

**TRUST-WIDE CLINICAL GUIDANCE DOCUMENT**

# GUIDELINES FOR FOOD & FLUID REFUSAL

Policy Number:	SD-G1
Scope of this Document:	All Staff
Recommending Committee:	<ul style="list-style-type: none"> <li>• Secure Division Physical Health Care Group</li> <li>• Local Division Physical Health Forum</li> </ul>
Approving Committee:	Executive Committee
Date Ratified:	May 2015
Next Review Date (by):	May 2018
Version Number:	Version 1
Lead Executive Director:	Executive Director of Nursing
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2015 – Version 1

Quality, recovery and wellbeing at the heart of everything we do

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### Further information about this document:

Document name	<b>SD-G1 GUIDELINES FOR FOOD &amp; FLUID REFUSAL</b>
Document summary	<b>The Trust has a statutory duty to provide care and also to look after the physical well being of all its patients. Patients are in a dependent position to the Service. Therefore, the Service must at all times act in accordance with the relevant statutory legislation and, unless indicated otherwise, must act in the best interests of the patient (including preserving life) wherever possible.</b>
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Published by Copies of this document are available from the Author(s) and via the trust's website	<b>Mersey Care NHS Trust 8 Princes Parade Princes Dock St Nicholas Place Liverpool L3 1DL Your Space Extranet: <a href="http://nww.portal.merseycare.nhs.uk">http://nww.portal.merseycare.nhs.uk</a> Trust's Website <a href="http://www.merseycare.nhs.uk">www.merseycare.nhs.uk</a></b>
To be read in conjunction with	<b>Physical Healthcare Policy Dysphagia Policy Enteral feeding Guidelines Food Hygiene Policy Infection prevention and control policy</b>
<b>This document can be made available in a range of alternative formats including various languages, large print and braille etc</b>	
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### Version Control:

		Version History:
Version 1	Executive Committee for Approval	14.5.2015

**SUPPORTING STATEMENTS** – this document should be read in conjunction with the following statements:

### **SAFEGUARDING IS EVERYBODY'S BUSINESS**

All Mersey Care NHS Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

### **EQUALITY AND HUMAN RIGHTS**

Mersey Care NHS Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Trust is committed to carrying out its functions and service delivery in line with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

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## **PURPOSE AND RATIONALE**

### **Purpose**

1. The Trust has a statutory duty to provide a therapeutic, safe living and working environment for patients and to protect the public, including visitors. The Trust's duty is not simply to provide care, but also to look after the physical well being of all its patients.
2. These guidelines provide 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.
3. Many of the Trust's patients are vulnerable, for a variety of reasons. Whilst patients are presumed to have capacity in the absence of contrary evidence, there are patients who may lack capacity on one, some or a range of situation-specific issues (including the capacity to make informed decisions to refuse food or fluids).
4. The Trust manages patients with mental disorder in a variety of community-based and hospital in-patient settings. Dependent upon their circumstances, patients may be managed under the Mental Health Act (formal detention, informal admission, Community Treatment Orders, Guardianship etc). Where a patient lacks the capacity to make an informed decision but is not objecting to admission and/or care/treatment, s/he may be managed under the Mental Capacity Act (MCA). Again, dependent upon the circumstances, the powers used under the MCA may be the general powers (sections 5 & 6), the Deprivation of Liberty Safeguard powers (DoLS) or Court of Protection powers. In emergency situations where any of the above MCA and MHA powers are not in place, interim powers under the Common Law may be applied.
5. The Trust's hospital in-patient services provide differing levels of security determined by patient need and/or the Courts. At one end of the spectrum patients are managed in general psychiatric units where they may or may not be detained against their will. At the other end patients are managed by the Trust's High Secure Services and, without exception, are all detained under the MHA. This latter group is detained in high secure care because of their dangerous, violent or criminal propensities. (see Reference 1)
6. At all times the Trust must act in the best interests of those in their care, including preserving life wherever possible.

### **Rationale**

7. The management of fluid and food refusal is potentially very complicated. These guidelines provide advice in all situations and ensure a consistent approach to the management of food and fluid refusal.
8. The management of fluid and food refusal is potentially very complicated. It ranges from situations in which practitioners will usually be confident (such as dehydration in a setting of severe depressive illness) to those which are

demanding professionally and emotionally (for example: where issues of capacity are unclear and/or where there is doubt over diagnosis).

9. These guidelines are intended to help to provide advice in all situations. All practitioners will be helped by seeking advice from experienced colleagues. There is specific advice in these guidelines for medical staff seeking second opinions on mental disorder and physical treatment together with the need to contact the Medical Director in complex cases either by telephone or, time permitting, in writing. The Trust's Legal Team (Patient Safety Directorate) will also be able to advise in complex cases. There is much experience in this area within the Trust (specifically at both Ashworth Hospital and the Eating Disorders Team at Rathbone). It is very important that practitioners from all professions are aware that they can seek and should seek the advice of their colleagues when dealing with these situations.
10. Physical restraint may need to be used as a last resort, after all practicable efforts to negotiate and persuade the patient to accept adequate fluids and nutrition have failed. It is acknowledged that this may be difficult and distressing and the advice of the Medical Director (or nominated deputy) and Executive Nurse (or nominated deputy) should be sought.

#### **OUTCOME FOCUSED AIMS AND OBJECTIVES**

11. For these Guidelines, the aims and objectives are as follows:
  - (a) To provide a prompt and effective response when a patient's physical health is compromised by fluid and/or food refusal.
  - (b) To take account of the legal and medical factors in deciding whether or not to feed or rehydrate patients against their will and the professional issues for nurses deciding to use restraint techniques.
  - (c) To provide practical advice on caring for patients in these circumstances.
  - (d) To address fluid refusal (see fluid refusal diagram) and food refusal (see food refusal diagram) **separately**. Fluid refusal for more than 24 hours becomes a medical emergency whereas food refusal only may be tolerated for some weeks - the procedure for fluid refusal must be followed when fluid intake is less than 500 ml in 24 hours or fluids are refused altogether.
  - (e) To highlight the dangers arising from re-feeding syndrome when re-introducing food to patients who have not eaten for 7-10 days with evidence of stress and depletion.
  - (f) Do not address treatments for underlying causes of food/fluid refusal (e.g. eating disorders, psychosis, protest).

## **SCOPE**

12. **This policy applies to:** people who access Mersey Care NHS Trust inpatient services.
13. **This policy does not cover:** outpatients, community, carers, relatives, staff and other visitors to the Trust.

## **DUTIES**

14. Trust Board – is responsible for ensuring that effective nutritional care systems are in place and that these are monitored. The provision of good quality food and fluid to meet the requirements of all patients is essential. The Trust supports and promotes the need for effective multi disciplinary working to provide the best possible care for patients, which includes meeting their nutritional needs.
15. **Chief Executive** – is responsible for ensuring the Trust meets its statutory and non-statutory obligations in respect of maintaining appropriate standards of privacy and confidentiality for patients and their carers in relation to the nutritional status, needs and requirements of patients.
16. **Executive Director of Nursing** – is accountable to the Trust Board for the implementation of the Policy and ensuring that appropriate physical health and nutrition care management is monitored and reported to the Trust Board accordingly.
17. **Divisional Head of Services** are responsible for delivering the nutritional and hydration agenda. They will:
  - (a) ensure that specialist advice, support and interventions will be provided according to an individual's dietary needs or preferences, including their religious and/or cultural dietary requirements.
  - (b) oversee a multi disciplinary approach to nutritional care and values the contribution of all staff groups working in partnership with service users and users.
  - (c) seek assurance of work in partnership with service users and carers to promote good nutrition as part of a healthy lifestyle, in keeping with a recovery focused approach, which emphasizes the prevention of poor nutrition as well as treatment.
19. **Modern Matrons and Team Managers** – will ensure:
  - (a) all staff are aware of these Guidelines.
  - (b) all staff have received appropriate training.
  - (c) all equipment is maintained, logged on the Trust medical device inventory and replaced when necessary

