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Royal Cornwall Hospitals NHS Trust

Eating Disorder and Low Body Weight Management for Patients Clinical Guideline

V2.0

February 2019

1. Aim/Purpose of this Guideline

1.1 This document is an update of the previous guideline. It has been produced to address areas of uncertainty regarding the management of adults with eating disorders at the interface between primary care and general medical secondary care (RCHT). The guideline seeks to enable a standard medical risk assessment at each stage that will guide patient care allowing:

1. Appropriate access to specialist support.
2. Appropriate use of inpatient care to support re-feeding.

1.2. **Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation**

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We can't rely on Opt out, it must be Opt in.

The DPA18 covers how the Trust obtains, hold, record, use and store all personal and special category (e.g. Health) information in a secure and confidential manner. This Act covers all data and information whether held electronically or on paper and extends to databases, videos and other automated media about living individuals including but not limited to Human Resources and payroll records, medical records, other manual files, microfilm/fiche, pathology results, images and other sensitive data.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the 'information use framework policy', or contact the Information Governance Team rch-tr.infogov@nhs.net.

2. The Guidance

2.1 Introduction

2.1.1 In recent years there has been an increased demand on specialist inpatient eating disorder beds. This has led to significant delays for many patients who have been recommended and accepted for inpatient treatment. As a result there are many patients at low BMI being managed and monitored in the community. We recognise that this places a significant additional burden on community based eating disorder services as well as primary care and community psychiatric teams. At times the services will need the specialist medical assessment of Royal Cornwall Hospital (RCHT). This assessment can enable safe and supported decision making regarding ongoing community support of the provision of the inpatient nasogastric refeeding.

2.1.2 In recent years there has been a stepwise increase in the number of patients being admitted to RCHT for refeeding. No specialist Physician,

Dietetic or Liaison Psychiatry resource has been commissioned to meet this increased need. It is therefore recognized that the standards of this guideline are targets which services should aim to reach but may not always be able to do.

2.1.3 National guidelines recommend the direct and consistent involvement of eating disorders teams in patients that are admitted to general hospitals. Historically this also has not been possible to achieve and descriptions of their direct involvement with RCHT remain an aspirational target.

2.1.4 The standard medical risk assessment that will be used is based on one developed at Kings College London. In line with national clinical guidance (MARSIPAN guidelines/NICE) it replaces an absolute measure of weight or body mass index with a matrix of medical risk factors to guide care. For information the matrix is included on the following page.

Medical Risk Matrix

System	Test or Investigation	Concern	Alert
Nutrition	BMI	<14	<12
	Weight Loss/Week	>0.5kg	>1.0kg
	Skin Breakdown	<0.1cm	>0.2cm
	Purpuric Rash		++
Circulation	Systolic BP (mmHg)	<90	<80
	Diastolic BP (mmHg)	<70	<60
	Postural Drop (Sit – Stand)	>10	>20
	Pulse Rate	<50	<40
Musculoskeletal (squat and sit up tests)	Unable to get up without using arms for balance	++	
	Unable to get up without using arms as leverage		++
	Unable to sit up without using arms as leverage	++	
	Unable to sit up at all		++
Temperature		<35C	<34.5C
Bone Marrow	White Cell Count (10*9/L)	<3.9	<2.0
	Neutrophil Count (10*9/L)	<1.7	<1.0
	Haemoglobin (g/L)	<120	<90.0
	Acute Hb drop		++
	(MCV and MCH raised – no acute risk)		
	Platelets (10*9/L)	<130	<110
Salt/Water Balance **Refer to RCHT CG on electrolytes for Treatment ***	Potassium (mmol/L)	<3.5	<3.0
	Sodium (mmol/L)	<133	<130
	Magnesium (mmol/L)	0.4 - 0.7	<0.4
	Phosphate (mmol/L)	0.6 - 0.8	<0.6
	Urea (mmol/L)	>7.8	>10
Liver	Bilirubin (umol/L)	>21	>40
	Alkaline Phosphatase (iu/L)	>130	>200
	AST (iu/L)	>34	>80
	ALT (iu/L)	>55	>90
	Gamma GT (iu/L)	>36	>90
Nutrition **Refer to RCHT CG on Hypoglycemia***	Albumin (g/L)	<35	<32
	Creatinine Kinase (iu/L)	>200	>250
	Glucose (mmol/L)	<3.5	<2.5
Differential Diagnosis	TFT, ESR		
ECG	Pulse Rate (beats/min)	<50	<40
	Corrected QT Interval (QTC)**		>450msec
	Arrhythmias		++

***For treatment of low electrolytes or blood glucose please refer to the appropriate RCHT Clinical Guideline** for treatment of Hypokalaemia, Hyponatraemia, Hypomagnesaemia, Hypophosphataemia, and Hypoglycemia in adults

****ECG- QTc values of concern >470 milliseconds in males, >480 milliseconds in females**

2.1.5 At each stage of care, multidisciplinary assessment and consultation between three key clinical groups should guide decision making:

- Medical (either GP or Physician)
- Dietetic (either community eating disorders or RCHT inpatient)
- Psychiatric (either community psychiatrist or Liaison Psychiatry)

2.2 What patient groups does this apply to?

2.2.1 This guideline applies to **Adult Patients** (18 and over) presenting with medical risks associated with low body weight or dietary restriction. This includes Anorexia Nervosa (AN) and disordered eating associated with psychiatric conditions.

