Shared Care Procedure For Admissions of Severely Ill Adult Patients Admitted To An Acute Medical Ward With An Eating Disorder

Guideline information

Guideline number: 875
Classification: Clinical
Supersedes N/A
Local Safety Standard for Invasive Procedures (LOCSSIP) reference: N/A
National Safety Standards for Invasive Procedures (NatSSIPs) standards: N/A
Version number: 1
Date of Equality Impact Assessment: 02/12/2025

Approval information

Approved by: MH&LD Written Control Documentation Group
Date of approval: 25.11.2025
Date made active: 09.12.2025
Review date: 25.11.2028

Summary of document:
Procedure` to ensure the safe and effective management of seriously ill patients suffering with an eating disorder admitted to an acute medical ward within Hywel Dda University Health Board.

To be read in conjunction with:
331 Adult enteral feeding policy opens in a new tab
209 Adult Refeeding Guidelines opens in a new tab
Mental Capacity Act 2005
596 Section 5(2) Doctors holding power policy opens in a new tab

Mental Health Act, 1983
Mental Health Act Code of Practice for Wales 2016
Use of restraint to feed (within reducing restrictive practice policy) opens in a new tab – currently in draft

Patient information:

Owning group: Shared Care Admissions for ED (adult)

Executive Director job title: Chief Operating Officer

Reviews and updates:
Version 1 – new 25.11.2025

Keywords
Eating Disorder, Re-feeding syndrome, Enteral Nutrition, Anorexia Nervosa

Glossary of terms
CMHT- Community Mental Health Team

Compensatory behaviours- Behaviours such as vomiting, exercising and laxative abuse.

EDS- Eating Disorders Service
MCA- Mental Capacity Act
MDT- Multi-disciplinary Team
Meal Support- Supporting distress around mealtimes to ensure adequate dietary intake.
MEED- Medical Emergencies in Eating Disorders. Guidance issued by the Royal College of Psychiatrists.
MHA- Mental health Act 1983
MHLS- Mental Health Liaison Service
NG- Naso-gastric feeding
ONS- Oral Nutritional Supplements
Post meal support- Support to manage emotions resulting from eating and to avoid compensatory behaviours.
RISH – Restrictive Intake Self Harm
SEDU- Specialist Eating Disorders Unit (Inpatient)
Water loading- Drinking excess water with aim of increasing weight prior to planned weighing.

Key points:

- Planning and co-ordination of the admission of patients with eating disorders to medical beds must be jointly undertaken by the Eating Disorders Service, Dietetics and Gastroenterologists.
- Physical monitoring and risk assessment must be undertaken with reference to MEED Guidelines.
- Patients with low body weight who have been severely restricting their nutritional intake can be subject to rapid deterioration and collapse. These risks are exacerbated when food is initially reintroduced. Therefore, close monitoring and specialist oversight of treatment plan is required.
- Eating disorders are serious mental illnesses which are characterised by fear of weight gain and poor insight. As such, patient with the condition are likely to feel compelled to make extreme efforts to avoid complying with aspects of treatment aimed at restoring weight. Staff need to be aware of this and be vigilant for covert behaviours.
- Consistency and clarity of approach is particularly important for the patients subject to this procedure: This document provides staff with a comprehensive procedure on the management of patients admitted due to complication of an eating disorder who require medical stabilisation/ refeeding.

Key contacts:
Eating Disorders Service: eatingdisordersservice.hdd@wales.nhs.uk. Tel 01267 229700
CNS Nutrition:
Acute Dietetics:
Mental Health Liaison Psychiatry: Mental.HealthLiaison.hdd@wales.nhs.uk

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Scope:

This clinical procedure should be used for all adult patients admitted to a general medical ward with a diagnosed eating disorder.
This procedure applies to all patients requiring medical stabilisation and/or presenting with refeeding syndrome risks as a consequence of an eating disorder.

Patient groups this procedure applies to;

- Adults known to Eating Disorder Service who require urgent admission for medical stabilisation related to an eating disorder.
- Adults known to Eating Disorder Service who may present in an emergency via A+E, AMAU or GP for admission for medical stabilisation related to an eating disorder.
- Adults not known to Eating Disorder Service who may present in an emergency via A+E, AMAU or GP for admission for medical stabilisation related to an eating disorder.
- This procedure applies to adults over 18 years old, however it is also applicable to patients over 16 that are identified by SCAMHS Eating Disorders Team as requiring medical admission.

Professions this procedure applies to;
Gastroenterology, Dietetics, Eating Disorders Service, Mental health Liaison Service, Community Mental Health Team, A+E, AMAU. It also applies to all HDUHB staff involved in service provision to this group of patients including Hotel Services.

Admission is usually via Gastroenterology at Prince Phillip Hospital (PPH), but this procedure should be used for all eating disorders medical stabilisation circumstances and applies to general hospitals across the HDUHB footprint.

