IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ABU WA'EL (JIHAD) DHIAB, *Petitioner/Plaintiff,* **v.** **BARACK H. OBAMA, et al.,** *Respondents/Defendants.*	**Civ. No. 05-1457 (GK)** ~~**FILED UNDER SEAL**~~

SUPPLEMENTAL MEMORANDUM IN SUPPORT OF PETITIONER'S APPLICATION FOR PRELIMINARY INJUNCTION AND AN IMMEDIATE ORDER FOR DISCLOSURE OF PROTOCOLS FORTHWITH
FILED SEPARATELY UNDER SEAL

This Supplemental Memorandum, filed separately under seal, accompanies the sealed filing of the November 2013 and December 2013 revised Guantánamo Bay force-feeding protocols referenced in Petitioner's Application For Preliminary Injunction filed in the above-captioned matter. The purpose of this Supplemental Memorandum is to explain key substantive differences between the March 2013 protocols [hereinafter cited as *March 2013 protocols*] and the November 2013 protocols [hereinafter cited as *November 2013 protocols*, attached hereto as Exhibit G] and December 2013 protocols [hereinafter cited as *December 2013 protocols*, attached hereto as Exhibit H].

1. *The presence of significant differences between the March 2013 protocols and the November 2013 and December 2013 protocols.* The November 2013 protocols state at the outset: "The medical management of detainees with significant weight loss detailed below is a significant deviation from previous JMG standard operating procedures and should be read in its entirety."

November 2013 protocols at 1. This sentence is omitted from the December 2013 protocols, even though in all other respects the November 2013 protocols and December 2013 protocols are nearly identical.

2. *Deletion of specified feeding rates and time span.* The March 2013 protocols specify rates of initial *continuous* force-feeding starting at 20 milliliters-per-hour (ml/hr) and gradually increasing to 100 ml/hr after 96 hours. *March 2013 protocols* at 15-16. The March 2013 protocols also specify that subsequent *intermittent* force-feeding typically is completed over 20 to 30 minutes. *Id.* at 18. The November 2013 and December 2013 protocols entirely omit these specifications, and the public version of the December 2013 protocols is redacted to conceal this omission. The currently operative force-feeding protocols impose no restrictions whatsoever on the speed with which detainees may be force-fed.

3. *Deletion of standard response to complaints about speed of force-feeding.* The March 2013 protocols contain a list of standard responses to detainee complaints and demands, one of which is that if a detainee complains about the speed of his force-feeding the attending nurse shall reply, "The doctor has ordered some medication which may help with the nausea; would you like me to administer it?" *March 2013 protocols* at 26. This response is entirely omitted from the list of standard responses set forth in the November 2013 and December 2013 protocols, *see November 2013 protocols* at 19, *December 2013 protocols* at 19, and the public version of the December 2013 protocols is redacted to conceal this omission. Evidently, JTF-GTMO staff now remain silent when a detainee complains about the speed of his force-feeding. *See* Exh. B ¶ 49 (detainee reports that "he has repeatedly requested that the process should be slowed down, over two hours, as is done with some prisoners, but his plea has fallen on deaf ears").

4. *Change of weight monitoring from daily to weekly.* The March 2013 protocols specify that force-fed detainees shall be weighed daily. *March 2013 protocols* at 8, 18. The November 2013 and December 2013 protocols specify that force-fed detainees shall be weighed weekly. *November 2013 protocols* at 6; *December 2013 protocols* at 6.

5. *Deletion of chair restraint guidelines.* The March 2013 protocols contain sixteen numbered paragraphs governing the use of the restraint chair in the force-feeding process, under the title "Chair Restraint System Clinical Protocol for the Intermittent Enteral Feeding of Detainees on Hunger Strike." *March 2013 protocols* at 18-19. These guidelines are omitted entirely from the November 2013 and December 2013 protocols. Government counsel have advised Petitioner's counsel that there is now a *separate* SOP that governs the use of restraint chairs, but that Government counsel "will not agree to provide you with that SOP . . . ." Declaration of Jon B. Eisenberg ¶ 3; see also *id.* ¶ 5.

6. *Expanded authorization of force-feeding.* The March 2013 protocols authorize force-feeding where a hunger-striker who has missed nine consecutive meals or has had weight loss to a level less than 85% of Ideal Body Weight has end-organ damage, pre-existing co-morbidity, more than 21 days on hunger strike, or a prescribed percentage of weight loss. *March 2013 protocols* at 2, 5. The November 2013 and December 2013 revised protocols authorize force-feeding where a detainee has sustained "clinically significant weight loss," which the revised protocols define as weight loss associated with end-organ damage, pre-existing co-morbidity, more than [redacted] days of weight loss, or a prescribed percentage of weight loss. *November 2013 protocols* at 2-3; *December 2013 protocols* at 2-3. This new construct in the November 2013 and December 2013 protocols, unlike the March 2013 protocols, authorizes force-feeding for a detainee with a pre-existing co-

morbidity such as hypertension without that detainee having had any missed meals or weight loss at all, or for a detainee with [redacted] days of weight loss no matter how little.

7. *Deletion of provision ensuring against rapid cycling of on-and-off force-feeding.* The March 2013 protocols provide for a return to oral nutrition "[w]hen a hunger striking detainee chooses to eat or when the detainee has attained 100% of calculated IBW for at least fourteen (14) consecutive days . . . ." *March 2013 protocols* at 24. The November and December 2013 revised protocols omit that provision, thereby allowing staff to suspend or resume force-feeding immediately upon minor and/or temporary weight fluctuations.

8. *Discontinuation of the medication Reglan.* The March 2013 protocols provide for long-term administration of the anti-nausea drug Reglan. *March 2013 protocols* at 15, 16. In evident belated recognition that Reglan's long-term use can cause tardive dyskinesia—a potentially irreversible disorder characterized by involuntary movements of the face, tongue, or extremities, *see generally PLIVA, Inc. v. Mensing*, 131 S. Ct. 2567, 2572 (2011)—JTF-GTMO has omitted all references to Reglan in the November 2013 and December 2013 protocols.

9. *Purge of all references to hunger-striking.* The March 2013 protocols are entitled "Medical Management of Detainees on Hunger Strike," and the words "hunger strike" and "hunger striker" appear throughout. The November 2013 and December 2013 protocols are entitled "Medical Management of Detainees With Weight Loss" and—in an Orwellian twist—are purged of all references to hunger-striking. Nowhere in the revised protocols do the words "hunger strike" or hunger striker" appear. Evidently the Government has decided to "re-brand" the current Guantánamo Bay hunger-strike as nothing more than an instance of mass unexplained weight loss, in an effort to diminish the efficacy of hunger-striking as a form of protest.

Respectfully submitted,

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Counsel for Petitioner/Plaintiff

Exhibit G

JOINT MEDICAL GROUP JOINT TASK FORCE GUANTANAMO BAY, CUBA Title: MEDICAL MANAGEMENT OF DETAINEES WITH WEIGHT LOSS	SOP NO: JMG 001 Effective Date: 06Aug2012 Revised Date: 14NOV2013
SCOPE: **JOINT MEDICAL GROUP, JOINT TASK FORCE , GTMO**	

REFERENCES:

(a) DoDI 2310.08E Medical Program Support for Detainee Operations, 2006.

ENCLOSURES:

(1) Refusal to Accept Food or Water/Fluids as Medical Treatment
(2) Weight Loss Medical Evaluation Sheet
(3) Weight Loss Medical Flow Sheet
(4) Approval Authority for Initiation of Involuntary Enteral Feeding
(5) Clinical Guidelines for the Evaluation, Resuscitation, and Feeding of Detainees on Long Term Non Religious Fast
(6) Nursing Staff Clinical Procedure Checklist for Intermittent Enteral Feeding of Detainees with Weight Loss
(7) Enteral Feeding Nursing Note
(8) Medical Equations, Calculations and Weight Formulas

I. BACKGROUND

A. A prolonged period of time without adequate food and water will have adverse health effects on the individual detainee and potentially the greater detainee population. Weight loss may be an indicator of long standing malnutrition or of an underlying medical problem, such as malignancy or infectious disease. Identification and early medical management of detainees with weight loss may prevent adverse health effects and death.

B. Patients with weight loss can be expected in any detained population. Maintaining adequate nutrition and health within a detained population is challenging. The medical management of detainees with weight loss in GTMO has evolved over time. The current medical management of detainees with weight loss in GTMO has been developed using procedures adapted from the Federal Bureau of Prisons.

C. The medical management of detainees with weight loss detailed below is a significant deviation from previous JMG standard operating procedures and should be read in its entirety. This SOP also incorporates the significant parts of SOP JTF-JMG #014 (01 Feb 09), which is hereby cancelled.

II. POLICY

A. The DoD and Joint Task Force Guantanamo (JTF GTMO) policy is to protect detainees' physical and mental health and provide appropriate treatment for disease. This includes preventing any serious adverse health effects or death from weight loss, chronic underweight or malnutrition. The Joint Medical Group (JMG) staff will provide health care monitoring and medical assistance as clinically indicated for detainees with weight loss.

B. Weight is one of the central non-invasive indicators of the health of the detainee. Historically it has been shown that simple visual monitoring of detainees may miss clinically significant weight loss. Therefore, all detainees will be weighed at least monthly. Detainees who are of concern to the medical staff will be weighed more frequently as clinically indicated. Every attempt will be made to obtain weights voluntarily, however weights may be obtained involuntarily to ensure compliance with this policy.

C. In the event a detainee refrains from eating or drinking to the point where it is determined by medical assessment that continued fasting will result in a threat to his life or seriously jeopardize his health, JMG medical personnel will make reasonable efforts to obtain voluntary consent for medical treatment. If consent cannot be obtained from the detainee, medical procedures necessary to preserve health and life shall be implemented without his consent pursuant to reference (a). When involuntary feeding/fluid hydration is medically required, the JMG Senior Medical Officer (SMO) will inform the JMG Commander. When the SMO and JMG Commander reach concurrence, they will inform the JTF Commander and request written approval to administer involuntary feeding/fluid hydration.

D. JMG will not initiate involuntary feeding/fluid hydration without the JTF Commander's knowledge and written approval. This approval authority does not preclude the Medical Officer from performing any emergent actions deemed medically necessary to preserve life and health.

E. Preventing [redacted] is important to maintaining good order and discipline in the detention environment. The procedures outlined in this SOP will be protected from release to detainees and other staff, visitors without a need to know, consistent with FOUO designation.

