21.1 GENERAL PRINCIPLES

- The provision of oral fluids forms part of basic patient care and should not be withdrawn or withheld. 1, 2, 3
- Artificial hydration, such as intravenous or subcutaneous fluids, has been classified as medical treatment in common law, although this definition has not been universally accepted. 1, 2, 3
- Blanket policies regarding the use of artificial hydration in dying patients are unhelpful. Decisions regarding hydration should be individualised to each patient. 4
- There is a lack of good evidence regarding the benefits, burdens and risks of artificial hydration in the dying phase. 5-12, 13, 16
- It is unclear whether dying patients develop symptoms of dehydration or whether artificial hydration improves these symptoms. 5-11
- The Mental Capacity Act 2005 highlights important factors that should be considered when making decisions about hydration at the end of life. 14, 15

21.2 GUIDELINES

- Decisions surrounding the use of artificial hydration should be discussed with the multi-professional team, patients and relatives in accordance with the Mental Capacity Act. 1, 2, 4, 11, 14 [Level 4]
- Decisions regarding the use of artificial hydration should take into consideration the potential harms and benefits to the patient. 1, 2, 4, 11 [Level 4]
- Hydration decisions should be individualised and include the participation of the family, patient and other disciplines. 13 [Level 4]
- A time-limited trial of hydration to assess if it improves symptoms may be appropriate in some patients. 4 [Level 4]

21.3 STANDARDS

1. Decisions surrounding the use of artificial hydration in dying patients should involve the multi-professional team and be clearly documented in the case notes. 1, 3, 4 [Grade D]
2. The use of artificial hydration in dying patients should be reviewed on a daily basis. 4 [Grade D]
3. If artificial hydration is continued in the dying phase, a rate of 1litre over 24 hours intravenously, subcutaneously or via a PEG / PEJ is the recommended regimen. 8 [Grade D]
21.4 REFERENCES


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