Aims:

- To establish consensus within HDUHB on the management of severely ill adult patients with an eating disorder requiring urgent/planned admission to an acute medical inpatient ward or those admitted in an emergency by any route.
- To ensure the safe and effective management of seriously ill patients suffering with an eating disorder who are admitted to an acute medical ward within HDUHB. To include the management of medical stabilisation and the risks associated with re-feeding syndrome (prevention, identification and management).
- To provide safe, effective, co-ordinated MDT care and timely medical treatment to adult patients who require medical stabilisation as a result of an eating disorder.

Objectives

- To provide guidance on the recognition of an eating disorder.
- To provide guidance on early identification of appropriate patients who are medically at risk due to an eating disorder, requiring admission to secondary care.

- The procedure outlines the referral pathway for those patients with an eating disorder, requiring admission to an acute medical ward.
- The procedure outlines the treatment and management of patients with an eating disorder on an acute medical ward.
- To outline best practice for the identification, prevention and treatment of re-feeding syndrome.
- To outline best practice to ensure that patients are not underfed.
- To provide guidance on the use of the Mental Health Act (MHA).
- Ensure appropriate communication between all members of the MDT.
- To ensure admission is outcome focused and there is a clear plan of care.
- Provide co-ordinated care to reduce and prevent gaps in service provision, using clear protocols and joint working agreements.
- Have clear processes around managing risk and safety.

INTRODUCTION

This procedure has been produced to inform and guide the multi-disciplinary team (MDT) involved in the management of seriously ill patients suffering with an Eating Disorder (ED) and requiring urgent/ planned treatment within an acute medical ward. It also applies to those patients admitted with the medical complications of an ED on an emergency basis via Accident and Emergency (A&E) Department within Hywel Dda University Health Board (HDUHB).

The need for this procedure was highlighted by the publication of 'Managing emergencies in eating disorders' (MEED) Guidelines (2022) which emphasises the need for all seriously ill patients with Anorexia Nervosa (AN) to be managed by an MDT experienced in re-feeding patients, in consultation with the Eating Disorder Service (EDS). In addition to this, the All Wales Framework for Eating Disorders (2009) identified the need for improved medical care and treatment for individuals suffering with an ED. This is further supported by the NICE publication Eating Disorders Quality standard which outlines the importance of co-ordinated care when patients move across services (NICE, 2018).

National statistics previously highlighted that patients with severe AN were being admitted to general medical units and, in some cases, deteriorating and dying. Reasons for this included non-adherence to nutritional treatment, and complications of treatment, such as refeeding syndrome, as well as underfeeding

Patients who require admission to medical wards should be treated by a team with experience of treating eating disorders and involving their carers, using protocols developed in collaboration with eating disorder specialists, and having staff trained to implement them. The inpatient team on the medical/paediatric unit should include (at least) a lead physician, a dietitian with specialist knowledge of eating disorders and a lead nurse. An eating disorders or liaison psychiatry service should provide sufficient support and training to medical wards (MEED 2022).

As a result of this HDUHB have identified a dedicated Gastroenterology Consultant to be the Responsible Physician to work alongside the MDT for individuals with a severe eating disorder requiring re-feeding within an acute medical ward. The Responsible Physicians are the Gastroenterology Consultants at Prince Phillip Hospital.

Through a shared care and patient centred approach to services provided, adults with eating disorders will be able to access the most appropriate treatment, leading to better outcomes for them.

This procedure has been produced to inform and guide the MDT involved in the management of patient care for adults with eating disorders, which have led to medical complications or refeeding risk which are no longer manageable in the community and may require treatment in an acute medical ward.

The decision to admit, care planning and discharge, needs to include coordinated input from mental health, physical health and all services involved in that individuals care.

This procedure is a collaboration between the Acute Services Gastroenterology team, Dietitians, Clinical Nutrition Specialist Nurse and Eating Disorders Service (EDS).

DEFINITION OF AN EATING DISORDER

Eating disorders are serious mental illnesses affecting people of all ages, genders, ethnicities and backgrounds. They are characterized by severe and persistent disturbance in eating behaviours and associated distressing thoughts and emotions. EDs focus on food and over-concern with body size and shape and can result in significant food restriction and chaotic eating patterns and may be accompanied by compensatory behaviours for example, self-induced vomiting, laxative abuse and excessive exercising. This can lead to severe malnutrition and other physical health and mental health risks.

RESTRICTED INTAKE AS SELF-HARM (RISH)

This formulation encompasses patients who present with disordered eating as a means of self-harm in the context of emotional instability/ interpersonal difficulties. This formulation does not meet the criteria for diagnosis of an eating disorder and therefore EDS do not offer treatment for this patient group. The evidence base supports treatment via the local pathway for wider psychological problems (CMHT/ IPTS etc). EDS can provide assessment and advice. **See appendix 14.**

OVERVIEW OF ANOREXIA NERVOSA

Predominantly it will be those patients with Anorexia Nervosa that will be admitted to a medical ward for medical stabilisation and/or re-feeding. Anorexia Nervosa has the highest mortality rate of any other psychiatric disorder. At least half of these deaths are due to the physical complications of the disorder (Arcelus et al 2011).

