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

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

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Introduction

This document is a supplement to the guidance that contains 13 reference guide summaries written for different interest groups, including physicians, psychiatrists, dietitians, GPs, nurses and managers, and people with eating disorders and their families and carers.

Each quick reference guide covers the following areas of care and is signposted to key parts of the main guidance:

- risk assessment (signposted to Chapter 2 and Appendix)
- location of care (signposted to Chapter 3)
- safe refeeding (signposted to Chapters 4 and 5)
- behavioural manifestations of eating disorders (signposted to Chapter 6)
- families and carers (signposted to Chapter 7)
- compulsory admission and treatment (signposted to Chapter 8)
- diabetes mellitus type 1 (signposted to Chapter 9 and Annex 1).
1: Summary sheet for psychiatrists

Who is this for?
Child and adolescent, adult, liaison and specialist eating disorder psychiatrists

a. Risk assessment

Patients with eating disorders can appear well even though 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 provided (Appendix 4) 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 4

b. Location of care

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

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. low or falling phosphate, potassium, magnesium or calcium) should be borne in mind. For some patients with coexisting medical illness, lower rates of refeeding may be appropriate, and vitamins and prophylactic phosphate should be considered. 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, the strength of their 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 should advise the medical and nursing team 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 engage with 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 clinical team. Meetings with the family or carers and, in the case of younger patients, with 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 the 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 9

g. Diabetes mellitus type 1

Diabetes complicates the management of any eating disorder. To promote weight loss, patients 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 1)
2: Summary sheet for physicians

Who is this for?
Physicians in emergency departments and acute medical wards

a. Risk assessment

Patients with eating disorders can appear well, and have normal blood test results, even though near to death. Fear may lead the patient to falsify their weight and over-exercise. Consult the risk assessment provided (Appendix 4) and use measures most relevant to the patient you are assessing. In the emergency department, consult a psychiatrist or eating disorders clinician, especially before discharging a patient. Use the checklist provided in Appendix 4.

See Chapter 2 and Appendix 4

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, care 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

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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 preempt 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

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f. Compulsory admission and treatment

Preventing a patient leaving hospital and imposing treatment are closely controlled activities and legislation 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 1
3: Summary sheet for GPs

Who is this for?
General practitioners

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 (Appendix 4) and apply the ones relevant to the patient. For young patients obtain parents’ account, but see the patient alone to hear their concerns.

See Chapter 2 and Appendix 4

b. Location of care

If diagnosis is clear and risk appears low, refer to secondary care and monitor weight changes, pulse, BP, bloods if needed (e.g. if the patient is very low weight or purging), and mental state in primary care until the referral is responded to. Identify a point of contact in case risks change. If risk is moderate or high, consider urgent referral to a specialist eating disorder 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 (e.g. low or falling phosphate, potassium, magnesium or calcium), gastrointestinal problems and electrolyte imbalance if patient may be purging.

See Chapters 4 and 5
Annexe 1: Summary sheets for assessing and managing patients with severe eating disorders

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. 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. GPs, physicians and psychiatrists must work closely together to optimise outcome in these complex clinical situations.

See Chapter 9 and Annexe
4. Summary sheet for nurses

Who is this for?
Nurses in the hospital and in the community

a. Risk assessment

A physical risk assessment may already have been completed. However, if not, please consult the risk assessment (Appendix 4) and go through the different areas. Note whether any results fulfill criteria for Amber or Red risk and make sure medical staff are aware of the results.

See Chapter 2 and Appendix 4

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. 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 (e.g. low or falling phosphate, potassium, magnesium or calcium) 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 needs a gastric 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 by e.g. 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 multidisciplinary 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 under the Mental Health Act. In the inpatient medical ward, 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. 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. 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 1
5: Summary sheet for relatives and carers

Who is this for?
Family and carers of people with severe eating disorders. It is suggested that you keep this handy, to refer to when you are concerned about a change and are unsure what to do or what will happen.

When to ask for urgent assessment
If you are very 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
- becoming unwell in a different way, such as diarrhoea or vomiting.

a. Risk assessment
Clinical staff will complete a risk assessment, to decide what level of care is needed. The areas of risk covered include current weight, rate of weight loss, muscle weakness and thoughts of self-harm. It will also include blood tests and an electrocardiogram. An important consideration for parents and carers of children and young people is how able you are to support your child. Accompany them if you can, and tell the medical staff about any concerns that you have. A risk assessment checklist is provided in Appendix 4.

See Chapter 2 and Appendix 4

b. Location of care
Depending on the result of the 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. If treatment on an eating disorder unit is considered necessary, they may have to stay in an acute hospital until a specialist eating disorder bed becomes available.

See Chapter 3
c. Safe refeeding

Following a period of sustained reduced oral intake, suddenly increasing food intake can be a health risk so it may need to be done in hospital. However, if considered safe to do so, it can be done at home with the support of professionals who may provide a meal plan to follow. This can be very stressful for the person and their families or carers, so ensure that you yourself have support.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

Your relative may be very scared to gain weight and may therefore avoid eating, hide food, over-exercise or make their weight seem more than it is. They may also over-eat (binge) and vomit afterwards. These are worrying and can be very challenging to manage, and they can happen both at home and in hospital. Ask for advice from staff how best to support your relative with these behaviours, and try to avoid getting drawn into encouraging them by e.g. bringing laxatives, low-calorie or binge foods into the hospital.