- (d) if the service user is discharged before referred to dietetics and nutritional status is a concern this will be included on the GP discharge notification/ Discharge Summary.
20. All **staff working with patients**, if it is relevant to their role and skills, are required to assess and manage physical healthcare in accordance with evidence based practice and trust policy.
21. **Nurses' professional accountability** - all registered nurse practitioners are professionally accountable to the Nursing and Midwifery Council, as well as having a contractual accountability to their employer and accountability to the law for your actions. The Code of Professional Conduct obliges you to put the interests of patients before your own interests and those of your professional colleagues.
22. A registered nurse must:
- Protect and support the health of individual patients and clients
  - Protect and support the health of the wider community
  - Act in such a way that justifies the trust and confidence the public have in you
  - Uphold and enhance the good reputation of the professions.
23. Registered nurses are personally accountable for their practice. This means they are answerable for their actions and omissions, regardless of advice or directions from another professional. They have a duty of care to their patients and clients, who are entitled to receive safe and competent care.
24. To practice competently, they must possess the knowledge, skills and abilities required for lawful, safe/ and effective practice without direct supervision. They must acknowledge the limits of your professional competence and only undertake practice and accept responsibilities for those activities in which you are competent.
25. If an aspect of practice is beyond their level of competence or outside their area of registration, they must obtain help and supervision from a competent practitioner until they and their employer consider that they have acquired the requisite knowledge and skill (see Reference 6)  
If they have any concerns about following the guidelines on food or fluid refusal, in relation to acting in the patient's best interests, they must discuss them with the Care Team.

## **PROCESS / PROCEDURE**

26. **Legal, ethical and professional issues** - when to Act and if Action is Appropriate - Guidelines for Responsible Clinician
- (a) In terms of the decision as to whether one has the right to intervene against a patient's will, there is no real difference between the

refusal of food and the refusal of fluids so they will be addressed together in this section.

- (b) Throughout, two overarching principles apply, namely the doctors' obligation to respect the sanctity of human life and the autonomy which a patient has over her/his personal choices (provided the patient has capacity for the particular choice being made).
- (c) In this country it is the case that 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) (see Reference 2) In other words, the general rule is that the autonomy of the patient is seen as the more important. (NB: in these circumstances we still owe a statutory duty under the MCA to continue to offer food and fluids to those people who refuse it – see MCA Code of Practice, 2007 ed., para. 9.28, p.167).
- (d) However, if the patient is detained under the Mental Health Act 1983 s/he cedes a range of autonomies that may include the autonomy to refuse food or fluid.
- (e) Similarly, if a patient lacks the capacity to refuse food or fluid, s/he will ordinarily cede this specific autonomy under Mental Capacity Act 2005 powers. However, there are exceptions to this (eg a valid Advance Decision to refuse food/fluids).
- (f) NB: 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).
- (g) As stated in the Guidelines Statement above, the Trust has both a statutory and a common law duty to care for the well being of its patients and act according to their best interests. Consequently, the Responsible Clinician (RC) or the Approved Clinician in charge of the treatment may decide that it is appropriate to intervene and ensure that the patient is nourished.

27. **Section 63**

- (a) Where patients are detained under Mental Health Act (MHA 1983) powers intervention against their will may be authorised under section 63 of that Act. This section states: The consent of a patient shall not be required for any medical treatment given to him for the

mental disorder from which he is suffering, if the treatment is given by or under the direction of the Approved Clinician in charge of treatment (Note, however, that this ONLY applies to treatments that do NOT require authorisation under sections 57, 58, 58A or 62 of the Act).

- (b) Medical treatment is very broadly defined in the following terms in Section 145 of the MHA 1983. Medical treatment includes nursing, psychological intervention and specialist mental health rehabilitation and care the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.
- (c) The courts have given a wide interpretation to the type of medical treatment that can be given under Section 63 of the Act to patients with a Mental Disorder. The case of B -v- Croydon Health Authority<sup>2</sup> established that feeding could, in certain circumstances, be seen as a type of medical treatment under Section 63, on the basis that relieving symptoms of a Mental Disorder was as much a part of the treatment as relieving the underlying cause of the Mental Disorder. If, therefore, the food refusal is seen as a symptom of the Mental Disorder, then the RC may authorise the feeding of the patient against his will under Section 63 without having regard to the patient's capacity.
- (d) Similarly, if food/fluid refusal prevents necessary treatment of a mental disorder (even though it may not be a symptom of that mental disorder) then, again, this may be prescribed and administered under Section 63 of the Mental Health Act 1983.
- (e) NOTE: Part IV of the MHA in which Section 63 falls, does NOT apply to patients detained under Sections 5(2), 5(4), 35, 135, 136, or 37(4) (place of safety directions), or to conditionally discharged patients under Sections 42 (2), 73 or 74 not recalled to hospital.
- (f) If a patient detained under Section 35 refuses food there should be plenty of time to review her/his Section. If he refuses fluid, and there is a need for prompt action. Is the fluid refusal a symptom of the patient's Mental Disorder? If so, section 62 would give similar powers to the RC, in this circumstance, as described for Section 63 above.

## 28. **Capacity**

- (a) Capacity and consent are not referred to in Section 63 and are therefore not a requirement of that section. However, if for any reason the clinician decides that food refusal is not connected with, or a result of, the symptoms of mental disorder, then Section 63 will not apply and consideration must be given as to whether the patient has capacity on either food or fluid refusal. It is essential that any decision on capacity in these circumstances is fully recorded with the

reasons for it. Patients may have capacity generally, but not on particular issues, and the clinician must conduct a Mental Capacity Act 2005 compliant assessment of capacity in relation to food and fluid refusal. Capacity may be lost temporarily.

- (b) If the clinician decides that an incident of food refusal does not fall under Section 63, then he must give consideration to whether the patient has the capacity to decide whether to refuse food or fluid.
- (c) The Mental Capacity Act (2005), section 3, states that: “A person is unable to make a decision for himself if he is unable:
  - To understand the information relevant to the decision;
  - To retain that information; or is unable to believe the information; or
  - To use or weigh that information as part of the process of making the decision;
  - To communicate his decision, whether by talking, using sign language or any other means
- (d) The Code of Practice notes: “It should be remembered that:
  - Any assessment as to an individual’s capacity has to be made in relation to the particular decision being made;
  - Capacity in an individual with Mental Disorder can vary over time and should be assessed at the time the decision in question needs to be taken;
  - All assessments of an individual’s capacity should be fully recorded in his notes.”
- (e) If it is thought that the patient does not fall within Section 63 and it is thought that he does have capacity, then the patient’s wishes must be followed. (NB: If the refusal of food and fluids is seen as life-threatening then the patient should be advised to consider making a signed, written, witnessed Advance Decision to this effect. To maintain validity, the Advance Decision must also include a statement acknowledging that in refusing food and drink he risks foreshortening his own life. If the patient does not make a valid written Advance Decision then, at the point he loses capacity, practitioners will default to acting in his best interests. - MCA Code of Practice, *ibid*, paras. 9.24-9.28, pp.166/7).
- (f) If, however, it is thought that the patient does not have capacity, then the doctor has the obligation to act in their best interests subject to the provisions of the Mental Capacity Act 2005. At this point a decision must be made to determine whether or not the proposed in-patient management and interventions amount to a deprivation of liberty. If deprivation of liberty is suspected the patient may need to be managed under the Deprivation of Liberty Safeguards and/or the Court of Protection.

- (g) If the clinician or clinicians in question are unclear as to what powers should apply, they should contact the Trust's Legal Team without delay.
- (h) If there is doubt as to whether the patient has capacity, then a second opinion should be sought. If doubt still remains, an application must be made to the Court of Protection.