The core features of Anorexia Nervosa are:

Persistent restriction of energy intake leading to significantly low body weight.

Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though significantly low weight).

Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight. Other features can include:

- Self-induced vomiting
- Binge eating
- Laxative abuse
- Excessive exercise
- Depression
- Anxiety
- Social withdrawal

MEED (2022) defines **RED risk BMI <13** and **AMBER risk BMI <15.** However, the **physical risks associated with the patient should not be assessed by BMI alone** as other factors may increase or decrease risk such as chronicity, rate of onset, compensatory behaviours and other conditions. It is therefore essential that a full individual clinical risk assessment is carried out **(Appendix 1)**.

ASSESSMENT / IDENTIFICATION OF AN EATING DISORDER

For patients not known to mental health services / those patients not previously diagnosed as having an ED, the SCOFF Questionnaire has been validated in specialist and primary care settings and can be used as a quick screening tool to aid the detection of ED **(Appendix 2)**.

Further assessment within the acute medical setting should be conducted with the involvement of the Consultant Physician, Dietitian and the Mental Health Liaison Service. If appropriate a joint assessment with MHLS and EDS can be arranged. It is also useful to seek information from the family/carers of the patient. See **Appendix 3** for recommended assessment domains.

Whilst medical monitoring and management must remain a priority in line with MEED guidelines, clinical teams should be mindful of the potential for over-reporting of restriction in patients with RISH presentations. Decisions regarding admission and refeeding should be guided not solely by patient-reported data, but by a comprehensive assessment of objective clinical indicators and medical risk. Where such indicators suggest genuine medical compromise, intervention is essential, regardless of diagnostic uncertainty.

Potential challenges to accurate risk assessment (MEED, 2022)

- Patients can appear well and this can falsely reassure the clinician.
- Consider parent/carer information when assessing risk.
- Patients may have an extremely powerful drive to exercise (including micro-exercise) that can override their lack of nutritional reserve, so that they appear very energetic right up to a physical collapse. Increased rather than reduced energy and activity levels is one of the features that distinguishes anorexia nervosa from starvation syndrome.
- Blood parameters that fall within laboratory reference ranges are frequently seen in advanced uncomplicated malnutrition and should not be taken as cause for reassurance.
- Do not reassure the patient that their risk is low. That will compound the dismissive nature of their eating disorder cognitions and increase perception that change is not necessary. Emphasise the severity of the problem and the lack of precision in risk assessment while making sure to conduct the necessary physiological and psychological examinations.
- Due to the nature of eating disorder cognitions and associated distress, a patient's fear of weight restoration may limit their capacity to provide an accurate account of their presentation. This can falsely reassure the clinician about the assessment of risk.
- Suicidal ideation is common in people with eating disorders. Suicide accounts for the cause of death for 20% of all deaths among adults with anorexia nervosa. Among both young people and adults with bulimia nervosa, and binge eating disorder, the risk of self-harm and suicide is increased.

Advice should be sought from the Eating Disorders Service as soon as possible. See Key contacts pg.3

MEDICAL RISK ASSESSMENT

Patients with an eating disorder can seem deceptively well. The medical risk arises from a combination of the restrictive (food and in some cases fluid) and the compensatory behaviours. Criteria for different risk levels are difficult to apply due to the influence of variables, for example, metabolic changes are most problematic if weight control measures such as vomiting and laxative abuse are used (**See Appendix 4** for interpretation of blood results specific to eating disorders).

Neither BMI nor blood tests alone are adequate markers of risk. It is accepted that assessment needs to include a range of measures in order to detect those patients whose state is deteriorating but who

are attempting to conceal the fact. No single parameter is, in and of itself, an adequate indicator of overall level of risk or illness (MEED, 2022)

LOCATION OF CARE

When a decision has been made to admit a patient to hospital, patients are to be admitted to a medical bed with the appropriate expertise (e.g. Gastroenterology, usually at PPH).

Medical ward admission for medical stabilisation is appropriate if:

- A patient is assessed as being at high medical risk (refer to MEED, 2022) **(Appendix 1)**.
- A patient has pre-existing electrolyte or renal abnormalities or co morbidity increasing the risk of re-feeding syndrome, such as significant infection (MEED, 2022).
- Patients that require a Naso-gastric tube (NGT) placement, position verification and monitoring until the risk of refeeding syndrome has reduced, and this is not available/and or appropriate in a SEDU.

PRE-ADMISSION CONSULTATION AND ROUTE OF REFERRAL FOR ADMISSION

Pre admission meeting to be held

Urgent/ Planned Admissions (See Appendix 5)

Urgent/planned admissions are for those patients that are known to Eating Disorder Services and the need for admission can be anticipated due to a gradually deteriorating picture.

