RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Guidance on Recognising and Managing Medical Emergencies in Eating Disorders

(Replacing MARSIPAN and Junior MARSIPAN)

Annexe 1: Summary sheets for assessing and managing patients with severe eating disorders

May 2022

Academy of Medical Royal Colleges

The Royal College of Psychiatrists' Medical Emergencies in Eating Disorders: Guidance on Recognition and Management has been endorsed by the Council of the Academy of Medical Royal Colleges, which represents all the Medical Royal Colleges and Faculties in the UK.

The Royal College of Psychiatrists, May 2022.

Contents

Introduction

This document is a supplement to the guidance, which is designed to support all clinicians likely to encounter patients with severe eating disorders, as well as other professions and groups.

It contains reference guide summaries written for 14 different interest groups, as listed on the contents page, who are considered to be the target audience of the guidance.

Each quick reference guide is two to three pages long, and covers the following areas of care with signposting to key parts of the guidance:

- Risk assessment:
  Signposted to Chapter 2 of the guidance (including Table 1: Risk assessment framework for assessing impending risk to life) and Appendix 3, Eating disorder risk checklist for emergencies
- Location of care:
  Signposted to Chapter 3
- Safe refeeding:
  Signposted to Chapters 4 and 5
- Behavioural manifestations of eating disorders:
  Signposted to Chapter 6
- Parents, relatives and carers:
  Signposted to Chapter 7
- Compulsory admission and treatment:
  Signposted to Chapter 8
- Diabetes mellitus type 1:
  Signposted to Chapter 9 and Annexe 3: Type 1 diabetes and eating disorders (T1DE).

1: Summary sheet for psychiatrists

Who is this for?
Child and adolescent, adult, specialist eating disorder psychiatrists assessing and managing patients with severe eating disorders. Note that there is dedicated guidance for liaison psychiatrists in summary 8 on page 18.

a. Risk assessment

Patients with eating disorders can appear well even though they are near to death. The fear of weight gain may lead the patient to falsify their weight and exercise. Please use any measures from the risk assessment tool provided (Chapter 2) that seem relevant to the patient you are assessing, including suicidal ideation. Take views of parents/close others into consideration when assessing risk.

See Chapter 2 and Appendix 3

b. Location of care

For a severely ill patient with an eating disorder, the safest inpatient bed is usually a dedicated specialist eating disorder bed. In some situations, admission to a medical or paediatric bed may be necessary, and the medical team must be supported fully by the psychiatric team. If eating disorder expertise is not available in the inpatient setting, the support of an eating disorders specialist in person or online should be obtained.

See Chapter 3

c. Safe refeeding

For most underweight patients with eating disorders, feeding can start between 1,400 and 2,000 kcal per day, rising by around 200 kcal per day until consistent weight restoration is achieved. Some patients may require nasogastric feeding and advice on managing this is provided. The possibility of refeeding syndrome (e.g. falling phosphate) should be borne in mind and for some patients with coexisting medical illness, lower rates of refeeding may be appropriate. A decision tree is provided (Figure 4 of the guidance). If lower rates of calorie provision are used, underfeeding syndrome with nutritional deterioration must be avoided.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

The psychiatrist should assess the patient for their motivation, strength of psychopathology, and behaviours that may influence recovery. These include covert (micro) exercising, hiding or disposing of food or nasogastric feed, and falsifying weight by drinking water or wearing weights. These behaviours should be brought to the attention of

the clinical team who you should advise on how to manage them. Sometimes medication can help to reduce anxiety in patients undergoing refeeding, and the psychiatrist will be central in advising on, e.g. olanzapine as an adjunct to care.

See Chapter 6

e. Families and carers

The psychiatrist should talk to families and carers during treatment and ensure an appropriate level of involvement in decision-making while taking the patient's wishes into consideration. Psychiatrists are particularly well placed to address anxiety and disagreements between family members or carers on treatment options. These issues need to be conveyed to the medical team. Meetings with the family or carers and (in the case of younger patients) parents should occur regularly with a member of the psychiatric team together with a member of the medical team.

See Chapter 7

f. Compulsory admission and treatment

The psychiatrist will advise on the need for compulsory treatment under legal orders or, in children (rarely), parental consent, and may be involved in the arrangement of such treatment. The medical team must be fully informed on what treatments are legally allowed and psychiatric consultation with patient, family/carers, mental health advocate and medical team will need to be more frequent. Rarely, psychiatrists may need to raise safeguarding concerns.

See Chapter 8

g. Diabetes mellitus type 1

Diabetes complicates the management of any eating disorder. Insulin or hypoglycaemic drugs may be avoided by the patient to promote weight loss and this can lead to failure of diabetic control. In the long term, increased severity of diabetic complications can occur. Psychiatrists and physicians must work closely together to optimise outcomes in these complex clinical situations.

(see Chapter 9 and Annexe 3)

2: Summary sheet for physicians

Who is this for?
Physicians in emergency departments and acute medical wards assessing and managing patients with severe eating disorders.

a. Risk assessment

Patients with eating disorders can appear well and have normal blood tests, even if they are near to death. Fear may lead the patient to falsify their weight and over-exercise. Consult the risk assessment tool (Chapter 2) and checklist provided, using measures relevant to the patient you are assessing. In the emergency department, consult a psychiatrist or eating disorders clinician, especially before discharging a patient.

See Chapter 2 and Appendix 3

b. Location of care

The patient may be on your service because of severe malnutrition or low potassium. Adult patients with an eating disorder are usually best managed in a specialist eating disorder bed or unit, unless they are severely ill, metabolically unstable or require close medical or biochemical monitoring. If management on a medical unit is felt to be in the patient's best interests, the support of an eating disorders specialist should still be obtained urgently to advise on the psychiatric management following stabilisation and mental health legislation if required.

