Royal Cornwall Hospitals NHS Trust

POLICY UNDER REVIEW

Please note that this policy is under review. It does, however, remain current Trust policy subject to any recent legislative changes, national policy instruction (NHS or Department of Health), or Trust Board decision. For guidance, please contact the Author/Owner.

Information Category	Detailed Information
Document Title:	Eating Disorder and Low Body Weight Management Clinical Guideline V3.1
This document replaces (exact title of previous version):	Eating Disorder and Low Body Weight Management for Patients Clinical Guideline V3.0
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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 LBW both in primary care and in the hospital setting.
Suggested Keywords:	Low Body Weight, Anorexia Nervosa, Eating disorders, underweight
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer

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Information Category	Detailed Information
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Manager confirming approval processes:	Clare Rotman
Name of Governance Lead confirming consultation and ratification:	Becky Lester
Links to key external standards:	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 AN 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 AN, 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 AN (College Report 130). 8. RC PSYCH Medical emergencies in eating disorders (MEED) Guidance on recognition and management CR233, May 2022 9. AN, 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.

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Information Category	Detailed Information
Related Documents:	1. Care Quality Commission (2008). Guidance on the treatment of AN under the Mental Health Act 1983. 2. Department of Health (2008). Code of practice Mental Health Act 1983. 3. Mehanna HM, Moledina J, Travis J. Refeeding syndrome: what it is, and how to prevent and treat it. BMJ 2008;336:1495-8 4. National Institute for Clinical Excellence (2004) Eating Disorders: Core Interventions in theTreatment and Management of AN, Bulimia Nervosa and Related Eating Disorders (Clinical Guideline CG9). British Psychological Society and Gaskell. 5. National Collaborating Centre for Mental Health (2006). Nutritional support in adults. Oral nutrition support, enteral tube feeding and parenteral nutrition. Clinical guideline 32. 6. Royal College of Psychiatrists (2005). Guidelines for the nutritional management of AN (College Report 130). Royal College of Psychiatrists and Royal College of Physicians (2010). 7. MARSIPAN: Management of Really Sick Patients with AN (College Report 162).
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This document is only valid on the day of printing

Controlled Document

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Eating Disorder and Low Body Weight Management Clinical Guideline

V3.1

November 2024

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Summary

This document 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.

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1. Aim/Purpose of this Guideline

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.

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.

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.

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, RC PSYCH Medical emergencies in eating disorders (MEED) Guidance on recognition and management CR233, May 2022, it replaces an absolute measure of weight or body mass index (BMI) with a matrix of medical risk factors to guide care. For information, the matrix is included on the following page.

1.5. This version supersedes any previous versions of this document.

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2. The Guidance

2.1 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 Hypoglycaemia in adults.

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

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 (LBW) 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 BMI is a proxy measure of medical risk in AN 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 LBW, 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.

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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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2.4 Medical Risk Matrix

System	Test or Investigation	Concern	Alert
Nutrition	BMI	<14	<
	Weight Loss/Week	>0.5kg	>
	Skin Breakdown	<0.1cm	
	Purpuric Rash		
Circulation	Systolic BP (mmHg)	<90	
	Diastolic BP (mmHg)	<7	
	Postural Drop (Sit – Stand)		
	Pulse Rate		
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			
Bone Marrow	White Cell Count (1		
	Neutrophil Coun		
	Haemoglo		
	Acute		
	(MCV and MCH		
	Pl		
Salt/Water Balance Refer to RCHT CG on electrolytes for Treatment *	P		
Liver			
Nutr Refer to R			
Hypo			
Diff			

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

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

2.5 Outcome of Community Based Assessment

2.5.1 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 outlined below.

2.5.2 Scores that do not fall into the risk areas

2.5.2.1 Referral to specialist Eating Disorder services and regular monitoring by GP. There is a limited physical health monitoring team in the Adult Community Eating Disorders Service. This team is available to support and advise GPs on physical risk in people with eating disorders. They can be contacted on cft.aedsphysicalhealth@nhs.net.

2.5.2.2 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.

2.5.2.3 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.

2.5.3 Scores in the concern area

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

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.

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2.5.4 Scores in the Alert area

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

2.5.4.2 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.

2.5.4.3 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.

2.5.5 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.

2.6 Regular Primary Care Monitoring

2.6.1 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 and electrolytes, glucose, LFT, magnesium and phosphate.

