



Prolonged fasting: an AuSPEN consensus statement

Clinical Practice Committee

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Background

- Prolonged preoperative and perioperative fasting remains common across Australian and New Zealand hospitals despite strong evidence supporting shorter, individualised fasting times.
- Audit data and local clinical experience identified wide variation in fasting practices, inconsistent adherence to ERAS principles, and frequent patient discomfort and dehydration due to unnecessary fasting.
- Rationale for guideline development:
 - To provide clear, evidence-based recommendations aligning with current ESPEN and ASA guidelines.
 - To reduce preventable nutrition deficits in hospitalised patients by standardising fasting duration and refeeding protocols.
 - To improve patient safety, comfort and recovery through consistent, multidisciplinary practice.
 - To align AuSPEN practice guidance with contemporary NHMRC and international evidence hierarchies.
 - To promote quality improvement across nutrition, nursing, anaesthesia and foodservice departments.

Aims

- Objective – to develop and optimal care pathway on perioperative fasting in surgical / acute care areas for Australasia
 - To explore areas around PF – e.g. protocols, time period, treating team preferences, communication to wards and nurses
 - Explore guidelines that exist within hospitals around OZ/NZ and causes of unavoidable fasting like procedures/ scans etc...

Methods

- Working group EOI, numerous meetings
- Systematic review
- AGREE II assessment of existing guidelines
- Modified Delphi process
- Development of consensus statements
- Development of a snapshot survey

Results

Existing guidelines

- AGREE II analysis
- Identified changes to practice
- Current “best practice”
- Specific situations

Reference	Country	Agree Domain Scores (%)						Overall Quality y	Systematic Method
		1	2	3	4	5	6		
Assessed by Lambert and Carey{Lambert.2016}									
National Collaborating Centre for Acute Care (2006){Anonymous:9WED_m5R}	United Kingdom	100	97	95	92	94	92	7	✓
Royal College of Nursing (2005){Westby.2005}	United Kingdom		97	94	86	85	50	7	✓
Plauth et al (2006){Plauth.2006}	European Union	92	67	84	82	23	100	6	✓
Weimann et al (2006){Weimann.2006}	European Union	89	58	82	81	15	100	6	✓
Weimann et al (2009){Weimann.2009}	Germany	78	58	89	65	56	92	6	✓
Plauth et al (2009){Plauth.2009}	Germany	78	58	86	65	52	92	6	✓
Plauth et al (2009){Plauth.2009hc}	European Union	92	72	77	88	87	71	6	?
Smith et al (2011){Smith.2011}	European Union	89	61	75	92	15	67	5	✓
American Society of Anesthesiologists (2011){Committee.2011}	United States	94	67	79	61	15	25	5	?
Braga et al (2009){Braga:2009en}	European Union	86	69	75	89	40	71	5	?
Nygren et al (2012)	International	69	50	65	88	38	88	5	?
Gustafsson et al (2012)	International	61	50	67	86	60	79	5	?
Scottish Intercollegiate Guidelines Network (2004)	United Kingdom	89	67	61	74	44	46	4	✓
American Society for Parenteral and Enteral Nutrition (2009)	United States	78	53	70	89	19	21	4	?
Planas et al (2011)	Spain	97	53	59	70	10	67	4	?
Montejo Conzalez et al (2011)	Spain	97	53	56	78	83	67	4	?
McClave et al (2009)	United States	72	61	67	66	10	54	4	?
Lassen et al (2012)	International	61	44	39	83	31	54	3	✖
Powell-Tuck et al (2011)	United Kingdom	64	42	29	75	10	83	3	✖
Additional guidelines assessed by AuSPEN working group									
International Committee for the Advancement of Procedural Sedation (2020){Green.2020}	International	99	65	81	93	56	96	6	✓
Australian and New Zealand College of Anaesthetists{Anonymous:SKYvj8rj}	Australia/New Zealand	62	28	18	60	17	23	5	✖

Please rate and comment



Statements

Part 1: Patient and clinician

Statement 1

- Fasting should be minimised in hospitalised patients to reduce the risk of malnutrition and post-operative complications
- Malnutrition is common in hospitalised patients and can be prevented. Post-operative fasting is often unnecessary and should be minimised to reduce patient distress and complications.
 - Level of Agreement: 100% agreement
 - NHMRC Level of Evidence: Level I-II