See Chapter 3

c. Safe refeeding

For many underweight patients with eating disorders, feeding can start between 1,400 and 2,000 kcal per day, rising by at least 200 kcal per day until weight restoration is achieved. Advice on managing nasogastric feeding is provided. The possibility of refeeding syndrome (e.g. low or falling phosphate, potassium, magnesium or calcium) should be borne in mind and for some patients with coexisting medical illness, severe malnutrition or other risk factors such as alcohol dependency, lower rates of refeeding should be considered. Underfeeding syndrome with nutritional deterioration should be avoided and specialist dietetic input is strongly advised.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

Challenging weight-losing behaviours such as exercising, hiding food or falsifying weight is difficult in a busy medical setting. Recruit a nurse with experience in eating disorders. Write

a management plan for sharing among ward staff. Consult an eating disorder specialist. Prepare a hospital protocol proactively with the local eating disorder team.

See Chapter 6

e. Families and carers

Ask for one member of the family to be the representative. Difficulties can arise when there is high anxiety, dissatisfaction with treatment and multiple clinical opinions. To pre-empt problems, invite carers/relatives to meetings, to be included in decisions in line with the patient's wishes, and answer questions. Agree to second opinions arranged by the hospital in the normal way.

See Chapter 7

f. Compulsory admission and treatment

Preventing a patient leaving hospital and imposing treatment are closely controlled activities. The legislation around these activities differs in each devolved administration within the UK. Certain types of nurse may legally prevent a patient leaving hospital for a limited time while a medical opinion is obtained. The doctor in charge may also prevent a patient leaving the ward for up to 72 hours while a longer detention under the Mental Health Act is considered. The legislation is complex, so check what you are allowed to do before the situation occurs. If compulsory detention and treatment seems unavoidable, contact a liaison or eating disorders psychiatrist as soon as possible to discuss implementation of correct legal measures. Instigating treatment (e.g. nasogastric feeding) without the patient's consent or an appropriate legal framework puts a health care professional at risk of legal action. Mental health legislation is designed to protect both the doctor and the patient so expert advice is crucial. In the emergency department the only way to prevent a patient leaving is to use the appropriate Mental Capacity Act, but this should be a rare requirement.

See Chapter 8

g. Diabetes mellitus type 1

Diabetes complicates the management of any eating disorder. Insulin or hypoglycaemic drugs may be avoided by the patient to promote weight loss and this can lead to failure of diabetic control. In the long term, increased severity of diabetic complications can occur and the risk of death is increased. Reintroduction of insulin can cause electrolyte shifts (especially potassium) and insulin should only be administered under supervision. The diabetic team should guide management, working closely with psychiatrists.

See Chapter 9 and Annexe 3

3: Summary sheet for GPs

Who is this for?
General practitioners assessing and managing patients with severe eating disorders.

a. Risk assessment

The key tasks in primary care are diagnosis, risk assessment and initial management. For a patient who may have an eating disorder, rapidly exclude other causes and look for weight concern, reluctance to eat and purging. Look at the items on the risk assessment tool (Chapter 2) and apply the ones relevant to the patient. For young patients, obtain parents' accounts, but see the patient alone to hear their concerns. Establish a system for ensuring follow-up of tests done in primary care.

See Chapter 2 and Appendix 3

b. Location of care

If diagnosis is clear and risk appears low, refer to secondary care and monitor in primary care until the referral is responded to. Secondary care should provide a named contact while waiting. If risk is moderate or high, consider urgent referral to eating disorders unit or referral to emergency department.

See Chapter 3

c. Safe refeeding

Refeeding someone with an established eating disorder of very low weight usually requires specialist oversight. However, GPs may be asked to work together with the specialist team to offer medical monitoring. For a patient who becomes unwell during refeeding, consider refeeding syndrome, gastrointestinal problems and electrolyte imbalance if the patient may be purging.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

Behaviours common in eating disorders, such as self-induced vomiting, may be identified in patients receiving outpatient care. Electrolytes should be measured and the treating team contacted. Over-exercising and rejection of food offered can be very difficult to manage and parents may need support and guidance, including signposting on online resources, to deal with difficulties manifest at home, in collaboration with the treating team.

See Chapter 6

e. Families and carers

Families and carers of patients with eating disorders often require support and information in primary care. They may be extremely anxious because their loved one may appear to be very unwell but not willing to accept treatment. Understanding the wellbeing needs of parents/carers is important for their own and their loved one's treatment. For a young patient, parents will almost always be involved and may require advice about how to make sure that the child receives adequate care.

See Chapter 7

f. Compulsory admission and treatment

A patient with an eating disorder who is at high risk and refusing treatment may require assessment under the Mental Health Act or equivalent. The role of the GP may be to make contact with emergency psychiatric services to request this or to respond to such services if they are requesting the GPs involvement, as well as providing the necessary documentation, and supporting and informing the patient and their family/carers.

See Chapter 8

g. Diabetes mellitus type 1

Diabetes complicates the management of any eating disorder. Insulin or hypoglycaemic drugs may be avoided by the patient to promote weight loss, and this can lead to failure of diabetic control. In the long term, increased severity of diabetic complications can occur. GPs, physicians and psychiatrists must work closely together to optimise the outcome in these complex clinical situations.

See Chapter 9 and Annexe 3

4. Summary sheet for nurses

Who is this for?
Nurses in the hospital and in the community providing care for patients with severe eating disorders.

a. Risk assessment

A physical risk assessment may already have been completed. However, if not, please consult the risk assessment tool (Chapter 2) and go through the different areas. Note whether any results fulfil criteria for Amber or Red risk and make sure medical staff are aware of the results.

