LAC+USC MEDICAL CENTER POLICY

Subject:	Original Issue Date:	Policy #
PATIENTS REFUSING FOOD OR WATER	9/11/12	**239**
	Supersedes: 5/9/17	Effective Date: 9/28/22

Departments Consulted:	Reviewed & Approved by:	Approved by:
Nursing Services Nutrition Services Department of Psychiatry Department of Medicine Office of Risk Management	Attending Staff Association Executive Committee Senior Executive Council	(Signature on File) Chief Medical Officer (Signature on File) Chief Executive Officer

PURPOSE

To establish a process for managing patients who refuse to eat or drink.

POLICY

All members of the multidisciplinary team are responsible for observing inpatient's nutritional status and bringing those observations to the attention of the primary treating physician.

Any inpatient that refuses to drink fluids for more than 2 days and/or refuses to eat for more than 5 days will be assessed by an Internist or Pediatrician, as appropriate. A registered dietitian will be consulted to assess identified patients. Palliative Care Service is to be consulted if the patient has been determined to be hospice eligible.

Minor children (under the age of 18) are unable to make this type of decision and require an adult surrogate for medical decision making.

Patients with capacity will be informed of the risks of not eating and will be provided with the recommendations of the physicians. A registered dietitian will also be consulted to inform the patient of risks of not eating. These discussions will be documented in the patient's medical records.

Patients, who appear to lack capacity or have a mental health diagnosis, will also be evaluated by a Psychiatrist to assess for contributing psychiatric conditions and to provide an assessment of medical decision making capacity. If there are no contributing psychiatric conditions, a Neurologist may be consulted to assess for other cognitive deficits impacting on the patient's ability/desire to eat.

Patients lacking capacity, who are **not involved in any Court oversight such as** a Probate conservatorship, Limited conservatorship, Temporary conservatorship or Lanterman-Petris-Short (LPS) conservatorship (all further referred to as "conservatorship") and have a surrogate decision maker, may have decisions regarding medical conditions, inclusive of feeding, made by the surrogate decision maker. This includes patients on LPS holds (72 hours, 14 day (first or second), 30 day and 180 day holds) as Court oversight is not established. .

Patients lacking capacity, who are **not** on a conservatorship and **do not** have a surrogate decision maker, and for whom feeding is recommended by the primary team, will have a 3200 petition filed with the Probate court asking for authorization to feed the patient against their will. Exception: Emergency situations where waiting on court process would place the patient at risk for death or serious disability.

Patients on conservatorship (conservatees) do not automatically lose the power to make medical decisions. The facility will obtain a copy of the letters of conservatorship to determine who has the power to make decisions for the conserved patients. Exception: Emergency situations where waiting on court process would place the patient at risk for death or serious disability.

Emergency situations, where waiting on a court process would place the patient at risk for death or serious disability, will be evaluated by an attending primary care physician and attending psychiatrist to determine the least restrictive and safest method of feeding the patient.

Acceptable methods of feeding/hydrating patients are: nasogastric feeding tubes, peripheral parenteral nutrition (PPN) or total parenteral nutrition (TPN).

Non-behavioral restraints may be used to safely administer necessary feedings for patients without capacity. See Nursing Policy 567 "Restraints: Non-Behavioral".

The Ethics Committees (Ethics Resource and Fetal, Infant, Child) are available for consultation, if necessary.

DEFINITIONS

Capacity: person's ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risk and alternatives.

Surrogate Decision Maker: person who has been designated to make health care decisions on behalf of the patient during the course of treatment or illness in the healthcare institution.,

Probate Conservatorship: consist of several types of court appointed decision makers on behalf of the incapacitated individual pursuant to California Probate Code section 1800, et seq. : General, Limited and Temporary.

Lanterman-Petris-Short (LPS) Conservatorship: court appointed conservatorship that provides procedural protection to a person's involuntary detainment, mental evaluation and treatment who presents a danger to themselves or others.

Lanterman-Petris-Short (LPS) Holds: involuntary confinement of a person deemed to have a mental disorder that makes them a danger to him/herself, and/or others and/or gravely disabled under the LPS act.