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- Additional blood tests include CRP, zinc, copper, selenium, iron, folate, vitamins (B12, A, E, D).

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

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

2.7 Assessment on Admission to RCHT

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.

2.7.1 Role of the Physician

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

2.7.2 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.

2.7.3 Role of Liaison Psychiatry Service

2.7.3.1 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 absconding.

2.7.3.2 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 AN's related psychopathology in influencing this.

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2.8 Medical Risk Matrix

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

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

2.9 Outcome of RCHT In-Patient MDT Assessment

2.9.1 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.

2.9.2 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).

2.9.3 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 1 pair o.d. or IV thiamine (unlicensed) 200-300mg o.d. 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'.

2.9.4 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 24hours) to ensure that any problems generated are corrected and allowing feeding rates to increase. That rate must increase to 15–20kcal/kg/day within 48 hours unless there are continuing biochemical and clinical problems that preclude such an

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increase.

2.10 Admission for re-feeding

2.10.1 The patient is unstable with significant medical risk factors. There may be additional psychiatric, social or treatment engagement factors that are influencing risk.

2.10.2 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.

2.11 Planning Inpatient Care

2.11.1 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 AN. At the present time, this means that patients should be admitted to either the Gastroenterology and Liver Unit or Grenville ward.

2.11.2 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.

2.11.3 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.

2.11.4 Ward staff should be aware that patients with AN 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.

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- Vomiting in toilets.
- Consuming excess fluids to distort weight.
- Carrying items during weighing.

2.11.5 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.

2.11.6 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.

2.12 Planning Discharge

2.12.1 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.

2.12.2 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.

2.12.3 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.

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2.12.4 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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2.13 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	Potassium (mmol/L)	<3.5	<3.0
	Sodium (mmol/L)	<133	<130
Refer to RCHT CG on electrolytes for Treatment *	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	Albumin (g/L)	<35	<32
Refer to RCHT CG on Hypoglycemia*	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 Hypoglycaemia in adults.

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

2.14 Mental Capacity and Legislation

2.14.1 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.

2.14.2 This section is in no way meant to be an expert guide on the assessment of mental capacity in AN. 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 AN, 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'.

2.14.3 This does not automatically mean that patients with AN 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.

2.15 Scope

2.15.1 This guideline applies to Adult Patients (18 and over) presenting with medical risks associated with LBW or dietary restriction. This includes AN and disordered eating associated with psychiatric conditions.

2.15.2 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.

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3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
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 Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

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

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Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Eating Disorder and Low Body Weight Management for Patients Clinical Guideline V3.1
This document replaces (exact title of previous version):	Eating Disorder and Low Body Weight Management for Patients Clinical Guideline V3.0
Date Issued/Approved:	November 2024
Date Valid From:	November 2024
Date Valid To:	06/10/2026
Directorate / Department responsible (author/owner):	Dr Adrian Flynn Consultant Liaison Psychiatrist. Dr James Bebb Consultant Gastroenterologist. Emily Callan, RCHT Lead Acute 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 LBW both in primary care and in the hospital setting.
Suggested Keywords:	Low Body Weight, Anorexia Nervosa, Eating disorders, underweight
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Gastroenterology Governance Group. Therapies Senior Management Team Meeting.
Manager confirming approval processes:	Clare Rotman

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Name of Governance Lead confirming consultation and ratification:	Becky Osborne
Links to key external standards:	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 AN 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 AN, 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 AN (College Report 130). 8. RC PSYCH Medical emergencies in eating disorders (MEED) Guidance on recognition and management CR233, May 2022 9. AN, 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.
Related Documents:	1. Care Quality Commission (2008). Guidance on the treatment of AN under the Mental Health Act 1983. 2. Department of Health (2008). Code of practice Mental Health Act 1983. 3. Mehanna HM, Moledina J, Travis J. Refeeding syndrome: what it is, and how to prevent and treat it. BMJ 2008;336:1495-8 4. National Institute for Clinical Excellence (2004) Eating Disorders: Core Interventions in the