F. Definitions.

1. Clinically Significant **Weight Loss.** For the purposes of this instruction, clinically significant weight loss is defined as follows:

a. The detainee's weight is less than 85% of the calculated ideal body weight (IBW).

b. The detainee has experienced a weight loss of greater than 15% from his usual body weight. For those detainees whose usual body weight is less than their ideal body weight, a weight loss of greater than 5% is considered clinically significant.

c. Weight loss or underweight associated with evidence of deleterious health effects during any period of weight loss reflective of end organ involvement or damage to include, but not limited to, seizures, syncope or pre-syncope, altered mental status, significant metabolic derangements, arrhythmias, muscle wasting, or weakness such that activities of daily living are significantly hampered.

d. A pre-existing co-morbidity that might readily predispose the detainee to end organ damage (e.g. hypertension, coronary artery disease or any significant kidney disease).

e. A prolonged period of weight loss, usually defined [redacted]

2. **Enteral feeder.** A detainee who the JTF Commander has authorized for involuntary feeding via an enteral feeding tube. It is important to note that an enteral feeder may or may not actually receive an enteral feed via a nasogastric tube on any specific day. Enteral feeders may still elect to eat a meal or to drink liquid nutrition despite being designated an enteral feeder

3. **Adequate Caloric Intake.** The number of calories required by a detainee to support daily metabolic functions and to maintain weight. Although this number varies by individual, for the purposes of this document adequate caloric intake is considered to be [redacted]

4. **Formulas:**

Usual Body Weight (UBW) = the greater of the following:

i. The weight of the detainee at in-processing physical exam.
ii. The average weight of the detainee for the past twelve months.

Ideal Body Weight (IBW) = [(Height in inches – 60) x 2.3 + 50] x 2.2

% Ideal Body Weight (% IBW) = [Current Weight (pounds) / Ideal Body Weight (pounds)] x 100

% Weight Loss (% WL) = [Usual Body Weight (pounds) – Current Weight (pounds) / Usual Body Weight (pounds)] x 100

III. Medical Management of Detainees with Weight Loss

A. Effective management of detainees with weight loss requires a close partnership between the JMG medical staff and the Joint Detention Group (JDG) security force.

B. Throughout the JTF, the JDG Security forces monitor each detainee's consumption and refusal of meals and water and report this information daily [redacted] which is forwarded to the JMG SMO daily.

C. The JMG SMO or his designee will review [redacted] for all detainees who have missed meals. For any detainees listed [redacted] as having missed meals the SMO will review the clinical information pertaining to that detainee, including the weight trend. The SMO may order a detainee weight or more frequent detainee weights based on the clinical information.

D. If a detainee weight obtained qualifies as a clinically significant weight loss the SMO will direct the detainee's medical provider to conduct an assessment. The intent of that assessment is to consider any medical and or behavioral cause of the weight loss.

E. Because of the presence of latent untreated tuberculosis in the detainee population, any detainee who loses [redacted] will have a Chest radiograph to rule out the possibility of active tuberculosis.

F. Using Enclosure (3), *Weight Loss Medical Evaluation Sheet,* a medical provider will perform a complete medical record review, an intake (food/fluids) history, and a general physical examination to include vital signs, weight, and Percent Ideal Body Weight (% IBW). The medical provider may order clinically indicated laboratory tests to assess the detainee's physical and metabolic status including but not limited to EKG, urinalysis, serum basic metabolic profile, liver function tests (LFTs), Magnesium (Mg), phosphate (PO4) and calcium (Ca). Once completed, Enclosure (2) will be signed by the medical provider and placed in the detainee's medical record.

G. The SMO will notify the Officer in Charge of the Behavioral Health Services (BHS) of any detainees that are added or removed from the list of individuals participating long term non religious fasting. If indicated, the BHS will perform a mental status exam and psychological assessment of the detainee. Documentation of the results and follow-up treatment plan will be placed in the detainee's medical record.

H. A JMG medical provider will advise each detainee who displays clinically significant weight loss as to the need to maintain weight. A nutritional consult may be offered. The medical staff will explain to the detainee via a linguist the health risks faced by the

detainee and encourag the detainee to resume eating food and drinking water. Documentation of this encouragement will be placed in the medical record.

I. After the initial medical evaluation, the medical providers will continue to assess the health of each detainee biweekly or as clinically indicated and document their findings using Enclosure (3), *Weight Loss Medical Flow Sheet*, available electronically on the network share drive.

J. The medical provider will discuss the medical care of the detainee with the SMO biweekly or as clinically indicated. The SMO will brief the chain of command of any serious medical issues concerning the detainees.

K. When a JMG Medical Provider determines that the detainee's life or health is threatened due to weight loss, immediate medical intervention may be indicated per guidance provided in DoDI 2310.08E. In such a case, the JMG Medical Provider will notify the SMO. The medical provider shall attempt to obtain voluntary consent for intervention. The medical provider shall document their counseling efforts and treatments in the detainee's medical record.

L. If medical intervention is required for a detainee who is losing weight, the SMO will notify the JMG Commander. The SMO or his designee will attempt to obtain voluntary consent for the intervention. If the detainee refuses reasonable care, it may be necessary to intervene involuntary to safeguard the detainee's health. If that occurs the SMO will discuss the care plan with the JMG commander. If the SMO and the JMG Commander concur, they will make a specific involuntary intervention request to the JTF Commander. Upon approval from the JTF Commander, the SMO will write medical orders to initiate treatment. Usually, the SMO/JMG Commander will receive the JTF Commander's authorization [redacted] email.

M. If involuntary enteral feeding is clinically indicated and authorized, Enclosure (4), *Approval Authority for Initiation of Involuntary Enteral Feeding,* will be completed by the SMO and placed in the detainee's medical record. These detainees will then be designated as enteral feeders.

N. The SMO or his/her representative will report detainees approved for enteral feedings via the JMG [redacted] SITREP to leaders within the JTF with a need to know including JTF Commander, [redacted]

O. Enteral feeders will be fed according to a schedule approved by the SMO as coordinated by the guard staff. All enteral feeders will be offered meals daily. If they refuse meals they will be offered to consume the enteral feed orally. If they refuse their meals and the opportunity to consume their enteral feed orally they will be offered to voluntarily accept enteral feeding. Only after they refuse all of the above will involuntary enteral feeding be initiated.

P. Clinical protocols for enteral feeding using graduated continuous and intermittent enteral feed infusions are found in Enclosure (5), *Clinical Guidelines for the Evaluation, Resuscitation, and Feeding of Detainees with Weight Loss* and includes the management of common electrolyte deficiencies. If the SMO deems it medically safe (e.g. low risk of re-feeding syndrome) based on the duration of the detainee's fast, involuntary enteral feeding may be initiated with graduated intermittent feeds as opposed to a continuous infusion.

Q. Enclosure (6), *Nursing Staff Clinical Procedure Checklist for Intermittent Enteral Feeding of Detainees with Weight Loss,* describes instructions for the use of the restraint chair for intermittent enteral feedings and Enclosure (10), *Medical Equations, Calculations and Weight Formulas* will be used to calculate caloric goals/needs.

R. Routine deviations from the above procedure for specific detainees must be approved by the Commander JTF.

S. Enteral Feeders will be weighed weekly, or more frequently as clinically indicated. Any continued weight loss in these detainees will be reported to the Commander, JTF.

IV. Weighing of Detainees

A. The JMG Weight Monitoring Nurse will review [redacted] frequently throughout each month ensuring each detainee has a weight entered for the current month.

B. The JMG Weight Monitoring Nurse will notify the JMG OICs and charge nurses of all ISNs that still need to be weighted for the month.

C. The JMG OICs will notify the JDG Watch Commander (WC) or Block NCO which detainee weights are still needed. Once the weights are obtained, the JMG Corpsman will report the detainee ISNs and weights to the charge nurse for documentation.

D. Detainee weights may be obtained on the cell blocks, during routine clinic and medical space visits, or while the detainee is an inpatient in the Detention Hospital or Behavioral Health Unit.

E. Scales will be zeroed prior to measurement.

F. Detainees should stand in the center of the scale without assistance and without touching walls or any nearby objects. If the detainee is unable to stand, he may be weighed while sitting in a feeding chair or wheelchair using a wheelchair scale, but the weight of the chair must be subtracted from the total weight obtained.

G. When detainees are weighed while on backboards or wearing shackles or other restrictive devices, the weight of those devices will be subtracted from the measured weight.

H. Once the guards have the detainee on the scale, a JMG member, usually a Hospital Corpsman assigned to the area where the detainee is located, will note the weight and give the measurement to the JMG Charge Nurse, who will forward the weight to the JMG Weight Monitoring Nurse. The JDG guard staff will enter the weight [redacted]

I. The JMG Weight Monitoring Nurse will report to the JMG Commander via the SMO and the JMG Deputy Commander and detainee who is overdue on their weights.

V. Monitoring Detainee Weights

A. The Charge Nurse will document the weight [redacted] in the detainee's medical record.

B. The SMO will receive daily information on missed meals and detainee weights [redacted]

C. The Weight Monitoring Nurse and the SMO will review [redacted] for trends and analysis no less than monthly to identify any detainee whose weight loss has become clinically significant as defined above and to obtain a long term overview of all detainee weights.

VI. Reporting Detainee Weights

A. Detainees being monitored for weight loss are reported [redacted]

B. The JMG Commander and the JMG Deputy Commander may request special analysis of the information [redacted] from the SMO at any time.

VII. Dietary Consultation

A. JMG providers may request a dietary consult for the detainee with the NH GTMO dietician for detainee education and recommendations to achieve optimal weight, potential medical consequences of obesity, health benefits of maintaining a normal IBW of 85% to 100%, and strategies to reduce weight and limit caloric intake.

VIII. In-processing

A. Upon arrival, the height and weight of each detainee will be determined and recorded [redacted]

IX. Out-processing

A. Each detainee will be weighed during out-processing. The detainee's in-processing and out-processing weights will be noted on the final narrative summary.

X. Cessation of Enteral Feeding

A. Most detainees will commence oral feeding on their own at some point. [redacted] they will no longer be designated enteral feeders. These detainees will continue to be monitored for their weight, fluid consumption and caloric intake. [redacted] a detainee may be considered for less frequent medical monitoring. [redacted] the SMO will notify the JMG Commander. If the SMO and JMG Commander concur, they will request from the JTF Commander permission to resume enteral feeding.

2. For evidence of malabsorption or other select cases, the SMO with the approval of the JMG Commander will determine an individualized care plan for transitioning an enteral feeder back to an oral diet. Generally, a three to five day period is sufficient for the transition to an oral diet. If the detainee has been intermittently consuming food by mouth during a period of weight loss, the transition to an oral diet may be achieved sooner.

Refusal to Accept Food or Water/Fluids as Medical Treatment

Detainee Number _____ Age _____ Date _____

The above detainee has refused food and/or water as medically recommended by the Medical Officer.