2.2.2 If the guideline is to be used for patients outside this age range, then it is at the discretion of the clinician and clinical team using it.

2.3 Pre-Hospital Assessment

2.3.1 It is important to recognize that body mass index (BMI) is a proxy measure of medical risk in Anorexia Nervosa and Eating Disorders. Additionally, metabolic changes are particularly concerning if associated weight control behaviours such as vomiting and laxative use are part of the clinical picture. Therefore, neither BMI nor blood tests alone are adequate markers of risk.

2.3.2 The assessment of overall medical risk should include examination of muscle strength, blood pressure, pulse rate, peripheral circulation and core temperature. The patient's involvement in services and current nutritional status and engagement with a nutritional plan are also key parts of the assessment.

2.3.3 For patients of concern presenting with low body weight, recent severe weight loss or symptoms of an eating disorder please undertake a full review of the risks using the matrix as below.

2.3.4 Role of the GP

For patients presenting early, the GP may be the only clinician involved at this stage (see Outcome section for guidance). Undertake the medical assessment as detailed in the matrix and collate the results. Assess the mental capacity of the patient to make decisions about their medical treatment. If referral or discussion with RCHT is required, it should be the GP that has this conversation.

2.3.5 Role of the Dietitian

Assess current nutritional state, current oral diet and patient's understanding of dietary options and engagement with a nutritional plan to improve nutritional status.

2.3.6 Role of Community Psychiatry / Eating Disorder Service

Assess and formulate the psychopathology of the patient's eating disorder. Explore additional risk behaviours and factors. Assess the patient's motivation, engagement with services and the impact this has upon risk. Consider the patient's mental capacity to make decisions about their medical risk and give consideration to the role of the Mental Health Act (MHA).

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	Postural Drop (Sit – Stand)	>10	>20
	Pulse Rate	<50	<40
Musculoskeletal (squat and sit up tests)	Unable to get up without using arms for balance	++	
	Unable to get up without using arms as leverage		++
	Unable to sit up without using arms as leverage	++	
	Unable to sit up at all		++
Temperature		<35C	<34.5C
Bone Marrow	White Cell Count (10*9/L)	<3.9	<2.0
	Neutrophil Count (10*9/L)	<1.7	<1.0
	Haemoglobin (g/L)	<120	<90.0
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Key: >greater than, < less than

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2.4 Outcome of Community Based Assessment

2.4.1 It is not possible to use an absolute score to dictate what medical intervention or clinical setting is necessary. Scores can be used dynamically to understand the evolving risks and can be shared with the patient to enable them to best understand how to maintain their medical safety. Worsening scores may require; more regular monitoring, broader communication, wider consultation, closer assessment or specific referral. The recommended responses are:

2.4.2 Scores that do not fall into the risk areas

2.4.2.1 Referral to specialist Eating Disorder services and regular monitoring by GP.

2.4.2.2 If the patient is stable then regular review and monitoring of the parameters is indicated with referral/ongoing involvement of the community eating disorders services.

2.4.2.3 If the patient is unstable a plan should be formulated to ensure that their nutritional status does not fall within the risk areas. This needs to be formulated alongside the community eating disorder service with primary care regularly reviewing medical risk.

2.4.3 Scores in the concern area

- Weekly monitoring by GP
- Consider hospital admission if medical risks are serious or unstable.
- Urgent referral to specialist services.

2.4.3.1 Regular review of parameters is required. We would recommend weekly. If areas of concern are increasing or unstable then a referral to the inpatient eating disorders unit may be required and should be discussed with the community Eating Disorders service. If there are concerning changes in medical risk with escalating areas of concern a referral to RCHT for an inpatient assessment of the medical risk can be considered. The patient's mental capacity to understand and agree to these requirements should be assessed. These medical risks should be shared with the patient's carer. Where the patient lacks mental capacity, consideration of what treatment is in their best interests is required. If the patient declines this treatment then an assessment under the Mental Health Act should be closely considered.

2.4.4 Scores in the Alert area

2.4.4.1 Immediate contact with RCHT to consider urgent medical assessment and possible admission. Inform eating disorder team and community psychiatrist.