See Chapter 2 and Appendix 3

b. Location of care

Patients with eating disorders who become very ill in the community often require an ambulance to take them to the emergency department and they may then be admitted to a medical ward. If the patient is already known to eating disorder services, contact the service and they may be able to locate an eating disorder bed, which is usually preferable to a medical bed unless there are specific medical treatments or assessments required.

See Chapter 3

c. Safe refeeding

In hospital, the multidisciplinary team will be responsible for prescribing a safe diet which will allow nutritional rehabilitation and at the same time avoid refeeding syndrome, from too-rapid feeding, and underfeeding syndrome from inadequate nutrition. Nurses will usually be responsible for making sure the diet or feed is administered and not disposed of by the patient and to manage nasogastric feeding. If the patient is being refed in the community, there is a small danger of refeeding syndrome, which is diagnosed by a falling phosphate level in the blood.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

Patients with eating disorders often engage in behaviours which limit weight gain and falsify weight. Nurses are in a good position to identify these behaviours and intervene to manage them. Nurses without experience of eating disorders should be supervised by more senior nurses so that they can have the skills to manage behaviours such as hiding food, exercising including micro exercising, and falsifying weight e.g. by drinking water. At the same time patients also need support and empathy which are vital nursing roles. Clear

systems for documentation of both behavioural manifestations and food/fluid intake are crucial for good nursing care.

See Chapter 6

e. Families and carers

Families and carers of patients with eating disorders in the community or hospital can be extremely anxious and require a lot of support and information. They may be desperate for the patient to be admitted to hospital but may also resist the idea of a Mental Health Act Section. An important role for the team, and particularly nurses, is to provide information and practical and emotional support.

See Chapter 7

f. Compulsory admission and treatment

A patient with an eating disorder who is at high risk and refusing treatment may require assessment under the Mental Health Act or equivalent. The nurse may be a member of the crisis team assessing the patient for compulsory treatment. In the inpatient setting, nurses qualified in mental health or in learning disabilities are able to apply Section 5.4 and prevent a patient from leaving hospital for up to 6 hours until a medical assessment is arranged.

See Chapter 8

g. Diabetes mellitus type 1

Diabetes complicates the management of any eating disorder. Insulin or hypoglycaemic drugs may be avoided by the patient to promote weight loss and this can lead to failure of diabetic control. In the long term, increased severity of diabetic complications can occur. The eating disorders nurse and the diabetes nurse need to work together and with the multidisciplinary team in managing these complex clinical problems.

See Chapter 9 and Annexe 3

5: Summary sheet for relatives and carers

Who is this for?

Family and carers of people with severe eating disorders.
You may want to keep this handy to refer to when you are concerned and are unsure what to do or what will happen. Carers, relatives and friends are an essential source of support.

When to ask for urgent assessment

If you are concerned or notice the following alarming symptoms/signs, encourage your relative to go to the emergency department for assessment or contact their eating disorder team immediately:

- fainting when standing up
- inability to climb stairs
- talking about ending their life
- acute food/water refusal
- intercurrent illness such as diarrhoea/vomiting.

a. Risk assessment

Clinical staff will complete a risk assessment to decide what level of care is needed. The areas covered are in the risk assessment tool (Chapter 2), including weight, rate of weight loss, muscle weakness and thoughts of self-harm. It will also include blood tests and an ECG (electrocardiogram/heart trace). An important consideration for parents and carers is how able you are to support your loved one. Accompany them if you can, and voice your areas of concern to the doctor or team member.

See Chapter 2 and Appendix 3

b. Location of care

Depending on their assessment, your relative may be treated as an outpatient, or as an inpatient on a medical or paediatric ward for medical stabilisation, or in an eating disorder unit. They may need to stay in an acute hospital until a specialist bed becomes available.

See Chapter 3

c. Safe refeeding

Following a period of sustained reduced oral intake, there is a risk from suddenly increasing food (re-feeding), so this may need to be done in hospital. However, if considered safe to do so, this can be done at home with the support of professionals who may provide a meal plan for you to follow. This can be very stressful, so ensure that you yourself have support.

See Chapters 4 and 5

d. Behavioural

Your loved one may be very scared to gain weight and avoid eating, hide food, over-exercise or make their weight seem more than it is. They may also overeat (binge) and vomit afterwards. These behaviours, which can happen both at home and in hospital, can be worrying and challenging to manage. Ask for advice from staff on how best to support your relative, and feel free to raise any concerns you may have. Some services offer carers training in how to manage eating disorders.

See Chapter 6

e. Families and carers

This is a very difficult time, so make sure that you have your own support network from family and friends. Beat, FEAST and Anorexia & Bulimia Care all have helpful online resources and support groups for people with eating disorders, and for their carers and loved ones. Many of these can be found by searching online. They also have helplines if you feel that you need to speak to someone. You may need to discuss your situation with your work to allow some flexibility and consider how best to manage other commitments.

See Chapter 7

f. Compulsory admission and treatment

If your relative is considered at high physical/mental risk from their eating disorder and is refusing treatment, clinical staff may decide that compulsory treatment is required (also known as 'sectioning'). The nearest relative is consulted and supported during this process.. Information is available on the MIND website about your rights. In some cases, compulsory treatment comes as a relief to the person, although they may not voice this, and when interviewed later many are grateful for the treatment received. Make sure that you have time and support to discuss the issues.

See Chapter 8

g. Type 1 diabetes mellitus

If a person with an eating disorder also has type 1 diabetes, they may avoid taking insulin to lose weight, putting them at risk of developing complications (the most urgent being diabetic ketoacidosis [DKA], when blood sugars become very high). As a carer, you will need to work closely with the psychiatrist, the diabetes specialist and your relative to avoid this from happening. Have a look at Chapter 9 to familiarise yourself with this particular situation.