29. **Best Interests**

- (a) Best Interest principles and the Doctrine of Necessity derive from common law but, since 2007, they are enshrined in and are subject to the conditions of the Mental Capacity Act 2005.
- (b) The following are extracts from the Mental Capacity Act 2005: "The person making the determination (of what is in a patient's best interests) must... so far as is reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him,... and must consider, so far as is reasonably ascertainable:
  - i. The person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity)
  - ii. The beliefs and values that would be likely to influence his decision if he had capacity, and
  - iii. The other factors that he would be likely to consider if he were able to do so.
- (c) He must take into account, if it is practicable and appropriate to consult them, the views of:
  - i. Anyone named by the person as someone to be consulted on the matter in question or on matters of that kind;
  - ii. Anyone engaged in caring for the person or interested in his welfare;
  - iii. Any done of a lasting power of attorney granted by that person;
  - iv. Any deputy appointed for the person by the court.

30. **The Issue of Advance Decisions**

- (a) Advanced decisions about treatment are dealt with in sections 24, 25 and 26 of the Mental Capacity Act (see also Chapter 9 of the MCA Code of Practice).
- (b) In summary an advanced decision "is not valid" if the patient;
  - i. Has withdrawn the decision at a time when he had capacity to do so;
  - ii. Has, under a Welfare Lasting Power of Attorney created after the advance decision was made, conferred authority on

- the doner to give or refuse consent to the treatment to which the advance decision relates;
- iii. Has done anything else clearly inconsistent with the advance decision remaining his fixed decision.
  - iv. Has not provided a written MCA compliant, Advance Decision in circumstances where the treatment in question is deemed to be a life-saving treatment (see 1.1.3 above)
- (c) An advance decision is not applicable to the treatment in question if at the material time the patient has capacity to give or refuse to consent to it... (or) any circumstances specified in the advance decision are absent, or there are reasonable grounds for believing that circumstances exist which the patient did not anticipate at the time of the advance decision and which would have affected his decision had he anticipated them.”
  - (d) Often clinicians will not have all the information and caution should be exercised before acting against the best interest of the patient on the basis of an advance decision that may not be valid. For example there may be uncertainty as to whether capacity existed at the time the decision was made. The Hospital’s solicitors can be contacted for advice.
  - (e) If a patient is under a Section of the Mental Health Act, then the provisions of the Act may override the advanced decision (but only if it refers to the refusal of a treatment authorised under Part 4 or 4A of the Act).

31. **Court Declarations**

- (a) Under the Mental Capacity Act 2005, all applications for a Court Declaration must be made to the Court of Protection.
- (b) “Section 15 of the Act provides the court with powers to make a declaration (as a ruling) on specific issues. For, example, it can make a declaration as to whether a person has capacity to make a particular decision to give consent for or take a particular action....” (Para 8.15 MCA 2005 Code of Practice, p.142).
- (c) General guidance in respect of Court of Protection applications is provided in Chapter 8 of the above Code of Practice. For specific guidance refer, in particular, to paras 8.7 – 8.24.
- (d) Note that Court of Protection approval should always be sought in advance of the administration of the following treatments (see MCA 2005 Code of Practice, Para 8.18):-
  - Withholding or withdrawal of artificial nutrition and hydration from patients in a permanent vegetative state
  - Organ or bone marrow donation by a person who lacks capacity
  - Non-therapeutic sterilisation

- Any case where there is an unresolved doubt or dispute about whether a particular treatment is in the patient's best interests.

32.

**General Advice**

- (a) In complex situations, and if there is time, it is advised that the following are obtained:
  - i. A second opinion upon the application of Section 63, relevant case law, capacity, duties and limitations under the MCA 2005 and any interventions, from a psychiatrist;
  - ii. A second opinion on the need for a particular treatment at the time and its urgency or otherwise (in the case of food and fluid refusal a Hospital Practitioner or physician would be the most appropriate person);
  - iii. The consequences of not doing it immediately or otherwise (again Hospital Practitioner or physician).
- (b) Lord Donaldson in Re (Reference 3) has given the following advice for cases in which there is doubt with regard to refusal to consent to treatment, which may be helpful if faced with a hunger striker: "A doubt falls to be resolved in favor of the preservation of life".
- (c) If feeding is being carried out for treatment of food refusal under Section 63, the Mental Health Act Commission recognises that further diagnostic and monitoring procedures may need to be carried out e.g. venipuncture, as part of that medical treatment. The House of Lords has ruled that feeding a patient by artificial means can constitute medical treatment. (Reference 4)
- (d) This was reinforced by the judgment which confirmed that nasogastric feeding was a medical process, forming an integral part of the treatment for anorexia nervosa. (Reference 5)

33.

**Record Keeping**

- (a) All interventions and observations by all disciplines at every stage should be recorded in the patient's clinical notes to comply with good practice. Good recording is vital to all clinical practice but in this situation where it is likely that all actions will be scrutinised the need for detailed recording, involvement of the patient and their representatives, advocates, carers and others is essential. Again there is specific advice within this guidance but the general approach is to record the basis of the decision, the decisions made and the action plans in detail at each stage and as far as it appropriate share those with the patient, the legal representative, advocate or others.
- (b) It is important in any consultation that a patient has sufficient appropriate information to be able to understand (if he has capacity) the need to take food/fluid and the consequences (obviously of particular importance) of not doing so. Not only is it

advisable that all such discussions are recorded, but there is also merit in sending the patient a letter containing the relevant information so that a) he can consider it at more leisure b) it can be confirmed that he has been given the information.

### **CONSULTATION**

34. The Guidelines are based on case law, clinical practice, expert opinion and literature listed in the Appendix.
35. The Guidelines have been developed by a group of Mersey Care Trust employees representing dietetics, medicine, nursing, psychology, social work, allied health professionals, legal advisor, pharmacy and clinical effectiveness (details in Appendix One).

### **CONTROLS AND ARCHIVING**

36. The Trust Secretary / Assistant Trust Secretary have responsibility for us the Trust's policy set.

### **IMPLEMENTATION AND MONITORING**

37. The Senior Mental Health Dieticians will develop an implementation plan. They will identify any barriers to the processes described in this Policy and/or substantive changes in current practice requiring inclusion in the implementation plan.
38. The application of this Policy will be monitored by the Trust Physical Health Strategy Group, via reporting of KPI's. CQUIN, audit of implementation of NICE guidelines, PLACE and CQC.

### **TRAINING AND SUPPORT**

39. 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.
40. All healthcare professionals who are directly involved in inpatient care will have the appropriate skills and competencies needed to ensure that service users' nutritional and hydration needs are met by monitoring using the appropriate charts.

41. As a minimum the following training will be in place:

Type of Training	Training Provider	Duration & Frequency
Legal- Mental Capacity Act	<ul style="list-style-type: none"> <li>Staff receive training on induction to the trust.</li> </ul>	Mandatory training
Training on MEWS observations	<ul style="list-style-type: none"> <li>All staff must be able to assess their own competency; clinical staff should identify their continuing professional development needs through appraisal and supervision.</li> <li>All clinical nursing procedures should be carried out in line with Royal Marsden Manual of Clinical Nursing Procedures, 9th edition.</li> <li>All registered and non registered nursing staff must have competencies assessed as per the trusts Physical Healthcare in the Mental Health Setting Skills Passport and Competency Log</li> </ul>	Training and updates as requested.
Training in Re feeding, Documentation of food and fluid charts. Training on MUST nutritional screening	<ul style="list-style-type: none"> <li>Refeeding will be to be included as part of MUST training. Updates to ward based staff when Dietitian is reviewing specific patient clinical condition.</li> </ul>	Training and updates when requested.

## REFERENCES

Reference 1	National Health Service Act (2006)
Reference 2	B -v- Croydon Health Authority [(1995) 2 WLR 294]
Reference 3	In Re T (adult: refusal of treatment ) (1993) Fam 95
Reference 4	Bland -v- Airedale NHS Trust, 1993 AC789.