The grave risks of not following the medical advice directing him to eat life-sustaining food and to drink water/fluids have been explained to the detainee. He states he understands that as a direct result of his refusal to eat and/or drink, he may experience hunger, nausea, tiredness, feeling ill, headaches, swelling of his extremities, muscle wasting, abdominal pain, chest pain, irregular heart rhythms, altered level of consciousness, organ failure and/or coma. He states he understands that his refusal to eat life-sustaining food or drink water/fluids and to follow medical advice may cause irreparable harm to himself or lead to his death. He states he understands that this is not a complete list of the risks involved with the refusal to follow medical advice.

The detainee states he understands the alternatives available to him including oral food and fluid oral rehydration solutions, oral nutritional supplements, and intravenous fluid hydration.

The detainee states he fully understands the risks to his health if he does not accept food and water as advised above.

Translator/ Witness Signature_____

Medical Provider Signature _____

Weight Loss Medical Evaluation Sheet

Detainee Number: _____ Date of Evaluation: _____

Date of Onset: _____ Drinking Fluids: Yes No

Number of Meals Missed: _____

HPI:

_____

MEDS:

_____

ALLERGIES: NKDA or _____ FOOD ALLERGIES: _____

PMH:

Physical Assessment:

In processing Wt: _____ lbs Usual Wt: _____ lbs/date:_____ IBW_____

Current Wt: _____lbs ____ % IBW %Wt Loss: _____

Heart Rate: _____ BP: _____/_____ RR: _____ T: _____ LOC: Yes No

Other Pertinent Physical Exam and Laboratory Findings:

Assessment: Detainee with Weight Loss

Plan:

1. Explained risks of inadequate intake of food and/or water to detainee. See *Refusal to Accept Food or Water/Fluids As Medical Treatment*, Enclosure (2).
2. Document and execute follow up plan .
3. Other:

Medical Provider: _____

Weight Loss Medical Flow Sheet

Ordered Weight frequency:

Detainee ISN ###

			Document caloric intake				Height	43		Comments
Date	Drinking ?	Eating?	am EF		pm EF		BMI	123 36	(lbs)	dizzy, nausea, constipation, diarrhea, abd pain, unable to pass tube
2013	ml	Y/N	po B	po L	po D	po Other	Total	%IBW	Weight	(ambulatory, coherent, alert, oriented, verbal, etc)

Signature Attending Physician

NSN 7540-00-634-4176	AUTHORIZED FOR LOCAL REPRODUCTION
MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
Date/Time	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry) JTF–JMG, Medical Department, Guantanamo Bay, Cuba
	Approval Authority for Initiation of Involuntary Enteral Feeding
	Detainee ISN _____ has experienced clinically significant weight loss.
	He meets the following clinical criteria for involuntary enteral feeding:
	____ There is evidence of deleterious health effects reflective of end organ involvement or damage
	to include but not limited to seizures, syncope or pre-syncope, significant metabolic
	derangements, arrhythmias, muscle wasting, or weakness such that activities of daily living
	are hampered.
	____ There is a pre-existing co-morbidity that might readily predispose to end organ damage (e.g.
	hypertension, coronary artery disease or any significant heart condition, renal insufficiency
	or failure, endocrinopathy, etc.).
	____ There is a prolonged period of weight loss
	____ The detainee is at a weight less than 85% of his calculated Ideal Body Weight (IBW).
	____ The detainee has experienced significant weight loss (greater than 15%) from previously
	recorded or in-processing weight.
	_____ The detainee's UBW is less than his IBW and he has lost greater than 5% of his UBW.
	Involuntary feeding is required to prevent risk of death or serious harm to health.
	Written approval to initiate involuntary enteral feeding has been obtained from Commander, Joint Task Force
	as required per Standard Operating Procedure 001. (Note: e-mail written approval is acceptable).
	Senior Medical Officer, JTF/GTMO-JMG-/

DETAINEE 'S IDENTIFICATION NUMBER:

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDICAL RECORD
STANDARD FORM 600 (rev. 9/05)

Clinical Guidelines for the Evaluation, Resuscitation, and Feeding of Detainees with Weight Loss

*****Note: These are *only* Guidelines. Clinical presentation of the patient will determine the individualized patient plan of care prescribed by the Credentialed Medical Provider! *****

Once a detainee with weight loss meets the criteria for enteral feeding, the following protocol may be initiated. If clinically indicated, after initial IV fluid resuscitation, the SMO may initiate intermittent or continuous enteral feedings of the detainee. In the event of multiple detainees with weight loss, isolating patients from each other is vital to prevent them from achieving solidarity and coercing other detainees to also lose weight. [redacted] initial IV fluid resuscitation lasting approximately 24 hours can occur in the DH, followed by transfer back to the camps to begin enteral feeding in an environment of single cell operations.

Hospital Day #1: Admit to the Detention Hospital

Assess vital signs upon admission and periodically as clinically indicated thereafter.

Assess need for fluid resuscitation.

If not drawn recently, consider obtaining a complete blood count (CBC), basic metabolic panel, calcium (Ca^{++}), magnesium (Mg^{++}), phosphorous (phos), and creatine kinase (CK).

Consider a 12 lead EKG upon admission.

The detainee's weight should be obtained and recorded upon admission and daily thereafter, unless a lesser frequency is clinically indicated.

When fluid resuscitation is medically indicated, it should begin with a 1-2 liter intravenous (IV) bolus of (isotonic crystalloid) normal saline or Ringer's Lactate. The amount of the IV bolus will be decided after reviewing the detainee's medical history for any co-morbid diseases.

Thiamine 100 mg IV one time dose, administered prior to giving any Dextrose or D_5. May be ordered and administered in the clinic, [redacted]

Follow with standard IV fluid hydration formulation: one liter of D_5 ½ normal saline with 20 mEq KCL, one vial of (water soluble) MVI, 500 mg of magnesium sulfate, one vial of trace elements, and 1 mg of folic acid. Run the IV fluid @ 100 ml/hr for 10 hours.

Oral supplements with potassium phosphate, magnesium oxide, folate, and multivitamin may be substituted if the patient will take by mouth.

Once the IV isotonic crystalloid rehydration fluid has infused, administer maintenance fluids of D_5 ½ normal saline with 20 mEq KCL @ 100 ml/hr, [redacted]

PRN medications

1) Glucose, 50 grams (D_{50}, 1 amp) IV if blood sugar < 60 and detainee lethargic or unresponsive.

2) Tylenol 650mg PO Q 6 hrs PRN pain, headache.

3) Mylanta 15-30 ml PO Q 4 hrs PRN indigestion, heartburn.

Hospital Days #2 and #3: Initiation of Enteral Nutrition

Proceed with enteral feeding tube placement and feeding as per Enclosure (8) using an 8 to 12 French feeding tube.

When the patient is at high risk for refeeding syndrome, consider ordering the following labs on days 2-4 of enteral feeding: basic metabolic panel, calcium, magnesium, phosphorus.

Intermittent Enteral Nutrition

If patient is clinically stable, nutritional supplementation can usually be provided via intermittent feedings.

This is usually accomplished using a daily or twice daily schedule with an appropriate quantity of the daily calories being delivered at each feeding. If enteral feeding is initiated via the intermittent method, titrate to goal gradually over several days to decrease the risk of refeeding syndrome. [redacted]

Medical restraints (e.g. chair restraint system) should be used for the safety of the detainee, medical staff, and guard force as outlined in Enclosure (8).

The recommended requirements to maintain feedings intermittently instead of continuously are as follows:

[redacted]

2) Four cans of Pulmocare, Jevity 1.5 Cal, TwoCal HN, or equivalent nutritional supplement.

3) Labs as needed to validate normal electrolyte status.

4) Stable clinical condition.

Discharge from Detention Hospital: Detainee Moves to Feeding Location

Once the detainee is medically stable the Medical provider will determine when the detainee can be discharged from the Detention Hospital and transferred to the feeding location in the camps. Prior to leaving the DH, the detainee's feeding tube will be removed. Medical staff shall determine the minimum number of enteral feedings necessary to meet the detainee's required nutritional needs.

Management of Enterally Fed Detainees Who have resolution of their weight loss

The medical staff will manage these individuals to avoid complications associated with the resumption of oral nutrition.

[redacted] the attending physician deems it to be medically appropriate, enteral feeding will be discontinued and oral self-feeding by the detainee shall resume

Resumption of oral nutrition includes the following strategies

a. Offer the detainee his choice of available standard diets.
b. Monitor the detainee for evidence of refeeding syndrome, often characterized by decreased serum phosphorus, magnesium, and potassium levels and peripheral edema.
c. [redacted] the SMO deems it medically appropriate, the detainee can usually be removed from the weight loss list.
d. Enteral feeding shall resume at any point it becomes medically necessary, in accordance with this SOP.

Resolved Weight Loss Follow-up Care

a. A medical provider will perform a complete medical evaluation on all prior enterally fed detainees within approximately 2 weeks after resumption of a regular diet. This medical evaluation will include vital signs, weight, physical examination, and labs if clinically indicated.
b. Prior enterally fed detainees found to have ongoing medical needs or exhibit signs and symptoms associated with re-feeding syndrome will have follow up visits as medically indicated.
c. A member of the medical staff will counsel the detainee regarding the health risks associated with further weight loss.
d. The medical provider may consider submitting a consult request to NH GTMO nutritionist for optimal diet evaluation and planning

Management of Common Electrolyte Deficiencies

Hypokalemia – Replace potassium with KCL elixir/tablets, 10 milliequivalents for every 0.1 mEq/L below the normal value of 4.0 in the detainee's serum. For example, if a detainee has a serum potassium of 3.4 mEq/L, 60 milliequivalents of KCL elixir/tablets should be ordered.

Hypomagnesaemia – Replace with magnesium oxide. Crush four 400 mg tablets (approximately 960 mg of bioavailable magnesium) and mix in water before adding to enteral solution. Continue daily until normal serum Mg^{++} level is confirmed by lab draw. Oral magnesium may cause diarrhea. Alternatively for severe hypomagnesaemia, 1-2 grams of magnesium sulfate may be infused intravenously over 30 minutes.

Hypophosphatemia – Replace with 4 packets of K-phos daily (total of 1000 mg of phosphorus, 1112 mg of potassium, and 656 mg of sodium daily) until normal serum phosphorus level is confirmed by lab draw. Alternatively, for severe hypophosphatemia, 15 mmol of sodium phosphate mixed in 250 ml of ½ NS may be given over 4-6 hours. Usually, this is repeated for a total of 4-8 doses.

