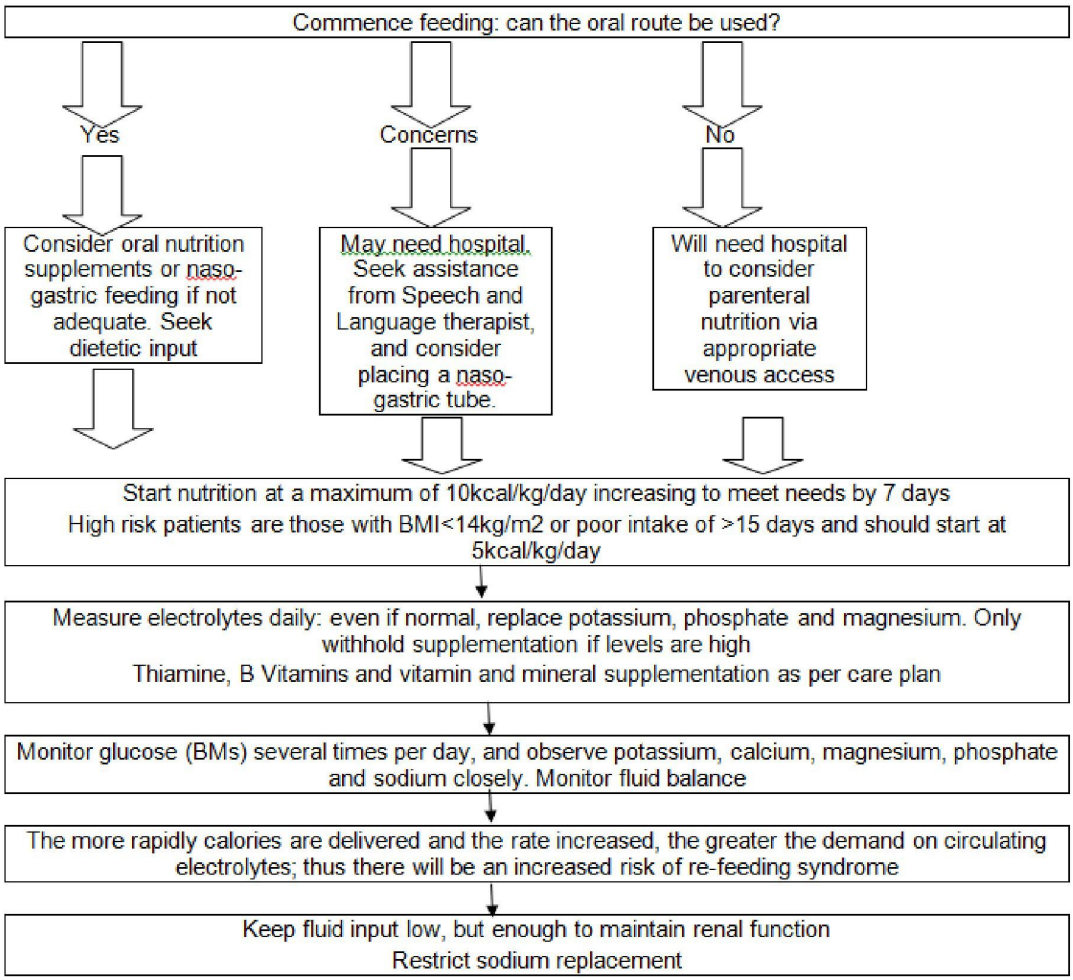
    - Magnesium, calcium and phosphate.
    - Liver function tests and Full Blood Count twice weekly
    - Likely causes for concern (discuss with GP) would be:
        - Potassium <3mmol/l
        - Magnesium <0.5mmol/l
        - Phosphate <0.5mmol/l
        - ALT or AST >4 x upper limit of normal range and rising
        - Glucose persistently <2
- Or if demonstrates any electrolyte indicators of Refeeding Syndrome i.e. decrease in serum phosphate, magnesium or potassium by 10-20% (mild); 20-30% (moderate), >30% (severe), discuss with GP