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	Treatment and Management of AN, Bulimia Nervosa and Related Eating Disorders (Clinical Guideline CG9). British Psychological Society and Gaskell. 5. National Collaborating Centre for Mental Health (2006). Nutritional support in adults. Oral nutrition support, enteral tube feeding and parenteral nutrition. Clinical guideline 32. 6. Royal College of Psychiatrists (2005). Guidelines for the nutritional management of AN (College Report 130). Royal College of Psychiatrists and Royal College of Physicians (2010). 7. MARSIPAN: Management of Really Sick Patients with AN (College Report 162).
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Dietetics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
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)
October 2023	V3.0	Review and updated hyperlinks	Emily Callan, Lead Acute Dietitian
August 2024	V3.1	Update of vitamins and micronutrient provision due to new national guidance	Emily Callan, Lead Acute Dietitian

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All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

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Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Eating Disorder and Low Body Weight Management for Patients Clinical Guideline V3.1
Directorate and service area:	Dietetics, Clinical Support
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Dr Adrian Flynn (Liaison Psychiatry)
Contact details:	01872 221041

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	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 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 LBW both in primary care and in the hospital setting.
4. How will you measure each 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 LBW with a primarily psychological cause. All staff involved in the management of LBW patients.

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Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** RCH Dietetics and Nutrition Professional Lead. Therapies Senior Management Team. CFT Dietetics and Nutrition Team.
6c. What was the outcome of the consultation?	Approved
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	

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Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Becky Osborne

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

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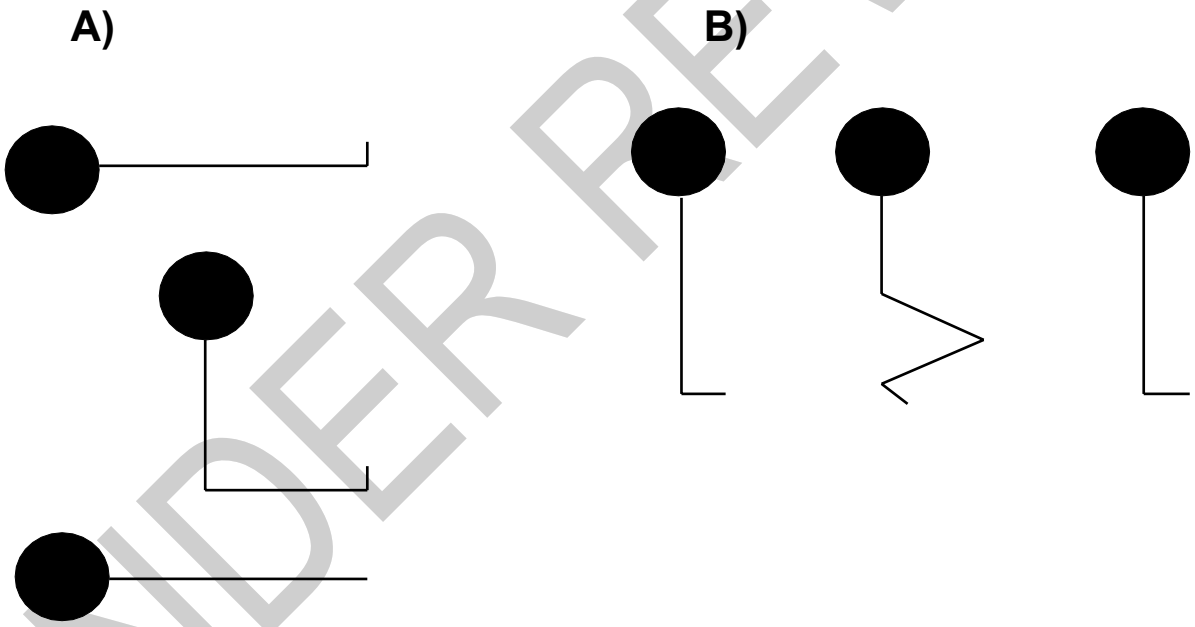
Appendix 3. Initial Assessment and Monitoring – useful resources

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) 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.

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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 e.g. 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.

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- 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.
- **DO NOT** comment on weight or appearance before or after weighing, even if it is a compliment.
- **DO NOT** 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.
- **DO NOT** 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.

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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.