Nursing Staff Clinical Procedure Checklist for Intermittent Enteral Feeding of Detainees with Weight Loss

NOTE: IF THE RN OR HM FEELS THEY ARE IN ANY DANGER OF PERSONAL HARM DURING AN ENTERAL FEED, THEY ARE TO WITHDRAW FROM THE SITUATION AND IMMEDIATELY INFORM THE GUARDS OF THEIR CONCERNS.

I. Preparation for Enteral Feeding:

- ☐ Verify Provider's Orders
- ☐ Confirm detainee was offered an oral, liquid meal
- ☐ Prepare feeding solution according to Provider's Orders [redacted]
- ☐ Clearly mark enteral feeding reservoir bag with detainee's ISN and date
- ☐ [redacted]

  Note: if the detainee must be enterally fed in a hospital bed or on a gurney, ensure head of bed is elevated 45 degrees
- ☐ [redacted]
- ☐ Direct the guards to wash the detainees hands if they are soiled with feces or other bodily substances
- ☐ [redacted]
- ☐ [redacted]
- ☐ Obtain a new enteral feeding tube
- ☐ Initiate medical monitoring of detainee: assess vital signs, circulation, discomfort
- ☐ Initiate Enteral Feed Nursing Note

II. Initiate Enteral Feeding:

- ☐ Perform Enteral Feeding Time Out, at least [redacted] JMG Staff members participate

The Registered Nurse will place the feeding tube in the stomach as follows:

- ☐ Prepare feeding tube with viscous lidocaine, olive oil, or sterile surgical lubricant according to the detainee's choice
- ☐ Offer the detainee topical anesthesia (viscous lidocaine) to the affected nostril
- ☐ Gently pass the feeding tube via the nasal passage into the stomach
- ☐ If required to reduce head and jaw motion during insertion of the EF tube:
  - ○ While the detainee is seated and appropriately restrained in the feeding chair, [redacted] guard will position themselves behind the detainee and hold the detainee's head in the midline position.
  - ○ [redacted]

[redacted]

- ☐ If a detainee is attempting to bite or chew the tube, the RN will ask the detainee to open his mouth for a visual confirmation that the tube is intact. If the detainee refuses, the RN shall immediately remove the tube, inspect it for damage, and re-insert it to accomplish the EF.

Confirmation of Feeding Tube Placement: [redacted] JMG Staff Members, including at least [redacted] Registered Nurse, will confirm proper tube placement as follows:

- ☐ Insert 10 mLs of air into the tube as a [redacted] JMG staff member auscultates the stomach
- ☐ Auscultate the stomach while the [redacted] JMG member inserts 10 mLs of air into the stomach
- ☐ Insert 10 mL test dose of water, aspirate, observe for return of stomach fluid
- ☐ If there is any doubt about correct tube placement, remove the feeding tube

Following confirmation of tube placement, continue with the following steps:

- ☐ Tape the feeding tube to the detainee's nose and forehead
- ☐ Connect the feeding tube to the reservoir bag
- ☐ Begin the feed flow, adjust the rate to the detainee's condition and tolerance

III. During Enteral Feeding:

- ☐ Ensure a Hospital Corpsman is present with the detainee and observing the detainee's condition and tolerance of the feed continuously throughout the entire administration of the enteral feed procedure
- ☐ Report any detainee threats of physical assault or exposure to body fluids to the guard staff immediately
- ☐ The detainee is not to be in the restraint chair for more than two hours.

IV. RN Assessment and Intervention:

- ☐ Assess detainee for nausea: if present, offer PRN medication as ordered
- ☐ Assess detainee for pain to abdomen, observe for distention; slow rate until complaint of pain is resolved

V. Completion of Enteral Feeding:

- ☐ Once feeding is complete, gently remove the feeding tube
- ☐ Assess detainee for nausea, discomfort
- ☐ Complete Enteral Feed Nursing Note
- ☐ Document number of calories administered via enteral feeding on the Enteral Feed Nursing Note and Weight Loss Medical Flow Sheet

- ☐ Flush the enteral feed reservoir bag with at least 300 mL of tap water or until clean. The reservoir may be used again for the same detainee on the same day. Dispose of the reservoir bag at the end of the day!
- ☐ Following completion of enteral feeding, the guard force will return the detainee to cell and observe his status.

VI. Detainee Biting of Enteral Feed Tube:

A detainee undergoing enteral feeding (EF) may attempt to bite and swallow the feeding tube, requiring serial exams, ongoing medical care, and possible removal of the tube via an EGD procedure. Identification of these detainees and management of the EF tube will assist the RN in reducing the incidence of this event. The following guidance is provided:

- ☐ When the detainee attempts to bite or chew the tube, the RN will direct the detainee to open his mouth for a visual confirmation that the tube is intact.
  - o If the detainee refuses, the RN shall immediately remove the tube, inspect it for damage, and re-insert it to accomplish the EF following enteral feeding tube insertion guidelines outlined in this SOP.
- ☐ When the detainee positions the tube between his teeth, the nurse will:
  - o Simultaneously turn off feed and stabilize the proximal end of the tube.
  - o Direct the guard staff to stabilize detainee's head in the midline position.
  - o Maintain traction on the proximal end of the tube until the detainee releases the tube from between his teeth. This may take considerable time.
  - o Remove the tube from the detainee's nose
- ☐ For detainees who continually attempt to bite the tube, the RN will direct guard staff to maintain 1:1 visual monitoring of detainee during EF sessions.

VII. JMG Staff Responses to Detainee:

- ☐ Detainee directs a change to EF contents or order of contents:
  Respond: **"This is the formula that the doctor has ordered for your nutritional requirements. I am not permitted to make any changes to the order."**
- ☐ Detainee demands to speak to the doctor:
  Respond: **"I will write a note in your chart for the doctor"**
- ☐ Detainee directs the nurse to place him in a particular location during EF:
  Respond: **"That decision is made by the guards."**

VIII. Quality Improvement Strategies

- ☐ The JMG Quality Management Nurse, in collaboration with SMO, SNE and the Medical OICs will implement performance measures to identify performance benchmarks and gaps in implementing the JMG Enteral Feeding process.

- ☐ Measurements will be structured to identify gaps in performance and develop strategies to reduce those gaps and maximize enteral feeding effectiveness and efficiency.

- ☐ The JMG Quality Management Nurse will collaborate with the JMG Training Officer to structure training sessions as needed to maximize enteral feeding program outcomes.

- ☐ Performance measures may include any of the following:
  - Hospital Corpsman or Registered Nurse present to directly observe detainee during entire administration of enteral feed
  - All results for labs ordered during Weight Loss Medical Evaluation are in chart
  - Post Weight Loss Medical Evaluation completed within 2 weeks and in chart
  - Detention Hospital admission weight obtained, listed in chart
  - Thiamine (PO or IV) administered before Dextrose or D5 for new long-term fasters
  - Detainee not in restraint feeding chair longer than 2 hours
  - Enteral feed Nursing Note is complete, signed by RN and in chart
  - Enteral feeding tube placement confirmed by [redacted] JMG staff, including at least [redacted] RN
  - Enteral Feed Reservoir bag is clearly marked with detainee's ISN and date
  - Detainee is fed with a new enteral feeding tube each time
  - Form: *Refusal to Accept Food or Water/Fluids as Medical Treatment* completed and in chart
  - Form: *Approval Authority for Initiation of Involuntary Enteral Feeding* completed and in chart

ENTERAL FEED NURSING NOTE

ISN:		AM/PM		Date:	

Detainee placed in restraints/restraint chair by guard staff for enteral feeding procedure.

INITIAL ASSESSMENT/VITAL SIGNS

☐ Detainee required Forced Cell Extraction to restraint chair/gurney or ☐ Detainee ambulated to feed chair/gurney.
Detainee placed in chair/gurney at _____.
☐ Detainee refused vital signs (For long-term fasters only)
☐ Vital Signs: T_____ HR _____ RR_____ BP_____ O2 sat_____% Weight_____ ☐ Pulses WNL x 4
☐ Detainee denies nausea/vomiting ☐ Detainee denies pain
☐ Other _____

PROCEDURE NOTE: INSERTION OF FEEDING TUBE

☐ Enteral Feeding Time Out performed with [redacted] Feed Team members.
Using: ☐ olive oil ☐ 2% viscous lidocaine ☐ sterile lubricant, an ☐ 8Fr ☐ 10Fr enteral feeding tube was inserted in the
☐ Right ☐ Left nostril using standard nursing procedure.
☐ Placement in stomach was confirmed by air auscultation by [redacted] JMG staff (at least [redacted] RN) and test dose with 10ml water.
Type of Nutritional solution: ☐ Pulmocare ☐ Ensure ☐ other _____ amount: _____ml _____ calories
Additives: ☐ water _____ml ☐ MgO _____mg ☐ Thiamine_____mg ☐ K-Phos _____mg ☐ Multivitamin X ____tab
Other:

ASSESSMENT DURING ENTERAL FEEDING

Enteral feeding initiated at_____.
Circulation assessed using at least one of the following every 15 minutes while restrained:
☐ No skin discoloration noted ☐ No edema noted ☐ Pulse Rate/Rhythm WNL ☐ Capillary Refill Time <3 seconds
Complaints/ Complications during feed: ☐ None ☐ Other _____

POST ENTERAL FEEDING ASSESSMENT

Enteral Feeding completed and Enteral Feeding Tube removed at _____.
Detainee's condition post enteral feed:
☐ Detainee denies pain ☐ Detainee denies nausea/vomiting ☐ No Injury/complaint noted.
☐ Injury/complaint noted. Describe:_____
☐ Physician notified (if applicable): Name:_____ Time:_____

Restraints released at _____ and detainee released to guard staff

☐ Detainee required Forced Cell Extraction back to cell ***OR*** ☐ Detainee ambulated back to cell.
HM/RN note:

HM signature: _____ **Date/Time:** _____

RN signature: **Date/Time:** _____

MEDICAL EQUATIONS, CALCULATIONS AND WEIGHT FORMULAS

Determination of Energy Requirements: TOTAL CALORIE PER KILOGRAM METHOD

Classification	Kcal/kg
Morbid obesity	20
Starvation, Ventilated, Intensive Care Unit	25
Ambulatory Maintenance	25-35
Malnutrition/ Moderate Stress	30-35
Severe Injuries/ Stress	35-45

HARRIS –BENEDICT EQUATION:

Men (kcal/day) = [66.47 + (13.75 x weight (kg)) + (5 x height (cm)) – (6.76 x age)] x activity factor x stress factor