CARE PLAN

- Should be managed in an inpatients unit with 24hr nursing cover
- Care should be discussed with physicians at the local acute hospital, with hospital admission considered within the discussion – where the decision is taken not to admit the patient, a written confirmation of the decision must be recorded
- Fluid replacement
    - 30ml/kg/day unless clinically dehydrated
- Reintroducing food: encourage a balanced diet from the menu (Food Plans in Appendix 1)
    - Limit intake to <10kcal/kg/day for first 48hours
    - If no problems intake can be increased in increments of 10kcal/kg/day
    - If no problems by day 5 and patient consuming total of 50kcal/kg/day all restrictions can be removed
- Vitamin and mineral supplementation including:
    - Oral Thiamine (100mg twice daily for 10days)
    - Vitamin B Co Strong (1-2 tablets, 3 times a day for 10 days)
    - Balanced vitamin and mineral supplement i.e. Forceval (one daily for 10 days)
- Electrolyte replacement unless pre-feeding lab tests were high, or acute kidney injury, or reduced renal function i.e. eGFR <30. In which case consult with hospital team.
- Continue to replace until feeding normalised

Electrolyte	**Likely requirement**	**Suggested Replacement**
Magnesium	0.4mmol/kg/d (orally)	Magnaspartate Sachets (10mmol per sachet)
Phosphate	0.3-0.6mmol/kg/d	Phosphate-Sandoz (16.1mmol per tablet)
Potassium	2-4 mmol/kg/d	Sando-K (12mmol per tablet)

Re-starting feeding in those at high risk of Refeeding Syndrome (adapted from BAPEN 2012 and DH 2010)



6.3.4 Extreme Risk

Individuals at the highest risk of life-threatening re-feeding problems should be admitted to hospital and treated according to the NICE guidelines on re-feeding (2017).

Details of clinical management of these patients is included for reference in event of patient refusing hospitalisation, but due to possible development of life-threatening refeeding problems this should be undertaken in hospital if at all possible.

CLINICAL ASSESSMENT:

- Nursing assessment and observations 4 hourly for first 5 days including:
  - Vital signs: BP, pulse, respiratory rate, random blood glucose monitoring, ketone monitoring, oxygen saturations, temperature
  - Weight

    - Food/fluid reported intake
    - Urine dipstick
    - Bowels
    - Any other signs of fluid overload, general infection or deterioration
- ECG monitoring for at least the first 48 hours of refeeding
- Blood tests twice daily for first five days:
    - Urea and Electrolytes, eGFR
    - CRP and ESR
    - Glucose
    - Magnesium, calcium and phosphate.
    - Liver function tests and Full Blood Count twice weekly
    - Likely causes for concern (discuss with GP) would be:
        - Potassium <3mmol/l
        - Magnesium <0.5mmol/l
        - Phosphate <0.5mmol/l
        - ALT or AST >4 x upper limit of normal range and rising
        - Glucose persistently <2
        - Or if demonstrates any electrolyte indicators of Refeeding Syndrome i.e. decrease in serum phosphate, magnesium or potassium by 10-20% (mild); 20-30% (moderate), >30% (severe), discuss with GP

CARE PLAN:

- Restoration and management of circulatory volume, fluid balance and electrolytes
- Fluid and food replacement
    - No solid food at this stage
    - 2-4 hourly increments of complete liquid oral supplements (e.g. Ensure Plus, Fortisip Bottle) to provide a total of <10kcal/kg/day for first 2 days
    - If extreme case (eg BMI <14kg/m^2 or prolonged poor intake >15days) to provide a total of <5kcal/kg/day for first 2 days
    - Most standard complete oral nutritional supplements are 1.5kcal/ml (~300kcal per bottle) so most patient's initial needs will be met with 1-2 bottles given as increments throughout the day.
    - This should be given with a personalised copy of the Supplement plan in Appendix 2
- Vitamin and mineral supplementation including:
    - Oral Thiamine (100mg twice daily for 10days)
    - Vitamin B Co Strong (1-2 tablets, 3 times a day for 10 days)
    - Balanced vitamin and mineral supplement i.e. Forceval (one daily for 10 days)
- Electrolyte replacement unless pre-feeding lab tests were high, or acute kidney injury, or reduced renal function i.e. eGFR <30. In which case consult with hospital team.
    - Continue to replace until feeding normalised

Electrolyte	Likely requirement	Suggested Replacement
Magnesium	0.4mmol/kg/d (orally)	Magnaspartate Sachets (10mmol per sachet)
Phosphate	0.3-0. 6mmol/kg/d	Phosphate-Sandoz (16.1mmol per tablet)
Potassium	2-4 mmol/kg/d	Sando-K (12mmol per tablet)

Feeding should not be withheld in individuals with low levels of potassium, magnesium or phosphate since electrolyte deficits are predominantly intracellular and cannot be corrected without commencing low levels of simultaneous feeding. Furthermore, the presence of normal or high-serum electrolytes does not exclude the risk of refeeding syndrome as these individuals may have whole-body electrolyte depletion, which may amount to thousands of millimols. Individuals with renal failure and raised serum electrolytes are therefore likely to require supplementation as refeeding and fluid replacement progresses and renal function improves.

