

THE STATE HOSPITALS BOARD FOR SCOTLAND

FOOD AND FLUID REFUSAL POLICY

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Accountable Executive Director	Director of Nursing, AHPs and Operations	

The date for review detailed on the front of all State Hospital policies/ procedures/ guidance does not mean that the document becomes invalid from this date. The review date is advisory and the organisation reserves the right to review a policy/ procedure/ guidance at any time due to organisational/legal changes.

Staff are advised to always check that they are using the correct version of any policy/ procedure/ guidance rather than referring to locally held copies.

The most up to date version of all State Hospital policies/ procedures/ guidance can be found on the intranet: <http://intranet.tsh.scot.nhs.uk/Policies/Policy%20Docs/Forms/Category%20View.aspx>

REVIEW SUMMARY SHEET

No changes required to policy (evidence base checked)

Changes required to policy (evidence base checked)

Summary of changes within policy:

- References check and updated
- Change to terminology regarding Senior Charge Nurse to Nurse in Charge
- Prisoner reference changed to patient
- Patient Centred Improvement team removed as a contributing author

Revised

- 21 June 22 – Appendix 3 RiO screen example removed as new system now implemented

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1. Policy Statement

This document provides advice to medical and nursing staff at the point at which physical health is compromised by food or fluid refusal. They explain the roles, responsibilities and process for the management of fluid and food refusal.

2. Intention

The purpose of this policy is to ensure any patient who refuses diet and/or fluids is managed in an appropriate individual manner. This document intends to highlight the legal aspects of managing such situations (in Scotland), explain the physical effects of food and fluid refusal and the most effective clinical practice and clinical management of those refusing to eat and or drink. The recommendations are based on the:

- Adults with incapacity Act 2000.
- Mental Health (care and Treatment) (Scotland) Act 2003.
- NICE guidance of nutritional support in adults (2006)
- BDA Mental Health Group, position statement of refeeding (2010)
- BDA Nasogastric feeding under restraint 2019.
- RCPsych MARSIPAN guidelines on feeding (2010/2014)
- MWC 'Right to treat' 2011
- Food and Fluid refusal in immigration removal centres; Guidance 2013
- Mental Health Act 2015
- MWC Significantly Impaired decision making ability – in individuals with eating disorders 2017
- SPS Food refusal policy 2018

This policy is to ensure that any patient within The State Hospital (TSH) care is adequately supported to eat and drink sufficient food and fluids to meet their individual nutritional needs for health and wellbeing. Patients will be assessed and supported on an individual basis to achieve their targeted needs in a stepwise approach with support from the multidisciplinary team and others as required.

3. Scope

This policy covers all patients within the TSH environment.

This policy does not cover: outpatients, community, carers, relatives, staff and other visitors to the Hospital.

This document aims to provide TSH staff with information about the legal aspects of such practices, the physical effects of food and fluid refusal, and the most effective practical and clinical management of individuals refusing to eat or drink. It also addresses the risks of refeeding, which are considerable in individuals who have been starving but who then decide to eat again.

Many of the recommendations are drawn from expert opinions expressed in 2006 (2017 update) NICE guidelines on nutrition support in adults, modified to take account of the care setting.

This document sets out the signs and symptoms of malnutrition and the effects of starvation. It also covers the identification, assessment and management of a patient who is intent on refusing food and, if appropriate, on recommencing eating and drinking.

A person is classed as refusing to eat and/or drink if this abstinence (less than 10% of their nutritional needs) is maintained for greater than 24 hours for fluids and for 72hours for food – however a person

can survive significantly longer without food than fluids. A patient's initial physical status (e.g. level of weight and hydration) is important to consider.

In addition to those refusing food, those patients who meet the following criteria for anorexia nervosa would also be included.

To be diagnosed with anorexia nervosa according to the DSM-5, the following criteria must be met:

1. Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health.
2. Intense fear of gaining weight or becoming fat, even though underweight.
3. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

Even if all the DSM-5 criteria for anorexia are not met, a serious eating disorder can still be present. Atypical anorexia includes those individuals who meet the criteria for anorexia but who are not underweight despite significant weight loss.