Reference 5	Fox -v- Riverside Health NHS Trust
Reference 6	Nursing & Midwifery Council (2015). Code of Professional Standards of Practice and Behavior for Nurses and Midwives

## FURTHER READING

American Psychiatric Association (2000) Practice Guideline for the Treatment of Patients with Eating Disorders (Revision): Supplement to the American Journal of Psychiatry\*

BMA/Law Society Assessment of Mental Capacity: Guidance for Doctors and Lawyers (available from the BMA)

Broadmoor Hospital Eating Disorder Group. Feb 2000 Guidelines for the Management of Severely Anorexic Patients.

Crisp Ah & McClelland L 1996 Anorexia Nervosa: Guidelines for Assessment and Treatment in Primary and Secondary Care Psychology Press Hove \*\*

Department of Health (2001) A Reference Guide to Consent for Examination or Treatment

Dixon.W. 1999. Hunger Strikes. Journal of American College Health. 48, 2, 87 - 90

Foster.S. 2000. Force-feeding, self-determination and the right to die. New Law Journal. June, 857 - 858.

Garner DM & Garfinkel PE (eds) 1997 Handbook of Treatment for Eating Disorders 2nd edition The Guildford Press, New York \*\*

General Medical Council Seeking patients consent: the ethical considerations

Hogg C 1996 Eating Disorders: A Guide for Primary Care Eating Disorders Association\*\*

Keywood.K. 1995. B v. Croyden Health Authority 1994, CA: Force-feeding the Hunger Striker under the Mental Health Act 1983. Web Journal of Current Legal Issues in association with Blackstone Press.

Lloyds Law Reports: Medical. 2000. R v. Collins ex P. Brady. 355 - 367.

Medical Law Monitor. 2000. Law report. 7, 5, p.8

Medical Law Reports. 2000. Detained psychiatric patient: forcible feeding and the right to die. 8, 251 - 273. Oxford University Press.

Newman Ward Patient Care Team. 2000 Physical Care Plan: Food refusal. Ashworth Hospital.

NICE. Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition. Clinical guideline 32. February 2006.

Oxford Radcliffe Hospital. 2003 Refeeding Syndrome: Guidelines.

Plunkett S. 2000 Draft Proposed Guidelines on Clinical Management of Food Refusal in Special Hospitals. Ashworth Hospital.

Seedhouse D (1997) Ethics. The Heart of Healthcare Wiley & Son UK\*

\* are in Library stock;

\*\* are available from Inter-Library Loan.

## **APPENDICES**

Appendix 1 - Diagrams for When to Act and if Action is Appropriate – Guidelines for Responsible Clinician

Appendix 2 - Diagram for Fluid Refusal (Multi-disciplinary actions/decisions)

Appendix 3 - Diagram for Fluid Refusal (RC)

Appendix 4 - Diagram for Food Refusal (routine nursing observations and procedures)