8 Palliative Care in the Context of Food Refusal

Individuals experiencing rapid and sudden deterioration in their condition should have their clinical condition and personal wishes constantly discussed and reviewed. Where they are admitted to hospital and continue to decline treatment or intervention, it is likely they will be returned to their prison or immigration removal centre. It is important to reassess the patient's swallowing and exclude any underlying physical cause for the refusal to eat, eg. Oral thrush, mouth ulcers, gastrointestinal symptoms. Liaison with the dieticians and the prison kitchen for consideration of a soft diet, nutritional supplements etc may also be appropriate again at this stage, and may increase the patient's willingness to consider taking some form of oral intake.

At the stage that terminal care is deemed appropriate, the prison/immigration removal centre will notify NOMS or the UKBA and the persons family. It is recommended that the patient is managed by the healthcare department in a healthcare centre with 24 hour nursing care.

In this situation a high degree of nursing care will be required. Medication may be given with the individual's consent to ease any pain and/or discomfort they may experience as this is not precluded by an advance decision refusing life support. Additionally, expertise from healthcare and community-based specialists in palliative care, such as community nursing services, should be sought and can provide invaluable guidance on possible adaptations to the individual's care, such as additional nursing care, changes to their medication, or the suitability of pressure-relieving beds.

Psychological support and, where appropriate, support for religion or faith according to the person's beliefs should be provided. Should the prisoner or detainee decide to end their food or fluid refusal, or wish to be treated during this phase, then transfer to hospital should take place promptly.

9 Training

There is no mandatory training associated with this policy. Ad hoc training sessions based on training needs can be organised through Practice Plus Group

Dissemination of this document will be via the Head of Healthcare in each department and clinical leads on each site. Notifications will be posted on the Practice Plus Group intranet.

Copies of this guideline can be found on Practice Plus Group intranet

10 Definitions

The terms used in this document are defined as follows:

9.0 PSI: Prison Service Instruction

9.1 NICE: National Institute of Health and Clinical Excellence

9.2 BAPEN: British Association of Parenteral and Enteral Nutrition

9.3 ESPEN: European Society of Parenteral and Enteral Nutrition

9.5 ASPEN: American Association of Parenteral and Enteral Nutrition

9.6 eGRF: estimated Glomerular Filtration Rate

9.7 CRP: C reactive protein

9.8 ESR: Erythrocyte Sedimentation Rate

9.9 NGT: Naso gastric Tube

9.10 PN: Parenteral Nutrition

9.11 BMI: Body Mass Index

9.12 U&Es: Urea and Electrolytes

9.13 AKI: Acute Kidney Injury

9.14 NBM: Nil by Mouth

9.15 MUST Manutrition Universal Screening Tool

9.16 NOMS: National Offender Management Service

9.17 UKBA: United Kingdom Border Agency

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Appendix

Appendix 1: Example Refeeding Food Plan

Name	
Number	
Date	
Weight	
Risk of Refeeding syndrome *e.g. High*	
Kcal/kg allowance *e.g. 10kcal/kg*	
Maximum Kcal per day (Calculate by current weight (kg) X Kcal/kg allowance) *e.g. 55kg x 10kcal/kg = 550kcal*	
Number of 100Kcal food portions allowed (Calculate by Maximum Kcal allowance/100) *e.g. 550kcal/100kcal = 5.5 portions per day*	

Example of ~ 100Kcal food portion	**Number of portions allowed:** **My chosen portions (tick up to the number in your portion allowance, try to make choices from each food group)**
Fruit & Vegetables: **(Vegetables are low in calories and high in vitamins, so these foods are good choices if you are at risk of Refeeding Syndrome)**	
1 X Banana	
2 X Oranges/Apples/Pears	
4 X Kiwi fruits/plums	
2 X large bowls of leafy green veg or green salad	
Starchy foods:	
1 X medium slice of bread (white or brown) with margarine	
1 X breakfast pack portion of cereal	
4 X new potatoes or 2 egg sized boiled potatoes	
1 X serving scoop plain pasta	
1 X serving scoop plain rice	
Dairy foods:	
1 X 200ml carton semi skimmed milk or soya equivalent (fortified)	