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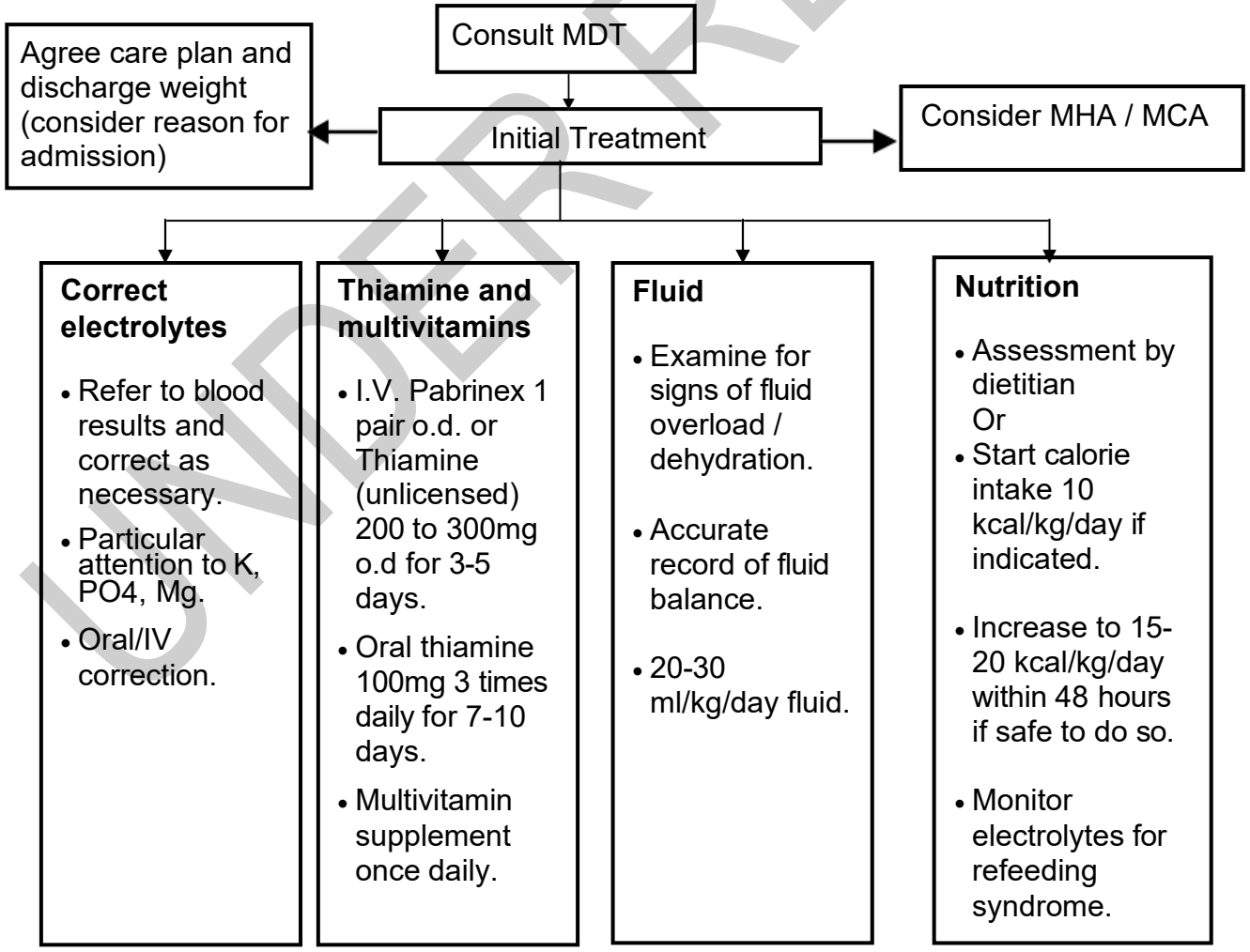
Appendix 5. Hospital Management of Patients With Low Body Weight

- Height, weight, BMI.
- BP, pulse.
- Temperature.
- SUSS test.
- Mental State Examination (MSE).
- ECG.
- Blood: FBC, U&E, LFT, TFT, CRP
  Albumin
  Ca, Zn, Cu, Fe, Se
  Folate, Vitamin B12, A, E, D, Mg, K, Phosphate
  Glucose



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Discharge

- MDT meeting one week prior to discharge.
- Involvement of family and carers where appropriate.
- Physician to communicate medical monitoring requirements to GP.
- Psychiatrist to arrange appropriate community based follow up.
- Dietary plan from Dietitian with follow up arranged.