Activity Description	Factor	Stress Description	Factor
Chair or bed bound	1.2 x BEE	Elective surgery	1 – 1.1 x BEE
Seated work with little movement	1.4 – 1.5 x BEE	Multiple trauma	1.4 x BEE
Seated work with little strenuous leisure activity	1.6 – 1.7 x BEE	Severe infection	1.2 – 1.6 x BEE
Standing work	1.8 – 1.9 x BEE	Peritonitis	1.05 – 1.25 x BEE
Strenuous work or highly active leisure activity	2 – 2.4 x BEE	Multiple/long bone fractures	1.1 – 1.3 x BEE
30 – 60 minutes strenuous leisure activity 4 – 5 times/week	2.3 – 2.7 x BEE	Infection with trauma	1.3 – 1.55 x BEE
		Sepsis	1.2 – 1.4 x BEE
		Closed head injury	1.3 x BEE
		Cancer	1.1 – 1.45 x BEE
		Burns	1.5 – 2.1 x BEE
		Fever	1.2 x BEE (per 1°C >37°C)

Determination of Protein Requirements:

Condition	Grams/kg/day
Renal Failure/Dysfunction	0.6 – 0.8 (40 gram min)
Dialysis Patients (moderate stress)	1 – 1.2
Dialysis Patients (high stress) Sepsis Liver Failure/Cirrhosis Re-feeding Syndrome	1.2 – 1.5
Multiple trauma	1.3 – 1.7
Catabolism	1.2 – 2
Post-op	1 – 1.5

Determination of Fluid Requirements:

	Free Water Requirement
1st 10 kg	100 mL/kg
2nd 10 kg	50 mL/kg
Each kg >20 kg	20 mL/kg (≤50 years)
	15 mL/kg (>50 years)
Method 2 – Age	
Young Athletic Adult	40 mL/kg
Most Adults	35 mL/kg
Elderly Adults	30 mL/kg
Method 3 – Energy Expenditure	
1 mL/kcal energy expenditure	

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APPROVED BY:

_____ / _____ _____
Signature/ Printed Name
Commander, Joint Medical Group Date

RECOMMENDED BY:

_____ / _____ _____
Signature/ Printed Name Required: ☒Yes ☐No
Deputy Commander, Joint Medical Group Date

_____ / _____ _____
Signature/ Printed Name Required: ☐Yes ☐No
Senior Medical Officer Date

_____ / _____ _____
Signature/ Printed Name Required: ☐Yes ☐No
Senior Nurse Executive Date

_____ / _____ _____
Signature/ Printed Name Required: ☐Yes ☐No
Director For Administration Date

_____ / _____ _____
Signature/ Printed Name Required: ☐Yes ☐No
Medical Planner Date

_____ / _____ _____
Signature/ Printed Name Required: ☐Yes ☐No
Senior Enlisted Leader Date

_____ / _____ _____
Signature/ Printed Name Required: ☐Yes ☐No
Director, Behavioral Health Services Date

REVIEW LOG: Directorate Reviewer:
Sig:_____ Date:_____
Sig:_____ Date:_____
Sig: Date:

SOP SUPERCEDED/ CANCELLED THIS DATE:

_____ / _____ _____
Signature/ Printed Name
Commander, Joint Medical Group Date

Exhibit H

JOINT MEDICAL GROUP JOINT TASK FORCE GUANTANAMO BAY, CUBA Title: MEDICAL MANAGEMENT OF DETAINEES WITH WEIGHT LOSS	SOP NO: JMG 001 Effective Date: 16DEC2013
SCOPE: JOINT MEDICAL GROUP, JOINT TASK FORCE , GTMO	

REFERENCES:

(a) DoDI 2310.08E Medical Program Support for Detainee Operations, 2006.

ENCLOSURES:

(1) Refusal to Accept Food or Water/Fluids as Medical Treatment
(2) Weight Loss Medical Evaluation Sheet
(3) Weight Loss Medical Flow Sheet
(4) Approval Authority for Initiation of Involuntary Enteral Feeding
(5) Clinical Guidelines for the Evaluation, Resuscitation, and Feeding of Detainees on Long Term Non Religious Fast
(6) Nursing Staff Clinical Procedure Checklist for Intermittent Enteral Feeding of Detainees with Weight Loss
(7) Enteral Feeding Nursing Note
(8) Medical Equations, Calculations and Weight Formulas

I. BACKGROUND

A. A prolonged period of time without adequate food and water will have adverse health effects on the individual detainee and potentially the greater detainee population. Weight loss may be an indicator of long standing malnutrition or of an underlying medical problem, such as malignancy or infectious disease. Identification and early medical management of detainees with weight loss may prevent adverse health effects and death.

B. Patients with weight loss can be expected in any detained population. Maintaining adequate nutrition and health within a detained population is challenging. The medical management of detainees with weight loss in GTMO has evolved over time. The current medical management of detainees with weight loss in GTMO has been developed using procedures adapted from the Federal Bureau of Prisons.

II. POLICY

A. The DoD and Joint Task Force Guantanamo (JTF-GTMO) policy is to protect detainees' physical and mental health and provide appropriate treatment for disease. This includes preventing

any serious adverse health effects or death from weight loss, chronic underweight or malnutrition. The Joint Medical Group (JMG) staff will provide health care monitoring and medical assistance as clinically indicated for detainees with weight loss.

B. Weight is one of the central non-invasive indicators of the health of the detainee. Historically, it has been shown that simple visual monitoring of detainees may miss clinically significant weight loss. Therefore, all detainees will be weighed at least monthly. Detainees who are of concern to the medical staff will be weighed more frequently as clinically indicated. Every attempt will be made to obtain weights voluntarily; however, weights may be obtained involuntarily to ensure compliance with this policy.

C. In the event a detainee refrains from eating or drinking to the point where it is determined by medical assessment that continued fasting will result in a threat to his life or seriously jeopardize his health, JMG medical personnel will make reasonable efforts to obtain voluntary consent for medical treatment. If consent cannot be obtained from the detainee, medical procedures necessary to preserve health and life shall be implemented without his consent pursuant to reference (a). When involuntary feeding/fluid hydration is medically required, the JMG Senior Medical Officer (SMO) will inform the JMG Commander. When the SMO and JMG Commander reach concurrence, they will inform the JTF Commander and request written approval to administer involuntary feeding/fluid hydration.

D. JMG will not initiate involuntary feeding/fluid hydration without the JTF Commander's knowledge and written approval. This approval authority does not preclude the Medical Officer from performing any emergent actions deemed medically necessary to preserve life and health.

E. Preventing [redacted] is important to maintaining good order and discipline in the detention environment, and in protecting detainee health. The procedures outlined in this SOP will be protected from release to detainees and other personnel, including JTF staff and visitors without a need to know, consistent with FOUO designation.

F. Definitions.

1. Clinically Significant **Weight Loss.** For the purposes of this instruction, clinically significant weight loss is defined as:

a. The detainee's weight is less than 85% of the calculated ideal body weight (IBW).

b. The detainee has experienced a weight loss of greater than 15% from his usual body weight. For those detainees whose usual body weight is less than their ideal body weight, a weight loss of greater than 5% is considered clinically significant.

c. Weight loss or underweight associated with evidence of deleterious health effects during any period of weight loss reflective of end-organ involvement or damage, to include, but is not limited to, seizures, syncope or pre-syncope, altered mental status, significant metabolic

derangements, arrhythmias, muscle wasting, or weakness such that activities of daily living are significantly hampered.

d. A pre-existing co-morbidity that might readily predispose the detainee to end organ damage (e.g. hypertension, coronary artery disease or any significant kidney disease).

e. A prolonged period of weight loss, usually defined as [redacted]

2. **Enteral feeder.** A detainee who the JTF Commander has authorized for involuntary feeding via an enteral feeding tube. It is important to note that an enteral feeder may or may not actually receive an enteral feed via a nasogastric tube on any specific day. Enteral feeders may still elect to eat a meal or to drink liquid nutrition despite being designated an enteral feeder

3. **Adequate Caloric Intake.** The number of calories required by a detainee to support daily metabolic functions and to maintain weight. Although this number varies by individual, for the purposes of this instruction, adequate caloric intake is considered to be [redacted] daily.

4. **Formulas:**

Usual Body Weight (UBW) = the greater of the following:
i. The weight of the detainee at in-processing physical exam.
ii. The average weight of the detainee for the past twelve months.

Ideal Body Weight (IBW) = [(Height in inches – 60) x 2.3 + 50] x 2.2

% Ideal Body Weight (% IBW) = [Current Weight (pounds) / Ideal Body Weight (pounds)] x 100

% Weight Loss (% WL) = [Usual Body Weight (pounds) – Current Weight (pounds) / Usual Body Weight (pounds)] x 100

III. Medical Management of Detainees with Weight Loss

A. Effective management of detainees with weight loss requires a close partnership between the JMG medical staff and the Joint Detention Group (JDG) guard force.

B. JDG guard forces monitor each detainee's consumption and refusal of meals and water and report this information daily [redacted] which is forwarded to the JMG SMO daily.

C. The JMG SMO or his designee will review [redacted] for all detainees who have missed meals. The SMO will review the clinical information pertaining to any detainee listed [redacted] as having missed meals, to include that detainee's weight trend.

The SMO may order a detainee weight at that time, or may order that the detainee be weighed more frequently than what is normally required for detainees in this instruction.

D. If the result of a detainee weight qualifies as a clinically significant weight loss, the SMO will direct the detainee's medical provider to conduct an assessment. The intent of the assessment is to consider any medical and or behavioral cause of the weight loss.

E. Because of the presence of latent untreated tuberculosis in the detainee population, any detainee who loses [redacted] will have a chest radiograph to rule out the possibility of active tuberculosis.

F. Using Enclosure (3), *Weight Loss Medical Flow Sheet,* a medical provider will perform a complete medical record review, an intake (food/fluids) history, and a general physical examination to include vital signs, weight, and Percent Ideal Body Weight (% IBW). The medical provider may order clinically indicated laboratory tests to assess the detainee's physical and metabolic status, including but not limited to EKG, urinalysis, serum basic metabolic profile, liver function tests (LFTs), Magnesium (Mg), phosphate (PO4) and calcium (Ca). Once completed, Enclosure (2) will be signed by the medical provider and placed in the detainee's medical record.

G. The SMO will notify the Officer-in-Charge of the Behavioral Health Services (BHS) of any detainees who are added or removed from the list of individuals participating in long term non-religious fasting. If indicated, the BHS will perform a mental status exam and psychological assessment of the detainee. Documentation of the results of this exam and follow-up treatment plan will be placed in the detainee's medical record.

H. A JMG medical provider will advise each detainee who displays clinically significant weight loss as to the need to maintain weight. The medical provider may offer a nutritional consult. The medical staff will explain to the detainee via a linguist the health risks faced by the detainee resulting from clinically significant weight loss and encourage the detainee to resume eating sufficient food and drinking water. Documentation of this counseling will be placed in the detainee's medical record.