1 X low fat or natural yoghurt (~125g)	
High protein foods	
2 X serving scoops of peas, beans, chickpeas or lentils	
100g (or ~1/2 tin) tuna in brine	
50g (or ½) breaded fish portion (so if you eat the whole portion, this counts as 2 from your daily allowance)	
1 egg plain omelette	
½ portion chicken leg (so if you eat the whole portion, this counts as 2 from your daily allow-ance)	
Drinks:	
NB: sugar free squash, tea, coffee, herbal teas and diet drinks do not contain any calories, but if you add milk to these then include it as per table; if you add sugar to these it is 20kcal per teaspoon (tsp). Add up how many teaspoons you use. These need to be included in your plan tsp sugar = 20kcal Number used: Total Calories from my allowance:	

For more detail about suitable menu options, speak to your catering manager as availability will vary depending on the site

Appendix 2: Example Oral Nutritional Supplement Plan

Name	
Number	
Date	
Weight	
Risk of Refeeding syndrome ***e.g. Extreme***	
Kcal/kg allowance *e.g. 5kcal/kg*	
Maximum Kcal per day (Calculate by current weight (kg) X Kcal/kg allowance) *e.g. 55kg x 5 kcal = 275kcal per day*	
Number of mls of supplement allowed (Calculate by Maximum Kcal per day/1.5) *e.g. 275kcal/1.5 = 183ml*	
Two hourly plan **(Calculate number of mls to be taken every 2 hours through the core day by dividing total number mls by 8)** *e.g. 183/8 = 23ml*	

Appendix 3: Patient Information Sheet when refusing food or drink

REFUSING FOOD OR DRINK – PRISONER OR DETAINEE ADVICE SHEET

Introduction

You have decided to refuse or severely limit your intake of food and/or drink. This decision is your right but it is important that you know about the likely effects of your actions at the outset. This advice sheet will help you to understand the effects of starvation and why you will be given different medical advice at different stages if you continue to refuse to eat or drink. It also explains why you might need to take great care and even have close medical supervision if you decide to start eating and drinking again after a prolonged period of starvation.