4. Details of Policy

Capacity

Patients and detainees have the legal right to refuse food and fluid, as does anyone receiving treatment in the community. This policy relates to patients in TSH only. *Although all efforts should be made to persuade patients to eat and drink, feeding against the will of anyone who is competent to make their own decisions can be considered assault. Relevant issues are laid out in Sections 24 to 26 of the Mental Capacity Act 2005, which cover advance decisions to refuse any type of treatment; these decisions, and their legal effect, have been analysed in a number of judicial reviews. (Stroud 2009).*

An adult person living in the community, with full mental capacity, has the right to choose whether to eat or not. Even if the refusal is tantamount to suicide, as in the case of a prolonged hunger strike, s/he cannot be compelled to eat or be forcibly fed (B -v- Croydon Health Authority 1995). However, if the patient is detained under the Mental Health Act 1983 he cedes a range of autonomies that may include the autonomy to refuse food or fluid.

It is important to recognise that where the patient is being managed under the Mental Capacity Act 2005 (as opposed to the Mental Health Act 1983) the management of food/drink refusal may amount to a deprivation of liberty (as opposed to a mere restriction). If this is the case it will be necessary to apply for a Standard Authorisation of Liberty (under the MCA's Deprivation of Liberty Safeguards). The board has both a statutory and a common law duty to care for the wellbeing of its patients and act according to their best interests. Consequently, the Responsible Medical Officer (RMO) or the Approved Clinician in charge of the treatment may decide that it is appropriate to intervene and ensure that the patient is nourished

The Mental Capacity Act 2005 Code of Practice describes the assessment of capacity and advance decisions and should be read in conjunction with this document.

A patient may (in Scotland) have an advance statement with regard to their wish to or not to be fed. The key characteristics of an advance decision for the purposes of the Mental Capacity Act 2005 include the following:

- The decision must be made by a person who is 18 or over and at a time when the person has capacity to make it.
- A qualifying advance decision must specify the treatment that is being refused, although this can be in lay terms.
- In order for this to apply to life-sustaining treatment, this must be specifically stated in the advance decision. For example, the person making the advance decision must state that it applies to refeeding as part of life-sustaining treatment, even if their life is at risk and without such treatment the person knows they will die.
- The decision and the statement verifying this must be in writing, signed and the signature witnessed. It is important to note that a person does not physically need to write their advance decision themselves. Advance decisions recorded in medical notes are considered to be in writing. If the person making the advance decision cannot sign it then another person can sign it for them at their direction and in their presence. As with a signature by the person themselves, the witness must be present when the third party signs.
- A person can change or completely withdraw the advance decision if they have capacity to do so. The withdrawal of an advance decision refusing life-sustaining treatment, such as food and fluid refusal, must be in writing.
- If there is doubt or a dispute about the existence, validity or applicability of an advance decision, then the Court of Protection can determine the issue. To be endorsable for the purpose of refusing life-supporting treatment, an advance decision should be valid, specific and applicable.

In Scotland, the decision must be made by a person who is 16 or over and at that time the person must have capacity to make it (AWI 2000).

The 2003 Mental Health Care and Treatment Act allows an individual to make a written statement when they are well, with regard to how they would prefer to be treated (or not treated) should they become unwell, and unable to make treatment decisions in the future. This would cover only treatments for mental disorder given under the 2003 Act and has to be witnessed by certain classes of people in order to be valid (chartered clinical psychologists, medical practitioners, registered occupational therapists, registered nurses, social workers, solicitors and people employed in the provision of (or in managing the provision of) a care service). An advance statement is not the same as a "living will" or an "advance directive" neither of which have any formal legal authority in Scotland and which are more often used in respect of treatment for physical conditions or end of life care. Although the 2003 Act does not state that an advance statement should be dated it should be standard practice for both the person and the witness to date their signatures.

The issue of capacity and consent warrants further consideration to manage. A patient may have capacity but is lacking in concept (reality) then the ability to support feeding under section 16 of the MH Act (T2/T3 required) for artificial nutrition can be adopted. Under an emergency civil duty of care (S243) second opinion for feeding is required.

Communication

Barriers to communication in a high secure setting are likely and multi-factorial in nature, from level of comprehension to clinical engagement. The clinical team are responsible for ensuring patients can fully comprehend the course of action. This role requires the clinical team to identify and source external input where required. For example; interpretation, translation, augmentative communication (electronic), other solutions may include Braille, BSL, and audio which support a patient to engage with interventions.

The Effects of Malnutrition

Malnutrition affects every system, causing vulnerability to infection, poor wound healing, impaired organ function, muscle weakness, depression and apathy.