- EDS Clinical Lead or designated deputy to coordinate a pre-referral meeting with key professionals (e.g. acute dietitian, Nutrition nurse, EDS dietitian, Gastroenterology Consultant). Pre admission template will be completed following this **(See Appendix 9)**.
- EDS will email the completed template to the appropriate Gastroenterology Consultant at Prince Phillip hospital, copying in the Consultant's secretary, in-patient and community dietitians and Care co-ordinator (CMHT).
- Once admission is agreed a patient dialogue will take place to ensure that treatment and expected outcomes are clear. An MDT meeting with relevant professionals will be held (aim of admission, care plan, roles of members of staff, admission length discussion, aftercare).
- A suitable admission date will then be arranged.
- EDS discuss planned admission date with Bed Manager in line with agreed outcome from MDT. Prior to admission a member of EDS will liaise with Gastroenterology ward to handover relevant information (pen picture, care plan, risk assessment) and prepare the care plan with the nursing team.

Emergency / Unplanned Admissions (See Appendix 6)

These are patients that are known to EDS but whose physical state has rapidly deteriorated causing significant medical risks.

- EDS contact resulting in concerns of significant medical risks.
- EDS contact local Medical Registrar on-call to ascertain appropriate actions (e.g. A+E attendance, Same Day Emergency Care (SDEC)).
- If a patient is admitted as an emergency via A+E and requires on-going medical stabilisation/refeeding due to their eating disorder the patient will be referred to the appropriate Gastroenterologist as per rota by the Medical team.
- Urgent input from Acute Dietetics to be requested by the Medical team.
- The EDS will contact medical ward to handover relevant information and prepare the care plan with the nursing team ASAP.
- If community plan appropriate, formulate in conjunction with Medical Registrar advice.

Alternatively, there may be patients that are **not known to EDS** but have been admitted as an emergency via A&E or are admitted with physical conditions which are subsequently attributed to an ED. The medical team will complete a referral to the Mental Health Liaison service (MHLS) as soon as practicable, following their admission. The referral should request a joint assessment with MHLS and EDS.

(See Appendix 7)

Some patients presenting to acute hospitals with food and/or fluid restriction may not have an Eating Disorder. At the time of admission, these patients may not have a formal diagnosis or be known to any specialist team. Possible alternative presentations include:

- Restrictive Intake Self-Harm (RISH)
- Mental health conditions (e.g. depression)
- Disordered eating in the context of neurodevelopmental conditions (e.g. Autism)

Once admitted, patient should be referred to MHLS for assessment, who may request joint assessment with EDS if required.

GOALS OF INPATIENT MEDICAL ADMISSION

The key tasks of the in-patient medical team are to:

- Re-feed the patient to achieve medical stabilisation.
- Avoid re-feeding syndrome caused by too rapid re-feeding.
- Avoid underfeeding syndrome caused by too cautious rates of re-feeding.
- Monitor blood abnormalities and physical complications and treat accordingly.
- Manage, with the help of mental health staff, the behavioural problems common in patients with anorexia nervosa such as sabotaging nutrition.
- Where appropriate, to treat patients under compulsion (using powers under the Mental Health Act), with the support of Mental Health staff. Mental Health services will need to determine who the Responsible Clinician is.

NUTRITIONAL CARE

The nutritional management of patients with AN forms an essential part of treatment. The first 7-10 days of feeding a seriously ill patient with AN poses a significant risk of developing re-feeding syndrome and its related complications.

Initial feeding (7-10 days) is aimed at medical stabilisation and prevention of any weight loss as opposed to weight gain, as well as building patient's tolerance to a calorie (Kcals) intake that will eventually promote weight restoration (BDA, 2019).

See HDUHB Re-feeding syndrome protocol (opens in a new tab)

Nasogastric feeding

If patients are unable to achieve adequate intake either via food and fluids orally or with the use of oral nutritional supplements as recommended by a dietitian and are medically at risk, nasogastric (NG) feeding may need to be considered. If this is the case, then an MDT will need to be arranged to discuss prior to the start of any NG feeding.

Where NG feeding has been deemed appropriate by the MDT, the dietitian and the CNS Nutrition team will be responsible for producing a plan to support the insertion and ongoing care of the NG tube and an appropriate feeding regimen in line with HDUHB Enteral Feeding Policy and Operational Guidelines (Guideline 331). Out of hours NG feeding in this group of patients **must not** take place as it will be managed by the dietitian and CNS Nutrition team.

In cases where a patient refuses NG feeding the MDT will consider the need for assessment under the Mental Health Act to determine the patient's capacity and legal framework for treatment. If NG feeding is deemed necessary and refusal persists, a plan for safe holding or restraint must be developed in accordance with legal and ethical standards. Prior to initiating any restrictive intervention, guidance must be sought from the Restrictive Practice team to ensure appropriate procedures and safeguards are in place. (**See Appendix 8**).

If the patient requires sedation to manage their distress/anxiety then this must be discussed with the Responsible Psychiatrist, or if out of hours with the On-Call Psychiatrist who may then chose to discuss with the On-Call Consultant Psychiatrist.