Statement 2

- In the preoperative period (before and during hospitalisation), patients who do not meet their energy needs from food should be encouraged to consume nutritional supplements or receive enteral nutrition
- Perioperative nutritional optimisation reduces surgical complications, especially in malnourished patients. ESPEN guidelines recommend nutritional support for patients with low oral intake and those unable to maintain 50% of recommended intake for over seven days.
 - Level of Agreement: High
 - NHMRC level of evidence: Level I

Statement 3

- For elective procedures, graded fasting precautions for liquids and solids are then recommended based upon this assessment of negligible, mild or moderate aspiration risk. Patients with negligible risk for aspiration, may
 - consume solids until 6 hours prior to anaesthesia
 - consume carbohydrate containing clear fluids or approved preoperative fluids until 2 hours prior to anaesthesia
- Level of Agreement: High
- NHMRC level of evidence: I

Statement 4

- Routine fasting from midnight is unnecessary for most patients, as it increases discomfort and dehydration without reducing aspiration risk.
 - Level of Agreement: 96% agreement
 - NHMRC level of evidence: Level I

Statement 5

- For postoperative patients where no ERAS protocols exist or when they are not implemented, it may be necessary to employ a variety of strategies to promote early introduction of an oral diet or enteral nutrition, including:
 - Initiate oral or enteral intake early after surgery.
 - Oral intake, including clear liquids, can be initiated within hours after surgery to most patients undergoing gastrointestinal surgery /resections.
 - Oral intake should, however, be adapted to individual tolerance and to the type of surgery carried out. In patients without complications, oral food and fluids should be recommenced as soon as possible, according to patient's tolerance and preferably within 4 - 24 hours after surgery
 - Where indicated or in patients in whom early oral nutrition cannot be initiated, nutrition support should be commenced as soon as possible after surgery. If possible, the enteral route should be selected otherwise use the parenteral route, and ideally within 24 hours or 48 hours after surgery.
 - Special regard should be applied to those undergoing major head and neck or gastrointestinal surgery for cancer or with severe trauma or with obvious undernutrition at the time of surgery in whom oral intake will be inadequate (<60%) for more than 10 days
 - Level of Agreement: High
 - NHMRC level of evidence: II-III

Statement 6

- Parenteral nutrition should continue until the time of surgery
 - Based on expert consensus and cohort studies for surgical oncology and malnourished patients.
 - Level of Agreement: High
 - NHMRC level of evidence: III

Statement 7

- Nutritional status should be assessed at admission, regularly during the stay in hospital, and if necessary, nutritional support continued after discharge in patients who have received perioperative nutritional support
 - Guidelines recommend this practice, supported by cohort studies linking post-discharge nutrition to recovery outcomes.
 - Level of Agreement: High
 - NHMRC level of evidence: III

Statement 8

- For intubated/ICU patients the following recommendations are made:
 - Enteral feeds do not routinely need to be ceased 6 hours prior to procedures in patients with cuffed endotracheal or tracheostomy tubes unless airway manipulation is anticipated. Feeds can continue until 30 minutes prior to the procedure and gastric contents aspirated.
 - For patients receiving post pyloric enteral feeding or parenteral nutrition, fasting prior to procedures is not necessary.
 - In patients with unsecured airways, or non-intubated patients, feeds can be stopped two hours prior surgical procedures and gastric contents aspirated
- Level of Agreement: 84% agreement
- NHMRC Level of Evidence: Level II

Statement 9

- If an elective operation is delayed, there should be consideration to provide the patient with a drink of water to prevent excessive thirst or dehydration
 - Level of Agreement: Moderate
 - NHMRC Level of Evidence: III-IV

Statements

Part 2: Institution

Statement 10

- Hospitals should implement fasting monitoring to ensure patients are not fasted unnecessarily or for prolonged periods. This should include the number of times fasted and total duration of fasting
 - Quality improvement studies demonstrate reduced fasting times with tracking systems.
- Level of Agreement: 100%
- NHMRC level of evidence: III

Statement 11

- All health facilities that implement fasting procedures should undertake periodic audits to determine if recommended fasting duration is being achieved and this measure should become a benchmark/performance indicator
 - Not currently a mandated audit benchmark under national policy, but:
 - Strongly encouraged within quality improvement frameworks.
 - Commonly included in ERAS programs and local hospital QI protocols.
 - May be counted under general NSQHS indicators related to patient nutrition and safety.
 - Level of Agreement: 100%
 - NHMRC level of evidence: III

