Stroke physician view- the challenges of nutrition and hydration on the stroke ward

Jatt Khaira
Consultant Stroke physician, Queen Elizabeth Hospital, Birmingham

Advanced Medicine RCP Feb 2018

Disclosures

Boehringer. MSK, BMS Medtronic – sponsorship to attend courses

- Regional Advisor RCP (West Midlands)
- NHS England Clinical Advisor
- BASP Executive board- Ordinary member for England
- Ex- GP (4 years)

Guidance:

NICE Care of dying adults in last days of life
March 2017
Dec 2015

GMC Care at the end of life

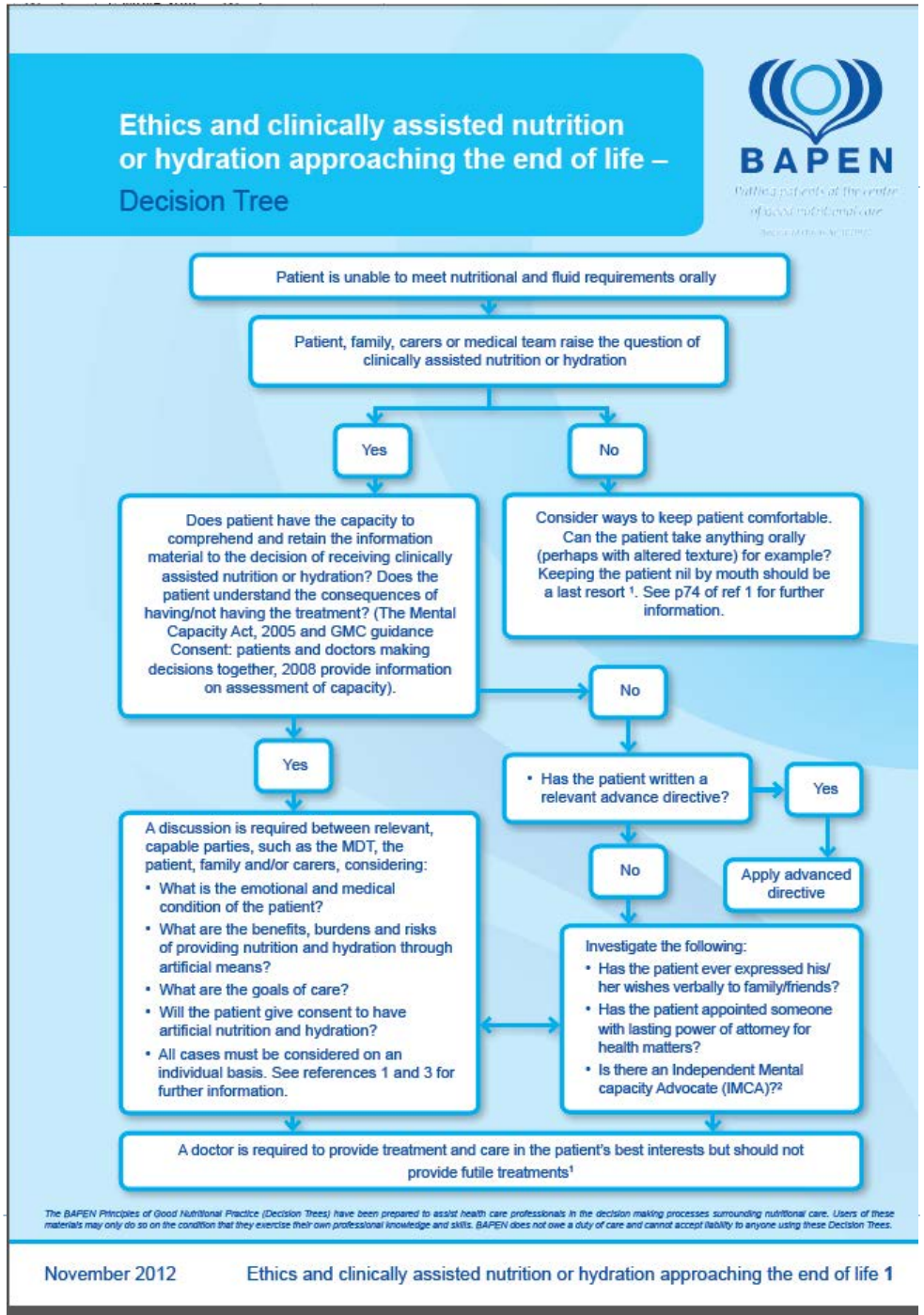
NICE nutrition support for adults Feb 2006

BAPEN decision tree

RCP Stroke guidelines 2016

GMC/RCP/BMA
Decisions to withdraw clinically assisted nutrition and hydration (CANH) from patients in permanent vegetative state (PVS) or minimally conscious state (MCS) following sudden onset profound brain injury