See Chapter 9 and Annexe 3

6: Summary sheet for people with eating disorders

a. Who is this for?
Patients with symptoms of eating disorders requiring medical attention.

a. Risk assessment

Eating disorders can threaten health and even life owing to medical complications, such as low weight, malnutrition and the effects of purging behaviour such as low potassium. The risk assessment tool (Chapter 2) lists the areas that can be affected, divided into levels of risk. See which areas might be relevant to you. The staff will be very interested in assessing your risk. Try to work with them to stay safe.

See Chapter 2 and Appendix 3

b. Location of care

Depending on your risk and age, you may be treated as an outpatient, a day patient or an inpatient in a specialist or a non-specialist unit such as a medical or paediatric ward. Eating disorders specialists should always be involved in the inpatient treatment of someone with an eating disorder – you can ask about this from the team looking after you. You may need to be in a medical ward if you need something that is only available there, such as heart monitoring or an intravenous drip. Your team will talk to you about continuing your treatment in the community once you are well enough, or whether you need a specialist unit.

See Chapter 3

c. Safe refeeding

You may be frightened of weight gain, even when it is medically indicated. Try to talk to the staff about your anxieties, letting them know what you can manage, and try to reach a compromise. Staff will need to increase your calories at first, carefully checking your blood test results regularly. If your potassium or phosphate level are low, this can be dangerous and will need tablets or intravenous medicines to correct it. You can also discuss medicines to help you manage your feelings if you are finding it very hard.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

You may be very scared of gaining weight and therefore feel compelled to avoid eating, hide food, exercise or make your weight seem more than it is. You may also be unable to control the urge to binge and vomit. Staff may have different levels of experience in helping with these behaviours, and you may find some you trust to talk to about these

compulsions and how to control them. Relationships with staff can sometimes feel like a battle; they should try to work with you, both of you fighting against the eating disorder.

See Chapter 6

e. Families and carers

Your family or carers and loved ones may be very worried about you and see things differently from you. It might help them be less anxious if you can convey the idea that although you cannot agree with them, you can respect their views. Sometimes, some members of the family may say you should be in hospital while others agree with you that you should stay at home. This sort of difference of opinion is usually best managed by a skilled expert in eating disorders, who will work with you to make sure the right people are involved in decisions about your care.

See Chapter 7

f. Compulsory admission and treatment

Occasionally, members of your family or carers and the clinical team may think you should be in hospital in order to save your life, even though you strongly disagree. The law allows the clinical team to insist that you go into hospital for treatment, but you can appeal to a tribunal. You may be interested to know that most patients treated against their will regard the treatment as having been helpful when interviewed later.

See Chapter 8

g. Diabetes mellitus type 1

If you have a combination of an eating disorder and type 1 diabetes, it can be very dangerous for you and worrying for those around you. You may be tempted to reduce your insulin to lose weight, but this risks you being admitted to hospital with your diabetes out of control. If you have poor control of your diabetes, you may experience more complications from diabetes in the long term. This situation should be managed with the help of a psychiatrist and a medical expert in diabetes. If you work together closely with your medical teams, you have a good chance of staying healthier.

See Chapter 9 and Annexe 3

7: Summary sheet for paediatricians

Who is this for?
Paediatricians in emergency departments and paediatric wards assessing and managing children or young people with severe eating disorders.

a. Risk assessment

Patients with eating disorders can appear well even though severely malnourished. The patient may falsify their weight and over-exercise. Consult the risk assessment tool (Chapter 2) and use measures that seem relevant to the patient you are assessing. Consult parents/carers to obtain more information about symptoms and behaviours. Common risks relate to daily intake, rapid weight loss, low weight, electrolyte imbalance and self-harm. In the emergency department, consult a psychiatrist or eating disorders clinician, especially before discharging a patient.

See Chapter 2 and Appendix 3

b. Location of care

The patient may be referred because of malnutrition or low potassium. However, for a severely ill patient with an eating disorder, a brief admission to a paediatric ward is usually appropriate followed by community treatment by a specialist eating disorders service. The support of an eating disorders specialist in person or online should be obtained urgently.

See Chapter 3

c. Safe refeeding

For most underweight patients with eating disorders, feeding can start between 1,400 and 2,000 kcal per day, rising by at least 200 kcal per day until weight gain is achieved. Advice on managing nasogastric feeding is provided. For most, this begins in hospital, accompanied by a plan to transition to oral food, usually with parental support, as soon as possible. The possibility of refeeding syndrome (e.g. falling phosphate) should be borne in mind and for some patients with coexisting medical illness lower rates of refeeding may be appropriate, in which case underfeeding syndrome with weight loss must be avoided.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

Challenging weight losing behaviours such as exercising, hiding food or falsifying weight is difficult in a busy paediatric setting. Recruit a nurse with experience in eating disorders.

Write a management plan for sharing among ward staff. Consult an eating disorder specialist.

See Chapter 6

e. Families and carers

Parents should be seen as an integral part of the management team. Difficulties can arise when there is high anxiety, dissatisfaction with treatment and multiple clinical opinions. To pre-empt problems, invite parents to meetings to be included in decisions, and answer questions. Agree to second opinions arranged by the hospital in the normal way.

See Chapter 7

f. Compulsory admission and treatment

Preventing a patient leaving hospital and imposing treatment are closely controlled activities. Certain types of nurse (see Chapter 8) may prevent a patient leaving hospital for up to 6 hours while a medical opinion is obtained. The doctor in charge can prevent a patient leaving the ward for up to 72 hours while mental health legislation is considered. Before this situation occurs, check what you are allowed to do and if it seems likely, contact a psychiatrist as soon as possible. In the emergency department, a way to prevent a patient from leaving is by using the Mental Capacity Act, but this would be extremely rare. For children, parental consent can potentially be used to enforce treatment, but this is rarely done nowadays and the Mental Health Act or equivalent is preferred.

