

SUMMARY

DECISION SUPPORT

PATIENT EDUCATION/SELF MANAGEMENT

Italicized words indicate language taken directly from the Mass Organized Hunger Strike Policy, IMSP&P, Volume 4, Chapter 22.2

Goals

- Provide appropriate medical care to patients participating in a mass hunger strike in accordance with Mass Organized Hunger Strike Policy (IMSP 4.22.2)
- Identify patients at risk during fasting
- Identify patients at risk for refeeding syndrome
- Safely refeed patients after fasting

Alerts

- Body Mass Index (BMI) under 18.5
- Food refusal ≥ 28 days
- Medical or mental health comorbidity
- Fluid refusal

Definitions

Hunger Strike: The conscious decision to refuse food or fluids to achieve a goal or set of demands

Mass Hunger Strike: An organized hunger strike including multiple inmates with a common goal and set of demands.

Mass Hunger strike participant: An inmate who is identified by California Department of Corrections and Rehabilitation (CDCR) custody staff as a participant in a mass organized hunger strike.

Refeeding Syndrome (RFS): The term refeeding syndrome describes a potentially fatal medical condition that may affect malnourished and/or ill patients in response to feeding. (See page 7)

Diagnostic Criteria/Evaluation of Fasting & Refeeding Syndrome

FASTING	REFEEDING SYNDROME		
	Negligible Risk	Modest Risk	High Risk
Patients may be at high risk for complications from fasting with any of the following: <ul style="list-style-type: none"> ▪ Pregnancy ▪ Elderly (≥65 years of age) ▪ Baseline BMI less than 18.5 kg/m² ▪ Taking medications that may pose a risk during prolonged fasting (e.g., insulin, antacids, diuretics) ▪ Chronic medical conditions such as: diabetes, hypertension, cancer, malabsorption, end stage liver disease, renal disease, inflammatory bowel disease, congestive heart failure, ischemic heart disease, etc. 	Less than 15 days of hunger strike participation without identified medical risks of fasting	<ul style="list-style-type: none"> ▪ Patients requiring monitoring due to medical risks ▪ Patients with: <ul style="list-style-type: none"> ♦ A BMI >16 but ≤18.5 kg/m² ♦ Loss of >10% but ≤15% of body weight during food refusal ♦ Food refusal of 15-28 days 	<ul style="list-style-type: none"> ▪ BMI ≤16 kg/m² ▪ Weight loss >15% of body weight since starting food refusal ▪ Low potassium, magnesium, or phosphate levels before resumption of feeding ▪ Food refusal for more than 28 days ▪ Medical or mental health conditions creating high risk of complications from fasting

Treatment Summary

1. Designated licensed health care staff will observe all participants daily and will determine if there is a need for immediate medical attention. (Sec. VII.A.5)
2. Health information on starvation, refeeding, and patient care resources should be distributed to hunger strike participants within one week of notification by custody of a hunger strike participant.
3. Within 72 hours of notification by custody that patient-inmates are mass hunger strike participants,
 - a. Health care staff shall review the high risk patient-inmate registries and medication lists to determine if any participants are at a high risk for complications of starvation and refeeding.
 - b. Some high risk participants may be scheduled for a PCP visit, vital signs, and Body Mass Index (BMI) determinations.
 - c. Refusals shall be documented in the eUHR.
 - d. If participants are prescribed high risk medications, a PCP may discontinue or adjust the medication dosage without a PCP visit.
 - e. Participants will be notified in writing regarding medication changes. (Sec. VII.6a)
4. Within one week of notification by custody of a hunger strike participant, the participant will be scheduled for a face-to-face triage assessment by an RN. (Sec. VII.A.7)
5. Appropriate housing for participants should be determined based on daily observation, nurse triage visits, and PCP visits.
6. After two weeks of participation in a hunger strike (as defined by custody), and at least weekly thereafter, all identified participants (even if not in a high risk group) shall be scheduled for a PCP visit which will include a BMI determination. (Sec. VII.A.9)
7. After three weeks of participation in a hunger strike: All hunger strike participants will be provided with written information about advance directive and a Physician Orders for Life Sustaining Treatment (POLST). (Sec. VII.A.11.a)
8. Refeeding:
 - Negligible Risk:** participants can eat and drink freely and require no specific monitoring.
 - Modest Risk:** most participants may be refeed with modified CDCR heart healthy diet for the first 48 hours by providing "1/2 CDCR diet."
 - High Risk:** refeeding will usually occur in a licensed medical setting. Intake is increased from 10 kcal/kg/day to 30 kcal/kg/day over one week. Patients are monitored for fluid, electrolyte, and cardiac abnormalities. (See pages 4-5 for specific refeeding recommendations).

Information contained in the Care Guide is not a substitute for a health care professional's clinical judgment. Evaluation and treatment should be tailored to the individual patient and the clinical circumstances. Furthermore, using this information will not guarantee a specific outcome for each patient. Refer to "Disclaimer Regarding Care Guides" for further clarification.