MONITORING PATIENTS

Monitoring procedures during admission detailed in box below:

Monitoring Nutrition Support (BDA, 2011. Adapted from NICE, 2006)

System	Examination	Frequency
Investigations	FBC, urea, electrolytes (including phosphate, magnesium and potassium), LFT's, albumin, creatinine kinase	Daily until stable Then 2 times a week Then weekly
	ECG	As indicated by baseline ECG
	Glucose	Baseline 4 hourly initially Daily once stable See section NICE guidelines for more information on hypoglycaemia.
Temperature		4 hourly or as medically indicated or until stable.
Circulation	BP & Pulse rate **sitting and standing**	4 hourly or as medically indicated or until stable.
Nutrition	Weight	Minimum twice weekly during the first 10 days of feeding. If rapid weight changes evident, increase frequency of monitoring. Then weekly
	Fluid	Daily fluid balance chart for the first 10 days of re-feeding or until any issues related to fluid intake have been resolved.
	Stools	Daily stool chart for the first 10 days of re-feeding or until any issues related to gut function have been resolved.

WEIGHING PATIENTS

It is expected that all patients will be weighed during their admission. When a patient refuses to be weighed, this should be documented and highlighted to the EDS.

Each patient must be weighed on admission as a baseline measurement, followed by a minimum of twice weekly weights. If rapid weight changes are evident (e.g. >1.5Kg), frequency of monitoring will need to be increased.

Patients should be weighed first thing in the morning, after the individual has emptied their bladder and prior to them eating or drinking anything. They should be weighed in their underwear or a light pair of pyjamas / nightdress. No footwear to be worn. On occasions spot weighing may be required, but this will be discussed with MDT.

MULTI PROFESSIONAL TEAM MEETINGS

Regular review meetings with MDT are required, minimum of weekly review.

There will be dialogue with the patient ahead of the MDT meeting to ensure that the treatment and expected outcomes are clear, ascertain patient's views and wishes and allow the opportunity for discussion and explanation.

Review meetings will be held on an agreed day. It is expected that all disciplines attend this meeting and if unable to attend to nominate a deputy or provide a written report for the team on progress, highlighting any difficulties or positive aspects. The care plan will be reviewed and amended as required at this meeting. The MDT meeting will confirm which professional will feedback to patient.

Discussions during the meeting should include:

- Review of previous meeting's decisions and recommendations.
- Update of the patients' physical state (to include weight, medical investigations, observations).
- Feedback from individual disciplines.
- Feedback from patient/carers (if appropriate)/advocate.
- Consideration given regarding consent, and the need for assessment under the Mental Health Act.
- Clarification of key issues and goals for next meeting.
- Review care plan, risks, contingencies and any need for NG feed.
- Discharge date to be set and a pre discharge meeting arranged.

MANAGING EATING DISORDERED BEHAVIOURS

Individuals with eating disorders may present with many challenging behaviours. An individualised care plan will be devised between EDS and medical ward staff for patients known to EDS (see **appendix 10** for example)

For patients not known to EDS for guidance see **Appendix 11** **and** **Appendix 12.**

It is essential that concordance with care plan and identification of ED behaviours are documented.

On occasions patients may require increased levels of observation to manage behaviours that are increasing medical risks/hindering progress.

The EDS aim to support the ward with mealtimes as much as is possible during working hours Monday to Friday 9.30am 4:30pm to support meal plan concordance (pre and post meal support).

CAPACITY AND THE USE OF THE MENTAL HEALTH ACT

When a patient refuses treatment, those involved in the care of the patient must consider and assess the individuals' decision making capacity. Patient's may present as having capacity but lack the ability to make informed decisions specifically related to their condition.

EDs are mental illnesses, and can lead to loss of capacity. Significant emaciation, anxiety or distress may all question the presumption of capacity. The nature of the mental illness means that ability to reason appropriately is impaired by a minimisation of the seriousness of their condition, an intense fear of food and weight gain and a lack of insight. Therefore, the patient may be giving apparently lucid reasons for refusing treatment but on further investigation, they are likely to be lacking in capacity.

If the patient lacks capacity and is refusing treatment for their ED then they should be assessed under the Mental Health Act.

Lifesaving treatment should not be delayed and can be given under certain Sections of the Mental Health Act, or in their best interests under the Mental Capacity Act or under Common Law.

If uncertain, seek guidance form the health boards Mental Capacity team, Mental health Act Administration Team or the Mental Health Liaison Service.

Mental Health Act

The Mental Health Act recognises EDs such as AN as a mental disorder and that feeding (including NG feeding) is regarded as treatment for the disorder, and so is permissible against the patient's will. Consideration needs to be given to the acceptance of the treatment plan in its entirety. Acceptance of minimal nutrition, which does not allow for weight restoration or refusal to adhere to other treatment boundaries, will render the treatment ineffective. In these situations adherence is insufficient and would indicate the need for assessment under the Mental Health Act.

A patient who is already an inpatient can be detained under Section 5(2) by the doctor (or nominated deputy) in charge of their care for up to 72 hours while a further Mental Health act assessment is arranged.