Starvation is also accompanied by adaptive changes in metabolism, which, coupled with the poor nutritional intake, lead to changes in cell function and depletion of specific electrolytes, minerals and micronutrients. These need to be appreciated when offering care to the malnourished. The likely changes include: deficiencies of specific vitamins and trace elements; decreases in active cell membrane pumping in response to deficient energy, causing whole-body depletion of intracellular potassium, magnesium, and phosphate, with simultaneous increases in intracellular sodium and water; low insulin concentrations and a partial switch from carbohydrate metabolism to ketone metabolism to provide energy; and reductions in protein synthesis.

If an individual is well nourished at the beginning of a fast and is prepared to take adequate fluid, they are usually at little risk of dying from malnutrition for at least six to eight weeks after commencing a complete fast. Nevertheless, the onset of some debilitation and vulnerability is extremely rapid and declines in muscle strength and resistance to infection, for example, are measurable within three days of refusing all food. Patients who may be undernourished to some extent before commencing food refusal and, furthermore, intercurrent illness or other co morbidity has dramatic effects on starvation and chances of survival. Indeed, it is estimated that previously normally nourished individuals can die from malnutrition within three weeks of stopping food intake if they are severely ill. Death from malnutrition is usually due to intercurrent infection or organ failure rather than from tissue loss per se. This reflects both specific nutrient deficiencies and the shutdown of metabolic functions which can occur when individuals are still of normal or even excessive weight, if they were obese at the start of their fast. If an individual is refusing all fluids as well as food, deterioration is very rapid, with death quite possible within 7 to 14 days, especially during hotter periods of the year

Establish the primary reason for food refusal

Patients may opt to refuse food and/or fluids as a method of protesting their innocence, highlighting a cause or remorse for an offence, such as a murder. It is important that any lack of mental capacity and/or mental illness is identified. Clearly established mental illnesses, particularly those in which delusional thought is common, such as depression or psychosis, may influence behaviour. Individuals may believe that their food is poisoned or their bowels will block if food is eaten. The lack of mental capacity must be considered, as its lack may influence matters by making the subject unable to comprehend the seriousness of the situation and the consequence that food refusal can have a fatal outcome. As a consequence, it is advisable to arrange a mental health and mental capacity assessment within the first seven to ten days, and at least before the person becomes too weak for thorough assessment. Obviously such an assessment may require translation services if English is not spoken to a sufficiently high standard.

Clinical assessment

It is important to explain to the individual that they are being examined so that healthcare professionals can monitor their health and well-being as it is the staff's objective to keep them as well as possible during the period of time they are fasting. As long as the individual refusing food agrees to the process, it is essential to make a full initial medical assessment. This includes a brief history of past and present medical problems and a full clinical examination.

Specific note should be made of:

- body weight
- temperature
- pulse, blood pressure
- and respiration rates as a baseline

This will allow future observations to be made against this baseline. Undernourished individuals may not show the normal signs of infection and, paradoxically, undernourishment may cause a fall in body temperature and white cell count rather than the normally observed rise. A minimum screen of chest

X-ray, urine microbiology and blood cultures must accompany any suspicion of intercurrent illness or non-specific deterioration in the severely malnourished, with other tests as appropriate.

A thorough assessment of nutritional status is always needed. This consists of establishing levels of recent food intake and usual body weight (from previously recorded measures and/or an individual's recollection), and performing a specific nutritional examination.

This comprises measurement of:

- current body weight and height to calculate body mass index (BMI) (namely weight in kilograms divided by height in metres squared, i.e. $BMI = kg/m^2$)
- and inspection for the presence of muscle wasting and loss of subcutaneous fat

Clothed appearances can be very deceptive especially in individuals who have developed limb oedema, which can make extremely thin arms and legs look quite robust. Individuals must therefore be examined in suitable clinical surroundings, dressed in only underwear. If this is not possible, you must at least ensure that you pull up their sleeve to get a more accurate picture of true upper-arm circumference.

Specific checks for signs of vitamin and other nutrient deficiencies must also be made.