I. After the initial medical evaluation, the medical providers will continue to assess the health of the detainee biweekly or as clinically indicated and document their findings using Enclosure (3), *Weight Loss Medical Flow Sheet*, available electronically on the network share drive.

J. The medical provider will discuss the medical care of the detainee with the SMO biweekly or as clinically indicated. The SMO will brief the chain of command of any serious medical issues concerning the detainees.

K. When a JMG medical provider determines that the detainee's life or health is threatened due to weight loss, immediate medical intervention may be indicated. In such a case, the JMG medical provider will notify the SMO. The medical provider shall attempt to obtain voluntary

consent for intervention. The medical provider shall document their counseling efforts and treatments in the detainee's medical record.

L. If medical intervention is required for a detainee who is losing weight, the SMO will notify the JMG Commander. The SMO or his designee will attempt to obtain voluntary consent for the intervention. If the detainee continues to refuse reasonable care necessary to safeguard the detainee's health, it may be necessary to intervene involuntary. If this occurs, the SMO will discuss the care plan with the JMG commander. If the SMO and the JMG Commander concur with the proposed care plan, the JMG Commander or SMO will make a specific involuntary intervention request to the JTF Commander. Upon approval from the JTF Commander, the SMO will order the treatment. Usually, the SMO/JMG Commander will receive the JTF Commander's authorization [redacted] email.

M. If involuntary enteral feeding is clinically indicated and authorized, Enclosure (4), *Approval Authority for Initiation of Involuntary Enteral Feeding*, will be completed by the SMO and placed in the detainee's medical record. These detainee will then be designated as an enteral feeder.

N. The SMO or his/her representative will report detainees approved for enteral feeding via the JMG [redacted] SITREP to leaders within the JTF with a demonstrated need-to-know, including JTF Commander, [redacted]

O. Enteral feeders will be fed according to a schedule approved by the SMO as coordinated with the guard staff. All enteral feeders will be offered standard detainee meals daily. If the detainees refuse meals, they will be offered to consume the enteral feed solution orally. If they refuse their meals and the opportunity to consume their enteral feed solution orally, they will be asked to accept enteral feeding voluntarily. Only after they refuse all of the above will involuntary enteral feeding be initiated.

P. Clinical protocols for enteral feeding using graduated, continuous, and intermittent enteral feed infusions are found in Enclosure (5), *Clinical Guidelines for the Evaluation, Resuscitation, and Feeding of Detainees with Weight Loss*, which also includes guidance for the management of common electrolyte deficiencies. If the SMO deems it medically safe (e.g. low risk of re-feeding syndrome) based on the duration of the detainee's fast, involuntary enteral feeding may be initiated with graduated intermittent feeds as opposed to a continuous infusion.

Q. Enclosure (6), *Nursing Staff Clinical Procedure Checklist for Intermittent Enteral Feeding of Detainees with Weight Loss*, establishes the steps to be used in performing enteral feedings, and Enclosure (8), *Medical Equations, Calculations and Weight Formulas* will be used to calculate caloric goals/needs.

R. Routine deviations from the above procedure for specific detainees must be approved by Commander, JTF-GTMO.

S. Enteral Feeders will be weighed weekly, or more frequently as clinically indicated. Any continued weight loss in these detainees will be reported to the Commander, JTF.

IV. Weighing of Detainees

A. The JMG Weight Monitoring Nurse will review [redacted] frequently throughout each month ensuring each detainee has a weight entered for the current month.

B. The JMG Weight Monitoring Nurse will notify the JMG OICs and charge nurses of all detainee ISNs that need to be weighted for the month.

C. The JMG OICs will notify the JDG Watch Commander (WC) or Block NCO which detainee weights are still needed. Once the weights are obtained, the JMG Corpsman will report the detainee ISNs and weights to the charge nurse for documentation.

D. Detainee weights may be obtained on the cell blocks, during routine clinic and medical space visits, or while the detainee is an inpatient in the Detention Hospital or Behavioral Health Unit.

E. Scales will be zeroed prior to measurement.

F. Detainees should stand in the center of the scale without assistance and without touching walls or any nearby objects. If the detainee is unable to stand, he may be weighed while sitting in a feeding chair or wheelchair using a wheelchair scale, but the weight of the chair must be subtracted from the total weight obtained.

G. When detainees are weighed while on backboards or wearing shackles or other restrictive devices, the weight of those devices will be subtracted from the measured weight.

H. Once the guards have the detainee on the scale, a JMG member, usually a Hospital Corpsman assigned to the area where the detainee is located, will note the weight and give the measurement to the JMG Charge Nurse, who will forward the weight to the JMG Weight Monitoring Nurse. The JDG guard staff will enter the weight [redacted]

I. The JMG Weight Monitoring Nurse will report to the JMG Commander via the SMO and the JMG Deputy Commander any detainee who is overdue on their weights.

V. Monitoring Detainee Weights

A. The Charge Nurse will document the weight [redacted] in the detainee's medical record.

B. The SMO will receive daily information on missed meals and detainee weights [redacted]

C. The Weight Monitoring Nurse and the SMO will review [redacted] for trends and analysis no less than monthly to identify any detainee whose weight loss has become clinically significant as defined above and to obtain a long term overview of all detainee weights.

VI. Reporting Detainee Weights

A. Detainees being monitored for weight loss will be reported [redacted]

B. The JMG Commander and the JMG Deputy Commander may request special analysis of the information [redacted] from the SMO at any time.

VII. Dietary Consultation

A. JMG providers may request a dietary consult for the detainee with the NH GTMO dietician for detainee education and recommendations to achieve optimal weight, potential medical consequences of obesity, health benefits of maintaining a normal IBW of 85% to 100%, and strategies to reduce weight and limit caloric intake.

VIII. In-processing

A. Upon first arrival to JTF-GTMO, the height and weight of each detainee will be determined and recorded [redacted]

IX. Out-processing

A. Each detainee scheduled for transfer from JTF-GTMO will be weighed during out-processing. The detainee's in-processing and out-processing weights will be noted on the final narrative summary.

X. Cessation of Enteral Feeding

A. Most detainees will commence oral feeding on their own at some point. [redacted] they will no longer be designated enteral feeders. These detainees will continue to be monitored for their weight, fluid consumption and caloric intake. [redacted] a detainee may be considered for less frequent medical monitoring. [redacted] the SMO will notify the JMG Commander. If the SMO and JMG Commander concur, they will request from the JTF Commander permission to resume enteral feeding.

B. For evidence of malabsorption or other select cases, the SMO, with the approval of the JMG Commander, will determine an individualized care plan for transitioning an enteral feeder back to an oral diet. Generally, a three- to five-day period is sufficient for the transition to an oral diet. If the detainee has been intermittently consuming food by mouth during a period of weight loss, the transition to an oral diet may be achieved sooner.

Refusal to Accept Food or Water/Fluids as Medical Treatment

Detainee Number _____ Age _____ Date _____

The above detainee has refused food and/or water as medically recommended by the Medical Officer.

The grave risks of not following the medical advice directing him to eat life-sustaining food and to drink water/fluids have been explained to the detainee. He states he understands that as a direct result of his refusal to eat and/or drink, he may experience hunger, nausea, tiredness, feeling ill, headaches, swelling of his extremities, muscle wasting, abdominal pain, chest pain, irregular heart rhythms, altered level of consciousness, organ failure and/or coma. He states he understands that his refusal to eat life-sustaining food or drink water/fluids and to follow medical advice may cause irreparable harm to himself or lead to his death. He states he understands that this is not a complete list of the risks involved with the refusal to follow medical advice.

The detainee states he understands the alternatives available to him including oral food and fluid oral rehydration solutions, oral nutritional supplements, and intravenous fluid hydration.

The detainee states he fully understands the risks to his health if he does not accept food and water as advised above.

Translator/ Witness Signature_____

Medical Provider Signature _____

Weight Loss Medical Evaluation Sheet

Detainee Number: _____ Date of Evaluation: _____

Date of Onset: _____ Drinking Fluids: Yes No

Number of Meals Missed: _____

HPI:

_____

MEDS:

_____

ALLERGIES: NKDA or _____ FOOD ALLERGIES: _____

PMH:

Physical Assessment:

In processing Wt: _____ lbs Usual Wt: _____ lbs/date:_____ IBW_____

Current Wt: _____lbs ____ % IBW %Wt Loss: _____

Heart Rate: _____ BP: _____/_____ RR: _____ T: _____ LOC: Yes No

Other Pertinent Physical Exam and Laboratory Findings:

Assessment: Detainee with Weight Loss

Plan:

1. Explained risks of inadequate intake of food and/or water to detainee. See *Refusal to Accept Food or Water/Fluids As Medical Treatment*, Enclosure (1).
2. Document and execute follow up plan .
3. Other:

Medical Provider: _____

Enclosure (2)

Weight Loss Medical Flow Sheet										
Ordered Weight frequency:									Detainee ISN	###
			Document caloric intake							Comments
Date	Drinking ?	Eating?	am EF		pm EF				(lbs)	dizzy, nausea, constipation, diarrhea, abd pain, unable to pass tube
2013	ml	Y/N	po B	po L	po D	po Other			Weight	(ambulatory, coherent, alert, oriented, verbal, etc)

Signature Attending Physician

Enclosure (3)

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD CHRONOLOGICAL RECORD OF MEDICAL CARE

Date/Time	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry) JTF–JMG, Medical Department, Guantanamo Bay, Cuba
	Approval Authority for Initiation of Involuntary Enteral Feeding
	Detainee ISN has experienced clinically significant weight loss.
	He meets the following clinical criteria for involuntary enteral feeding:
	____ There is evidence of deleterious health effects reflective of end organ involvement or damage, to include, but not limited to, seizures, syncope or pre-syncope, significant metabolic derangements, arrhythmias, muscle wasting, or weakness such that activities of daily living are hampered.
	____ There is a pre-existing co-morbidity that might readily predispose to end organ damage (e.g. hypertension, coronary artery disease or any significant heart condition, renal insufficiency or failure, endocrinopathy, etc.).
	____ There is a prolonged period of weight loss.
	____ The detainee is at a weight less than 85% of his calculated Ideal Body Weight (IBW).
	____ The detainee has experienced significant weight loss (greater than 15%) from previously recorded or in-processing weight.
	____ The detainee's UBW is less than his IBW and he has lost greater than 5% of his UBW.
	Involuntary feeding is required to prevent risk of death or serious harm to health.
	Written approval to initiate involuntary enteral feeding has been obtained from Commander, Joint Task Force Guantanamo as required per Standard Operating Procedure 001. (Note: e-mail written approval is acceptable).
	Senior Medical Officer, JTF-GTMO/JMG

DETAINEE'S IDENTIFICATION NUMBER:

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDICAL RECORD
STANDARD FORM 600 (rev. 9/05)

Clinical Guidelines for the Evaluation, Resuscitation, and Feeding of Detainees with Weight Loss

*****Note: These are *only* Guidelines. Clinical presentation of the patient will determine the individualized patient plan of care prescribed by the Credentialed Medical Provider! *****

Once a detainee with weight loss meets the criteria for enteral feeding, the following protocol may be initiated. If clinically indicated, after initial IV fluid resuscitation, the SMO may initiate intermittent or continuous enteral feedings of the detainee. In the event of multiple detainees with weight loss, isolating patients from each other is vital to prevent them from achieving solidarity and coercing other detainees to also lose weight. [redacted] initial IV fluid resuscitation lasting approximately 24 hours can occur in the Detention Hospital. Afterwards, the detainee should be transferred back to the camps to begin enteral feeding in an environment of single cell operations.