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/carers, friends, support groups and charities (Beat, Anorexia & Bulimia Care, FEAST). There are many helpful online resources, support groups and helplines available for people with eating disorders, and for their carers and loved ones. You may need to discuss your situation with your work to allow some flexibility for caring for your relative.

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 (‘sectioning’ and kept in hospital under the Mental Health Act). You may agree with this, but feel caught between doing what your relative wants and what is best for them. Sometimes compulsory treatment comes as a relief to the person, although they may not voice this, and they might only realise and express later that they are grateful for the treatment they have received. Make sure that you have time and support to discuss the issues.

See Chapter 8
g. Type 1 diabetes mellitus

Having an eating disorder and type 1 diabetes is a complicated condition. Your relative may avoid taking insulin to lose weight and are at risk of, e.g., diabetic ketoacidosis, 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.

See Chapter 9 and Annexe 1
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 because they can lead to low weight, malnutrition and the effects of purging behaviour (such as low potassium). Our risk assessment (Appendix 4) lists the areas that can be affected, divided into levels of risk. Staff will explain which areas are relevant to you and let you know what they need to do to try and keep safe.

See Chapter 2 and Appendix 4

b. Location of care
You may be treated as an outpatient, a daypatient or an inpatient in a specialist or a non-specialist unit such as a medical or children’s ward (depending on your age). 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. In general, specialist eating disorder services are better equipped to look after patients with eating disorders. However, sometimes 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.

See Chapter 3

c. Safe refeeding
You may be very wary of weight gain, while the staff might be very keen on it. The staff will try to help you with your anxieties about it: let them know what you can manage, and try to reach a compromise. Staff will need to increase your calorie intake at first, while regularly checking your blood test results. Sometimes your potassium or phosphate level may be low. This is dangerous and may need tablets or intravenous medicines to correct it. You can also ask for medicines to help you manage if you are feeling upset or anxious and 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 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. They will talk with you about these compulsions, and how to control them. Relationships with staff can sometimes feel like a battle; they should try to work with you, building up some trust, so that both of you are fighting together 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. If you cannot agree with them, it can still be helpful to empathise with their concerns and 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 later say that they regard the treatment as having been helpful.

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 your diabetes getting out of control and admission to hospital. 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 1
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 provided 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. Use the risk assessment checklist provided (Appendix 4).

See Chapter 2 and Appendix 4

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 can begin in hospital and continue at home under expert guidance. 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 falling weight 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 preempt problems, invite parents to meetings, include them in decisions and answer their questions. Agree to second opinions arranged by the hospital in the normal way.

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 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 the Mental Health Act 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, the patient can be prevented from leaving 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. Insulin 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. 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 1
8: Summary sheet for liaison psychiatrists

Who is this for?
Liaison psychiatrists 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 checklist provided (Appendix 4) 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 specialist psychiatrist.

See Chapter 2 and Appendix 4

b. Location of care

For a severely ill patient with an eating disorder, the safest inpatient bed is usually in a dedicated specialist eating disorder unit. 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 at least 200 kcal per day until weight gain is achieved, e.g. 2,400 kcal per day. 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 psychiatric consultation with patient, family and medical team will need to be more frequent.

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 and physicians must work closely together to optimise outcome in these complex clinical situations.

See Chapter 9 and Annexe 1
9: Summary sheet for dietitians

Who is this for?
Dietitians providing input to primary care, acute medical and paediatric wards and eating disorder services

a. Risk assessment
The patient will usually have been assessed by a doctor, and should have a medical risk assessment as per the checklist in Appendix 4. 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 4

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 a specialist 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 disorder 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 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

**7. 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

**8. 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 1
10: Summary sheet for managers and commissioners coordinating care

Who is this for?
Senior managers in 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 Appendix 4.

See Chapter 2 and Appendix 4

b. Location of care
Unfortunately, there a severe dearth of eating disorder specialist psychiatrists and specialist inpatient settings. Commissioners should expect to be part of a multi-agency planning meeting including acute and psychiatric partners to identify local need. The expectation is that community will be achieved following treatment in a medical ward wherever possible but 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
c. 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

7. Compulsory admission and treatment

Patients with eating disorders occasionally require compulsory treatment. Medical and other units should have a Mental Health Act 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

f. 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 1
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

b. 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 Appendix 4.

See Chapter 2 and Appendix 4

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, 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

7. 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 1
12: Summary sheet for generic psychiatry teams

Who is this for?
Generic teams in adult general 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 (Appendix 4) and apply the ones relevant to the patient. For young patients obtain parents’ account. 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 4

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

**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 outcome in these complex clinical situations.

See Chapter 9 and Annexe 1
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 close to death. Consult the risk assessment framework checklist (Appendix 4) and use measures most relevant to the patient that you are assessing. Anyone with one or more Red ratings or several Amber ratings should probably be considered high risk, with a low threshold for admission. Once the risk assessment framework has been completed, the other parts of the checklist provided should also be completed.

See Chapter 2 and Appendix 4

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.

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 for sharing among emergency department staff.

See Chapter 6

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 and resources such as Beat, Anorexia & Bulimia Care or FEAST.

See Chapter 7

d. 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, contact the psychiatrist as soon as possible. If you do something to the patient, such as pass a nasogastric tube without consent, outside 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
Annexe 1: Summary sheets for assessing and managing patients with severe eating disorders

e. 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 1