2.4.4.2 Multidisciplinary assessment and care planning is required. The patient may require immediate medical intervention such as

dietary supplementation and a clear care plan developed with the community eating disorder service and CMHT psychiatrist will be required. These patients require ongoing specialist and medical assessment and management. The patient may require an inpatient assessment at RCHT with possible referral for an admission for nasogastric re-feeding. An assessment of the patient's mental capacity to consent to these interventions should be undertaken. Where the patient lacks mental capacity, consideration of what treatment is in their best interests is required. If the patient declines this treatment then an assessment under the Mental Health Act is recommended.

2.4.5 Timing of Admission

Hospital admission is disruptive to a patient's routines and self-management, and the availability of dietetic input and a liaison psychiatrist is important in the assessment and planning of in-patient care. If admission is not required as an emergency, then community based clinicians should consider whether an admission on a Friday or at the weekend can be delayed until a Monday. Consultation with the duty AMU consultant or medical registrar may assist in this decision.

2.5 Regular Primary Care Monitoring

2.5.1 We recommend the following rapid risk assessment which can be undertaken as regularly as required by the care plan in primary care. For unstable and deteriorating or in the initial part of their assessment, this should be undertaken weekly. As patients become more stable and the risks have been carefully quantified 2-4 weekly reviews can be considered. The results and findings should be shared with the patient, so that they have an understanding of the ongoing medical risks.

- BMI (please record weight and height)
- Blood pressure and pulse rate lying and standing
- Muscle strength
- Examination of the skin – integrity / circulation
- Temperature for those at high risk of hypothermia
- A physical exam - consider for example signs of falls or infection
- This can be supplemented by assessment of metabolic change by blood tests including full blood count, urea & electrolytes, glucose, LFT, magnesium and phosphate
- Additional blood tests include CRP, zinc, copper, selenium, iron, folate, vitamins (B12, A, E, D)

2.5.2 An ECG is recommended if the patient's BMI is less than 15 kg/m2. Also it should be undertaken if the patient is taking drugs that have an effect on the QT interval.

2.5.3 Additional assessments of muscle strength and hydration etc. are included in the appendix.

2.6 Assessment on Admission to RCHT

2.6.1 Patients that are admitted to RCHT should have a full medical risk assessment, as per the matrix below. A review of the current issues of concern and alert, as above should be completed. This should be supplemented by an assessment by a Consultant Physician, a Dietitian and a member of the Liaison Psychiatry Team. This assessment should be completed within 24 hours of admission and should include a multidisciplinary discussion to establish the ongoing care plan.

2.6.1.1 Role of the Physician

- Physical examination.
- Coordinate the medical risk assessment and collate results.

2.6.1.2 Role of the Dietitian

Assess current nutritional state, current oral diet and patient's understanding of dietary options. Explain the nutritional role of nasogastric feeding as appropriate.

2.6.1.3 Role of Liaison Psychiatry Service

2.6.1.3.1 Review patient's previous eating disorder treatment including previous episodes of inpatient care and the use of the Mental Health Act. Explore current engagement with services and views of community teams involved in the referral. Establish whether an inpatient eating disorder bed has been previously requested. Assess the patient's mental state and motivation including an assessment of the presence of co-morbid psychiatric disorders and other risk factors including:

- Harm to self
- Risk of self-neglect
- Risk of abscond

2.6.1.3.2 Assess the patient's mental capacity in relation to accepting treatment options including nasogastric feeding. Pay particular attention to the patient's ability to weigh information and the influence of anorexia related psychopathology in influencing this.

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	Unable to get up without using arms as leverage		++
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2.7 Outcome of RCHT In-Patient MDT Assessment

2.7.1 Discharge

The patient is stable, medical risk factors do not indicate immediate risk and appropriate follow up with community based eating disorder and psychiatric services has been arranged.

2.7.2 Brief admission for assessment

An ongoing assessment of the medical risk is required including the risk of re-feeding syndrome. Depending on the patient's weight, behavioural issues, risk factors and mental state, oral or nasogastric feeding may be recommended. If the patient is likely to remain for less than 72 hours and weight restoration is not an essential part of the medical risk, oral feeding may be sufficient, but NG feeding may be offered. If weight restoration is an immediate and essential part of the medical risk profile, this can only be safely undertaken as an RCHT through NG feeding (see below).

2.7.3 Undertake:

- At least daily monitoring of re-feeding bloods and additional bloods as clinically indicated. Additional blood tests include CRP, zinc, copper, selenium, iron, folate, vitamins (B12, A, E, D).
- Thiamine Replacement – iv Pabrinex 3pairs tds for 3-5 days. Then oral thiamine 100mg od.
- If nasogastric feeding has been recommended insert tube as per appropriate guidance and refer to a dietitian and commence re-feeding according to the clinical guideline for commencing enteral feeding 'out of hours'.

2.7.4 Under the following circumstances:

- significant ECG abnormalities
- substantial electrolyte abnormalities at baseline (before feeding starts)
- active comorbidities, infections etc.
- significant comorbidities, especially cardiac, including heart failure
- very low initial weight (BMI<12kg/m^2) 2) may require fewer calories initially
- patient has not yet started thiamine and other vitamin replacements
- when beginning enteral (e.g. nasogastric) feeding.