Contact the Mental health Act Administration Team, Mental Health Liaison Service for guidance or the Approved Mental Health Professional Service from the patient's home county.

Discharge / Transfer Meeting

A meeting prior to discharge will be held with all relevant members of the MDT. There should be general agreement that discharge is appropriate, this will be likely when medical stabilisation has been achieved and an agreed care plan for treatment after discharge / transfer can be implemented. Criteria for re-admission will need to be discussed and agreed.

Options following medical stabilisation and discharge from medical ward:

- Specialist Eating Disorder Unit (SEDU). Referrals can only be made via the EDS Clinical lead or nominated deputy if not available.
- General Mental health in-patient ward.
- Discharge home – with an agreed plan from community services for mental health and physical health monitoring.

The discharge plan will be devised with the involvement of the patient and will be communicated to all relevant parties including the General Practitioner (GP) via a discharge letter from the medical team. EDS and the CMHT will be responsible for inputting this plan onto Care Partner (mental health records).

RESPONSIBILITIES

All staff have a responsibility for ensuring that this procedure is universally applied. Optimal care for patients with nutritional problems are enhanced by an MDT approach that acknowledges the skills and training of the individuals and professions involved.

Mental Health Liaison Service:

Responsible for receiving referrals from medical wards of patients not known to EDS, screening referral. Arranging and attending joint assessment with EDS as required. Completion of Comprehensive Assessment Tool for patients assessed.

Community team:

Clinical Lead - Eating Disorders Service Responsible for liaising with the Gastroenterologist, the ward and the Nutrition & Dietetics team prior to and during admission.

Requesting pre-admission meeting and completing referral proforma **(see Appendix 9).** Ensure pre-admission parameters and clinical interventions have been implemented prior to request for admission e.g. community supported meal plan, ECG, baseline observations, refeeding bloods and refeeding medication.

In collaboration with the ward team responsible for the development of the patients care plan, monitoring of outcomes and discharge planning.

Eating Disorders Service (EDS)–

Responsible for providing high quality expert evidence-based assessment and treatment to those individuals experiencing complex high risk eating disorders diagnoses.

EDS will support the patient and the ward team during admission and will aim to visit daily Monday to Friday for updates, to support with meals where possible, and to help resolve any issues that may arise.

EDS will address family concerns and involve both patients and their families in discussions about treatment.

EDS will advise on appropriate onward care following medical stabilisation.

Senior members of Eating disorder Service will offer specific training (e.g. ED awareness and managing mealtimes) as required, and this can be requested by the ward.

Advanced Nurse Practitioner (EDS) – To support the training and education of staff in relation to medical management of eating disorders. ANP to monitor physical health of patient in community until admission and respond to any concerns, liaising with GP or Medical staff as required.

EDS Dietitian – Identify if community patient is at high risk of refeeding syndrome and recommend Thiamine, vitamins and minerals as per adult re-feeding guidelines (policy 209). Responsible for informing the Acute Dietitian of any imminent EDS patients who may need admission. Dietetics to agree on Lead Dietitian to be responsible for refeeding meal plan. Liaising with the acute dietitian during admission and during discharge planning to ensure continuity of care.

Care co-ordinator – Responsible or Care and Treatment Plan (as per Mental Health Measure) and WARRN assessments. Part of discharge planning meeting. Update GP as appropriate.

GP – for unknown patients to the EDS to highlight concerns regarding potential eating disorders to CMHT. If MEED RED risks to advise SDEC or A+E attendance **(see Appendix 1)**

Inpatient team:

Gastroenterologist/ Medical team – Responsible for managing medical risks.

Acute Dietitian & CNS Nutrition – Responsible for assessing and monitoring the nutritional needs of the patient whilst on the medical ward. Liaising with the medical, nursing and EDS dietitian prior to and during admission and to also be involved in discharge planning. Part of MDT decision making process for NG feeding requirements. Responsible for the management of NG refeeding and provides support when NG feeding is required.

Nutrition and Hydration Group- Responsible for the oversight of all aspects of nutrition and hydration care within the Health Board. This includes ensuring appropriate policies and procedures are in place and compliance is monitored.

TRAINING

Eating disorder Service will provide specific training (e.g. ED awareness and managing mealtimes) as required, and this can be requested by the ward.

NG insertion and care training for key members of the team (for doctors and nursing staff) as advised via Nutrition & Dietetics.

Contact Learning and Development team for bespoke training (e.g. MCA).

FURTHER INFORMATION

All Wales Framework for Eating disorders (2009)

BDA mental Health Group Practical guidelines for Re-feeding adult patients with Anorexia Nervosa (2018)

MEED (2022) Managing Medical Emergencies in Eating Disorders

Mental Capacity Act (2005)

Mental Health Act, 1983

Mental Health Act Code of Practice for Wales 2016

National Institute for health and clinical Excellence (NICE) Eating Disorders Recognition and Treatment (NG69) – 2017

National Institute of Clinical Excellence (NICE) nutrition support in adults – Clinical guideline 32 – 2006. Best practice advice on the care of adults who are malnourished or at nutritional risk.