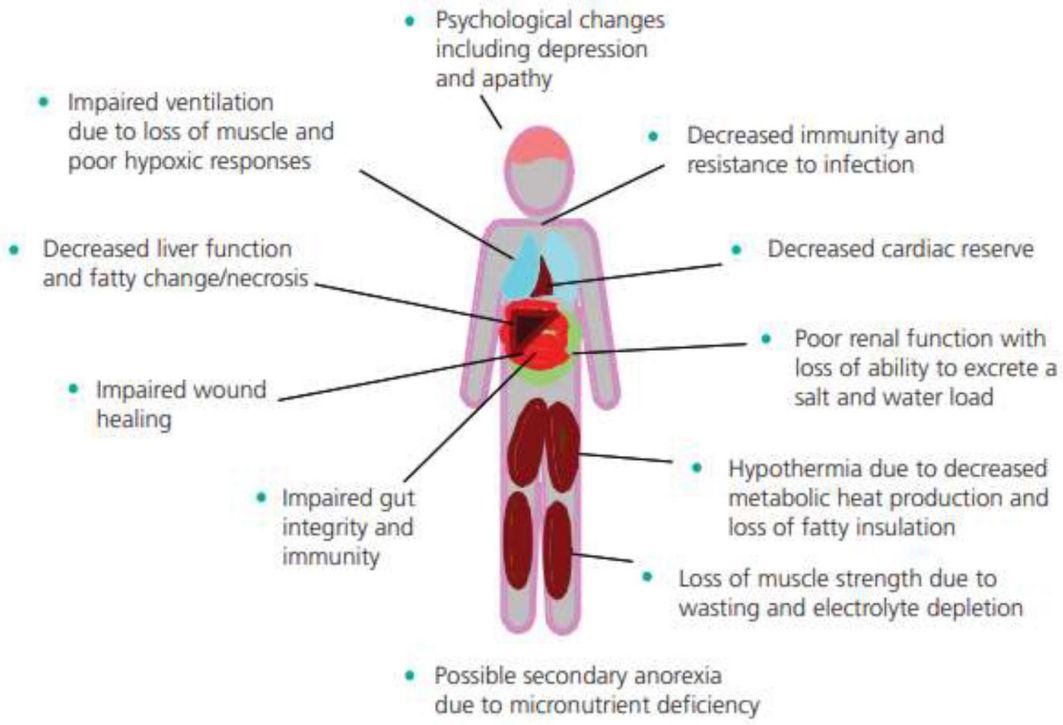
Your Legal Rights

Anybody has the legal right to refuse food and fluids and, although we will try to persuade you to eat and drink, we will not try to feed you against your will unless independent experts believe that you have a psychological or physical illness that makes you unable to decide for yourself. The relevant parts of UK law that allow you to make your own decisions about taking food and fluids (or any other type of treatment) are laid out in Sections 24 to 26 of the Mental Capacity Act 2005 and you can see the details of this if you wish and in the patient information booklet *Making decisions about your health, welfare and finances… Who decides when you can't?* which is available from office of public guardian at gov.uk

Your refusal to consent to having food or fluid remains binding on everybody even if starvation or illness makes you unable to go on resisting feeding or other treatment. You will not therefore be given food or fluids artificially if you continue to make it clear that this is your wish, even if you can no longer express your desires by either talking or indicating them. This applies even if it means that you will die. However, you can change your mind at any time to stop your fast and agree to appropriate treatment.

The Effects of Starvation

Figure 2.1: The effects of malnutrition



Starvation affects every part of the body and it will make you weak and vulnerable to infections. Your skin may become fragile and you are likely to develop uncomfortable or painful sores, particularly in the mouth and on bony pressure points. You may feel cold and people often become constipated although some develop diarrhoea. Lack of food is likely to affect your thinking, probably making you very depressed or withdrawn. Eventually, it will start to damage your major organs which can fail completely, leading to death.

If you are well nourished when you begin to refuse food, and you are prepared to take adequate fluids, you are unlikely to die from starvation for at least six to eight weeks, even if you eat nothing. However, you will be affected in some ways very quickly. Weakness and lowered resistance to infection can occur within three days of refusing all food and, if you are already undernourished when you stop eating, or you have any illness, survival will be much shorter. Even well nourished individuals can die from starvation in three weeks if they become ill.

The Effects of Avoiding Fluids

If you decide to refuse all fluids, your deterioration in health will be extremely rapid and you could die within a week to 10 days, especially during hot weather.

Medical Care During Food Refusal

If you have decided to refuse food or fluids, you will be offered care. This will include an initial assessment of your general health and eating habits and a general physical examination. We would also recommend that you have some blood tests to be sure that you are starting in good health or, that if you do have a problem, you are fully aware of it and the extra risks it might entail. We will also recommend that you take at least one multivitamin supplement each day and that any food that you do decide to eat is reasonable from a nutritional point of view.

If you go on fasting, we will offer you a further medical assessment each week, and more frequent assessments as you become weaker and more likely to develop problems. We will also suggest weekly blood tests which might also need to become more frequent. Whenever you have a medical assessment (and quite possibly at other times), you will be asked to confirm that you do wish to go on refusing food and/or fluids and that you understand the increasing risks.

The Dangers While Refeeding

When the body starves, it loses many minerals and vitamins and the function of all cells and organs is decreased. This can make reintroduction of food quite dangerous. As a result, if you do decide at some point to stop your food refusal protest, you may be advised very strongly to eat very little at first while taking plenty of vitamin and mineral supplement tablets. Indeed, if you have become very malnourished, the dangers of refeeding can be so extreme that you might even be advised to go to hospital for very close monitoring of your heart and blood chemistry while food is trickled back into your system possibly via a tube in the nose.

Choosing a Representative

Since refusing food will eventually lead to your becoming very ill and even dying, you will be asked to find a suitable person to ensure that your wishes are followed once you cannot express them yourself. This could be a relative or friend who you trust, but could also be a member of your own faith, your doctor, an independent doctor if in an immigration removal centre, or another health professional of your choice. Information on the protocol for visits by external medical practitioners to detainees in immigration removal centres can be provided for you. It is clearly essential that you discuss all of your wishes with your representative throughout your period of food refusal and that you feel that they can represent your intentions accurately. You should also appreciate that this may be very difficult for a relative or friend.
(information adapted from from DH 2010 and HMP Stoke Health 2020)

Appendix 4: Link to Advanced Decisions Policy

Guidance can be found on Practice Plus Group Intranet under Policy Manager

https://mypracticeplus.com/policy-manager/2019/07/advance-decisions-in-health-in-justice

Appendix 5: Example of Appropriate Medical Notes Entry

Ensure entry includes:

1. Met with patient, when and at what time.
2. Where the patient was seen (healthcare, cell, Seg etc)
3. Who was present
4. What was discussed.