A lower starting intake commencing at 5–10kcal/kg/day is suggested with early review (12 to maximum 24h) to ensure that any problems generated are corrected and allowing feeding rates to increase. That rate must increase to 15–20kcal/kg/day within 48h unless there are continuing biochemical and clinical problems that preclude such an increase.

2.8 Admission for re-feeding

2.8.1 The patient is unstable with significant medical risk factors. There

may be additional psychiatric, social or treatment engagement factors that are influencing risk.

2.8.2 Patients admitted at this stage of their care will have significant medical risks and will, in all but the most exceptional circumstances, require careful calorific intake via nasogastric re-feeding. RCHT is not a specialist eating disorders unit and cannot provide expert monitoring of oral re-feeding. This can be undertaken informally with the patient's consent. However if the patient lacks capacity, is being coerced to accept treatment or is declining the treatment based on medical risk factors then a Mental Health Act assessment will be necessary.

2.9 Planning Inpatient Care

2.9.1 Patients being admitted for brief periods to allow for the assessment or correction of dynamic risk factors may be treated on the Medical Admissions Unit. If patients require a longer period of care, they should be admitted to a clinical area with some skills and experience in the care of patients with anorexia nervosa. At the present time, this means that patients should be admitted to either the Gastroenterology and Liver Unit or Grenville ward.

2.9.2 It is the responsibility of the multidisciplinary team to outline treatment goals and interventions that ensure the patient is appropriately treated and gaining weight in a safe and therapeutic way. We recommend the provision of a care plan and the care plan template is included in the appendices. This should be completed by the relevant ward staff and shared with the patient. A weekly MDT between the Physician, Dietitian and Liaison Psychiatry Service is recommended.

2.9.3 It is likely that the care plan will involve many or all of the following factors:

- Strict bedrest
- Twice weekly weight
- Daily bloods
- 1:1 care

2.9.4 Ward staff should be aware that patients with anorexia nervosa may experience significant anxiety as they gain weight. They should be alert to the following factors that the person may engage in:

- falsifying weight
- exercising obsessively
- wearing little clothing to induce shivering
- interfering with feeding
- vomiting in toilets
- consuming excess fluids to distort weight
- carrying items during weighing

2.9.5 A number of strategies may improve care planning, concordance and

treatment outcome. This includes:

- a consistent approach from staff
- a staff team that are trained and familiar with this patient group
- additional staffing such as one-to-one supervision may be required
- adhering to the care plan with the patient
- nursing the patient in an area in where they can be easily monitored
- ensuring curtains remain open to enable best rest
- locking bathroom doors to prevent covert exercise or vomiting

2.9.6 Family and carers

It may be important in the patient's management to ensure that family and carers are engaged in understanding the treatment approach that is being taken. With the patient's consent the care plan should be shared with them and they may be involved in multidisciplinary team discussions.

2.10 Planning Discharge

2.10.1 The multidisciplinary team should meet in the week prior to discharge to ensure goals have been achieved and appropriate follow up arrangements made. It is important that a discharge related care plan is promptly communicated with the following:

- Community eating disorders service
- Community mental health team
- Community dietitian
- GP
- Inpatient eating disorders unit if appropriate

2.10.1.1 Role of the Physician

Review the medical risks in the standardised medical risk assessment and consider relevant concerns and alerts in the context of the planned and available support on discharge. Recommend appropriate GP follow up, frequency and monitoring.

2.10.1.2 Role of the Dietitian

Ensure the patient has an understanding of the discharge based diet plan that may include oral feeding and/or supplementation as required.

2.10.1.3 Role of the Psychiatrist

Ensure that appropriate documentation, planning and follow up has been arranged and coordinated with the relevant services.
Provide a psychiatric discharge summary within 24 hours of discharge.

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2.11 Mental Capacity and Legislation

2.11.1 The appropriate use of the mental health act or mental capacity legislation must be considered on a case-by-case basis. In RCHT the Liaison Psychiatry service will act in accordance with RCHT Mental Health Act, Mental Capacity Act and Responsible Clinician Policies, as well as national guidance and legislation.

2.11.2 This section is in no way meant to be an expert guide on the assessment of mental capacity in anorexia nervosa. It is recognized that this is a complex area. However in a recent review of this area (see Reference 9), legal opinion has been given in the following ways:

'obsessive fear of weight gain makes her incapable of weighing the advantages and disadvantages of eating in any meaningful way'.

'inappropriate indifference to matters of life and death and it seems as if it has not entirely hit home'.

'due to ongoing severe body dysmorphia, false beliefs about her weight shape and nutritional state and absolute fear of weight gain from her anorexia, she was and is unable to apply the information to herself or believe in the need for it. The reality and importance of the associated risks including death of her malnourished state are therefore not truly appraised which means she is unable to weigh up the information provided in the decision making process'.