PROCEDURE

I. Minor children:

- Minors (children under the age of 18 years) require an adult surrogate for medical decision making. Unless disqualified through due legal process, parents are the decision-makers for their minor children. There is a strong presumption that parents will act in the best interest of the child. However, if a medical care provider determines that a parental decision is not in the best interest of the minor, as mandated reporters, the medical provider should make an immediate referral to child protection services (DCFS).

- If the need to intervene for the best interest of the child is deemed to be emergent and life threatening if delayed and parental consent has either been withheld or unobtainable, needed emergency care should be provided while referral to child protection agencies is underway. The attending physician in charge of the patient care should document the need for the lifesaving intervention in the medical record.
- Once a DCFS social worker is involved, the social worker is authorized to provide the consent if there is an emergent situation that requires immediate treatment for the alleviation of severe pain or the immediate diagnosis or treatment of an unforeseeable medical, surgical, dental or other remedial condition or contagious disease which if not immediately diagnosed and treated would lead to serious disability or death.

II. Adult patients lacking capacity/not on a conservatorship/with surrogate:

- Surrogate decision maker will be provided with the risks/benefits/alternatives available for the patient to assure adequate nutrition. This will include not only the feeding, but also includes measures that may be taken to safely administer the feeding.
- If, in the judgment of the primary care physician, the surrogate decision maker is not acting in the best interest of the patient, a Probate 3200 petition may be considered for authorization to feed the patient. Contact Risk Management for consultation on 3200 petition process.

III. Adult patient lacking capacity/not on conservatorship/without surrogate:

- If medical assessment indicates a life-threatening status, refer to "emergency procedure" below.
- If medical condition is urgent, but not life-threatening and feeding is recommended, the primary team will contact Risk Management to initiate the Probate 3200 petition process.

IV. Adult patients on conservatorship:

- If medical assessment indicates a life-threatening status, refer to "emergency procedure" below.
- Obtain a copy of the letters of conservatorship.

- Contact the conservator to review letters of conservatorship regarding power to make medical decisions.
- If the conservatee has power to make medical decisions, discuss the situation with conservator and determine the need to inform the court to seek authority to feed the patient.
- If the conservator has power to make medical decisions for the patient, provide the conservator with risks/benefits/alternatives available for the patient to assure adequate nutrition. This will include information about the feeding as well as other measures that may be taken to safely administer the feeding.
- If the conservator does not have the power to make medical decisions for the patient, work with the conservator to prepare court documents (i.e., seven-point letter, declaration) in support of conservator's request to the court for authority to consent for feeding. Risk Management or Psychiatry and the Law Division of Psychiatry may be consulted for assistance.

V. Emergency Procedure:

- The medical urgency to feed a patient without capacity against their will must be documented by the Attending Physician on the primary team.
- The medical record will also contain a statement from an Attending Psychiatrist/Neurologist documenting concurrence that the patient lacks capacity for medical decision making.
- Patients needing urgent feeding and residing in an acute psychiatric bed will be transferred to the General Medicine or Pediatric Service and into an acute medical bed. Exceptions may be made with regard to the primary team assignment if another specialty is deemed more appropriate to serve as the primary team based on the patient's clinical circumstances.

VI. Feeding Patient:

- A registered dietitian will be consulted as to the recommended route, product, volume, rate and timing of the feeding. When possible, the RD (or dietitian) will work with the patient to identify those food preferences the patient is willing to consume.
- A physician order containing specific direction for the feeding, sedation and restraints will be present on the medical record before initiating the feeding.
- The least restraint necessary will be used to safely insert any tube or IV to be used as the route for administering the feeding.
- Restraint must only be used if patient meets criteria for non-behavioral restraints.
- Patients receiving tube feeds will also be offered food trays during regular meal times. Any intake of regular food will be documented in the patient's medical record.
- All patients on feedings will have strict documentation of Intake and Output (I&O).

RESPONSIBILITY

Administrators
Attending Staff
House staff
Allied Health Professionals
Nursing Staff

PROCEDURE DOCUMENTATION (REFERENCES)

California Hospital Association: Consent Manual 38th Edition
Probate Code Section 1800 et seq.
Welfare and Institutions Code 5000 et seq
Welfare and Institutions Code 369 (d)

REVISION DATES

March 11, 2014; May 9, 2017,September 28, 2022