These include:

- *Mouth*: A red, sore tongue suggests B group vitamin deficiencies, while a smooth tongue may reflect iron deficiency. If the individual is consuming any food or fluid, ask if it is painful to eat or drink and whether their sense of taste is normal (some deficiencies, such as zinc, can cause loss or alteration of taste sensation).
 - Poor iron status can also cause sores at each side of the mouth which hurt when eating or speaking (angular cheilitis), while more generalised peri-oral sores, especially if the patient also has a perineal rash, suggest zinc depletion.
 - Swollen, bleeding gums with loss of teeth occur in scurvy from vitamin C deficiency.
- *Hair*: Recent abnormal hair loss or a change in hair growth towards finer, curly hair can follow any severe or chronic illness but is particularly seen in malnourished individuals developing trace element deficiencies.
- *Skin*: Specifically look for thinning of the skin, damage from minimal trauma and poor repair to such damage. The skin over the knuckles and back of the hand seems particularly vulnerable and appearances may resemble severe dermatitis. The skin over the anterior aspect of the lower leg also seems particularly prone to changes from malnourishment, with dry, fragile, flaking “snake” skin suggestive of essential fatty acid deficiency. Specific rashes or skin abnormalities can also indicate deficiencies such as zinc, vitamin C and some B group vitamins.
- *Nails*: Periods of poor nutrition lead to poor nail growth and nails that break easily. If these periods have been intermittent, the nails are sometimes horizontally ridged. Fragile, thin, spoon-shaped nails are another sign of iron deficiency.

While performing the general clinical examination, pay close attention to hydration status, noting signs of both under- and over-hydration. Dehydration is suggested by loss of skin turgor, pale and cold extremities, a dry tongue, dry oral mucosa and sunken eyes. Fluid overload is suggested by a raised jugular venous pressure or signs of pulmonary congestion. The development of oedema in malnourished individuals who have no other likely cause, such as congestive cardiac failure, is a worrying sign, often occurring in individuals who are developing infection or significant organ dysfunction. In the past, it has often been ascribed to a low serum albumin caused by malnourishment, but in recent years this view has changed and most experts now agree that albumin levels have nothing to do with nutritional status. Even patients approaching death from malnutrition, for example with a BMI of 10–11, often have entirely normal albumin levels, and even low protein starvation does not cause low albumin per se although it makes it more likely that the individual will

become ill while still at a higher body weight. Low albumin with or without oedema should therefore be viewed as a marker of illness, indicating that the individual is mounting an inflammatory response, usually to overt or hidden infection. Medical assessments and advice from health professionals working for the prison or immigration removal centre may be perceived as threats and, if this is the case, the possibility of finding alternative “impartial” health professionals to undertake such assessments should be explored.

Laboratory assessments

Although haematological and biochemical measurements can contribute to nutritional assessment, none are specific for nutritional risk. If the patient is agreeable, the following parameters should be checked initially, with plans to monitor them as food refusal continues, and especially to continue their monitoring were the individual to decide to recommence feeding.

- *Full blood count (FBC)*: Malnutrition may be accompanied by anaemia and, when present, haematinics should be measured. Many undernourished individuals have a low white cell count with possible reductions in both lymphocytes and neutrophils. A raised neutrophil count should raise the suspicion of infection but so should a sudden fall. The severely malnourished can have partial bone marrow failure which is unmasked if white cells accumulate in an area of infection but cannot be replaced rapidly enough in the circulation.
- *Urea and electrolytes*: Malnourished individuals often have a dangerously low plasma potassium level, particularly with any refeeding. However, because it is a predominantly intracellular cation, even significant whole-body depletion may not be accompanied by low plasma values. Indeed, high plasma potassium levels may be seen in an individual who is actually depleted in whole-body terms, if they have also developed any renal impairment from ingesting little or no fluid. Obviously, the biochemical abnormalities may then include raised or rising creatinine and urea levels, but in individuals of very low body weight, these renal indices may be far lower than expected for a given level of renal dysfunction.
- *Magnesium and calcium*: Low magnesium levels are also common in malnourishment, especially with refeeding. Low calcium levels are less common and, if present, should prompt assessment of vitamin D status since they suggest osteomalacia (bone alkaline phosphatase levels may be raised in these circumstances).
- *Phosphate*: Low plasma phosphate levels are extremely common in the malnourished and pose significant dangers. However, as with potassium, it is important to recognise that whole-body depletion may not be reflected in low plasma values and, indeed, that plasma levels may be high if there is any degree of renal failure. If this is the case, phosphate levels may plummet to a life-threatening degree with refeeding, especially if simultaneous fluid administration corrects any renal impairment. *C-reactive protein (CRP) and erythrocyte sedimentation rate (ESR)*: An unexplained raised or rising CRP or ESR should be taken to indicate infection, even if there are no other symptoms or signs, and in the severely malnourished this should prompt treatment (see below). *Glucose*: Glucose levels are often low and may require specific support in the very malnourished. An acute hypoglycaemic episode is another indicator of latent infection.
- *Liver function tests*: Liver function tests are frequently abnormal in the malnourished, usually with raised transaminases (alanine transaminase (ALT) or aspartate transaminase (AST)) with lesser effects on alkaline phosphatase (ALP). Synthetic function reflected in albumin or International Normalised Ratio, prothrombin time (INR) is usually normal, and any disturbance of these should be considered worrying. Low albumin is seen with infection (usually accompanied by raised CRP) while increased INR usually reflects acute liver steatosis and necrosis, often as the result of refeeding. In these circumstances, transaminase levels can be very high, reaching values in the thousands. If the individual does develop abnormal blood tests, the implications should be discussed with them and decisions made on what, if any, treatments are acceptable to them.