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MANAGEMENT RECOMMENDATIONS DURING FASTING

Day	<i>Initiate the CCHCS Hunger Strike Policy</i>
<p>Within 1 day of notification of participation in mass hunger strike</p>	<p>While patient-inmates are participating in a hunger strike, health care staff will not prescribe meal replacements including milk, juice, or nutritional supplements for participants, even if they have lost more than 10 percent of their body weight. (Sec. VII.A.8)</p> <p>(For refeeding at any stage, see Refeeding Management page 4-5)</p> <p><u>NURSING</u> Designated licensed health care staff will observe all participants daily and will determine if there is a need for immediate medical attention. (Sec. VII.A.5)</p> <ul style="list-style-type: none"> ◆ Observations should include: <ul style="list-style-type: none"> ▪ visual check of inmates on the hunger strike ▪ brief verbal contact ▪ observation of any obvious health issues ▪ documentation of findings in the eUHR ◆ Education should include: <ul style="list-style-type: none"> ♦ encouraging 1.5 liters or more/day fluid intake ♦ provide patient education hunger strike fact sheet at initial contact regarding fasting and refeeding facts, and medical care information ◆ Within 24 hours of notification to health care executives by custody regarding mass hunger strike participants: All participants will be notified by health care staff that they will continue to be eligible for sick call evaluation per Chapter 4, Access to Care policy. (Sec. VII.A.4.a) ◆ Health care staff will report to the Primary Care (Clinic) RN of all participants with any change in condition that might indicate patient needs housing change/higher level of care. Patients needing immediate health care will be transported to the TTA for evaluation. <p><u>PRIMARY CARE PROVIDER</u> : Evaluation as clinically indicated</p>
<p>1-3 Days after notification of participation in mass hunger strike</p>	<p><u>NURSING</u>: Daily observation</p> <p><u>PRIMARY CARE PROVIDER</u>:</p> <ul style="list-style-type: none"> ▪ <u>IDENTIFY HIGH RISK PATIENTS</u>: Within 72 hours of notification of participation, health care staff will review records to identify patients with conditions or medications placing them at risk for complications during fasting (see page 1) ▪ <u>MEDICATION ADJUSTMENT</u>: Within 72 hours of notification of hunger strike participation: Medications will be dose adjusted or discontinued for patients if their use increases the risk of complications during fasting. (Note: a PCP visit is not required to adjust/discontinue medications) <ul style="list-style-type: none"> ▪ Medications which may require adjustment or discontinuation due to potential risk to fasting individuals include insulin, oral hypoglycemic agents, antihypertensive agents, nonsteroidals (NSAIDs), antacids (may interfere with phosphate absorption), diuretics (discontinue if possible, especially in those refusing fluids.) ▪ <u>PCP VISIT</u>: Based on clinical judgment, some high risk participants may be scheduled for a PCP visit. (Sec. VII.A.6.a) The PCP visit should include: <ul style="list-style-type: none"> ▪ Recording vital signs, weight, and BMI (see page 12) ▪ Consideration of baseline labs: CBC, CMP, magnesium, phosphate ▪ Counseling regarding the medical risks of starvation ▪ Counseling of the medical risks of refeeding after prolonged fasting ▪ Encouraging consumption of 1.5 liters or more of fluid each day ▪ Consider reissuing patient education fact sheet Refusals of scheduled PCP visits will be documented in the eUHR <p><u>MENTAL HEALTH</u> Within 72 hours of notification by custody that patient-inmates are mass hunger strike participants: Mental health staff shall review the health care Mass Hunger Strike Participant list for participant(s) in the mental health program and make appointments for patient-inmates who require evaluation by the mental health primary clinician (or other mental health clinician). (Sec. VII.A.6.b) Mental health staff are also advised to review the Developmental Disabilities Program (DDP) list for mass hunger strike participants and make appropriate appointments for evaluation.</p>

SUMMARY	DECISION SUPPORT	PATIENT EDUCATION/SELF MANAGEMENT
MANAGEMENT RECOMMENDATIONS DURING FASTING		
<p>4-7 days of mass hunger strike participation</p>	<p><u>NURSING</u> <i>Within one week of notification by custody of a hunger strike participant, the participant will be scheduled for a face-to-face (FTF) triage assessment by an RN. (Sec. VII.A.7)</i> This assessment should include:</p> <ul style="list-style-type: none"> ◆ education (see patient education page PE-1) <ul style="list-style-type: none"> ▪ <i>the adverse effects and risks of starvation and the refeeding syndrome. (Sec. VII.A.7)</i> ▪ the need to consume 1.5 liters or more of fluid each day ▪ providing the hunger strike patient education fact sheet regarding starvation and refeeding facts, and medical care information ▪ signs and symptoms of dehydration, potential for dizziness when moving quickly ◆ height and weight (noting presence of restraints), scale should be identifiably marked, whenever possible the same scale should be used at each weighing session (record scale used) ◆ vital signs ◆ additional focused system assessment to assess for signs of dehydration, altered mental status, and other physical abnormalities that would require referral to a higher level of care. <p><i>The RN shall document the encounter or refusal in the eUHR. (Sec. VII.A.7)</i></p> <p><u>PCP</u> <i>If participants are prescribed high risk medications, a PCP may discontinue or adjust the medication dosage without a PCP visit. Participants will be notified in writing regarding medication changes. (Sec. VII.A.6.a)</i></p>	
<p>7-14 days of mass hunger strike participation</p>	<p><u>NURSING</u> Daily nursing observation</p> <p><u>PCP</u> PCP evaluation as clinically indicated</p>	
<p>14—20 days of mass hunger strike participation</p>	<p><u>NURSING</u> Daily nursing observation</p> <p><u>PCP</u> <i>After two weeks of participation in a hunger strike (as defined by custody), and at least weekly thereafter, all identified participants (even if not in a high risk group) shall be scheduled for a PCP visit which will include a BMI determination. (Sec. VII.A.9) and baseline labs as clinically indicated.</i></p> <p><i>After three weeks of participation in a hunger strike:</i> <i>All hunger strike participants will be provided with written information about advance directives and a Physician Order for Life Sustaining Treatment (POLST). (Sec. VII.A.11.a)</i> (See prolonged fasting patient education handout, page PE-2)</p> <p>Consider need for higher level of care (especially with >15% weight loss or BMI of <19 kg/m²) Patients offered:</p> <ul style="list-style-type: none"> ◆ Thiamine 100 mg po daily ◆ B complex, one po daily ◆ Multivitamin, one po daily 	
<p>21 -34 days of mass hunger strike participation</p>	<p><u>NURSING</u> Daily nursing observation At 21-28 days of participation in a hunger strike: Consider referral for evaluation of need for higher level of care (especially with >15% weight loss or BMI of <19 kg/m²)</p> <p><u>PCP</u> At least weekly PCP visit If the participant accepts a PCP visit, the PCP should assess and document:</p> <ul style="list-style-type: none"> ◆ Clinical assessment including hydration status and need for closer observation or a higher level of care ◆ <i>If the participant accepts a primary care visit, the PCP will perform and document a determination of capacity for informed consent as defined by California Code of Regulations (CCR), Title 15, Section 3353.1 Participants who lack capacity for informed consent shall be reported to the Chief of Mental Health, Dental Program Health Program Manager III, CME, CNE, and CEO. (Sec. VII.A.11.b)</i> ◆ Need for lab testing (CBC, CMP, magnesium, and phosphate) 	
<p>35 days onward of mass hunger strike participation</p>	<p><u>NURSING</u> Daily nursing observation</p> <p><u>PCP</u> At least weekly PCP evaluation, consideration of higher level of care placement</p>	