For Example:
"I met with Mr B in his cell at 2pm this afternoon. I was accompanied by Nurse A and Mr B gave his consent for PO D to also be present. We discussed Mr B's ADRT and the fact he is refusing treatment for [add] He is aware he will deteriorate and die [add timeframe if possible]. We discussed that he is likely to experience the following symptoms [add]. We also discussed who he wanted contacted (i.e. his wife but only after he died), and what palliative treatment, including pain relief he wanted (i.e. paracetamol only)"

5. Setting out capacity assessment was undertaken according to test set out in the MCA
6. Addressing each part of test as appropriate to outcome and the outcome:
   Does the patient have an impairment of, or disturbance in the functioning of the mind or brain?
   No – end test. State the patient therefore has capacity.
   Yes – give reasons why and go on to consider part 2 of the test:
   Does the patient understand the information relevant to the decision? Yes/no and an explanation/detail evidence as to why
   Is the patient able to retain that information? Yes/no and an explanation/detail evidence as to why
   Is the patient able to weight/use the information as part of the process of making a decision? Yes/no and an explanation/detail evidence as to why
   Is the patient able to communicate his decision (whether by talking/using sign language or other means)? Yes/no and an explanation/detail evidence as to why
7. State whether the patient therefore has capacity or not.
8. Detail actions and next steps e.g. "nurse A will draw up a care plan to include Mr Bs wishes as discussed. Nurse A will then discuss this with Mr B and ask him to sign it. I will review again tomorrow"
9. The care plan and any ADRT should be discussed with the patient at least daily whilst they are refusing treatment to ensure they have the option to change their mind. This discussion should be carefully documented in clinical notes.

Appendix 6: Pathogenesis of Refeeding Syndrome

In starvation, insulin concentrations decrease and glucagon increases. As a consequence, glycogen stores are quickly converted to glucose, and gluconeogenesis is activated – resulting in glucose generation from protein and lipid breakdown products. Lipase in adipose tissue is activated releasing a large quantity of fatty acids and glycerol. Free fatty acids and ketones replace glucose as main energy source. In starvation the catabolism of fat and muscle leads to loss of lean body mass, water and minerals (Love 1986, Champe & Harvey 1994)

During Refeeding there is a change in metabolism from fat to carbohydrate. Triggered by the glucose load on feeding, Insulin is released. With carbohydrate repletion and increased insulin production there is an increased movement of glucose, phosphorus, potassium and water into cells. Anabolism and protein synthesis is also stimulated (Champe & Harvey 1994)

Severe hypophosphataemia occurs as a result of low body phosphorus during starvation and the movement of phosphorus into cells during refeeding. This is also associated with low magnesium and low potassium.

In starvation, even though there is total body depletion of electrolytes, serum levels can appear low due to altered rates of renal excretion. It is therefore essential to monitor electrolytes during early stages of feeding as it is during this time the electrolyte shifts will occur (Soloman & Kirby 1990; Brooks & Malnick 1995).

Appendix 7: Clinical sequallae of altered electrolytes in Refeeding Syndrome

(Solomon & Kirby 1990; Brooks & Melnick 1995)

Electro-lyte	Cardiac	Respira-tory	Hepatic	Renal	GI	Neuro-mus-cular	Haem atologic
Low phos-phate	Altered myocar-dial func-tion. Arrhyth-mias Conges-tive heart failure	Acute ventila-tor fail-ure	Liver dysfunc-tion			Lethargy weakness Seizures Confusion Coma Paralysis Rhabdomy-olysis	Anaemia WBC dysfunc-tion Thrombocyto-poenia Haemorrhage Red cell 2, 3 Diphospho-glycerate defi-ciency
Low po-tassium	Arrhyth-mias Cardiac arrest	Respira-tory de-pression	Exacerba-tion of he-patic ence-palopathy	De-creaseed urinary concen-trating ability. Polyuria Polydipsia De-creased GFR	Consti-pation Ileus	Paralysis Rhabdomy-olysis, Weakness	
Low magne-sium	Arrhyth-mia Tachy-cardia	Respira-tory de-pression			Abdo pain Diar-rhoea Consti-pation	Ataxia Confusion Muscle trem-ors Weakness Tetany	
Low cal-cium	Arrhyth-mia					Rhabdomy-olysis Tetany	