Monitoring

- U+E, Phos, Mg: daily for first 7 days then twice weekly, • Glucose: four times daily, • FBC/LFT: twice weekly.
- BP, pulse, temperature: 4 times daily if BMI <13 kg/m2 or twice daily if BMI <15 kg/m2.
- Fluid balance: daily.
- Weight: twice weekly - target 0.5-1.0 kg weight gain per week.
- MSE: regular review and assessment by Liaison Psychiatry.
- Consider need for 1:1 care. Ward to complete inpatient LBW care plan.
- Engage family and carers as appropriate.

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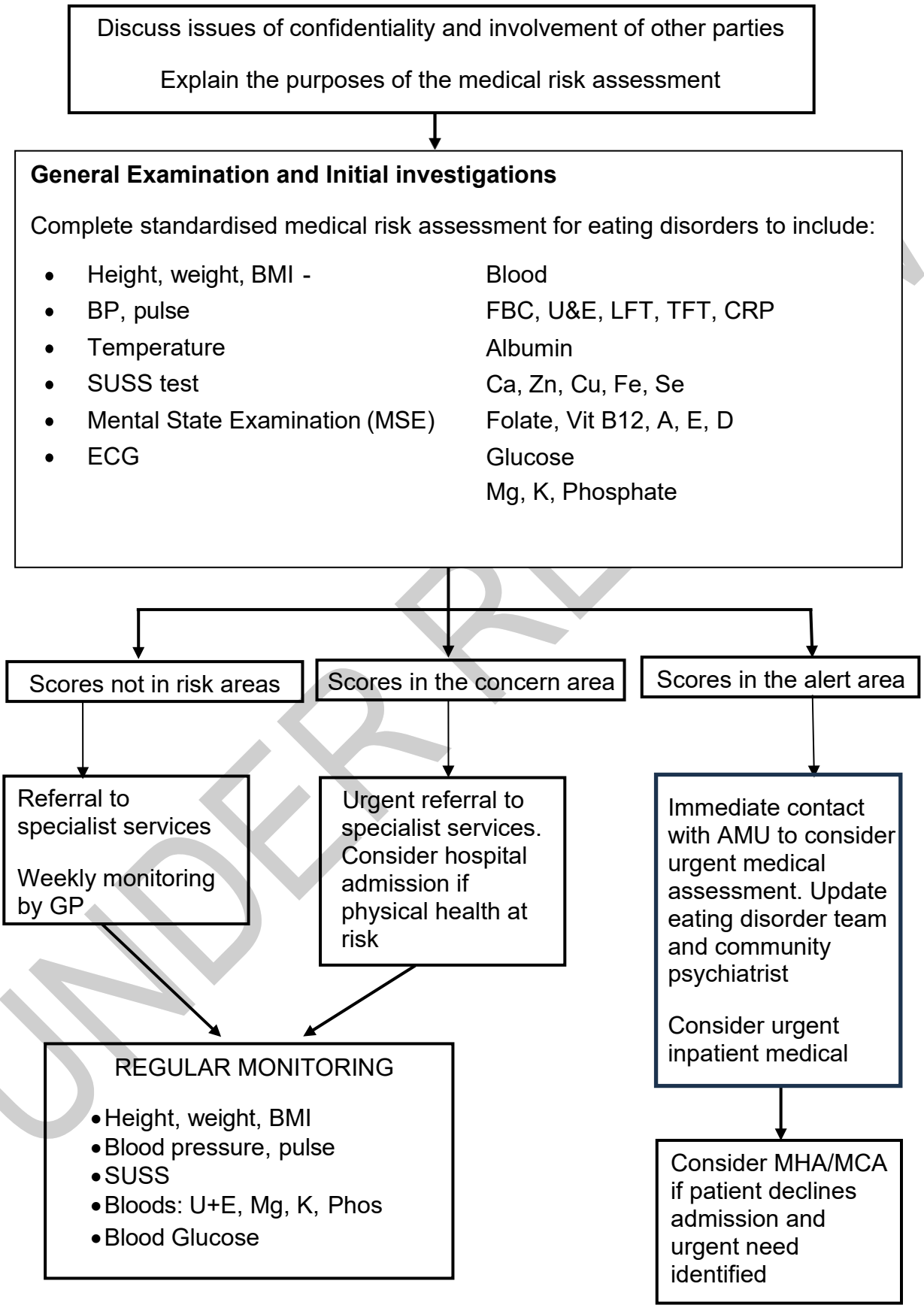
Appendix 6. Pre-Hospital Management of Patients with Low Body Weight



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