RCP Oral feeding difficulties and Dilemmas 2010


Ethics and clinically assisted nutrition or hydration approaching the end of life –
Decision Tree
BAPEN
Patient is unable to meet nutritional and fluid requirements orally
Patient, family, carers or medical team raise the question of clinically assisted nutrition or hydration
Yes
No
Does patient have the capacity to comprehend and retain the information material to the decision of receiving clinically assisted nutrition or hydration? Does the patient understand the consequences of having/not having the treatment? (The Mental Capacity Act, 2005 and GMC guidance Consent: patients and doctors making decisions together, 2008 provide information on assessment of capacity).
Consider ways to keep patient comfortable. Can the patient take anything orally (perhaps with altered texture) for example? Keeping the patient nil by mouth should be a last resort [1]. See p74 of ref 1 for further information.
No
Yes
• Has the patient written a relevant advance directive?
Yes
No
Apply advanced directive
A discussion is required between relevant, capable parties, such as the MDT, the patient, family and/or carers, considering:
• What is the emotional and medical condition of the patient?
• What are the benefits, burdens and risks of providing nutrition and hydration through artificial means?
• What are the goals of care?
• Will the patient give consent to have artificial nutrition and hydration?
• All cases must be considered on an individual basis. See references 1 and 3 for further information.
Investigate the following:
• Has the patient ever expressed his/her wishes verbally to family/friends?
• Has the patient appointed someone with lasting power of attorney for health matters?
• Is there an Independent Mental capacity Advocate (IMCA)?[2]
A doctor is required to provide treatment and care in the patient's best interests but should not provide futile treatments[1]
The BAPEN Principles of Good Nutritional Practice (Decision Trees) have been prepared to assist health care professionals in the decision making processes surrounding nutritional care. Users of these materials may only do so on the condition that they exercise their own professional knowledge and skills. BAPEN does not owe a duty of care and cannot accept liability to anyone using these Decision Trees.
November 2012
Ethics and clinically assisted nutrition or hydration approaching the end of life 1

Practicalities of managing nutrition:

Assessing patient capacity/ adjustment reaction

Trial of NG
Pureed diet/SF
Mittens/ bridle
fluids/ hypoglycaemia/ mouthcare
Managed Risk feeding

DOLS
Duty of candour

Refeeding

TPN/early PEG/RIG/ JEJ/open gastrostomy/jejunostomy

Themes:

Individualised care

True MDT working (vs medical model)/shared decision making

Honesty and active listening

Managing uncertainty

Context **-Daily Mail, LCP**
-stages of grief/loss
-loss of control (pt., relatives, HCP)

Managing carers: I

Stroke disease -sudden
-'he looks so well'
-Natural progression/expectations eg ICH

Reviewing of prognosis

Sanctity vs quality of life

Fluctuations in clinical state 'emotional rollercoaster'

Loss of confidence in plan

'ripple effect'
'Ready to let them go'

Managing carers:2

Spiritual/religious beliefs

Family conflict
Large families
Guilt- ‘giving up’ vs ‘it is cruel’
Next of kin
Step/Adult stepchildren/Blended families
Extended family

Remote relatives

‘rehab potential’

Financial implications- getting married

Practicalities of communicating with relatives

Transparency
Side rooms
Regular meetings
Repeated discussions
In person vs telephone vs email
Time
Flexible appointment times
Changing the plan
Weekend/evening cover
Involve palliative team, nutrition support team, chaplaincy
'Agree to disagree'-2nd opinion
Book next appointment

Special challenges:

Dementia pts- frailty
alcohol
young
New co-malignancy
Very old: 'docs said this before and he always bounces back'
Medial family/single doctor in family
Only children

Organ donation

Previous NHS complaint

Effect on team- :

Disagreement- SLT vs medical

Junior support- FYs, HCA, junior nurses/therapists

'Don't know all answers'- prognosis- islands of knowledge

Emotionally draining

Oncall team/SpR

Discharge:

Home – obligation by families to take patients home?
Nursing home/hospice
CHC

Continuity of care-GP gold standard framework
PEG training
Ongoing fluids
Community DNAR

Readmissions

Pressure to discharge

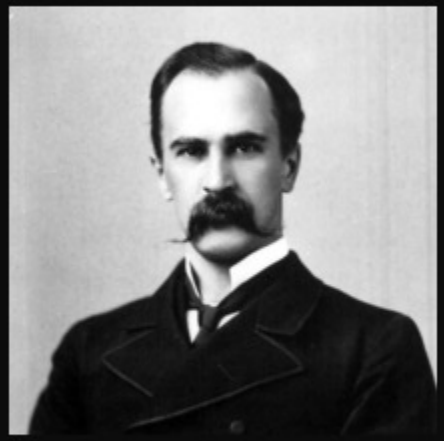
Kisiizi Hospital, Uganda

Time to revisit offering routine post bereavement meetings?

Dr Ian Spillman, Medical superintendent:
'how will the relatives feel in 6 weeks time?'

Art of medicine vs science

William Osler



He who studies medicine without books sails an uncharted sea, but he who studies medicine without patients does not go to sea at all.

AZ QUOTES