Appendix 5 - Diagram for Re-feeding Syndrome

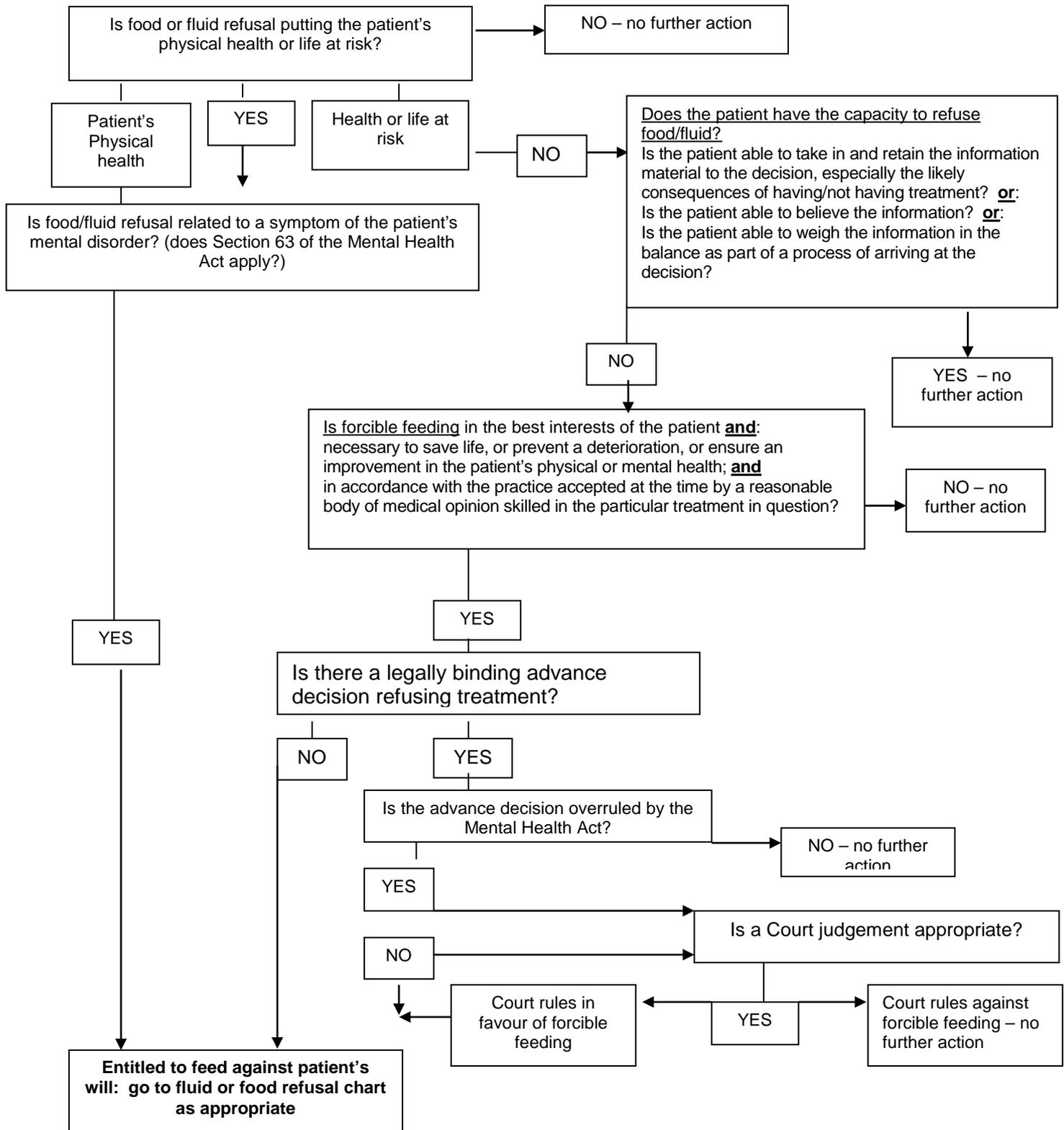
Appendix 6 - Authors Reviewers

Appendix 7 - Guideline Summary

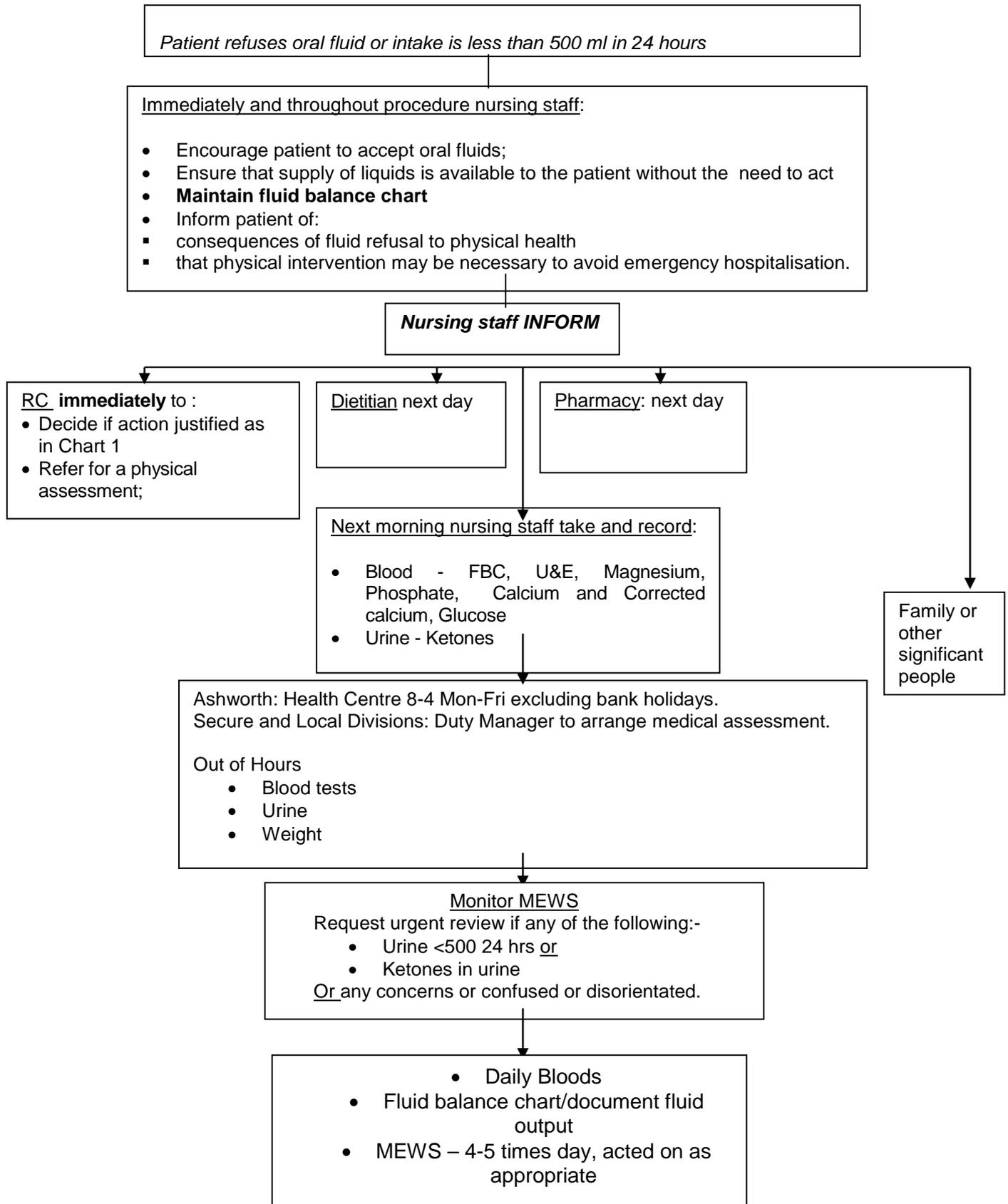
Appendix 8 - Implementation Plan

## Appendix 1 - When to Act and if Action is Appropriate – Guidelines for RC

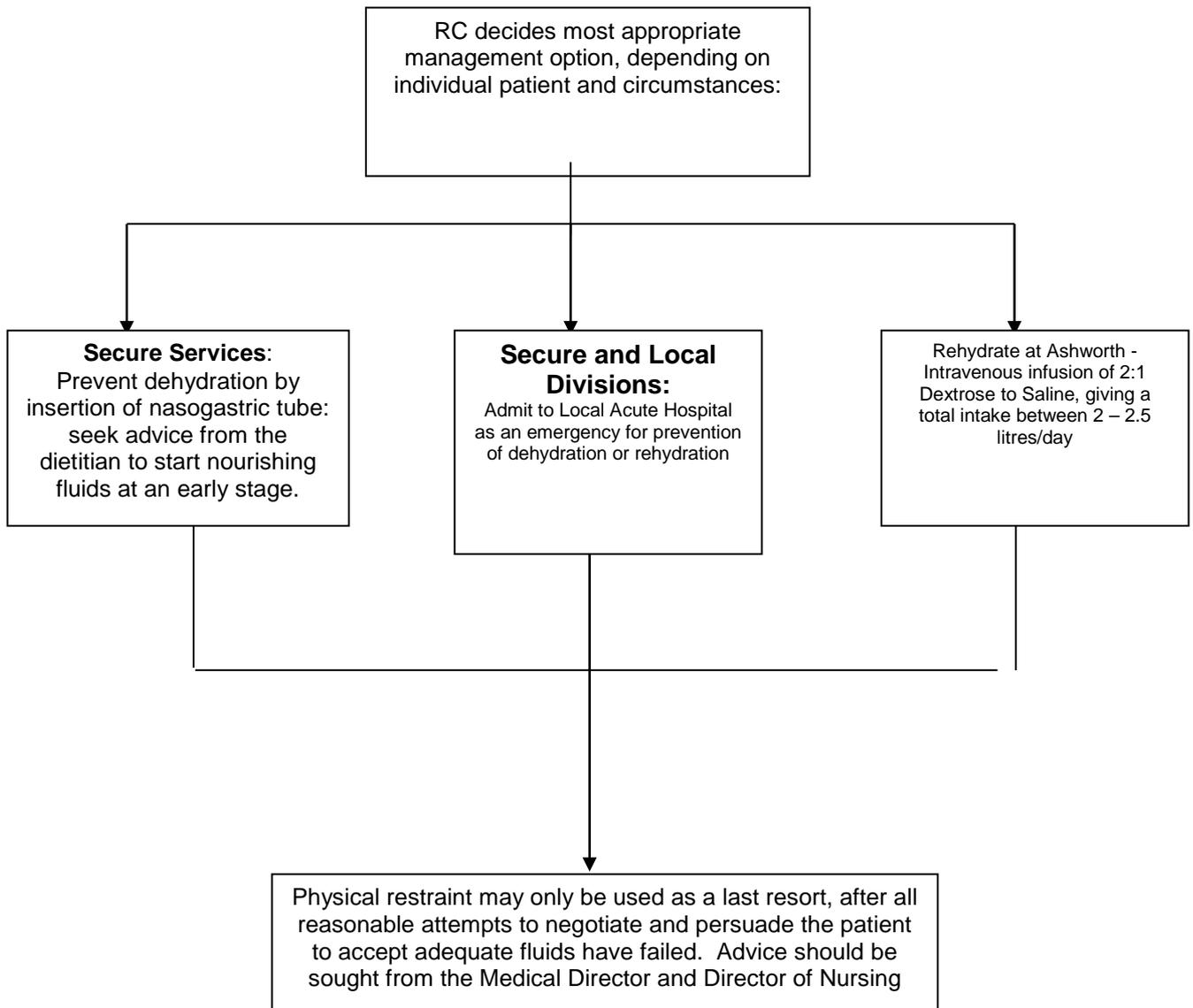
(NB: This chart is an 'aide memoire' to decision-making. RCs, Multi-disciplinary Teams and Clinical Staff must be familiar with the full text of the Guidelines)