See Chapter 8

g. Diabetes mellitus type 1

Diabetes complicates the management of any eating disorder. The patient might avoid insulin to promote weight loss and this can lead to failure of diabetic control. In the long term, increased severity of diabetic complications can occur. Reintroduction of insulin can cause electrolyte shifts (especially potassium) and insulin should only be administered under supervision. The diabetes team should guide management, working closely with psychiatrists.

See Chapter 9 and Annexe 3

8: Summary sheet for liaison psychiatrists

Who is this for?
Liaison psychiatrists assessing and managing patients with severe eating disorders in general hospitals.
See also RCPsych's Liaison psychiatry for every acute hospital (CR183)

a. Risk assessment

Patients with eating disorders can appear well even though severely malnourished. The patient may falsify their weight and over-exercise. Consult the risk assessment tool (Chapter 2) and checklist (Appendix 3), and use measures that seem relevant to the patient you are assessing. Common risks relate to low weight, electrolyte imbalance and self-harm ideation. If needed, consult with an eating disorder psychiatrist.

See Chapter 2 and Appendix 3

b. Location of care

For a severely ill patient with an eating disorder, the safest inpatient bed is usually in a specialist unit or a dedicated specialist eating disorder bed. If that is not available or appropriate, the patient may require admission to a medical bed, and the medical team must be supported fully by the liaison psychiatric team. If eating disorder expertise needs reinforcing, the support of an eating disorders specialist in person or online should be obtained. The psychiatrist should support the medical team at all stages even if the patient is very ill and unable to communicate.

See Chapter 3

c. Safe refeeding

For most underweight patients with eating disorders, feeding can start between 1,400 and 2,000 kcal per day, rising by around 200 kcal per day until weight gain is achieved,. Some patients may require nasogastric feeding and advice on managing this is provided in Chapter 4. The possibility of refeeding syndrome (e.g. falling phosphate) should be borne in mind. For some patients with coexisting medical illness, lower rates of refeeding may be appropriate in which case underfeeding syndrome with nutritional deterioration must be avoided.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

The liaison psychiatrist should assess the patient for the presence of behaviours which may sabotage recovery. These include exercise including micro exercise, hiding or disposing of food or feed, and falsifying weight. These behaviours should be brought to the attention of

the medical team, who should be advised on how to manage them. Medication (e.g. olanzapine) may be advised to reduce anxiety in patients undergoing refeeding and the psychiatrist should advise the team on this.

See Chapter 6

e. Families and carers

The liaison psychiatrist is likely to meet with members of the family and will become aware of issues in the family which need to be addressed in treatment. These include extreme anxiety and disagreements between family members on treatment options. These issues need to be conveyed to the medical team. Meetings with the family should occur regularly with a member of the liaison psychiatric team together with members of the medical team.

See Chapter 7

f. Compulsory admission and treatment

The liaison psychiatrist will advise on the need for compulsory treatment under legal orders and may be involved in the arrangement of such treatment. The medical team must be fully informed on what treatments are allowed and there will need to be more frequent psychiatric consultation with the patient, family and medical team.

See Chapter 8

g. Diabetes mellitus type 1

Diabetes complicates the management of any eating disorder. To promote weight loss, the patient may avoid insulin or hypoglycaemic drugs, which can lead to failure of diabetic control. In the long term, increased severity of diabetic complications can occur. Psychiatrists and physicians must work closely together to optimise outcome in these complex clinical situations.

See Chapter 9 and Annexe 3

9: Summary sheet for dietitians

Who is this for?
Dietitians providing input to primary care, acute medical wards and eating disorder services. If you are not specially trained in eating disorders dietetics, consult a dietitian who is so trained.

a. Risk assessment

The patient will usually have been assessed by a doctor, and should have a medical risk assessment as per this guidance. As a dietitian, you are in a good position to provide a nutritionally informed opinion about a number of areas including the degree of likely patient cooperation with treatment, severity of malnutrition, micronutrient deficiencies, physical symptoms due to malnutrition, risk of refeeding syndrome and, where appropriate, parental knowledge and feeding practices, possible food allergies or socially acceptable dietary restrictions e.g. veganism.

See Chapter 2 and Appendix 3

b. Location of care

You may meet the patient in the community, in a medical ward, a paediatric ward or an eating disorders inpatient or day service. In each location, your role is to assess, advise on nutritional risk and implement appropriate plans, in liaison with an eating disorders dietitian as needed.

See Chapter 3

c. Safe refeeding

In this area, your expertise is invaluable. You will be aware of the risks of rapid feeding but also the (probably greater) risks of underfeeding. You will advise on the most appropriate route of refeeding, oral food, oral nutritional supplement or enteral feeding, (nasogastric or nasojejunal), and the nature of the diet or feed. You will advise on rate of refeeding and associated micronutrients provision. You will work closely with doctors, nurses and therapy staff in the multidisciplinary team and liaise with the specialist eating disorders clinicians as needed, if not within a specialist team. Particularly for younger patients in the community but also in hospital, you will liaise with parents and carers and provide advice on nutritional treatment.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

A trusting relationship between patient and dietitian is key to promoting successful recovery. Without it, the patient may feel compelled to oppose nutritional treatment. The dietitian uses communication and counselling skills as well as motivational enhancement.

Sometimes the dietitian may need to challenge the patient and this can affect the relationship. Patients unable to make progress with oral food may need nasogastric feeding which is a specialist dietetic area. Patients with type 1 diabetes and eating disorders present particular challenges for nutritional/physical health restoration, as do those with coeliac disease and multiple confirmed food allergies.