2.11.3 This does not automatically mean that patients with anorexia lack capacity to make decisions about their care. But, it does caution clinicians to be aware that the psychopathology of the disorder can interfere with the ability to weigh information and apply it personally. If mental capacity is found to be lacking, then decisions about what is in the best interests of the patient are specific to that patient. They are particular to those circumstances and may need to be the subject of careful multidisciplinary consideration and consultation with the patient and those that can advocate for them.

2.12 References

1. National Institute for Health and Care Excellence (2017) Eating Disorders: Recognition and Treatment. NICE Guideline 69.

2. Care Quality Commission (2008). Guidance on the treatment of anorexia nervosa under the Mental Health Act 1983.

3. Department of Health (2008). Code of practice Mental Health Act 1983.

4. Mehanna HM, Moledina J, Travis J. Refeeding syndrome: what it is, and how to prevent and treat it. BMJ 2008;336:1495-8

5. National Institute for Health and Care Excellence (2004) Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders (Clinical Guideline CG9).

6. National Collaborating Centre for Mental Health (2006). Nutritional support in adults. Oral nutrition support, enteral tube feeding and parenteral nutrition. Clinical guideline 32.

7. Royal College of Psychiatrists (2005). Guidelines for the nutritional management of anorexia nervosa (College Report 130).

8. Royal College of Psychiatrists & Royal College of Physicians (2010). MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa (College Report 162).

9. Anorexia, Capacity, and Best Interests: Developments in the Court of Protection Since the Mental Capacity Act 2005. Beverley Clough. Medical Law Review, Volume 24, Issue 3, 1 August 2016, Pages 434–445.

3. Monitoring compliance and effectiveness

Element to be monitored	An audit process will be developed to prospectively monitor concordance with the guideline for any LBW patients admitted to RCHT.
Lead	Dr Adrian Flynn (Liaison Psychiatry)
Tool	A tool based around the standards of care delineated in the guideline, is being developed.
Frequency	All relevant (psychological causation) LBW patients will be monitored
Reporting arrangements	The audit will be registered with CFT and RCHT audit services. Reporting will be to the RCHT Nutrition Team and CFT quality group. If there are issues of concordance then this will be reported through the RCHT Safeguarding Group. The results will be reported annually.
Acting on recommendations and Lead(s)	The lead in making recommendations regarding clinical practice will be the: The RCHT Nutrition Team The Liaison Psychiatry Service
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders

4. Equality and Diversity

4.1 This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

4.2 Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Document Title	Eating Disorder and Low Body Weight Management for Patients Clinical Guideline V2.0		
Date Issued/Approved:	January 2019		
Date Valid From:	February 2019		
Date Valid To:	February 2022		
Directorate / Department responsible (author/owner):	Dr Adrian Flynn Consultant Liaison Psychiatrist Dr James Bebb Consultant Gastroenterologist Barbara Walsh RCHT Lead Dietitian Marilyn Conroy Dietitian EDS		
Contact details:	01872 221041		
Brief summary of contents	This guidance sets a clear protocol for the management of adults presenting with LBW. It promotes high quality patient care at the interface between primary and secondary care and between mental and physical health services. This document has been produced to address uncertainty regarding the management of adult patients with low body weight (LBW) both in primary care and in the hospital setting.		
Suggested Keywords:	Low Body Weight, Anorexia, Eating disorders, underweight		
Target Audience	RCHT	CFT	KCCG
	✓		
Executive Director responsible for Policy:	Medical Director		
Date revised:	April 2018		
This document replaces (exact title of previous version):	Clinical Guideline for Management of Low Body Weight Patients with a Primarily Psychological Cause V1.0		
Approval route (names of committees)/consultation:	Gastroenterology Governance Group Specialist Medicine Business and Governance Group		
Divisional Manager confirming approval processes	Johanna Floyd		

Name and Post Title of additional signatories	Not required			
Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings	{Original Copy Signed}			
	Joy Worthington			
Signature of Executive Director giving approval	{Original Copy Signed}			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	✓	Intranet Only	
Document Library Folder/Sub Folder	Clinical/Nursing generic			
Links to key external standards	Governance Team can advise			
Related Documents:	Care Quality Commission (2008). Guidance on the treatment of anorexia nervosa under the Mental Health Act 1983. Department of Health (2008). Code of practice Mental Health Act 1983. Mehanna HM, Moledina J, Travis J. Refeeding syndrome: what it is, and how to prevent and treat it. BMJ 2008;336:1495-8 National Institute for Clinical Excellence (2004) Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders (Clinical Guideline CG9). British Psychological Society & Gaskell. National Collaborating Centre for Mental Health (2006). Nutritional support in adults. Oral nutrition support, enteral tube feeding and parenteral nutrition. Clinical guideline 32. Royal College of Psychiatrists (2005). Guidelines for the nutritional management of anorexia nervosa (College Report 130). Royal College of Psychiatrists & Royal College of Physicians (2010). MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa (College Report 162).			
Training Need Identified?	No			