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VOLUNTARY REFEEDING AFTER HUNGER STRIKE

Refeeding: Assessment of Risk and Management

Assessment of Risk of Refeeding Syndrome¹

The relative risk of Refeeding Syndrome is based on an assessment of:

- BMI
- percentage weight loss from initial weight (if known)
- comorbid illness
- to some degree the duration of participation in the hunger strike, though the length of participation may not accurately reflect the level of starvation

Management of Refeeding Syndrome

General Principles

- Correct biochemical abnormalities and fluid imbalances
- Perform a medication review and a screening exam
- Prevent symptoms (4 fundamental factors):
 - ✦ Early identification of at risk individuals
 - ✦ Lab evaluation before starting feeding
 - ✦ Monitoring during refeeding
 - ✦ Appropriate feeding regimen

Treat based on the refeeding risk assessment according to guidelines below and Table 1, page 8

NEGLIGIBLE RISK OF REFEEDING SYNDROME

Individuals who have not been identified as requiring closer monitoring (no significant pre-existing medical conditions and baseline BMI > 18.5 kg/m²) and have been hunger strike participants for ≤14 days are at little risk of refeeding problems.

REFEEDING RECOMMENDATIONS WITH NEGLIGIBLE RISK

- May be allowed to eat and drink freely and no specific monitoring of refeeding is necessary. Careful assessment of hydration status and possible tests of renal function are indicated if patient has refused fluid for several days

MODEST RISK OF REFEEDING SYNDROME

Individuals who have been identified as requiring closer monitoring during hunger strikes (preexisting medical condition or baseline BMI ≤18.5 kg/m²), or meet one of the following criteria:

- a BMI >16 but <18.5 kg/m²
- loss of >10% but <15% of their body weight during food refusal
- refused food for 15-28 days
- BMI >18.5 and weight loss ≤10% and 15-28 days of refusal of food

REFEEDING RECOMMENDATIONS WITH MODEST RISK

Location

- Refeeding can take place in a general population setting

Monitoring

- Continue daily bedside observation for two days
- RN will discuss or refer to PCP patients with identified signs or symptoms, in particular those on chronic care medications

Refeeding

Calorie limitation:

- Recommend ≤20 kcal/kg/day for the first 2 days (1/2 of usual CDCR diet– max 4-5 carb “servings”)
- If no problems arise over first 48 hours, patient may be advised to increase consumption of standard CDCR heart healthy diet to consume ¾ of normal caloric intake for next two days as tolerated, then regular diet without restrictions.

Route: Oral

Nutritional Source: CDCR heart healthy diet (limited to 4-5 carbohydrates “servings” per meal see Table 4, page 11)

- Depending on institution factors and number of inmates involved can provide “1/2 CDCR diet” by:
 - ✦ Group feed inmates from hunger strike alone so kitchen can prepare trays with 1/2 portions and only four to five carb “servings”/meal
 - ✦ Cell feed inmates using trays with 1/2 portions and only 4-5 carb “servings”/meal
 - ✦ Prepare sack “lunches” for each meal that contain only 4-5 carb “servings”/meal

Fluid: should generally be limited to around 30 ml/kg/day. This figure could be doubled if dehydration is diagnosed either clinically or on BUN/creatinine results. (Example 170 lb man=77 kg x 30 ml/kg = 2310 ml/day)

¹ Khan: Refeeding Syndrome: A Literature Review, Gastroenterology Research and Practice Volume 2011 (2011)

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VOLUNTARY REFEEDING AFTER HUNGER STRIKE

Refeeding: Assessment of Risk and Management (cont)

HIGH RISK OF REFEEDING SYNDROME

- ◆ A BMI <16 kg/m²
- ◆ Weight loss >15% of body weight since starting food refusal
- ◆ Low potassium, magnesium, or phosphate levels before the onset of feeding
- ◆ Hunger strike participant for **more than 28 days**
- ◆ Significant mental health or medical comorbidities
- ◆ BMI ≥16 and >28 days of refusal of food

Refeeding Recommendations**Location Considerations**

- Refeed in a licensed medical setting with 24 hour nursing, availability of daily labs, pharmacy, and dietary services.

Monitoring Considerations

- Blood tests prior to refeeding, then daily for at least 2-3 days (sodium, potassium, phosphate, magnesium, calcium, glucose, BUN, creatinine)
- Normal or high serum electrolytes does not preclude the risk of refeeding syndrome as these patients may have whole body electrolyte depletion, which may amount to thousands of millimoles.
- Due to whole body depletion, even patients with renal failure (elevated serum electrolytes) are likely to need supplementation as refeeding-fluid replacement progresses and renal function improves.
- Feeding should not be withheld if potassium, magnesium, or phosphate are low since electrolyte deficits are mostly intracellular and cannot be corrected without starting low levels of simultaneous feeding.
- Liver function tests prior to refeeding and at least once several days after refeeding commences.
- Watch for signs of fluid overload, infection, or general deterioration, and have a low threshold for moving to higher level of care should any clinical or biochemical abnormalities become concerning.
 - Likely causes of concern would include:
 - ▶ Potassium levels <3.0 mmol/l
 - ▶ Magnesium levels <0.5 mmol/l
 - ▶ Phosphate levels <0.5 mmol/l
- Monitor EKG daily for at least the first 48 hrs of feeding (look for EKG evidence of electrolyte disturbance: potassium, calcium, magnesium, especially QT prolongation.)