See Chapter 6

e. Families and carers

The dietitian may support treatment at home along with the therapy team, explaining principles of nutrition to the family/carers. In hospital, the dietitian may need to meet with the family/carers to explain changes in the refeeding process, such as beginning nasogastric tube feeding.

See Chapter 7

f. Compulsory admission and treatment

Patients on a compulsory treatment order may require feeding assisted by staff, occasionally with sedation. The dietitian needs to work closely with medical and nursing staff to manage this very challenging process. There are dietetic guidelines, endorsed by the British Dietetic Association, on modifying standard dietetic practice for patients who are detained and require nasogastric tube feeding against their will.

See Chapter 8

g. Diabetes mellitus type 1

Diabetes complicates the management of any eating disorder. To promote weight loss, the patient may avoid insulin or hypoglycaemic drugs, and this can lead to failure of diabetic control. The dietitian with expertise in both eating disorders and diabetes, working together with medical and nursing staff can contribute significantly to the management of this challenging combination.

See Chapter 9 and Annexe 3

10: Summary sheet for managers and commissioners coordinating care

Who is this for?
Senior managers in NHS trusts, private units and other organisations providing care for people with severe eating disorders. Commissioners responsible for funding care for people with severe eating disorders within a defined geographical region.

a. Risk assessment

Requests for funding will often be accompanied by assessments, chronology of events and statements describing the risks to the patient if treatment is not provided. Managers and commissioners should be familiar with the risk assessment process so they can respond. A risk assessment checklist has been provided in Chapter 2.

See Chapter 2 and Appendix 3

b. Location of care

Unfortunately, there is a severe dearth of eating disorder specialist psychiatrists and specialist inpatient settings. Commissioners should expect to be part of a multi-agency planning meeting that includes acute and psychiatric partners, to identify local need. The expectation is that community care will be achieved following treatment in a medical ward wherever possible. However, if inpatient care is required, this should occur rapidly and as close to home as possible.

See Chapter 3

c. Safe refeeding

This depends on the availability of knowledgeable medical, psychiatric and dietetic staff who have communicated in advance about how to manage the treatment of a patient with a severe reaction disorder admitted to the hospital. We advise that commissioners require that all hospitals into which a patient with a severe eating disorder may be admitted should establish a planning group, consisting of a psychiatrist, a physician, a dietician, a nurse and a manager to discuss in advance how such an admission would be managed and to produce a policy document with clear recommendations. Members of this group should have time in their job plans for management and educational activities to support this area, and be linked to clinical networks.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

Managers and commissioners are often involved in decisions about funding extra staff to provide support for patients or parents/carers through mealtime coaching, post meal supervision, responding to distress, reducing opportunities to purge and replacing lost calories as per the care plan. The argument is usually between the medical ward and the mental health service about who should fund special nursing for eating disorder patients. The solution will vary in different contexts but in every unit decisions on this matter should be agreed in advance.

See Chapter 6

e. Families and carers

Managers and commissioners may be approached by family members or carers for a number of reasons. The family/carer may be seeking funding for a particular treatment, they may be unhappy with the treatment that is being received. It can be useful for a manager to join the clinical team when meeting with the family/carers, so that resource issues can be addressed and families/carers supported to make complaints via provider PALS (patient advice and liaison services) or formal complaint routes when necessary. If second opinions are requested, they are best organised through the hospital rather than directly by the family/carers.

See Chapter 7

f. Compulsory admission and treatment

Patients with eating disorders occasionally require compulsory treatment. Medical and other units should have a Mental Health Act (or equivalent) liaison manager to ensure compliance with mental health law. Units admitting children need access to expertise in safeguarding legislation. A Responsible Clinician may need to be commissioned to oversee care for a specific patient admitted to a medical or paediatric ward, and medical care may need to be commissioned for a psychiatric inpatient.

See Chapter 8

g. Diabetes mellitus type 1

Diabetes mellitus when combined with an eating disorder provides enormous challenges to the clinical team. Physicians, paediatricians and psychiatrists all require special training and experience to manage the combination and that should be supported by management, facilitating postgraduate education where such multi-professional training has not been available.

See Chapter 9 and Annexe 3

11: Summary sheet for psychologists and therapists

Who is this for?
Psychologists and other professionals responsible for managing, supervising and providing psychological therapy for eating disorders.

a. Risk assessment

Therapists' main role is to administer an accepted form of psychological therapy. However, they also need to be clear that the patient in front of them is well enough to attend (and leave) a therapy session. They should have access to a complete risk assessment with current updates so that they know what might give rise to concern. The most likely areas are body mass index (BMI), electrolytes in patients who purge, and behaviour by the patient aimed at concealing true BMI. The therapist or a team member weighs the patient and the result is available in the session. It is useful to keep a graph of weight and use it in the session so that any deterioration is clearly visible. If the patient is at risk of low potassium recent results (at most 1–2 days old) need to be available in the session. Other monitoring tests are usually done by other team members, but could be done by the therapist. Any concerns of the therapist, including non-attendance at monitoring, should be discussed urgently with the supervisor and the team doctor. A risk assessment checklist is provided in Chapter 2.

See Chapter 2 and Appendix 3

b. Location of care

Therapy may take place in primary, outpatient or inpatient care. The therapist should ensure that a supervisor and doctor are readily available to deal with concerns.