Version Control Table

Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
October 2013	V1.0	Initial Issue	Dr Adrian Flynn (Liaison Psychiatry)
January 2019	V2.0	Change of title; amended medical risk matrix; updated in line with NICE CG69 2017.	Dr Adrian Flynn (Liaison Psychiatry)

Appendix 2. Initial Equality Impact Assessment Form

Name of Name of the strategy / policy /proposal / service function to be assessed **Eating Disorder and Low Body Weight Management for Patients Clinical Guideline V2.0**					
Directorate and service area: Specialist Medicine/Gastroenterology				**Is this a new or existing *Policy?*** Existing	
Name of individual completing assessment: Barbara Walsh				**Telephone:** 01872 25 2409	
1. *Policy* Aim* *Who is the strategy / policy / proposal / service function aimed at?*	Hospital clinical staff, including; physicians, dieticians, psychiatrists, general and mental health nurses and junior medical staff involved in the management of LBW patients.				
2. *Policy* Objectives*	To set a clear protocol for the management of adults presenting with low body weight (LBW) .				
3. *Policy* – intended Outcomes*	To promotes high quality patient care at the interface between primary and secondary care and between mental and physical health services. To address uncertainty regarding the management of adult patients with low body weight (LBW) both in primary care and in the hospital setting.				
4. *How will you measure the outcome?	Reporting and investigation of any incidents of poor care/management involving this patient group.				
5. Who is intended to benefit from the *policy*?	All patients who have a low body weight (LBW) with a primarily psychological cause All staff involved in the management of LBW patients				
6a Who did you consult with	Workforce	Patients	Local groups	External organisations	Other
	X				
b). Please identify the groups who have been consulted about this procedure.	**Please record specific names of groups** Safeguarding Adults Operational Group Psychiatric Liaison				
What was the outcome of the consultation?	Ratified				

7. The Impact
Please complete the following table. **If you are unsure/don't know if there is a negative impact you need to repeat the consultation step**.

Are there concerns that the policy **could** have differential impact on:				
Equality Strands:	Yes	No	Unsure	Rationale for Assessment / Existing Evidence
Age		√		This guidance aims to set a clear protocol for the

Sex (male, female, trans-gender / gender reassignment)		√		management of adults presenting with LBW. It promotes high quality patient care at the interface between primary and secondary care and between mental and physical health services. This document has been produced to address uncertainty regarding the management of adult patients with low body weight (LBW) both in primary care and in the hospital setting. It is intended to ensure a consistent approach in caring for this patient group, regardless of equality strand, and reducing risk.
Race / Ethnic communities /groups		√		
Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.		√		
Religion / other beliefs		√		
Marriage and Civil partnership		√		
Pregnancy and maternity		√		
Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian		√		

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked "Yes" in any column above and
- No consultation or evidence of there being consultation- this excludes any *policies* which have been identified as not requiring consultation**. or**
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.	**Yes**		**No**	**X**

9. If you are **not** recommending a Full Impact assessment please explain why.

No adverse effects on any of the protected characteristics.

Signature of policy developer / lead manager / director Barbara Walsh, Nutrition Support Dietitian	Date of completion and submission 14/01/2019

Names and signatures of members carrying out the Screening Assessment	1. Barbara Walsh 2. Human Rights, Equality & Inclusion Lead	

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.

A summary of the results will be published on the Trust's web site.

Signed: Barbara Walsh, Nutrition Support Dietitian

Date: 14/01/2019

Appendix 3. Initial Assessment and Monitoring – useful resources

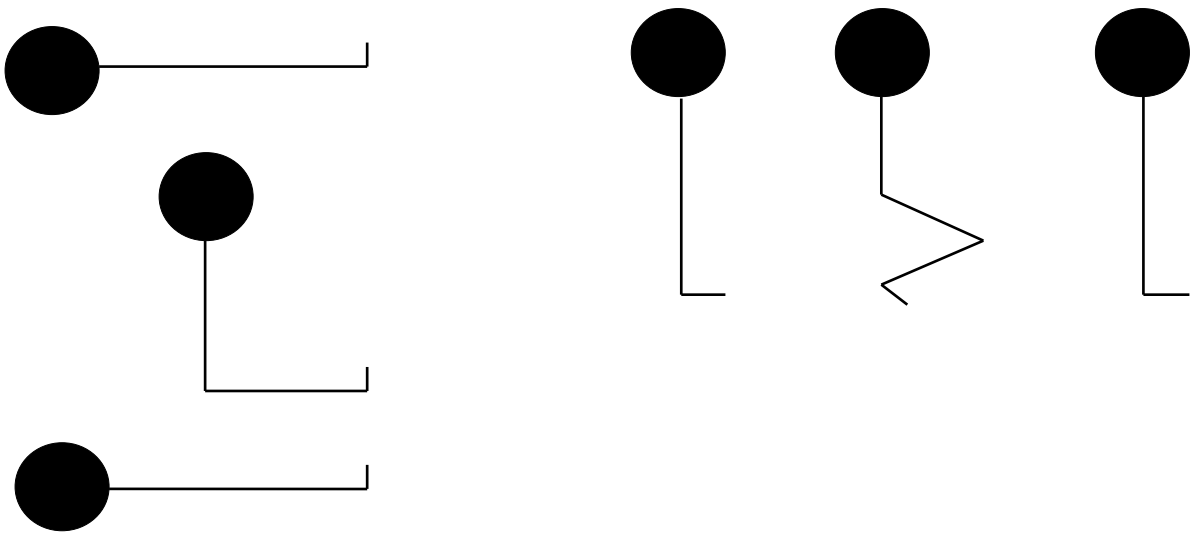
SCOFF questions – answering yes to 2 or more suggests a possible eating disorder.