I. Hospital Day #1: Admit to the Detention Hospital

Assess vital signs upon admission and periodically as clinically indicated thereafter.

Assess need for fluid resuscitation.

If not drawn recently, consider obtaining a complete blood count (CBC), basic metabolic panel, calcium (Ca^{++}), magnesium (Mg^{++}), phosphorous (phos), and creatine kinase (CK).

Consider a 12 lead EKG upon admission.

The detainee's weight should be obtained and recorded upon admission and daily thereafter, unless a lesser frequency is clinically indicated.

When fluid resuscitation is medically indicated, it should begin with a 1-2 liter intravenous (IV) bolus of (isotonic crystalloid) normal saline or Ringer's Lactate. The amount of the IV bolus will be decided after reviewing the detainee's medical history for any co-morbid diseases.

Thiamine 100 mg IV one time dose, administered prior to giving any Dextrose or D_5 may be ordered and administered in the clinic [redacted]

Follow with standard IV fluid hydration formulation: one liter of D_5 ½ normal saline with 20 mEq KCL, one vial of (water soluble) MVI, 500 mg of magnesium sulfate, one vial of trace elements, and 1 mg of folic acid. Run the IV fluid @ 100 ml/hr for 10 hours. Oral supplements with potassium phosphate, magnesium oxide, folate, and multivitamin may be substituted if the patient will take by mouth.

Once the IV isotonic crystalloid rehydration fluid has infused, administer maintenance fluids of D_5 ½ normal saline with 20 mEq KCL @ 100 ml/hr, [redacted]

PRN medications

1) Glucose, 50 grams (D_{50}, 1 amp) IV if blood sugar < 60 and detainee lethargic or unresponsive.

2) Tylenol 650mg PO Q 6 hrs PRN pain, headache.

3) Mylanta 15-30 ml PO Q 4 hrs PRN indigestion, heartburn.

II. <u>Hospital Days #2 and #3:</u> Initiation of Enteral Nutrition

Proceed with enteral feeding tube placement and feeding as per Enclosure (6) using an 8 to 12 French feeding tube.

When the patient is at high risk for refeeding syndrome, consider ordering the following labs on days 2-4 of enteral feeding: basic metabolic panel, calcium, magnesium, phosphorus.

Intermittent Enteral Nutrition

If patient is clinically stable, nutritional supplementation can usually be provided via intermittent feedings.

This is usually accomplished using a daily or twice daily schedule with an appropriate quantity of the daily calories being delivered at each feeding. If enteral feeding is initiated via the intermittent method, titrate to goal gradually over several days to decrease the risk of refeeding syndrome. [redacted]

Medical restraints (e.g. chair restraint system) should be used for the safety of the detainee, medical staff, and guard.

The recommended requirements to maintain intermittent feedings instead of continuously are as follows:

[redacted]

2) Four cans of Pulmocare, Jevity 1.5 Cal, TwoCal HN, or equivalent nutritional supplement.

3) Labs as needed to validate normal electrolyte status.

4) Stable clinical condition.

III. Discharge from Detention Hospital: Detainee Moves to Feeding Location

Once the detainee is medically stable the Medical provider will determine when the detainee can be discharged from the Detention Hospital and transferred to the feeding location in the camps. Prior to leaving the DH, the detainee's feeding tube will be removed. Medical staff shall determine the minimum number of enteral feedings necessary to meet the detainee's required nutritional needs.

Management of Enterally Fed Detainees Who Have Resolution of Their Weight Loss

The medical staff will manage these individuals to avoid complications associated with the resumption of oral nutrition.

[redacted] the attending physician deems it to be medically appropriate, enteral feeding will be discontinued and oral self-feeding by the detainee shall resume.

Resumption of Oral Nutrition Includes the Following Strategies

a. Offer the detainee his choice of available standard detainee meals.
b. Monitor the detainee for evidence of refeeding syndrome, often characterized by decreased serum phosphorus, magnesium, and potassium levels and peripheral edema.
c. [redacted] the SMO deems it medically appropriate, the detainee can usually be removed from the weight loss list.
d. Enteral feeding shall resume at any point it becomes medically necessary in accordance with this SOP.

Resolved Weight Loss Follow-up Care

a. A medical provider will perform a complete medical evaluation on all prior enterally fed detainees within approximately 2 weeks after resumption of a regular diet. This medical evaluation will include vital signs, weight, physical examination, and labs if clinically indicated.
b. Prior enterally fed detainees found to have ongoing medical needs or exhibit signs and symptoms associated with re-feeding syndrome will have follow up visits as medically indicated.
c. A member of the medical staff will counsel the detainee regarding the health risks associated with further weight loss.

d. The medical provider may consider submitting a consult request to NH GTMO nutritionist for optimal diet evaluation and planning

Management of Common Electrolyte Deficiencies

Hypokalemia – Replace potassium with KCL elixir/tablets, 10 milliequivalents for every 0.1 mEq/L below the normal value of 4.0 in the detainee's serum. For example, if a detainee has a serum potassium of 3.4 mEq/L, 60 milliequivalents of KCL elixir/tablets should be ordered.

Hypomagnesaemia – Replace with magnesium oxide. Crush four 400 mg tablets (approximately 960 mg of bioavailable magnesium) and mix in water before adding to enteral solution. Continue daily until normal serum Mg^{++} level is confirmed by lab draw. Oral magnesium may cause diarrhea. Alternatively for severe hypomagnesaemia, 1-2 grams of magnesium sulfate may be infused intravenously over 30 minutes.

Hypophosphatemia – Replace with 4 packets of K-phos daily (total of 1000 mg of phosphorus, 1112 mg of potassium, and 656 mg of sodium daily) until normal serum phosphorus level is confirmed by lab draw. Alternatively, for severe hypophosphatemia, 15 mmol of sodium phosphate mixed in 250 ml of ½ NS may be given over 4-6 hours. Usually, this is repeated for a total of 4-8 doses.

Nursing Staff Clinical Procedure Checklist for Intermittent Enteral Feeding of Detainees with Weight Loss

NOTE: IF THE RN OR HM FEELS THEY ARE IN ANY DANGER OF PERSONAL HARM DURING AN ENTERAL FEED, THEY ARE TO WITHDRAW FROM THE SITUATION AND IMMEDIATELY INFORM THE GUARDS OF THEIR CONCERNS.

I. Preparation for Enteral Feeding:

- ☐ Verify Provider's Orders.
- ☐ Confirm detainee was offered an oral, liquid meal.
- ☐ Prepare feeding solution according to Provider's Orders [redacted]
- ☐ Clearly mark enteral feeding reservoir bag with detainee's ISN and date.
- ☐ [redacted]

  Note: if the detainee must be enterally fed in a hospital bed or on a gurney, ensure head of bed is elevated 45 degrees
- ☐ [redacted]
- ☐ Direct the guards to wash the detainees hands if they are soiled with feces or other bodily substances.
- ☐ [redacted]
- ☐ [redacted]
- ☐ Obtain a new enteral feeding tube.
- ☐ Initiate medical monitoring of detainee: assess vital signs, circulation, discomfort.
- ☐ Initiate Enteral Feed Nursing Note.

II. Initiate Enteral Feeding:

- ☐ Perform Enteral Feeding Time Out, at least [redacted] JMG Staff members participate.

The Registered Nurse will place the feeding tube in the stomach as follows:

- ☐ Prepare feeding tube with viscous lidocaine, olive oil, or sterile surgical lubricant according to the detainee's choice.
- ☐ Offer the detainee topical anesthesia (viscous lidocaine) to the affected nostril.
- ☐ Gently pass the feeding tube via the nasal passage into the stomach.
- ☐ If required to reduce head and jaw motion during insertion of the EF tube:
  - o While the detainee is seated and appropriately restrained in the feeding chair, [redacted] guard will position themselves behind the detainee and hold the detainee's head in the midline position.
  - o [redacted]

[redacted]

- ☐ If a detainee is attempting to bite or chew the tube, the RN will ask the detainee to open his mouth for a visual confirmation that the tube is intact. If the detainee refuses, the RN shall immediately remove the tube, inspect it for damage, and re-insert it to accomplish the EF.

Confirmation of Feeding Tube Placement: [redacted] JMG Staff Members, including at least [redacted] Registered Nurse, will confirm proper tube placement as follows:

- ☐ Insert 10 mLs of air into the tube as a [redacted] JMG staff member auscultates the stomach.
- ☐ Auscultate the stomach while the [redacted] JMG member inserts 10 mLs of air into the stomach.
- ☐ Simultaneous auscultation is permissible as long as [redacted] JMG members are able to independently confirm tube placement.
- ☐ Insert 10 mL test dose of water, aspirate, observe for return of stomach fluid.
- ☐ If there is any doubt about correct tube placement, remove the feeding tube.

Following confirmation of tube placement, continue with the following steps:

- ☐ Tape the feeding tube to the detainee's nose and forehead.
- ☐ Connect the feeding tube to the reservoir bag.
- ☐ Begin the feed flow, adjust the rate to the detainee's condition and tolerance.

III. During Enteral Feeding:

- ☐ Ensure a Hospital Corpsman is present with the detainee and observing the detainee's condition and tolerance of the feed continuously throughout the entire administration of the enteral feed procedure.
- ☐ Report any detainee threats of physical assault or exposure to body fluids to the guard staff immediately.
- ☐ The detainee is not to be in the restraint chair for more than two hours.

IV. RN Assessment and Intervention:

- ☐ Assess detainee for nausea: if present, offer PRN medication as ordered.
- ☐ Assess detainee for pain to abdomen, observe for distention; slow rate until complaint of pain is resolved.

V. Completion of Enteral Feeding:

- ☐ Once feeding is complete, gently remove the feeding tube.
- ☐ Assess detainee for nausea, discomfort.
- ☐ Complete Enteral Feed Nursing Note.
- ☐ Document number of calories administered via enteral feeding on the Enteral Feed Nursing Note and Weight Loss Medical Flow Sheet.