NPSA NG alert 2011

Oral Feeding Difficulties and Dilemmas – report of a working party. Royal College Physicians January 2010

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CR162 - 2014. Royal college of Psychiatrists and Royal college of Physicians Adult re-feeding guidelines – Managing patients at risk and preventing re-feeding syndrome. Hywel Dda health Board - 2011
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331 – Adult enteral feeding policy. 209 Reefing guidelines. (in progress) Use of restraint to feed (within reducing restrictive practice policy)

SCOFF Questionnaire, John Morgan (1999), Leeds Partnerships NHS Foundation Trust

RESTRICTIVE INTAKE SELF-HARM (RISH) - Practice considerations for the management of RISH across care settings and age (2025) Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Appendix 1 - Individual Clinical Risk Assessment

The following parameters may be used as a guide to inform the medical risk of an individual. Medical admission should be considered if a patient scores in the 'RED Risk' column.

A guide to the medical risk assessment for eating disorders; (MEED, 2022).

MEED RISK	Red Risk	Amber Risk
Weight loss	Recent loss of weight of ≥1kg/week for 2 weeks (consecutive) in an undernourished patient Rapid weight loss at any weight, e.g. in obesity or ARFID	Recent loss of weight of 500–999g/week for 2 consecutive weeks in an undernourished patient
BMI	<13	13-14.9
HR (awake)	<40	40-50
Cardio-vascular health	Standing systolic BP less than 90 , associated with recurrent syncope and postural drop in systolic BP of >20mmHg or increase in HR of over 30bpm	Standing systolic BP <90 associated with occasional syncope; postural drop in systolic BP of >15mmHg or increase in HR of up to 30bpm
Hydration status	Fluid refusal Severe dehydration (10%): reduced urine output, dry mouth, postural BP drop (see above), decreased skin turgor, sunken eyes, tachypnoea, tachycardia	Severe fluid restriction Moderate dehydration (5–10%): reduced urine output, dry mouth, postural BP drop (see above), normal skin turgor, some tachypnoea, some tachycardia, peripheral oedema
Temperature	<35.5°C tympanic or 35.0°C axillary	<36°C
Muscular function (SUSS test) (Appendix 13)	Unable to sit up from lying flat, or to get up from squat at all or only by using upper limbs to help (Score 0 or 1)	Unable to sit up or stand from squat without noticeable difficulty (Score 2)

Other clinical state	Life-threatening medical condition, e.g. severe haematemesis, acute confusion, severe cognitive slowing, diabetic ketoacidosis, upper gastrointestinal perforation, significant alcohol consumption	Non-life-threatening physical compromise, e.g. mild haematemesis, pressure sores
ECG abnormalities	QTc >450ms (females), >430ms (males) Or any other significant ECG abnormality	QTc >450ms (females), >430ms (males). And no other ECG anomaly Taking medication known to prolong QTc interval
Biochemical abnormalities	Hypophosphataemia and falling phosphate Hypokalaemia (<2.5mmol/L) Hypoalbuminaemia Hypoglycaemia (<3mmol/L) Hyponatraemia Hypocalcaemia Transaminases >3x normal range Inpatients with diabetes mellitus: HbA1C >10% (86mmol/mol)	
Haematology	Low white cell count Haemoglobin <10g/L	
Disordered eating behaviours	Acute food refusal or estimated calorie intake <500kcal/day for 2+ days	

Appendix 2 - Assessment / Identification of an Eating Disorder

For those patients not known to mental health services / those patients not previously diagnosed as having an ED the **SCOFF Questionnaire** has been validated in specialist and primary care settings and can be used as a quick screening tool to aid the detection of ED. This tool uses five simple screening questions. Though not diagnostic, a score of 2 or more positive answers may indicate that the individual has an ED, highlighting the need for a more detailed assessment.

The questions are as follows:

- Do you ever make yourself ***sick*** because you feel uncomfortably full?
- Do you worry you have lost ***control*** over how much you eat?
- Have you recently lost more than ***one stone*** (6.3Kg) in a three-month period?
- Do you believe yourself to be ***fat*** when others say you are too thin?
- Would you say that ***food*** dominates your life?

Appendix 3 - Assessment Should Include:

Height and weight: To include weight history, how quickly has the patient lost weight? Rapid weight loss increases risk.

Body Mass Index: The body mass index is calculated by the formula weight in Kgs divided by height in metres².

Patient's feelings about weight gain: This will help to determine the patient's ability to engage in a weight restoring/re-feeding programme and inform the need for an assessment under the mental health act.

Compensatory behaviours: Engaging in compensatory behaviours such as self-induced vomiting and/or laxative abuse significantly increases a person's risk. These factors also need to be taken into account when determining the patients care plan. Likewise excessive exercising will also need to be managed. These behaviours possibly are concealed or covert.