Re-feeding syndrome (RFS)

An individual who decides to recommence eating after refusing food for more than a few days is at potential risk of refeeding syndrome, especially if they were malnourished at the outset. Refeeding

syndrome can be fatal and hence caution is needed, necessitating the need of medical and dietetic assessment.

The PEN group guidance identify those at risk whom have had very little or no food for > 5 days, this being high risk if their BMI<16kg/m² with little or no diet for 5-10 days.

Table 1: Individuals at High Risk of Refeeding Syndrome (NICE 2006)

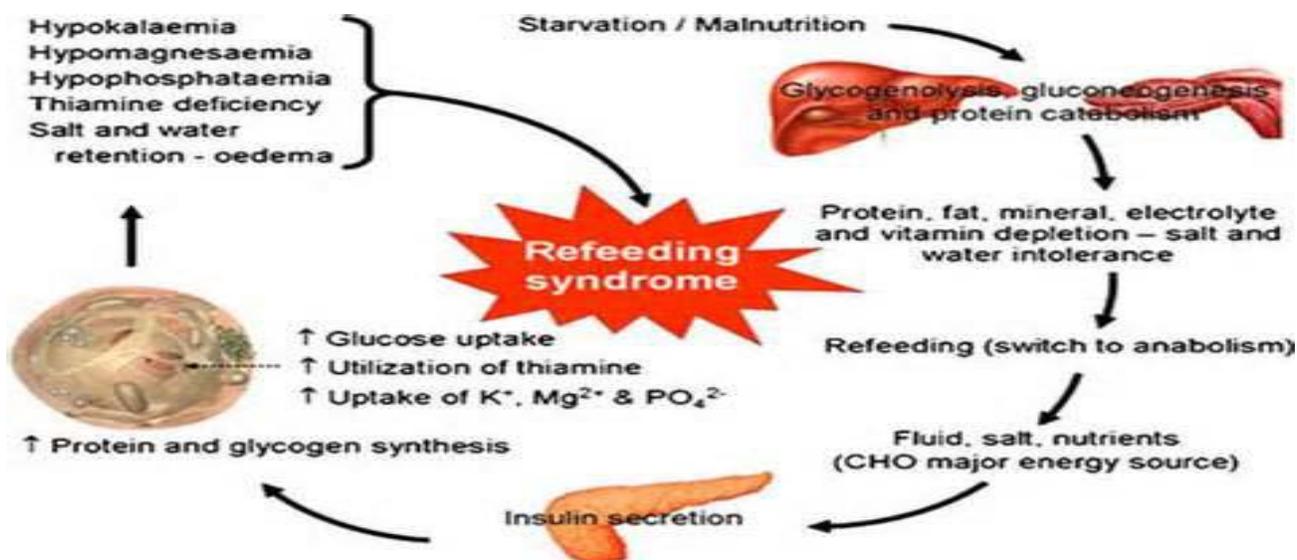
Patient has one or more of the following:	Patient has two or more of the following:
<ul style="list-style-type: none"> BMI less than 16 kg/m² Unintentional weight loss greater than 15% within the last 3–6 months Little or no nutritional intake for more than 10 days Low levels of potassium, phosphate or magnesium prior to feeding. 	<ul style="list-style-type: none"> BMI less than 18.5 kg/m² Unintentional weight loss greater than 10% within the last 3–6 months Little or no nutritional intake for more than 5 days A history of alcohol abuse or drugs including insulin, chemotherapy, antacids or diuretics

Refeeding syndrome encompasses a range of life-threatening clinical and biochemical abnormalities occurring when food is given to starving individuals.