- ☐ Flush the enteral feed reservoir bag with at least 300 mL of tap water or until clean. The reservoir may be used again for the same detainee on the same day. Dispose of the reservoir bag at the end of the day.
- ☐ Following completion of enteral feeding, the guard force will return the detainee to cell and observe his status.

VI. Detainee Biting of Enteral Feed Tube:

A detainee undergoing enteral feeding (EF) may attempt to bite and swallow the feeding tube, requiring serial exams, ongoing medical care, and possible removal of the tube via an EGD procedure. Identification of these detainees and management of the EF tube will assist the RN in reducing the incidence of this event. The following guidance is provided:

- ☐ When the detainee attempts to bite or chew the tube, the RN will direct the detainee to open his mouth for a visual confirmation that the tube is intact.
  - o If the detainee refuses, the RN shall immediately remove the tube, inspect it for damage, and re-insert it to accomplish the EF following enteral feeding tube insertion guidelines outlined in this SOP.
- ☐ When the detainee positions the tube between his teeth, the nurse will:
  - o Simultaneously turn off feed and stabilize the proximal end of the tube.
  - o Direct the guard staff to stabilize detainee's head in the midline position.
  - o Maintain traction on the proximal end of the tube until the detainee releases the tube from between his teeth. This may take considerable time.
  - o Remove the tube from the detainee's nose.
- ☐ For detainees who continually attempt to bite the tube, the RN will direct guard staff to maintain 1:1 visual monitoring of detainee during EF sessions.

VII. JMG Staff Responses to Detainee:

- ☐ Detainee directs a change to EF contents or order of contents:
  Respond: **"This is the formula that the doctor has ordered for your nutritional requirements. I am not permitted to make any changes to the order."**
- ☐ Detainee demands to speak to the doctor:
  Respond: **"I will write a note in your chart for the doctor"**
- ☐ Detainee directs the nurse to place him in a particular location during EF:
  Respond: **"That decision is made by the guards."**

VIII. Quality Improvement Strategies

- ☐ The JMG Quality Management Nurse, in collaboration with SMO, SNE and the Medical OICs will implement performance measures to identify performance benchmarks and gaps in implementing the JMG Enteral Feeding process.

- ☐ Measurements will be structured to identify gaps in performance and develop strategies to reduce those gaps and maximize enteral feeding effectiveness and efficiency.

- ☐ The JMG Quality Management Nurse will collaborate with the JMG Training Officer to structure training sessions as needed to maximize enteral feeding program outcomes.
- ☐ Performance measures may include any of the following:
  - o Hospital Corpsman or Registered Nurse present to directly observe detainee during entire administration of enteral feed.
  - o All results for labs ordered during Weight Loss Medical Evaluation are in chart.
  - o Post Weight Loss Medical Evaluation completed within 2 weeks and in chart.
  - o Detention Hospital admission weight obtained, listed in chart.
  - o Thiamine (PO or IV) administered before Dextrose or D5 for new long-term fasters.
  - o Detainee not in restraint feeding chair longer than 2 hours.
  - o Enteral feed Nursing Note is complete, signed by RN and in chart.
  - o Enteral feeding tube placement confirmed by [redacted] JMG staff, including at least [redacted] RN.
  - o Enteral Feed Reservoir bag is clearly marked with detainee's ISN and date.
  - o Detainee is fed with a new enteral feeding tube each time.
  - o Form: *Refusal to Accept Food or Water/Fluids as Medical Treatment* completed and in chart.
  - o Form: *Approval Authority for Initiation of Involuntary Enteral Feeding* completed and in chart.

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ENTERAL FEED NURSING NOTE

ISN:		AM/PM		Date:	

Detainee placed in restraints/restraint chair by guard staff for enteral feeding procedure.

INITIAL ASSESSMENT/VITAL SIGNS

☐ Detainee required Forced Cell Extraction to restraint chair/gurney or ☐ Detainee ambulated to feed chair/gurney.
Detainee placed in chair/gurney at _____.
☐ Detainee refused vital signs (For long-term fasters only)
☐ Vital Signs: T_____ HR _____ RR_____ BP_____ O2 sat_____% Weight_____ ☐ Pulses WNL x 4
☐ Detainee denies nausea/vomiting ☐ Detainee denies pain
☐ Other _____

PROCEDURE NOTE: INSERTION OF FEEDING TUBE

☐ Enteral Feeding Time Out performed with [redacted] Feed Team members.
Using: ☐ olive oil ☐ 2% viscous lidocaine ☐ sterile lubricant, an ☐ 8Fr ☐ 10Fr enteral feeding tube was inserted in the
☐ Right ☐ Left nostril using standard nursing procedure.
☐ Placement in stomach was confirmed by air auscultation by [redacted] JMG staff (at least [redacted] RN) and test dose with 10ml water.
Type of Nutritional solution: ☐ Pulmocare ☐ Ensure ☐ other _____ amount: _____ml _____ calories
Additives: ☐ water _____ml ☐ MgO _____mg ☐ Thiamine_____mg ☐ K-Phos _____mg ☐ Multivitamin X ____tab
Other:

ASSESSMENT DURING ENTERAL FEEDING

Enteral feeding initiated at_____.
Circulation assessed using at least one of the following every 15 minutes while restrained:
☐ No skin discoloration noted ☐ No edema noted ☐ Pulse Rate/Rhythm WNL ☐ Capillary Refill Time <3 seconds
Complaints/ Complications during feed: ☐ None ☐ Other _____

POST ENTERAL FEEDING ASSESSMENT

Enteral Feeding completed and Enteral Feeding Tube removed at _____.
Detainee's condition post enteral feed:
☐ Detainee denies pain ☐ Detainee denies nausea/vomiting ☐ No Injury/complaint noted.
☐ Injury/complaint noted. Describe:_____
☐ Physician notified (if applicable): Name:_____ Time:_____

Restraints released at _____ and detainee released to guard staff

☐ Detainee required Forced Cell Extraction back to cell ***OR*** ☐ Detainee ambulated back to cell.
HM/RN note:

_____
_____
_____
_____

HM signature: _____ **Date/Time:**_____

RN signature: _____ **Date/Time:**_____

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Enclosure (7)

MEDICAL EQUATIONS, CALCULATIONS AND WEIGHT FORMULAS

Determination of Energy Requirements: TOTAL CALORIE PER KILOGRAM METHOD

Classification	Kcal/kg
Morbid obesity	20
Starvation, Ventilated, Intensive Care Unit	25
Ambulatory Maintenance	25-35
Malnutrition/ Moderate Stress	30-35
Severe Injuries/ Stress	35-45

HARRIS –BENEDICT EQUATION:

Men (kcal/day) = [66.47 + (13.75 x weight (kg)) + (5 x height (cm)) – (6.76 x age)] x activity factor x stress factor

Activity Description	Factor	Stress Description	Factor
Chair or bed bound	1.2 x BEE	Elective surgery	1 – 1.1 x BEE
Seated work with little movement	1.4 – 1.5 x BEE	Multiple trauma	1.4 x BEE
Seated work with little strenuous leisure activity	1.6 – 1.7 x BEE	Severe infection	1.2 – 1.6 x BEE
Standing work	1.8 – 1.9 x BEE	Peritonitis	1.05 – 1.25 x BEE
Strenuous work or highly active leisure activity	2 – 2.4 x BEE	Multiple/long bone fractures	1.1 – 1.3 x BEE
30 – 60 minutes strenuous leisure activity 4 – 5 times/week	2.3 – 2.7 x BEE	Infection with trauma	1.3 – 1.55 x BEE
		Sepsis	1.2 – 1.4 x BEE
		Closed head injury	1.3 x BEE
		Cancer	1.1 – 1.45 x BEE
		Burns	1.5 – 2.1 x BEE
		Fever	1.2 x BEE (per 1°C >37°C)

Determination of Protein Requirements:

Condition	Grams/kg/day
Renal Failure/Dysfunction	0.6 – 0.8 (40 gram min)
Dialysis Patients (moderate stress)	1 – 1.2
Dialysis Patients (high stress) Sepsis Liver Failure/Cirrhosis Re-feeding Syndrome	1.2 – 1.5
Multiple trauma	1.3 – 1.7
Catabolism	1.2 – 2
Post-op	1 – 1.5

Determination of Fluid Requirements:

	Free Water Requirement
1st 10 kg	100 mL/kg
2nd 10 kg	50 mL/kg
Each kg >20 kg	20 mL/kg (≤50 years)
	15 mL/kg (>50 years)
Method 2 – Age	
Young Athletic Adult	40 mL/kg
Most Adults	35 mL/kg
Elderly Adults	30 mL/kg
Method 3 – Energy Expenditure	
1 mL/kcal energy expenditure	

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APPROVED BY:

[redacted] [redacted] 16 Dec 13
CDR, JMG
Commander, Joint Medical Group Date

RECOMMENDED BY:

[redacted] 16 DEC 13
Signature/ Printed Name Required: ☒Yes ☐No
Deputy Commander, Joint Medical Group Date

_____ / _____ _____
Signature/ Printed Name Required: ☐Yes ☐No
Senior Medical Officer Date

_____ / _____ _____
Signature/ Printed Name Required: ☐Yes ☐No
Senior Nurse Executive Date

_____ / _____ _____
Signature/ Printed Name Required: ☐Yes ☐No
Director For Administration Date

_____ / _____ _____
Signature/ Printed Name Required: ☐Yes ☐No
Medical Planner Date

_____ / _____ _____
Signature/ Printed Name Required: ☐Yes ☐No
Senior Enlisted Leader Date

_____ / _____ _____
Signature/ Printed Name Required: ☐Yes ☐No
Director, Behavioral Health Services Date

REVIEW LOG: Directorate Reviewer:
Sig:_____ Date:_____
Sig:_____ Date:_____
Sig:_____ Date:_____

P SUPERCEDED/ CANCELLED THIS DATE:

_____ / _____ _____
Signature/ Printed Name
Commander, Joint Medical Group Date

CERTIFICATE OF SERVICE OF SEALED DOCUMENTS

I hereby certify that I caused a true and correct copy of the Supplemental Memorandum In Support of Petitioner's Application for Preliminary Injunction with the supporting exhibits, to be served via email on April 18, 2014, on the following:

Andrew I. Warden
U.S. Department of Justice
Federal Programs Branch
20 Massachusetts Avenue, NW
Washington, DC 20530
Email: Andrew.warden@usdoj.gov

/s/ Elizabeth L. Marvin
Eric L. Lewis
Elizabeth L. Marvin
Counsel for Petitioner/Plaintiff