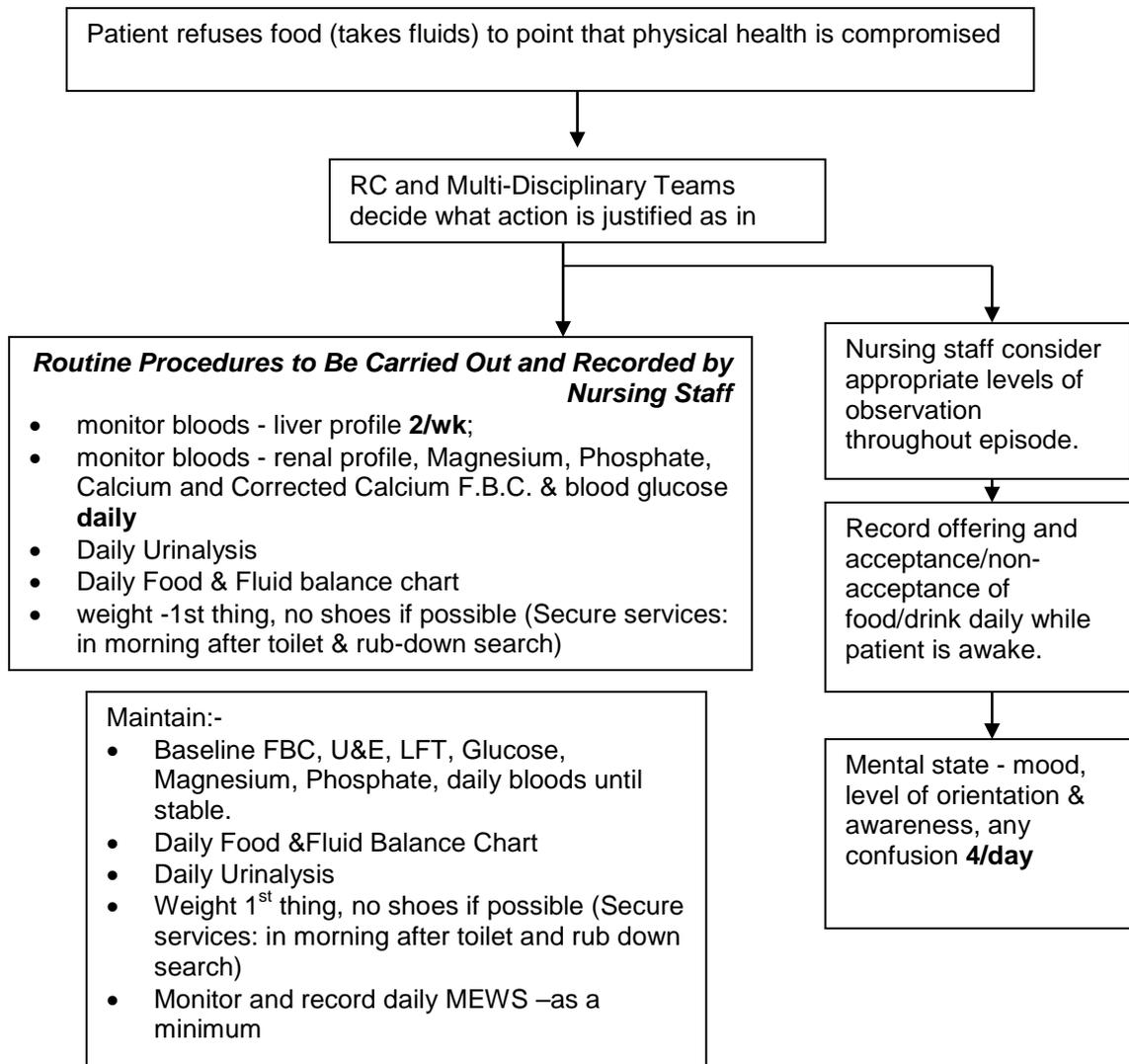
## Appendix 2 - Fluid Refusal (Multi-disciplinary actions/decisions)



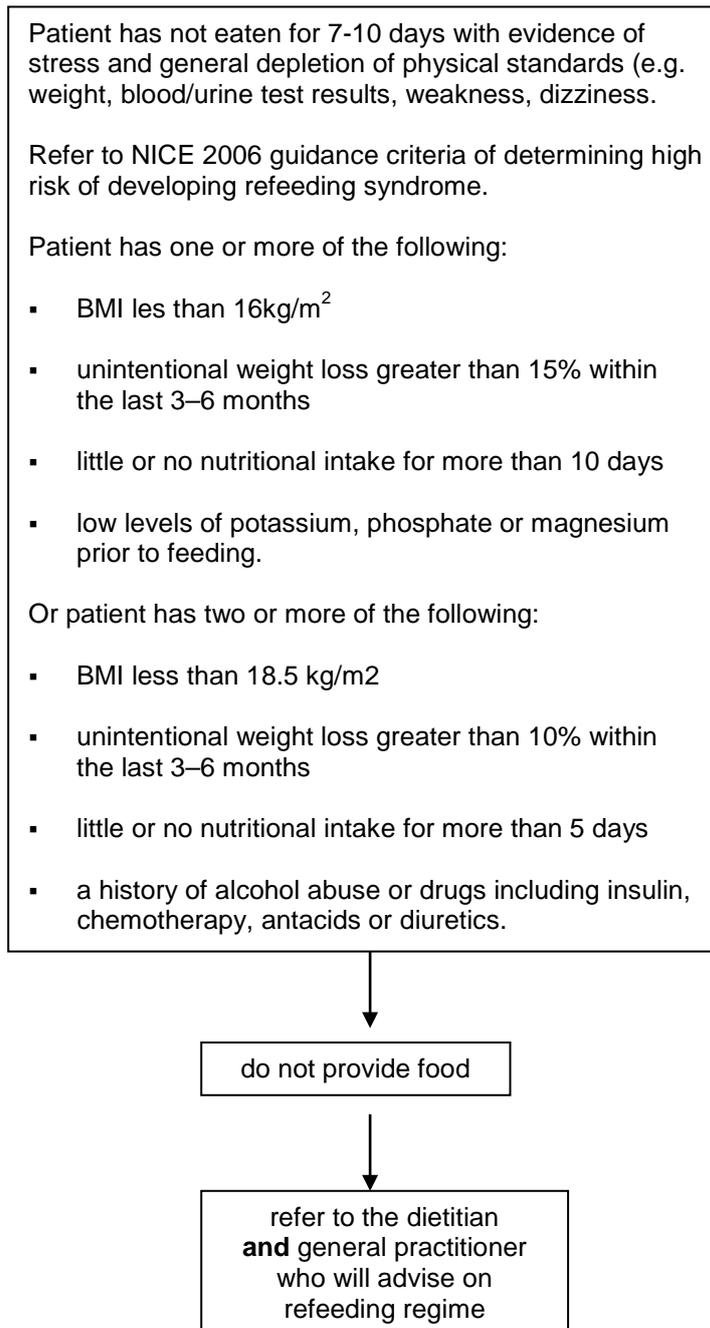
### Appendix 3 - Fluid Refusal (RC)



## Appendix 4 - Food Refusal (routine nursing observations and procedures)



## Appendix 5 - Re-feeding Syndrome



**NB:** inappropriate feeding after a period of starvation can lead to serious complications including death. Detailed guidance from the Oxford Radcliffe Hospital on avoiding refeeding syndrome (appendix 2). Also refer to the NICE 2006 Guidelines Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition for guidance.

## Authors/Reviewers

The Food and Fluid Refusal Guidelines Group consisted of representatives of all main disciplines, drawn from those areas of the hospital with most experience of and responsibility for managing the care of patients who refuse fluid and/or food.

Maggie Clifton (Coordinator)	Research & Development Department
Dr James Collins	RC
Mike Hardman	Social Work
Val Hildrey	Dietitian
Terry Hindle	Nursing/Acacias Ward
Frank Moore	Nursing/Arnold Ward
Keith Scholey	Psychology
B Shaw	Nursing/Beeches Ward
Sarah Smith	Physical Health Centre Manager
Karen Spencer	Occupational Therapy/Rehabilitation Service.

Additional expertise contributed by:

Dr Diane James, Medical Director, Mersey Care NHS Trust  
 Prof. N Krasner, Consultant gastroenterologist, Aintree Hospital NHS Trust  
 Mr J. Wiseman, Mental Health Act Legislation Practitioner

The Food and fluid Refusal guidelines have been reviewed and amended to ensure they are suitable for trust wide use by Representatives of Multidisciplinary Team.