Refeeding

- Strongly consider providing prophylactic supplementation of phosphate, potassium, and magnesium as outlined in Table 1 even if baseline levels are normal.
- Thiamine stores last 2-3 weeks. If patient has fasted a significant length of time recommend giving thiamine 100 mg prior to refeeding: Thiamine 100 mg can be added to IV fluid (D5NS) and infused over 1-2 hours or thiamine 100 mg can be given IM.
- **Calorie limitation:** Intake 5-10 kcal/kg/day for the first 24 hours
 - If no problems occur, intake can be increased by increments of 5-10 kcal/kg/day
 - Restrictions can be lifted after 5-7 days if no problems and patient taking >35-40 kcal/kg/day
- **Route:** Nasogastric (NG) tube (continuous or every 2 – 4 hour bolus) if patient cannot safely take food orally. Oral feeding is preferred, if safe.
- **Nutritional source:**
 - Liquid nutritional supplement (by mouth or NG) Carnation Instant Breakfast Lactose Free[®]: meets the specifications for refeeding in Table 1. Contains 1 kcal/ml so daily volumes are likely to be in the 300 – 400 ml range. (See Table 2, page 9)
 - CDCR heart healthy diet (composition is consistent with Table 1). Amount is limited in kcal/kg/day as outlined in Table 3, page 10.
- Fluid should generally be limited to no more than 30 ml/kg/day. (May need to be increased if dehydration assessed either clinically or on BUN/creatinine results.) Attempt to maintain a “zero” fluid balance. (See Table 1) (Example 170 lb man=77 kg x 30 ml/kg = 2310 ml/day)
- Multivitamin and trace element supplement should be provided:
 - Thiamine 100 mg po daily X 7 days
 - B complex 1 po daily X 7 days
 - Multivitamin one po daily x 60 days
- If the patient is at a community hospital and stable after 72 hours, the sending institution/utilization management nurse shall contact the hospital to discuss discharge.

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STAGES OF FASTING

**Fasting is generally well tolerated for up to 2 weeks as long as fluid intake is sufficient.
Early fasting weight loss can be 1-2 kg per day.**

BASELINE (DAY 0)	<p>Usual Diet</p> <p>Carbohydrates are primary calorie source (approximately 60% of normal diet). After eating a meal → blood sugar rises → insulin is released. Insulin:</p> <ul style="list-style-type: none"> ▪ promotes glucose uptake and storage (glycogenesis) ▪ inhibits fat breakdown ▪ increases uptake of intracellular potassium <p>Excess caloric intake is converted to fat.</p>
Day 1-3 Fasting	<p>Hunger pangs and stomach cramps disappear after the 2nd to 3rd day.</p> <p>Glucose levels begin to fall → glucagon is released and insulin secretion falls.</p> <p>Glycogen stores are depleted in an effort maintain glucose levels. Glycogen stores rarely last more than 72 hours.</p>
Day 4-13 Fasting	<p>Brain and RBCs require glucose as energy source. With depletion of glycogen stores, glucose is made from non carbohydrate sources (e.g., from muscle protein) (this is gluconeogenesis).</p> <p>Fatty acids are broken down to provide energy as well (for organs other than brain and RBCs).</p> <p>Body fat and protein (muscle) are lost, as well as total body potassium, phosphate, magnesium.</p> <p>Serum electrolyte levels are maintained at the expense of intracellular stores.</p>
Day 14-34 Fasting	<p>Symptoms may include: dizziness, 'feeling faint', difficulty standing, 'lightheadedness' or 'mental sluggishness, sensation of cold, weakness, loss of thirst, fits of hiccoughs.</p> <p>Physical findings: severe ataxia, bradycardia, orthostatic hypotension.</p> <p>Hydration status needs to be closely monitored. Avoid excess saline administration as it may cause hypokalemia.</p> <p>Thiamine deficiency occurs in the second or third week of fasting.</p> <p>The average weight loss in this phase is 0.3 kg per day.</p>
Day 35-42 Fasting	<p>This is considered the most unpleasant phase by those who have survived prolonged fasting due to the symptoms of thiamine deficiency:</p> <ul style="list-style-type: none"> ◆ Oculomotor symptoms develop due to progressive paralysis of ocular muscles from thiamine deficiency. Oculomotor symptoms include: <ul style="list-style-type: none"> ▪ Uncontrollable nystagmus ▪ Diplopia, converging strabismus ▪ Vertigo (very unpleasant) ▪ Vomiting ◆ Extreme difficulty swallowing water ◆ Medical complications arise at ≥18% loss of initial body weight
Day 42 and Later Fasting	<p>Progressive asthenia (malaise, fatigue)</p> <ul style="list-style-type: none"> ▪ Increasing confusion, incoherence ▪ Profound concentration problems ▪ Somnolence, indifference to surroundings <p>More serious complications:</p> <ul style="list-style-type: none"> ▪ Loss of hearing and/or eyesight ▪ Hemorrhage: gingival, esophageal, other gastrointestinal sites <p>Organ failure: extreme bradycardia, Cheyne-Stokes respiration, disruption of all metabolic activity</p> <p>Life-threatening symptoms develop at 30% loss of initial body weight</p>
Day 45 –75 Fasting	<p>Death from cardiovascular collapse and/or severe ventricular dysrhythmia (e.g. prolonged QT)</p> <p>More rarely, lactic acidosis from sepsis due to immune system dysfunction, small bowel obstruction, or multiple organ failure.</p>

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REFEEDING SYNDROME (RFS)¹

Definition:

- Refeeding syndrome (RFS) describes the biochemical changes, clinical manifestations, and complications that can occur as a consequence of feeding a malnourished catabolic individual.
- RFS is not defined by a clear set of signs and symptoms.
- There is no internationally agreed definition of RFS: it is a term referring to a wide spectrum of biochemical abnormalities and clinical consequences.
- Hypophosphatemia is the adopted surrogate marker to diagnose RFS though low serum phosphate is not pathognomonic.
- There are limitations to relying on low serum phosphate as levels may be normal in patients with multi-organ failure, in the presence of impaired renal function, or in patients in a stable state of starvation prior to onset of feeding.