Problems include:

- cardiac failure
- pulmonary oedema and dysrhythmias
- acute circulatory fluid overload or circulatory fluid depletion
- hypophosphataemia;
- hypokalaemia
- hypomagnesaemia and occasionally hypocalcaemia;
- hypoglycaemia
- rhabdomyolysis
- neurological manifestations
- and liver dysfunction

Pathophysiology



Literature (e.g. MARSIPAN guidelines and BDA food re-introduction in re-feeding syndrome) highlights the degrees of risk and provides guidance on reintroducing food relative to the risk category. In extreme cases, this may entail tightly controlled reintroduction of nutrients with careful physical and biochemical monitoring in a hospital setting.

Individuals at modest, high or extreme risk from refeeding syndrome should have their management discussed with one of the dietitians and a general medic at the end of a fast. Hospital admission may well be the most reliable way to institute refeeding for these individuals so that their clinical state, including temperature, blood pressure, respiration rate, body weight, fluid balance and biochemistry, can be rigorously monitored while controlled dietary intake and adequate vitamin and electrolyte supplements are started.

Wernicke-Korsakoff syndrome

This syndrome occurs due to acute thiamine deficiency because of increased thiamine demand as starving cells switch back to carbohydrate metabolism. Wernicke-Korsakoff syndrome is seen particularly frequently in alcoholics who may have low liver stores of thiamine, but it can occur in any starved individual on recommencement of food intake.

This syndrome, accompanied by acute neurological abnormalities, involves one or more of the following:

- apathy and disorientation
- nystagmus
- ophthalmoplegia or other eye movement disorders

5. Roles and Responsibilities

It is important that professionals involved in implementing these guidelines have the necessary skills, competence and support to deliver a high quality of care within the professional codes of conduct. All healthcare professionals who are directly involved in patient care need to ensure that patients nutritional and hydration needs are met by monitoring using the appropriate charts.

Clinical Team/involved Healthcare professionals

Identification of any patient 'at risk' of food and or fluid refusal is the responsibility of any member of the clinical team to highlight. Initial recording and accurate documenting of all diet and fluids taken and those offered and refused is essential, using the agreed Food, fluid and elimination chart (Appendix 1).

RMO/Consultant has a responsibility to:

- lead the clinical team in decisions regarding appropriate psychiatric and medical care of a patient refusing diet and or fluids for a period of time.
- liaise with the clinical team regarding level of risk and direct need for transfer of care for feeding/fluids as required and/or the establishment of the provision of fluids at ward level (IV/sub cut).
- advise the necessary authorities of such needs (for example, the Scottish Ministers for a restricted patient that required transfer to Hospital).
- liaise with pharmacy regarding any need for changes of medication (dose/type related).
- support dietetics with the provision of any agreed artificial feeding.
- support negotiating with patient regarding diet and fluids, advising patient of risk.
- liaise with family/carers' regarding input and level of physical health risk at this time.
- address any issues in relation to patient's mental state and/or capacity as it pertains to their intake (or lack thereof) of food and/or fluids.

Dietitian

- The Dietitian role is to assess the patient's nutritional requirements (using known weight if available, or alternative methods) and advise of appropriate method and type of feeding to meet the patient's clinical needs.
- Regular monitoring and ongoing assessment, to support change in meal plan as required.
- Liaise with Multi-disciplinary team regarding ongoing issues and needs.
- Aim for patient to resume food and fluid to support nutritional needs and maintain optimum BMI for that individual.

Catering

- To support the request for any reasonable additional or alternative food items for a designated period of time to support managing the clinical situation.

Senior Charge Nurse/Nurse in Charge

- To maintain regular (daily) contact with carers/family/named person as appropriate regarding management of individual refusing diet and fluids and updates those with plan of care.

Nursing

- To support the patient's physical health, encouraging diet and fluids relevant to their needs to meet their nutritional requirements in a timely manner depending on the clinical picture.
 - Complete nutritional screening using The State Hospital – Nutrition Screening Tool (Appendix 2) within 7 days of admission (to identify risk) (on Rio).
 - Complete the Health and Wellbeing plan on RiO to address nutritional needs in line with dietetics and other member of the MDT (and update timely as required).
- To assist the patient with their physical needs as any deterioration in their physical health negates assistance.
- To provide regular physical health monitoring as guided by clinical team in line with physical health needs (use of standard assessments as appropriate such as Food, Fluid and elimination charts, NEWS scores).
- To appraise family/carers along with nurse in charge/charge nurse senior nursing and RMO as required

Pharmacy

- To liaise with both Medical and Dietetic staff regarding agreed needs, to obtain supplies and ensure accurate prescribing of IV fluids and/or medication for rehydration or re-feeding purposes within the State Hospital site. This would include obtaining IV fluids for rehydration purposes (regime: as per secondary care recommendation), and vitamin/mineral supplementation as per Dietetic recommendations e.g. oral thiamine, vitamin B compound strong and magnesium.