See Chapter 3

c. Safe refeeding

In primary care and outpatients, the therapist may manage nutritional treatment with some input from dietician and doctor. The therapist should be clear what is happening to weight and other risk factors. If there is a concern about risk, the dietician or doctor should be consulted.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

Therapists frequently have to help patients deal with behaviours that can impede recovery. These include drinking water to increase apparent weight, excessively exercising and taking laxatives to reduce weight. As long as they are known, the behaviours can be

addressed in therapy. However, some might only come to light later on, e.g. when the weight chart is apparently stable but muscle strength sharply declines. The therapist needs to be aware of these possibilities and discuss them with other members of the multidisciplinary or primary care team. They can then be brought up in therapy and addressed with the patient.

See Chapter 6

e. Families and carers

The therapist may be providing family therapy for an eating disorder, and the same requirements for supervision and medical consultation apply as for individual therapy. Sometimes it can be useful to see the family as part of individual therapy, especially if there are substantial anxieties about the patient's physical state.

See Chapter 7

f. Compulsory admission and treatment

Under revised mental health legislation, a psychologist can be the responsible clinician for an inpatient. Senior psychologists should consider whether they wish to take on this role. For therapists treating patients receiving compulsory treatment, the role can be paradoxically split between the patient support and advocate role and being a member of the team which is imposing compulsory treatment. This should be discussed in therapy. The patient may have mixed feelings about being compelled to have treatment.

See Chapter 8

f. Diabetes mellitus type 1

Diabetes mellitus when combined with an eating disorder can lead to severe medical problems. The therapist needs to have a good knowledge of both eating disorders and diabetes and be aware of the patient's current medical problems. Sometimes neglecting the diabetes can seem like a form of self-harm. In others, the combination can emphasise how powerful the eating disorder can be, as in a patient who said, "I'd rather be blind than fat."

See Chapter 9 and Annexe 3

12: Summary sheet for generic psychiatry teams

Who is this for?
Generic teams in general adult and child and adolescent psychiatry.

a. Risk assessment

The arrival of a severely ill patient with a severe eating disorder in your clinic or emergency department can present problems if the clinicians are unfamiliar with these disorders. The key tasks are diagnosis, risk assessment and initial management. For a patient who may have an eating disorder, rapidly exclude other causes and look for weight concern, reluctance to eat and purging. Look at the items on the risk assessment tool (Chapter 2) and apply the ones relevant to the patient. For young patients, obtain parents' accounts. If there are indicators of increased risk (red or amber items) consider admission. If in doubt, consult an eating disorders clinician.

See Chapter 2 and Appendix 3

b. Location of care

If diagnosis is clear and risk appears low, monitor in outpatients and consider referral to specialist eating disorder services. If risk is moderate or high, consider urgent referral to eating disorders services or admission to a medical or paediatric unit.

See Chapter 3

c. Safe refeeding

Refeeding of someone with an established eating disorder usually requires specialist oversight. In the absence of a specialist bed, or while waiting for one, consult a local physician and dietitian and arrange a consultation (online if necessary) with an eating disorders specialist.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

Behaviours associated with eating disorders, such as self-induced vomiting, may be identified in patients receiving outpatient therapy or admitted to a generic inpatient service. Electrolytes should be measured. Over-exercising and rejection of food offered can be very difficult to manage in the community and on the ward. Consult an eating disorders specialist on the most appropriate care.

See Chapter 6

e. Families and carers

Families and carers of patients with eating disorders require support and information. They may be extremely anxious because their loved one may be very unwell but not willing to accept treatment. For a patient under 18, parents will almost always be involved and have a key role in their child's care and recovery. There are good resources to support families and carers to which they should be signposted.

See Chapter 7

f. Compulsory admission and treatment

A patient with an eating disorder who is at high risk and refusing treatment may require assessment under the Mental Health Act or equivalent. In crisis teams, you may be asked to arrange assessment under the Mental Health Act, as well as providing the necessary documentation and supporting and informing the patient and their family/carers.

See Chapter 8

g. Diabetes mellitus type 1

Diabetes complicates the management of any eating disorder. To promote weight loss, the patient may avoid insulin or hypoglycaemic drugs, and this can lead to failure of diabetic control. In the long term, increased severity of diabetic complications can occur. Psychiatrists must work closely together with physicians and GPs to optimise the outcome in these complex clinical situations.

See Chapter 9 and Annexe 3

13: Summary sheet for emergency department staff, on-call medical and paediatric staff

Who is this for?
Doctors in the emergency department, on-call medical and paediatric registrars.

Introduction
Patients with eating disorders will be very anxious and frightened about being in the emergency department. They may feel that they do not deserve treatment, so ensure that you do not trivialise their illness by suggesting that they are not sick enough, that they do not have a low enough BMI or that they appear too well for treatment.

a. Risk assessment

Patients with eating disorders can appear well, even when they are close to death. Consult the risk assessment tool (Chapter 2) and checklist (Appendix 3) and use measures most relevant to the patient that you are assessing.

Anyone with one or more Red rating or several Amber ratings should probably be considered high risk, with a low threshold for admission. Red ratings include:

- BMI <13/<70% mBMI
- Recent weight loss >1 kg/week for 2 weeks in an underweight patient
- HR (awake) <40
- Recurrent syncope with standing BP <90 systolic (<0.4th percentile for age) and postural drop >20 mmHg (or increase HR >30 [>35 if <16])
- Fluid refusal or signs of dehydration
- Temperature <35.5°C tympanic/35°C axillary
- Long Qt or other ECG abnormalities
- Low glucose/sodium/potassium/calcium/phosphate/albumin
- Low WCC, Hb <10
- Acute food refusal/very low calorie intake per day
- Physical struggles with carers over nutrition
- High levels of uncontrolled exercise (>2 hours/day)
- Daily purging behaviours
- Self-harm
- Moderate–high risk suicidal ideas.

Once the risk assessment framework has been completed, the other parts of the checklist provided should also be completed.