Physiology:

- Reintroduction of nutrition to a starved or fasted individual results in a rapid decline in both gluconeogenesis and anaerobic metabolism mediated by the rapid increase in serum insulin.
- Insulin stimulates the movement of extracellular potassium, phosphate, and magnesium to the intracellular compartment with rapid fall in the extracellular concentration of these ions.
- Osmotic neutrality must be maintained resulting in the retention of sodium and water.
- Reactivation of carbohydrate-dependent metabolic pathways increases demand for thiamine, a cofactor required for cellular enzymatic reactions.
- The deficiencies of phosphate, magnesium, potassium, and thiamine occur to varying degrees and have different effects in different patients.

Clinical Manifestations:

- Symptoms of RFS are variable, unpredictable, may occur without warning, and may occur late.
- Symptoms occur because changes in serum electrolytes affect the cell membrane impairing function in nerve, cardiac, and skeletal muscle cells.
- Variable clinical picture in RFS reflects the type and severity of biochemical abnormality.
- Mild derangements in these electrolytes may cause no symptoms.
- More often, the spectrum of presentation ranges from simple nausea, vomiting, to lethargy, respiratory insufficiency, cardiac failure, hypotension, arrhythmias, delirium, coma, and death.
- Clinical deterioration may occur rapidly.
- Low serum albumin concentration may be an important predictor for hypophosphatemia.

The optimum timing for correcting abnormalities in established RFS has been controversial.

The view that correction of electrolyte abnormalities must occur before commencement of feeding has been revised and recent National Institute of Health and Clinical Excellence guidelines from the United Kingdom indicate that feeding and correction of biochemical abnormalities can occur in tandem without deleterious effects to the patient, but no randomized control trial (RCT) data is available to support either view.

¹ Khan: Refeeding Syndrome: A Literature Review, Gastroenterology Research and Practice Volume 2011 (2011),

TABLE I: REFEEDING CALORIE & SUPPLEMENT RECOMMENDATIONS FOR HIGH RISK PARTICIPANTS*

Day	Calorie Intake (All feeding routes)	Monitoring and Treatment Supplements
Day 1 Refeeding	<p>For extreme cases: 5 kcal/kg/day[‡]</p> <p>Other cases: 10 kcal/kg/day[‡]</p> <p>Composition of refeeding diet: Carbohydrate: 50-60% Fat: 30-40% Protein: 15-20%</p> <p>If RFS is suspected based on clinical and biochemical assessment or the patient develops intolerance to artificial nutritional support, the energy intake should be reduced or stopped.</p>	<p>Mineral Supplements: Phosphate: 0.5-0.8 mmol/kg/day Potassium: 1-3 mmol/kg/day Magnesium: 0.3-0.4 mmol/kg/day Sodium: <1 mmol/kg/day (restricted)</p> <p>IV fluids: Restricted, maintain “zero” fluid balance</p> <p>Vitamins: IV Thiamine + vitamin B complex 30 minutes prior to feeding</p> <p>Cardiac and lab monitoring as required</p>
Day 2-4	<p>Increase by 5 kcal/kg/day[‡] as tolerated.</p> <p>If RFS is suspected based on clinical and biochemical assessment or the patient develops intolerance to artificial nutritional support, the energy intake should be reduced or stopped.</p>	<p>Check all biochemistry and correct any abnormalities</p> <p>Thiamine + vitamin B complex orally or IV until day 3</p> <p>Cardiac and lab monitoring as required</p>
Day 5-7	<p>Increase up to 20-30 kcal/kg/day[‡]</p> <p>If RFS is suspected based on clinical and biochemical assessment or the patient develops intolerance to artificial nutritional support, the energy intake should be reduced or stopped.</p> <p>Feeding rate should be increased to meet full requirements for fluid, electrolytes, vitamins, and minerals if the patient is clinically and biochemically stable.</p>	<p>Check electrolytes, renal and hepatic function and minerals</p> <p>Fluid: maintain “zero” fluid balance</p> <p>Consider iron supplement from day 7</p> <p>Cardiac and lab monitoring as required</p>
Day 8-10	<p>30 kcal/kg/day[‡] or increase to full requirement</p> <p>Feeding rate should be increased to meet full requirements for fluid, electrolytes, vitamins, and minerals if the patient is clinically and biochemically stable.</p>	<p>Cardiac and lab monitoring as required</p>

- *Much of the literature on Refeeding Syndrome comes from experience with severely ill, catabolic patients in the Intensive Care Unit. Often these patients had underlying chronic illnesses as well and/or were post-op.*
- *Experience with two prior mass hunger strikes at CDCR (in 2011), both lasting 21 days, demonstrated that most inmate participants refused to be weighed or be evaluated by health care staff. Participants ended their hunger strike after various lengths of time. Even those who accepted no CDCR food for 21 days did well and did not manifest any problems with refeeding, even though they declined to follow recommendations for gradual reintroduction of kcal.*

*** High risk of refeeding syndrome:**

- ♦ Food refusal more than 28 days
- ♦ BMI <16 kg/m²
- ♦ Weight loss >15% during the hunger strike
- ♦ Low potassium, magnesium, or phosphate levels before resumption of feeding
- ♦ Medical or mental health conditions creating high risk of complications from fasting

[‡]Measure weight daily to use for all calculations

TABLE 2: LIQUID NUTRITION SUPPLEMENT FOR HIGH RISK PARTICIPANTS*

Table 2: Suggested Refeeding Regimen for Hunger Strike Patients Using Liquid Nutritional Supplement Based on Recommended Requirements in Table 1

- ◆ Patients at high risk for refeeding syndrome initially may require liquid nutritional supplement (LNS) feeding.
- ◆ LNS meets the recommended requirements for use in refeeding and these can be given orally or via tube feeding.
- ◆ LNS may also be indicated for patients who do not gain weight upon refeeding and who have lost >10% of body weight. (IMSPP volume 4, chapter 20, outpatient therapeutic diets)
- ◆ Generally start with 10 kcal/kg/day (5 kcal/kg/day in very severe cases)