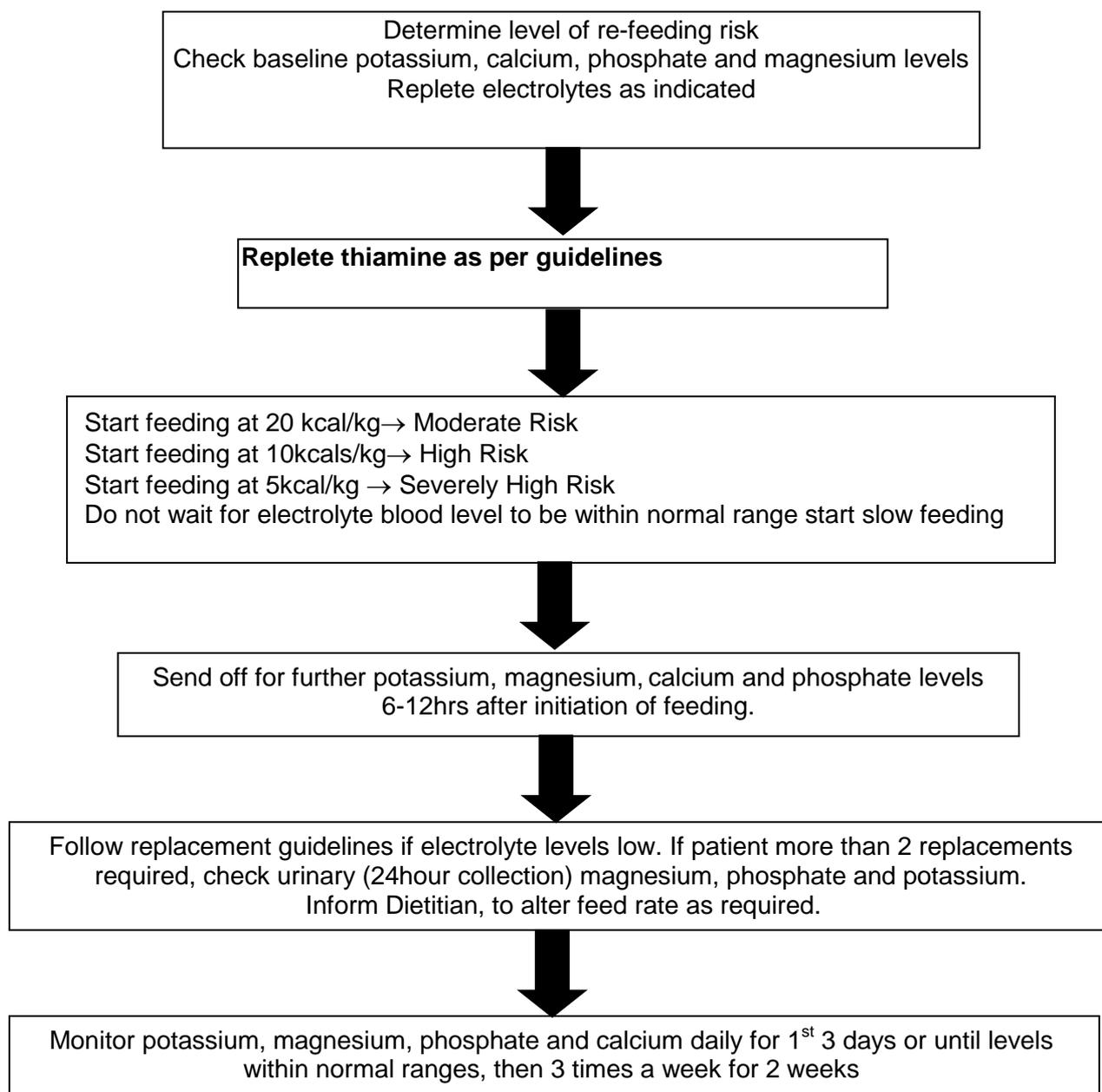
Dr Kevin Booth	GP
Dr Noir Thomas	Consultant Forensic Psychiatrist
Dr Tavernor	Consultant Psychiatrist/Clinical Director
Dr Vinjamuri	Consultant Psychiatrist
Michelle Barton/Laura Clark	Dietitian
Anna Ashton	Dietitian
Steve Clark	Head Pharmacist
Jim Wiseman and Barry Judge	Mental Health Act Legislation Practitioner

The guidelines have been circulated to secure physical health care meeting and physical health forum for comments.

## Guideline Summary

### Oxford Recommendations – Re feeding syndrome flow chart

See full guidelines for definition and list of at risk patients



**MONITORING the severely at risk – Restore circulatory volume and monitor fluid balance and overall clinical status closely. Monitor cardiac rhythm continually in these patients and any other who develop cardiac arrhythmias (NICE 2006)**

## Appendix 8 - IMPLEMENTATION PLAN

	<b>Issues identified/Action to be taken</b>	<b>Timescale</b>
<p><b>1. Co-ordination of implementation</b></p> <ul style="list-style-type: none"> <li>• How will the implementation plan be co-ordinated and by whom?</li> </ul> <p><i>Clear co-ordination is essential to monitor and sustain progress against the implementation plan and resolve any further issues that may arise.</i></p>	<p>Services available to be regularly reviewed and updated by Legal team/ Medics/Primary health care team</p>	<p>On going</p>
<p><b>2. Engaging staff</b></p> <ul style="list-style-type: none"> <li>• Who is affected directly or indirectly by the policy?</li> <li>• Are the most influential staff involved in the implementation?</li> </ul> <p><i>Engaging staff and developing strong working relationships will provide a solid foundation for changes to be made.</i></p>	<p>Policy could potentially affect all staff and patients</p>	<p>On going</p>
<p><b>3. Involving service users and carers</b></p> <ul style="list-style-type: none"> <li>• Is there a need to provide information to service users and carers regarding this policy?</li> <li>• Are there service users, carers, representatives or local organisations who could contribute to the implementation?</li> </ul> <p><i>Involving service users and carers will ensure that any actions taken are in the best interest of services users and carers and that they are better informed about their care.</i></p>	<p>All patients would be informed of the policy should they have an issue with food and fluid refusal</p>	<p>On going</p>

<p><b>4. Communicating</b></p> <ul style="list-style-type: none"> <li>• What are the key messages to communicate to the different stakeholders?</li> <li>• How will these messages be communicated?</li> </ul> <p><i>Effective communication will ensure that all those affected by the policy are kept informed thus smoothing the way for any changes. Promoting achievements can also provide encouragement to those involved.</i></p>	<p>Updated policy available for all staff to access – signatures to be obtained once disseminated.</p>	<p>On going</p>
<p><b>5. Resources</b></p> <ul style="list-style-type: none"> <li>• Have the financial impacts of any changes been established?</li> <li>• Is it possible to set up processes to re-invest any savings?</li> <li>• Are other resources required to enable the implementation of the policy eg. increased staffing, new documentation?</li> </ul> <p><i>Identification of resource impacts is essential at the start of the process to ensure action can be taken to address issues which may arise at a later stage.</i></p>	<p>There is no financial impact to the policy. All training will be provided in house by Dietitian, healthcare staff for clinical issues. Legal team to address concerns.</p>	<p>On going</p>

<p><b>6. Securing and sustaining change</b></p> <ul style="list-style-type: none"> <li>• Have the likely barriers to change and realistic ways to overcome them been identified?</li> <li>• Who needs to change and how do you plan to approach them?</li> <li>• Have arrangements been made with service managers to enable staff to attend briefing and training sessions?</li> <li>• Are arrangements in place to ensure the induction of new staff reflects the policy?</li> </ul> <p><i>Initial barriers to implementation need to be addressed as well as those that may affect the on-going success of the policy</i></p>	<p>Priority to be given to staff to attend information/teaching sessions were patients are currently highlighted at risk. Subsequent sessions to be arranged to communicate changes.</p>	<p>On going</p>
<p><b>7. Evaluating</b></p> <ul style="list-style-type: none"> <li>• What are the main changes in practice that should be seen from the policy?</li> <li>• How might these changes be evaluated?</li> <li>• How will lessons learnt from the implementation of this policy be fed back into the organisation?</li> </ul> <p><i>Evaluating and demonstrating the benefits of new policy is essential to promote the achievements of those involved and justifying changes that have been made.</i></p>	<p>Food and fluid charts to be evaluated. Positive intervention to be fed back to the service. Use of the care pathway to be well documented in the care plan with outcomes</p>	<p>On going</p>
<p>8. Other considerations</p>		

# Equality and Human Rights Analysis

**Title: Trust-Wide Guidelines for food and fluid refusal**

**Area covered: Trust- Wide**

**What are the intended outcomes of this work?**

The Trust manages patients with mental disorder in a variety of in- patient and community settings.