6. Equality and Diversity

The State Hospitals Board (the Board) is committed to valuing and supporting equality and diversity, ensuring patients, carers, volunteers and staff are treated with dignity and respect. Policy development incorporates consideration of the needs of all Protected Characteristic groups in relation to inclusivity, accessibility, equity of impact and attention to practice which may unintentionally cause prejudice and / or discrimination.

The Board recognises the need to ensure all stakeholders are supported to understand information about how services are delivered. Based on what is proportionate and reasonable, we can provide information/documents in alternative formats and are happy to discuss individual needs in this respect.

If information is required in an alternative format, please contact the Person-Centred Improvement Lead on 01555 842072.

Line Managers are responsible for ensuring that staff can undertake their role, adhering to policies and procedures. Specialist advice is available to managers to ensure that reasonable adjustments are in place to enable staff to understand and comply with policies and procedures. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Patient pre-admission assessment processes and ongoing review of individual care and treatment plans support a tailored approach to meeting the needs of patients who experience barriers to communication (e.g. Dementia, Autism, Intellectual Disability, sensory impairment). Rapid access to interpretation / translation services enables an inclusive approach to engage patients for whom English is not their first language. Admission processes include assessment of physical disability with access to local services to support implementation of reasonable adjustments. Patients are encouraged to disclose their faith / religion / beliefs, highlighting any adapted practice required to support individual need in this respect. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Carers / Named Persons are encouraged to highlight any barriers to communication, physical disability or anything else which would prevent them from being meaningfully involved in the patient's care (where the patient has consented) and / or other aspects of the work of the Hospital relevant to their role. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy”.

7. Stakeholder Engagement

Key Stakeholders	Consulted (Y/N)
Patients	N
Staff	Y
TSH Board	Y
Carers	N
Volunteers	N

8. Communication, Implementation, Monitoring and Review of Policy

This policy will be communicated to all stakeholders within The State Hospital via the intranet and through the staff bulletin.

The Advisory Group (PHSG) will be responsible for the implementation and monitoring (case review of incident due to rarity) of this policy. The implementation will be reviewed with audit (quantitative evaluation) of case examples being reviewed after a period of implementation. This period of implementation is unable to be defined as it is dependent on referrals which meet the re-feeding criteria. For example, this can be zero in 12 months or 3 within 9 months.

The policy will be reviewed every three years, unless significant change in national and or local guidelines depicts this is required earlier. If there is a relevant occurrence a review of the procedure can be under taken to assess the impact and relevance of the policy.

9. References

- BDA 2010 BDA MH group, Refeeding protocol for seriously ill patients with anorexia nervosa. Position statement of refeeding

- DoH 2010 Guidelines for the clinical management of people refusing food in immigration removal centres and prisons
- Food and Fluid refusal in immigration removal centres; Guidance 2013
- Guidelines for the clinical management of people refusing food in immigration removal centres and prisons
- MWC 'Right to treat' 2011
- MWC 2014 Good Practice Guide, SIDMA and eating disorders. MWC 2014.
- MWC Significantly Impaired decision making ability – in individuals with eating disorders 2017
- NHS QIS (2006) – Guidance for Referrals to Specialist Eating Disorders Services
- NICE guidance of nutritional support in adults (2006)
- NICE 2008. Enteral feeding practice in Adults. NICE 2008
- PEN Group re-feeding guidelines 2011
- RCPsy MARSIPAN guidelines on feeding (2010)
- SPS Food refusal policy 2018



The State Hospital – Nutrition Screening Tool

Screening Date		Screening undertaken by	
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SECTION 1 - Patients Details	
Patient Name	
Patient Date of Birth	
CHI	
Ward	

Following completion, please file original in patients notes and send copy/email to dietetics department.