Carnation Instant Breakfast® Lactose Free (Product Code Number 9871633888)	
Kilocal/ml	1.0
Caloric distribution (% of Kcal)	
Protein	14%
Carbohydrate	51%
Fat	35%
Protein Source	Calcium Caseinate
NPC: N Ratio	155:1
N6:n3 Ratio	4.1:1
Osmolality (mOsm/kg water)	480
Free water	85%
Meets 100% RDI for 21 key micronutrients	2100 ml
Appropriate for these diets:	Lactose-free, gluten-free, low residue, kosher, low-sodium, low-cholesterol

Day 1 10 kcal/kg/day	10 kcal x 72 kg [‡] =720 kcal x 1 kcal/ml=720 ml/day Provide in 6 small feedings of 120 ml/feeding Approximate feeding times are as follows: 6:00 AM, 9:00 AM, 12:00 PM, 3:00 PM, 6:00 PM, 9:00 PM
Day 2 15 kcal/kg/day	15 kcal x 72 kg [‡] = 1080 kcal x 1 kcal/ml= 1080 ml/day Provide in 6 small feedings of 180 ml/feeding Approximate feeding times are as follows: 6:00 AM, 9:00 AM, 12:00 PM, 3:00 PM, 6:00 PM, 9:00 PM
Day 3-4 20 kcal/kg/day	20 kcal x 72 kg [‡] = 1440 kcal x 1 kcal/ml=1440ml/day Provide in 6 small feedings of 240 ml/feeding Approximate feeding times are as follows: 6:00 AM, 9:00 AM, 12:00 PM, 3:00 PM, 6:00 PM, 9:00 PM
Day 5-6 25 kcal/kg/day	25 kcal x 72 kg [‡] = 1800 kcal x 1 kcal/ml=1800ml/day Provide in 6 small feedings of 300 ml/feeding Approximate feeding times are as follows: 6:00 AM, 9:00 AM, 12:00 PM, 3:00 PM, 6:00 PM, 9:00 PM
Day 7-8 30 kcal/kg/day	30 kcal x 72 kg [‡] = 2160 Kcal x 1 kcal/ml = 2100ml/day Provide in 6 small feedings of 360 ml/feeding for gradual introduction. Approximate feeding times are as follows: 6:00 AM, 9:00 AM, 12:00 PM, 3:00 PM, 6:00 PM, 9:00 PM

[‡]Daily weights should be taken and used for calculations

* High risk, see page 5

TABLE 3: REFEEDING USING CDCR HEART HEALTHY DIET FOR HIGH RISK PARTICIPANTS*

**Table 3: Suggested Refeeding Regimen for Hunger Strike Patients Using CDCR Heart Healthy Menu (For patients who can tolerate solid food.)
Based on Recommended Requirements in Table 1**

CDCR heart healthy diet

- Average Daily Calories 2750
- Approximate Caloric distribution (% kcal)
 - Protein 15 %
 - Fat 30%
 - Carbohydrate 55

Note: limiting “carbs” in the initial phase of refeeding is important. Most CDCR meal menus provide 7-9 carbohydrate “servings” (15 grams of carbohydrate = 1 serving/meal)
When adjusting/preparing refeeding trays/sacks, limit carbohydrate servings to 4-5/meal.
(See Table 4)

The table below illustrates how to refeed using CDCR Heart Healthy Menu for a reference patient whose current weight is 158 lbs / 72 kg after coming off a hunger strike for over 14 days.

High Risk for RFS	Sample Heart Healthy Diet Menu Choices
Day 1 10 kcal/kg/day	10 kcal x 72 kg [‡] =720 kcal/day Breakfast- 4 oz nonfat milk, 2 oz hot cereal, 1 oz breakfast meat or eggs, 2 oz juice Lunch- 1 slice bread, 2 oz meat with 1 package mustard or 2 oz peanut butter, 1 small fresh fruit, 8 oz SF beverage Dinner- 2 oz meat, 4 oz vegetables, 2 oz starch, 4 oz fruit, 8 oz SF beverage
Day 2 15 kcal/kg/day	15 kcal x 72 kg [‡] = 1080 kcal/day Breakfast- 4 oz nonfat milk, 2 oz breakfast meat or eggs, 4 oz hot cereal, 2oz juice Lunch- 3 slices bread, 2 oz meat with 1 package mustard, 1 small fresh fruit, 8 oz SF beverage Dinner- 3 oz meat, 4 oz vegetables, 4 oz starch, 4 oz fruit, 8 oz SF beverage
Day 3-4 20 kcal/kg/day	20 kcal x 72 kg [‡] = 1440 kcal /day Patient to eat ½ portion of foods/beverages with provision of 4-5 carbohydrate “counts”/ meal at each meal served. (SF Beverage 100%)
Day 5-6 25 kcal/kg/day	25 kcal x 72 kg [‡] = 1800 kcal /day Patient to eat ⅔ portion of all foods/beverages with provision of 4-5 carbohydrate “counts”/ meal at each meal served. (SF Beverage 100%)
Day 7-8 30 kcal/kg/day	30 kcal x 72 kg [‡] = 2160 kcal/day Patient to eat ¾ portion of all foods/beverages with provision of 4-5 carbohydrate “counts”/ meal at each meal served. (SF Beverage 100%)

[‡]Daily weights should be taken and used for calculation.

* High risk, see page 5

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TABLE 4: EXAMPLE CDCR MENU WITH CARBOHYDRATE COUNT

Typical CDCR heart healthy meals contain 7-9 “servings” of carbohydrate/meal. (15 gram carbohydrate = 1 serving)
 Carbohydrate (CHO) counts are calculated for each meal and the current CHO counting menu can be found on Allied Health—> Dietary Services Lifeline page under Diabetic Education materials
 (Note: AE is “Alternate Entrée for religious diets)