See Chapter 2 and Appendix 3

b. Location of care

Patients considered at high risk after completion of the risk assessment should be admitted to an acute medical/paediatric bed for medical stabilisation and safe refeeding, pending assessment by a psychiatrist or eating disorder specialist, and location of a specialist eating disorders bed if necessary. If the patient is admitted to an acute bed, it is advised to consult an eating disorders specialist in person or online urgently for support and advice.

For patients considered able to go home, the emergency medicine doctor, or medical or paediatric registrar should ensure that a referral has been made to the local eating disorder service prior to discharge. This can usually be done online. Do not assume that the next person in the chain (such as the GP) will do this. Consider talking to the eating disorders service prior to discharge if within hours, or a psychiatrist if out of hours.

See Chapter 3

c. Safe refeeding

For most underweight patients with eating disorders, feeding can start at 1,400–2,000 kcal per day, rising by at least 200 kcal per day until weight gain is achieved, e.g. 2,400 kcal per day. Advice on managing nasogastric feeding is provided in Chapter 4. The possibility of refeeding syndrome (e.g. falling phosphate) should be borne in mind and for some patients with coexisting medical illness, lower rates of refeeding may be appropriate, in which case underfeeding syndrome with nutritional deterioration must be avoided.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

Challenging weight-losing behaviours (such as exercising, hiding food or falsifying weight) is difficult in a busy emergency department. A staff member may need to stay with the patient constantly to detect and manage these issues. Write a management plan to share among emergency department staff.

See Chapter 6

e. Families and carers

Consider the concerns of the parent/carer, who may have a considerable amount of knowledge about their loved one's eating disorder, and include them in decision-making about location of care. For those in whom this is a new presentation, provide them with information/resources such as Beat, Anorexia & Bulimia Care or FEAST.

See Chapter 7

f. Compulsory admission and treatment

Preventing a patient from leaving hospital and imposing treatment are closely controlled activities. Certain types of nurse (See Chapter 8) may prevent a patient leaving hospital for a limited time while a medical opinion is obtained. The doctor in charge can prevent a patient leaving the ward for up to 72 hours while longer detention under the Mental Health Act is considered. Before this situation occurs, check what you are allowed to do and, if it seems likely to happen, contact the psychiatrist as soon as possible. If you do something to the patient without consent (such as pass a nasogastric tube,) outside of Mental Health Act guidelines, the patient may take you to court for alleged assault. In the emergency department, the only way to prevent a patient leaving is using the Mental Capacity Act, and this would be extremely rare.

See Chapter 8

g. Diabetes mellitus type 1

Diabetes complicates the management of any eating disorder. To promote weight loss, the patient may avoid insulin or hypoglycaemic drugs, and this can lead to failure of diabetic control. In the long term, increased severity of diabetic complications can occur. Reintroduction of insulin can cause electrolyte shifts (especially potassium) and insulin should only be administered under supervision. The diabetes team should guide management, working closely with psychiatrists.

See Chapter 9 and Annexe 3

14: Summary sheet for physiotherapists

Who is this for?

Physiotherapists in general adult, child and adolescent and specialist services assessing and managing patients with severe eating disorders.

a. Risk assessment

A severely ill patient with an eating disorder may present with problems within the realm of physiotherapy expertise. Look at the items on the risk assessment tool (Chapter 2) and consider whether they may indicate or interfere with physiotherapy treatment. Risks that may emerge include poor mobility, difficulties transferring and liability to fall, as well as increased activity levels and dysfunctional exercising behaviour.

See Chapter 2 and Appendix 3

b. Location of care

In a medical ward, the patient is likely to be very unwell with weakness and possible electrolyte disturbance. In other services, including paediatric and psychiatric wards, BMI may not be so low, but the patient will still be subject to risks mentioned above. For patients who purge, at any weight, risks of cardiac arrhythmia and low blood pressure can affect mobility.

See Chapter 3

c. Safe refeeding

Refeeding the patient in hospital will mainly be the remit of doctors, nurses and dietitians. However, the physiotherapist may become involved in the general care of the patient, together with nurses, and help maintain functional movement, safety with transfers, improve mobility and help prevent pressure sores and venous thrombosis in a patient, with or without a nasogastric tube or intravenous infusion.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

The behavioural problems that can complicate the patient's treatment include some areas in the remit of the physiotherapist, as well as the nurses. These include working to address dysfunctional exercising behaviours, both covert and overt, including increased standing, 'fetching' items, fixed and held postures, reducing clothing to induce shivering, or leaving the ward to exercise in other areas of the hospital.

See Chapter 6

e. Families and carers

The physiotherapist may well be in contact with family members, especially in younger patients. They may require support to manage the patient's distress in dealing with restrictions on mobility, and with their own understandable anxiety and distress about their relative's serious illness. Educating carers about how to approach excessive exercise can also prove very useful.

See Chapter 7

f. Compulsory admission and treatment

A patient with an eating disorder who is at high risk and refusing treatment may require assessment under the Mental Health Act or equivalent. Compulsory treatment usually does not influence the provision of physiotherapy interventions because they are always provided with consent. If a patient is thought to lack capacity, discuss with senior ward staff about whether that affects physiotherapy treatment.

See Chapter 8

g. Diabetes mellitus type 1

Diabetes complicates the management of any eating disorder. Insulin or hypoglycaemic drugs may be avoided by the patient in order to promote weight loss and this can lead to failure of diabetic control. In the long term, increased severity of diabetic complications can occur. The patient may have neuropathy with numbness of toes or fingers or a tendency to faint when standing and retinopathy with reduced vision and the physiotherapist must be aware of these risks as part of assessment and treatment planning. Consult with senior ward staff about any modifications of approach that may be required.

See Chapter 9 and Annexe 3