- Do you make yourself **S**ick because you feel uncomfortably fat?
- Do you worry you have lost **C**ontrol over how much you eat?
- Have you recently lost more than **O**ne stone in a three month period?
- Do you believe yourself to be **F**at when others say you are too thin?
- Would you say that **F**ood dominates your life?

A test for muscle strength - Sit up-Squat-Stand (SUSS) Test

NICE (2004) and MARSIPAN recommend including this in regular monitoring of LBW patients with AN. This test is routinely used for the assessment of patients with AN but may also be useful when assessing LBW associated with other pathology.

A) **B)**



A) Sit-up
Patient lies down flat on the floor and sits up without, if possible, using their hands as leverage.

B) Squat-stand
Patient squats down and rises without, if possible, using their hands as leverage.

A test for hydration

The sign to notice is dizziness or faintness standing from sitting. Assess the postural drop in blood pressure, that is the difference between lying and standing blood pressure and heart rate.

Eating Disorders Service Guidelines for weighing and establishing the height of people with eating disorders in primary care

- If at all possible, use a private room.
- Calibrated digital scales are essential for accuracy.
- Accuracy will be improved if the scales remain in one location and are not moved.
- The scales must be on a hard surface.

At the first meeting, it is important that you and the patient:

- Discuss how often you will be meeting.
- Check you both know the purpose of the sessions and how this information will be shared. (Is the goal weight gain or maintenance for example and who will be informed of the results, and does the patient want to be informed?).
- Measure and document standing height. People should stand straight and stretched, feet together with heels, buttocks and shoulder blades touching the vertical wall, the head positioned in the Frankfurt plane (imaginary line from centre of the ear hole to the lower border of the eye socket). The head plate is lowered until it lightly touches the top of the head. Repeat every 3 months while the person is still growing (for some people growth continues until 18).
- Discuss and agree the details of the weighing sessions ideally:-
  - one layer of light clothing
  - no shoes/boots or belts
  - ask to remove all items from pockets or anything else that carries weight eg mobile phones and keys.
  - advise that bladder needs to be emptied before each weight appointment.

Helpful tips for weight monitoring sessions:

All of these are what you are likely to try to do anyway as part of good practice. Very often though, people get very worried about 'not saying the wrong thing' that will worry and upset the patient. While we are all used to being very encouraging to patients, and saying 'well done', this is often not helpful to the patient struggling with an eating disorder. While the patient will be anxious, by sticking to these suggestions this anxiety is less likely to escalate.

- A quiet calm atmosphere is especially helpful.
- Keep waiting time to a minimum and explain if possible if there is a delay.
- Allow sufficient time for weighing (about 10 minutes).
- It is important to weigh **only once** to avoid additional confusion and anxiety.
- **DON'T** comment on weight or appearance before or after weighing, even if it is a compliment.
- **DON'T** comment about your own weight or appearance, however well intentioned.
- **DO** share the weight with the person unless specifically instructed not to.
- **DO** use a calm neutral tone to inform the person about their current weight.
- **BE PREPARED** for the person to react differently to how you might expect. Even if they are aiming for weight gain, they still might be upset. Similarly while they might be disappointed at weight loss on one level, they might also be pleased.
- **DON'T** get into discussions about their weight but suggest they talk over their feelings with the person they see for support.
- DO let them know you understand it is a struggle for them and encourage them in their efforts with that struggle.

Appendix 4. Re-feeding Syndrome

RFS is a potentially life-threatening complication of refeeding in undernourished individuals. On refeeding, the body shifts from fat to carbohydrate metabolism, triggering an insulin surge. This causes increased cellular uptake of glucose, phosphate, potassium, magnesium and fluid. Consequently serum levels of these electrolytes decrease leading to complications such as neurological weakness and cardiac failure.