BREAKFAST			LUNCH			DINNER		
100% FRUIT JUICE CRACKED WHEAT CEREAL PANCAKES, 4" P BUTTER ...OR SAUSAGE -PIA SYRUP ...OR DIET SYRUP MARGARINE READIES NONFAT MILK-PIA COFFEE-PIA	4 OZ 6 OZ 3 EA 2 OZ 2 OZ 2 OZ 2 OZ 2 EA 8 OZ 8 OZ	Cart: Choices 1 1 1/2 4 1 0 2 1/2 0 0 1 0	LUNCHMEAT SANDWICH ...LUNCHMEAT ...MUSTARD ...WHEAT BREAD SUNFLOWER SEEDS GRAHAM CRACKERS FRESH FRUIT SUGAR FREE BEVERAGE	2 OZ 2 PK 4 SL 1 PK 2 PK 1 EA 1 PK	Cart: Choices 0 0 4 1/2 1 1/2 1 0 7	GREEN SALAD W/DRSG BREADED FISH BAKED POTATO BROCCOLI WHEAT BREAD COCKTAIL SAUCE MARGARINE READIES ICED CAKE SUGAR FREE BEVERAGE	3/4CP/1 EA 4 OZ 1 EA 4 OZ 2 SL 1 OZ 2 EA 1 PC 8 OZ	Cart: Choices 0 1 1 1/2 0 2 1/2 0 7 1/2
PEANUT BUTTER (AE)	2 OZ	1	CHEESE SLICE 2/3 OZ (AE)	3 EA	0	VEG BEANS (AE)	8 OZ	2 1/2
FRUIT SERVING OATMEAL EGGS-PIA TRI-TATER POTATOES WHEAT TOAST/BREAD MARGARINE READIES NONFAT MILK-PIA COFFEE-PIA	4 OZ 6 OZ 2 EA 2 EA 2 SL 2 EA 8 OZ 8 OZ	Cart: Choices 1 1 1/2 0 2 2 0 1 0	LUNCHMEAT SANDWICH ...LUNCHMEAT ...MUSTARD ...WHEAT BREAD CHIPS COOKIES-PIA FRESH FRUIT SUGAR FREE BEVERAGE	2 OZ 2 PK 4 SL 1 PK 1.25 OZ 1 EA 1 PK	Cart: Choices 0 0 4 1 2 1 0 8	GREEN SALAD W/DRSG TAMALE PIE-PIA SPANISH RICE GREEN BEANS TORTILLAS BROWNIE, PLAIN SUGAR FREE BEVERAGE	3/4CP/1 EA 8 OZ 6 OZ 4 OZ 2 EA 1 PC 8 OZ	Cart: Choices 0 2 2 0 3 1 1/2 0 8 1/2
PEANUT BUTTER SANDWICH ...PEANUT BUTTER -PIA ...JELLY-PIA ...OR DIET JELLY ...WHEAT BREAD CARROT COINS GRAHAM CRACKERS FRESH FRUIT SUGAR FREE BEVERAGE	2 OZ 1 OZ 1 OZ 4 SL 1 PK 2 PK 1 EA 1 PK	Cart: Choices 1 1 1/2 2 1/2 1 0 2 1 0 9	PEANUT BUTTER SANDWICH ...PEANUT BUTTER -PIA ...JELLY-PIA ...OR DIET JELLY ...WHEAT BREAD CARROT COINS GRAHAM CRACKERS FRESH FRUIT SUGAR FREE BEVERAGE	2 OZ 1 OZ 1 OZ 4 SL 1 PK 2 PK 1 EA 1 PK	Cart: Choices 1 1 1/2 0 4 0 1 1/2 1 0 9	GREEN SALAD W/DRSG 2 EGG ROLLS PANCIT OR FRIED RICE GREEN BEANS ICED CAKE SUGAR FREE BEVERAGE	3/4CP/1 EA 2 OZ 6 OZ 4 OZ 1 PC 8 OZ	Cart: Choices 0 2 2 0 2 1/2 6 1/2
EGGS (AE)	2	0	CHEESE SLICE 2/3 OZ (AE)	3 EA	1/2	VEG BEANS (AE) HAMBURGER PATTY (RMA)	8 OZ 1 EA	2 1/2 0
FRUIT SERVING CORNMEAL MUSH BEEF HASH-PIA EGG-PIA WHEAT TOAST/BREAD MARGARINE READIES NONFAT MILK-PIA COFFEE-PIA	4 OZ 6 OZ 6 OZ 1 EA 2 SL 2 EA 8 OZ 8 OZ	Cart: Choices 1 2 1/2 2 0 2 0 1 0	TUNA CALZONE PBU/CHSE CRACKERS COOKIES-PIA FRESH FRUIT SUGAR FREE BEVERAGE	1 EA 1 PK 1.25 OZ 1 EA 1 PK	Cart: Choices 0 0 4 1 2 1 0 8	GREEN SALAD W/DRSG TURKEY TETRAZZINI MIXED VEGETABLES DINNER ROLL 2 OZ MARGARINE PATTIES FRUIT CRISP SUGAR FREE BEVERAGE	3/4CP/1 EA 8 OZ 4 OZ 1 EA 2 EA 4 OZ 8 OZ	Cart: Choices 0 2 1/2 2 0 4 0 8 1/2
EGG -PIA (AE)	1 EA	0	...JELLY-PIA / DIET JELLY ...OR DIET JELLY PEANUT BUTTER -PIA (AE)	1 OZ 1 OZ 2 OZ	1 1/2 0 1	VEG BEANS (AE) TURKEY HOT DOGS (RMA)	8 OZ 2 EA	2 1/2 0
CANNED FRUIT COOKED RICE CEREAL EGGS-PIA PINTO BEANS TORTILLAS SALSA NONFAT MILK-PIA COFFEE-PIA	4 OZ 6 OZ 2 EA 6 OZ 2 EA 2 OZ 8 OZ 8 OZ	Cart: Choices 1 1 1/2 0 2 3 0 1 0	SUB SANDWICH ...LUNCHMEAT/CHEESE ...HOGIE ROLL ...RELISH ...MUSTARD ...MAYONNAISE PACKET GRAHAM CRACKERS FRESH FRUIT SUGAR FREE BEVERAGE	2 OZ 1 EA 1 EA 2 EA 1 EA 2 PK 1 EA 1 PK	Cart: Choices 0 3 0 0 0 1 1/2 1 0 5 1/2	GREEN SALAD W/DRSG POULTRY/BEEF HOT DOGS -PIA HOTDOG BUNS RED CHILI BEANS MIXED VEGETABLES CHEESE SHREDDED ONIONS KETCHUP MUSTARD SHORTCAKE W/ FRUIT TOPPING SUGAR FREE BEVERAGE	3/4CP/1 EA 2 EA 2 EA 6 OZ 4 OZ 1 OZ 1 OZ 1 EA 1 EA 1 PC 8 OZ	Cart: Choices 0 1 1/2 2 2 1/2 0 0 0 0 2 1/2 8 1/2
CHEESE SLICE (AE)	3 EA	0	BEANS (AE) BR CHICKEN PATTY (RMA)	6 OZ 1 EA	2 1			2 1

BMI CALCULATOR:

Body Mass Index Table																																				
Normal					Overweight					Obese					Extreme Obesity																					
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height (inches)	Body Weight (pounds)																																			
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

Source: Adapted from Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report.