Some patients may be detained under the Mental Health Act and others may in services not detained but have capacity issues.

The Trust has a legal duty to look after all who come under its care.

Most patients/service users will be vulnerable for a variety of reasons and may not be able to make informed decisions in relation to refusing food or fluids. The situations and reasons a person may refuse fluids and food can be quite complex.

These guidelines are intended to help to provide advice in all situations.

**These guidelines seek to**

- Provide framework for caring for patients when their physical health is compromised by fluid and/or food refusal.
- Act in the best interests of patients, including preserving life wherever possible.
- Ensure patients' legal and human rights are addressed.

**Who will be affected?**

**Service users/Patients**

**Staff**

## **Evidence**

**What evidence have you considered?**

**The guidelines and the high secure guidelines.**

**Disability inc. learning disability**  
**Capacity issues are addressed**  
**Mental health Act issues are addressed.**

The management of fluid and food refusal is potentially very complicated. It ranges from situations in which practitioners will usually be confident such as dehydration in a setting of severe depressive illness to those which are demanding professionally and emotionally such as a patient where issues of capacity are unclear who has a psychiatric illness where there has been diagnostic doubt. These guidelines are intended to help to provide advice in all situations. All practitioners will be helped by seeking advice from experienced colleagues. There is specific advice in these guidelines for medical staff seeking second opinions on mental disorder and physical treatment together with the need to contact the Medical Director in complex cases either by telephone or, time permitting, in writing. The hospital solicitors will also be able to advise in complex cases.

**Sex**  
**No issues identified within discussions.**

**Race**  
**No issues identified within discussions.**

**Age**  
**Capacity issues are addressed**  
**Mental health Act issues are addressed.**

**Gender reassignment (including transgender)**  
**No issues identified within discussions.**

**Sexual orientation**  
**No issues identified within discussions.**

**Religion or belief**  
**No issues identified within discussions.**

**Pregnancy and maternity**  
**No issues identified within discussions.**

**Carers**  
**No issues identified within discussions.**

**Other identified groups**

No issues identified within discussions.

Cross cutting

Equality and Human Rights statement included ( page 3).

**Human Rights**

**Is there an impact?**

**How this right could be protected?**

**This section must not be left blank. If the Article is not engaged then this must be stated.**

**Right to life (Article 2)**

**Section 4 page 7 looks at Legal , ethical and professional issues . There are Guidelines specifically for Responsible Clinicians (Medics). In England an adult 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 and cannot be compelled to eat or be forcibly fed(B-v-Croydon Health Authority) Reference 2 p20 ). However if a patient is detained under the Mental Health Act they cede a range of autonomy's and that may include the right to refuse food or fluids.**

**Also if a patient deemed to lack capacity they will also cede autonomy.**

**It is important to note that where a patient is being managed under the Mental Capacity Act 2005 rather the Mental Health Act 1983 the Management of felid/food refusal may amount to a deprivation of liberty . If this is the case it will be necessary to apply for a standard Authorisation Of Liberty.**

	<p>The Trust has a legal duty and common law duty to care for the well being of its patients and act in their best interests.</p>
<p>Right of freedom from inhuman and degrading treatment (Article 3)</p>	<p>It is important to note that where a patient is being managed under the Mental Capacity Act 2005 rather than the Mental Health Act 1983 the Management of Food/Fluid Refusal may amount to a deprivation of liberty. If this is the case it will be necessary to apply for a standard Authorisation Of Liberty.</p> <p><b>Physical restraint and article 3</b></p> <p>Physical restraint may need to be used as a last resort after exhaustive efforts to negotiate and persuade the patient to accept adequate fluids and nutrition. It is acknowledged that this may be difficult and distressing and the advice of the Medical Director (or nominated deputy) and Executive Nurse (or nominated deputy) should be sought.</p> <p><u>This action would appear to be proportionate because it is about trying to help protect the lives of patients and there is a legitimate aim of preserving life.</u></p> <p>These guidelines are intended to provide advice to medical and nursing staff at the point at which physical health is compromised by food or fluid refusal. The</p>

**guidelines:**

- **start when a patient's physical health is compromised by fluid and/or food refusal**
- **include the legal and medical factors to be assessed in deciding whether or not to feed or rehydrate patients against their will and the professional issues for nurses deciding to use restraint techniques;**
- **provide practical advice on caring for patients in these circumstances;**
- **address fluid refusal (pp. 13-14 ) and food refusal (pp. 15) separately - fluid refusal for more than 24 hours becomes a medical emergency whereas food refusal only may be tolerated for some weeks - the procedure for fluid refusal must be followed when fluid intake is less than 500 ml in 24 hours or fluids are refused altogether;**
- **highlight the dangers arising from re-feeding syndrome when re-introducing food to patients who have not eaten for 7-10 days with evidence of stress and depletion; (p. 16)**
- **do not address treatments for underlying causes of food/fluid refusal (e.g. eating disorders, psychosis, protest);**
- **are based on case law, clinical practice and expert opinion.**

<b>Right to liberty (Article 5)</b>	<b>Human Rights Based Approach Supported.</b>
<b>Right to a fair trial (Article 6)</b>	<b>Human Rights Based Approach Supported.</b>
<b>Right to private and family life (Article 8)</b>	<b>Human Rights Based Approach Supported.</b>
<b>Right of freedom of religion or belief (Article 9)</b>	<b>Human Rights Based Approach Supported.</b>
<b>Right to freedom of expression Note: this does not include insulting language such as racism (Article 10)</b>	<b>Human Rights Based Approach Supported.</b>
<b>Right freedom from discrimination (Article 14)</b>	<b>Human Rights Based Approach Supported.</b>

### Engagement and involvement

**Consultation undertaken with Trust wide multidisciplinary groups including Medics/Nursing/Dieticians/Allied Health Care/Legal and Pharmacy/Social Work.**

### Summary of Analysis

**Eliminate discrimination, harassment and victimisation**

**The guidelines are about food and fluid refusal of patients within the Trust.**

**Patients may refuse food and fluids for a variety of issues related to their mental health. The service has a legal duty to act in the 'best interests' of the patient when this occurs. This document sets out the actions and considerations that clinical staff need to be aware of and adhere to.**

**The guidelines do not discriminate against any of the protected groups.**

**They are mindful of the human rights of patients taking into account the issues of capacity, consent and the legal duties of the Trust in caring for patients.**

**Advance equality of opportunity**

**N/A**

**Promote good relations between groups**

**N/A**

**What is the overall impact?**

**No negative impact in relation to the protected characteristics has been identified.**

**The impact is intended to be positive in relation to human rights and in particular article 2 and article 3.**

**Addressing the impact on equalities**

**N/A**

**For the record**

**Name of persons who carried out this assessment (Min of 3 ):**

**Anna Ashton**

**Michelle Barton**

**George Sullivan**

**Date assessment completed: 30.04.2015**

**Name of responsible Director: Executive Director of Nursing**

**Date assessment was signed: 22.05.2015**

# Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

<b>Category</b>	<b>Actions</b>	<b>Target date</b>	<b>Person responsible and their Directorate</b>
<b>Transparency (including publication)</b>	<b>Policy to be placed within the Public Domain via Trust website (including the equality assessment).</b>		