Risk factors for developing refeeding syndrome (NICE 2006)

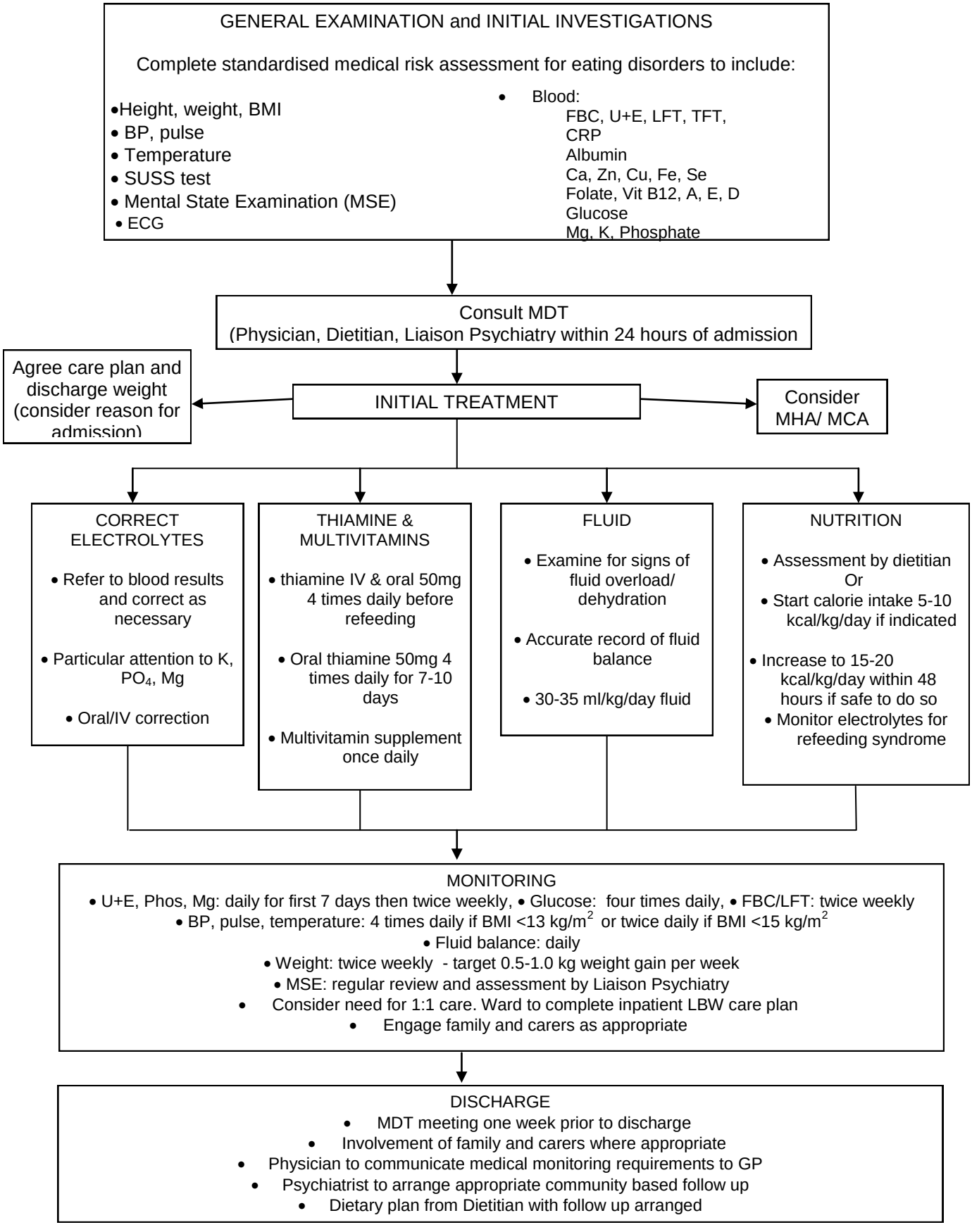
Moderate Risk
Patient has one of the following:
- BMI < 18.5kg/m2
- Unintentional weight loss > 10% within the previous 3-6 months
- Very little intake for > 5 days

High Risk
Patient has one of the following:
- BMI less than 16kg/m2
- Unintentional weight loss > 15% within the previous 3-6 months
- Very little nutritional intake for greater than 10 days
- Low levels of potassium, phosphate or magnesium prior to feeding

Or patient has two or more of the following:
- BMI < 18.5kg/m2
- Unintentional weight loss >10% within the previous 3-6 months
- Those with very little intake for greater than 5 days
- A history of alcohol abuse or drugs including insulin, chemotherapy, antacids or diuretics

Severely High Risk
Patient has both of the following:
- BMI < 14
- Negligible intake for >15 days

Appendix 5. Hospital Management of Patients With Low Body Weight



Appendix 6. Pre-Hospital Management of Patients with Low Body Weight