SECTION 2 - Calculating BMI																	
Weight (kg) =																	
Height (m) =																	
BMI =	(from BMI chart on separate sheet)																
	<table border="1"> <thead> <tr> <th colspan="2">BMI SCORES</th> </tr> </thead> <tbody> <tr> <td><15</td> <td>2</td> </tr> <tr> <td>15 - 18.4</td> <td>1</td> </tr> <tr> <td>18.5 - 24.9</td> <td>0</td> </tr> <tr> <td>25 - 29.9</td> <td>1</td> </tr> <tr> <td>30 - 34.9</td> <td>2</td> </tr> <tr> <td>35 - 39.9</td> <td>3</td> </tr> <tr> <td>≥40</td> <td>4</td> </tr> </tbody> </table>	BMI SCORES		<15	2	15 - 18.4	1	18.5 - 24.9	0	25 - 29.9	1	30 - 34.9	2	35 - 39.9	3	≥40	4
BMI SCORES																	
<15	2																
15 - 18.4	1																
18.5 - 24.9	0																
25 - 29.9	1																
30 - 34.9	2																
35 - 39.9	3																
≥40	4																
SECTION 2 score from above table (maximum score 4) =																	

(BMI ranges taken from SIGN 8 Guideline)

SECTION 3 - Weight Change	
Has the patient's weight changed in the last 3 months? (NOT last NST score weight).	
<input type="checkbox"/> YES	
<input type="checkbox"/> NO <i>(score 0 for this section and skip to section 4)</i>	
<input type="checkbox"/> UNKNOWN <i>(score 0 for this section and RESCREEN if weight change information becomes available)</i>	
If yes, by how much?	
<input type="checkbox"/> LOSS	kg
<input type="checkbox"/> GAIN	kg
Using the "Weight Change Chart", please enter the weight change score below.	
SECTION 3 score (maximum score 2) =	

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SECTION 4 - Nutritional Assessment		Comments/ Details
1. Has the patient been prescribed an antipsychotic, antidepressant or mood stabiliser?	<input type="checkbox"/> YES = 1 <input type="checkbox"/> NO = 0 <input type="checkbox"/> UNKNOWN = 0	
2. Does the patient have any ongoing physical therapeutic reason for a special diet or require assistance. (Examples are allergies, diabetes, constipation, high cholesterol, ethnic or religious needs physical or learning disability)?	<input type="checkbox"/> YES = 1 <input type="checkbox"/> NO = 0 <input type="checkbox"/> UNKNOWN = 0	
3. Is the patient currently experiencing any physical short-term acute illness, disease or treatment which may limit their ability to meet their current nutritional requirements? (examples are vomiting and diarrhoea, flu, infection, chemotherapy)	<input type="checkbox"/> YES = 1 <input type="checkbox"/> NO = 0 <input type="checkbox"/> UNKNOWN = 0	
4. Does the patient have difficulty chewing, swallowing, or digesting food? (If swallowing difficulties reported, refer directly to Speech and Language Therapist)	<input type="checkbox"/> YES = 1 <input type="checkbox"/> NO = 0 <input type="checkbox"/> UNKNOWN = 0	
5. Does a global assessment of the patient suggest inappropriate nourishment? (loose/tight fitting clothes, fragile skin, poor wound healing, apathy, wasted muscles, poor appetite, altered taste sensation, altered/heavy smoking habits).	<input type="checkbox"/> YES = 1 <input type="checkbox"/> NO = 0 <input type="checkbox"/> UNKNOWN = 0	
6. Does the patient indicate a disordered eating pattern (e.g. bingeing, restricting food) or pre-empt thoughts for food, and/or refuse 2 or more meals a day?	<input type="checkbox"/> YES = 1 <input type="checkbox"/> NO = 0 <input type="checkbox"/> UNKNOWN = 0	
SECTION 4 score (maximum score 6) =		

Please copy the patient's score from each section in the appropriate space below and enter total. Match the overall score to Management Grid scores and note action required.

SECTION 5 - Overall Score and patient management	
Section 2 score	
Section 3 score	
Section 4 score	
TOTAL	



MANAGEMENT GRID	SCORE	0	1-2	3-5	6 or above
	RISK	Minimal Risk	Low Risk	Medium Risk	High Risk
	ACTION	No action required, routine care	Observe, Healthy Eating Diet	Referral to Dietician Set up weight trigger points	Urgent Referral to Dietician
	SCREENING	Annually <small>IF ADMISSION PATIENT SCORES 0 RESCREEN IN 3 MONTHS.</small>	Quarterly	Monthly	Monitor and review weekly

This Nutritional Screening Tool does not replace your professional clinical judgement, if there are additional clinical concerns please discuss with relevant services/CTM.