Refeeding Syndrome flowchart for patients receiving enteral nutrition

Refeeding syndrome is defined as a group of clinical symptoms which can occur in starved or malnourished patients upon restarting oral or enteral nutrition. The electrolyte and fluid shifts associated with this syndrome can result in severe clinical instability and therefore require careful medical and dietetic management to minimise risk. Delay in commencement of feeding can prolong or worsen risk of refeeding syndrome. This flowchart provides guidance for patients who are on an enteral feed only at the Royal Hospital for Neuro-disability.

1 Immediately alert medical team and dietitian (or CRS if out of hours) if you suspect a patient is at risk of Refeeding Syndrome

Those <u>at risk of refeeding syndrome</u> may include:

1. Nil by mouth/tube for 5 days or more
2. Poorly controlled diabetes
3. Commencing feed following placement of a new feeding tube with pre-existing poor oral intake
4. Pre-existing low levels of Magnesium or Potassium
5. BMI less than 18.5kg/m^2 in addition to one of the above factors

2 Check relevant biochemistry and repeat daily for up to 10 days

<u>Relevant Bloods:</u>

1. Renal Profile
2. Bone Profile
3. Magnesium
4. Liver Profile
5. Full Blood Count

3 Doctors to prescribe refeeding prophylaxis medications for first 10 days of feeding

<u>Refeeding Prophylaxis Medications:</u>

100mg Thiamine - three times a day
1-2 tablets Vitamin B Co Strong - three times a day
1 tablet Soluble Forceval - once daily

4 Commence feeding as soon as possible, delays place patients at further risk

Request urgent dietetic review on ext 5080 and identify that patient is at risk of refeeding syndrome

<u>OR</u>

If <u>out of hours</u> then commence Out of Hours Starter Feeding Regimen for those at risk of Refeeding Syndrome

5 Replacement of electrolytes

	Levels:	Recommended Prescription:
Magnesium	0.5 – 0.7mmol/l	1 sachet Magnesium Aspartate (10mmol/sachet) 2 – 3 times daily
	<0.5 mmol/l	IV replacement in acute hospital
Phosphate	0.5 – 0.8mmol/l	2 x Phosphate Sandoz tablets twice daily (16mmol phosphate/tablet)
	<0.5 mmol/l	IV replacement in acute hospital
Potassium	2.5 – 3.5mmol/l	Sando K: 2 x 12 mmol tablets 3 – 4 times daily
	<2.5 mmol/l	IV replacement in acute hospital

PERFORM ECG for ALL electrolyte abnormalities as soon as low levels detected. Then daily, until electrolytes are within reference range

6 Monitoring

After commencing feed monitor NEWS2 at least 4 times daily and alert medical team to changes in clinical condition
Check for signs of oedema and inform medical team if identified
Commence fluid balance charts