To the Emergency Department and Hospital Staff: This patient is at risk for refeeding syndrome

Thank you for caring for our patient.

This patient has been on a protracted hunger strike with no documented nutritional intake of state provided meals over the past _____ days.

- His or her oral intake may have consisted of water only.
- Some patients may have had access to canteen food or food from other sources but this cannot be confirmed or assumed.

Please **DO NOT FEED PATIENT IN THE EMERGENCY DEPARTMENT**

It is safe to administer intravenous fluid (including dextrose) in the ED but **IV Thiamine** should be added to the IV fluid along with supplementation of **potassium, magnesium, and phosphate** as outlined in the CCHCS refeeding guidance on page 8, labeled Table 1.

Please monitor carefully for **hypokalemia, hypophosphatemia, and hypomagnesemia**.

While baseline electrolytes will likely be normal prior to administration of fluids or food, these will rapidly shift intracellularly following refeeding. Problems can arise at any time in the first week after refeeding has begun.

Once admitted please continue to monitor the patient's labs with particular attention to phosphate, potassium, magnesium, calcium, creatinine, and glucose.

Cardiac monitoring may be indicated.

- Refeeding regimens will vary depending on severity of patient's starvation, weight loss, pre-fast BMI and comorbid medical conditions.
- All refeeding regimens suggest starting feeding at 5-10 kcal/kg/day (depending on severity)
- Composition of feeding should be lower glucose (**no Ensure!**).
Khan¹ recommends 50-60% carbohydrate, 30-40% fat and 15-20% protein
- Kcal/kg is increased as tolerated over 5-10 days. (*If this patient is stable at 3 days and is taking at least 20 kcal/kg please contact the sending institution or UM for discussion of discharge timing.*)

Helpful references:

- 1.) *Refeeding Syndrome: A Literature Review*, L. U. R. Khan, J. Ahmed, S. Khan, and J. MacFie, Gastroenterology Research and Practice Volume 2011
- 2.) *Refeeding syndrome: what it is, and how to prevent and treat it*, Hisham M Mehanna, consultant and honorary associate professor, BMJ 2008;336:1495-1498

Please contact our institution if questions: Telephone # _____

Note to health care staff: Send copy of Table 1 on page 8 of this guide to ED with patient.

PATIENT EDUCATION/SELF MANAGEMENT

HUNGER STRIKE PATIENT FACT SHEET

RISKS OF FLUID REFUSAL

- ◆ Not drinking fluid can cause **death** within days
- ◆ Not drinking fluid can cause lasting organ damage
- ◆ You will get symptoms very soon if you do not drink fluids
- ◆ You should drink at least 6 cups of fluid every day



RISKS OF FASTING

- ◆ Not eating food for a long time (prolonged fasting) can cause **death**
- ◆ Not eating food can cause lasting organ damage
- ◆ You may become dizzy during your hunger strike. You should move slowly and carefully to avoid falls
- ◆ You may get many other symptoms the longer you refuse food such as: weakness, confusion, vomiting, stomach pain and higher risk of infections
- ◆ If you are in good health when you start to refuse food and you keep on drinking water, you will probably survive for weeks
- ◆ After prolonged fasting (starvation) you may have lasting organ damage even after you start eating again and gain weight.

RISKS OF REFEEDING

- ◆ **Death** may happen when you start eating after not eating for a long time. This is called Refeeding Syndrome
- ◆ If you have lost more than 10 lbs or have not eaten for more than 14 days, talk to health care staff **before** you eat again
- ◆ Your risk of death is less if you start eating under medical care
- ◆ If you have not eaten for many days, you should start to eat by taking only small amounts of food the first few days and then step up to normal eating over 5-7 days

ABOUT YOUR HUNGER STRIKE



- ◆ **MONITORING:** Health care staff will watch you for signs of serious illness during your hunger strike.
- ◆ **ACCESS TO HEALTH CARE:** You may access health care services at any time during your hunger strike just like when you are not on a hunger strike.
- ◆ **MEDICATION CHANGES:** Your primary care provider may change or stop some of your medications during your hunger strike to lower your risk of problems.

PATIENT EDUCATION/SELF MANAGEMENT**Information for Patients with Prolonged Fasting**
(To be distributed to patients after participation in hunger strike for ≥ 14 days)**WHAT YOU NEED TO KNOW**

- ◆ You have not been eating for such a long time that you are in danger of lasting medical harm, even with medical care.
- ◆ You may die, even after you start to eat again.
- ◆ Now is the time for you to think about what medical care you want when you are no longer able to talk to health care staff.
- ◆ Health care staff is concerned about your health so they will check with you to see if you understand that you may die if you refuse food or fluid and that you have clear reasons for refusing food or fluid.

**Advanced Directive
Physician's Order for Life Sustaining Treatment (POLST)**

- ◆ If you go into a coma or your heart stops, you will get all the medical care needed to try to save your life, including CPR, food, and fluids.
- ◆ You should fill out the Advance Directive and Physician's Order for Life Sustaining Treatment (POLST) forms if you do NOT want health care staff to give you medical care when you are not able to speak.
- ◆ If you want to complete Advance Directive and POLST forms, ask health care staff for the form. Fill them out and return the completed forms to your provider for discussion and signature.
- ◆ Health care staff will not give you food or fluid as long as you make it clear that you do not want them to.



If you have questions or are concerned about changes in your health you may contact health care staff at any time.