Statement 12

- Clinical staff should receive education regarding fasting practices/procedures and the avoidance of starvation
 - Educational interventions have shown improvements in adherence to guidelines.
 - Level of Agreement: 100%
 - NHMRC level of evidence: III

Statement 13

- Where applicable, ERAS guidelines should be followed
 - Systematic reviews and high-quality RCT support the use of ERAS guidelines, but local practice varies
 - Level of Agreement: High
 - NHMRC level of evidence: I

Statement 14

- Health facilities should implement appropriate and responsive technologies to all areas impacting on patient and operating theatre flow to ensure fasting is monitored and minimised
 - Several quality improvement programs have successfully reduced fasting with tech integration
- Level of Agreement: High
- NHMRC level of evidence: III

Statement 15

- Food services within healthcare facilities should have adequate flexibility to provide nourishing snacks and meals outside regular mealtimes to minimise the nutritional deficits incurred by patients in the perioperative period
 - Supported by several best practice guidelines, local research finding increased nutritional intake and patient satisfaction, reduced waste
 - Level of agreement: High
 - NHMRC level of evidence: IV

Statement 16

- Fasting clocks", a fasting register, ward "mini bars" and other novel approaches should be discussed, and quality improvement measures implemented to avoid unnecessary fasting
 - Practical experience and pilot data strongly support implementing such strategies as part of broader fasting improvement programs
 - Improved communication between teams (especially via fasting boards or digital displays), reduced fasting times, higher patient satisfaction and comfort.
 - Level of Agreement: Moderate
 - NHMRC level of evidence: IV

Statements not widely endorsed

- Initiate tube feeding for patients in need within 24 h after surgery. Start tube feeding with a low flow rate (e.g. 10–max. 20 ml/h) due to limited intestinal tolerance. It may take 5 to 7 days to reach the target intake and this is not considered harmful in low risk patients.
- The patient should be NBM from 2 hours pre-surgery.
- An operation should not be cancelled or delayed just because the patient is chewing gum, sucking a boiled sweet, or smoking immediately before anaesthesia administration.
- Only free oral fluids should be indicated. No clear oral fluids should be implied in hospitals unless a risk prevails e.g. following head and neck surgical procedures
- A preoperative diet is inadequate in all nutrients and should not be the sole source of nutrition for more than one day.
- Patients can drink clear fluids and an unlimited amount of water up to 2 hours before anaesthesia administration
- Milk in tea and coffee is considered a solid since amount and possibility of curdling are difficult to control. It should therefore have the same fasting time as solids.
- Intake of fried or fatty food or meat may require a longer fasting time (ie, 8 hours or more)

Outcome

- This consensus provides a unified national framework for minimising unnecessary fasting, supporting safe nutrition care, and enhancing recovery across diverse hospital settings

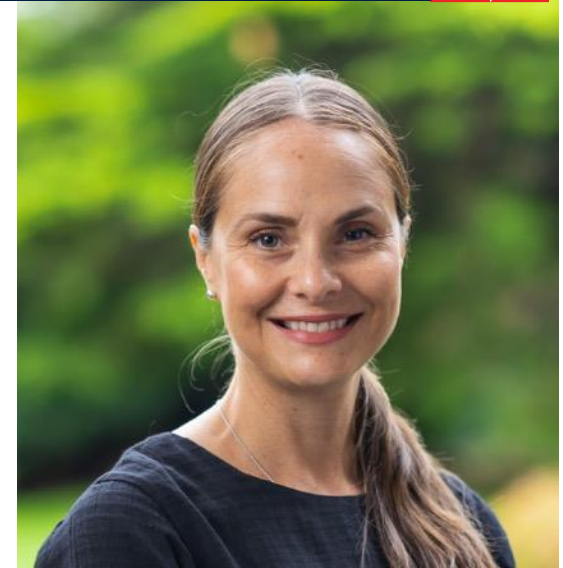
Situations not covered by these statements

- Newest ANZCA guidelines regarding GLP-1 analogues
- NBM orders due to dysphagia; fasting while awaiting speech pathology assessment/enteral access

Next steps

- Ratification of these guidelines
 - Iterative process: please comment
- Publication
 - AuSPEN website
 - ESPEN journals
- Distribution of survey
- Implementation strategies





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