Mood: An assessment of the patient's mood should be conducted to ensure accurate diagnosis and risk of suicidality

Diet: A detailed record of the patient's current diet, including any supplements, is required to inform the re-feeding programme; however it is important to try to corroborate the patients account as this may not always be accurate

Physical Health: To include **sitting and standing pulse, sitting and standing blood pressure**, core temperature and SUSS test **(Appendix1)**

Electrocardiogram (ECG) to determine any cardiac abnormalities

Co-Morbidity: Assessment needs to determine whether the patient's weight loss is due to another mental health problem for example; depression, anxiety, OCD, personality disorders, ASD, alcohol/illicit substance abuse.

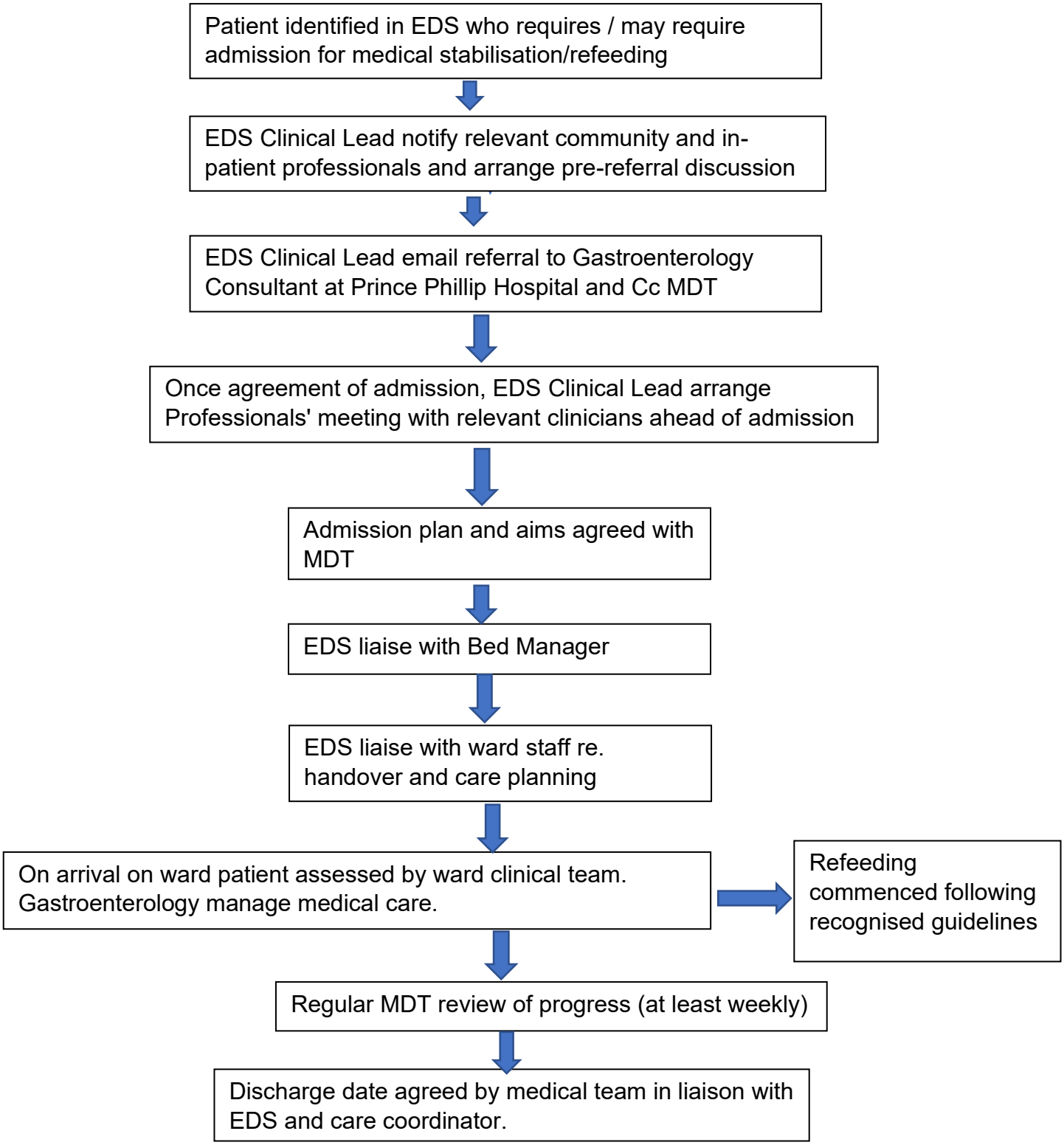
Differential Diagnosis: Assessment needs to consider other possible medical diagnoses for example, Crohns disease, Diabetes and other medical conditions that may result in weight loss. **Patients presenting with diabetes will require joint working with the diabetes department.**

Blood Chemistry: To include urea and electrolytes (U&E's), liver function tests (LFT's), phosphate (PO4), magnesium (Mg), calcium (Ca), Creatine Kinase (CK), glucose, thyroxin and full blood count (FBC). The results will indicate level of risk, inform re-feeding programme and also potentially alert professional to eating disordered behaviours. **(Table 1**)

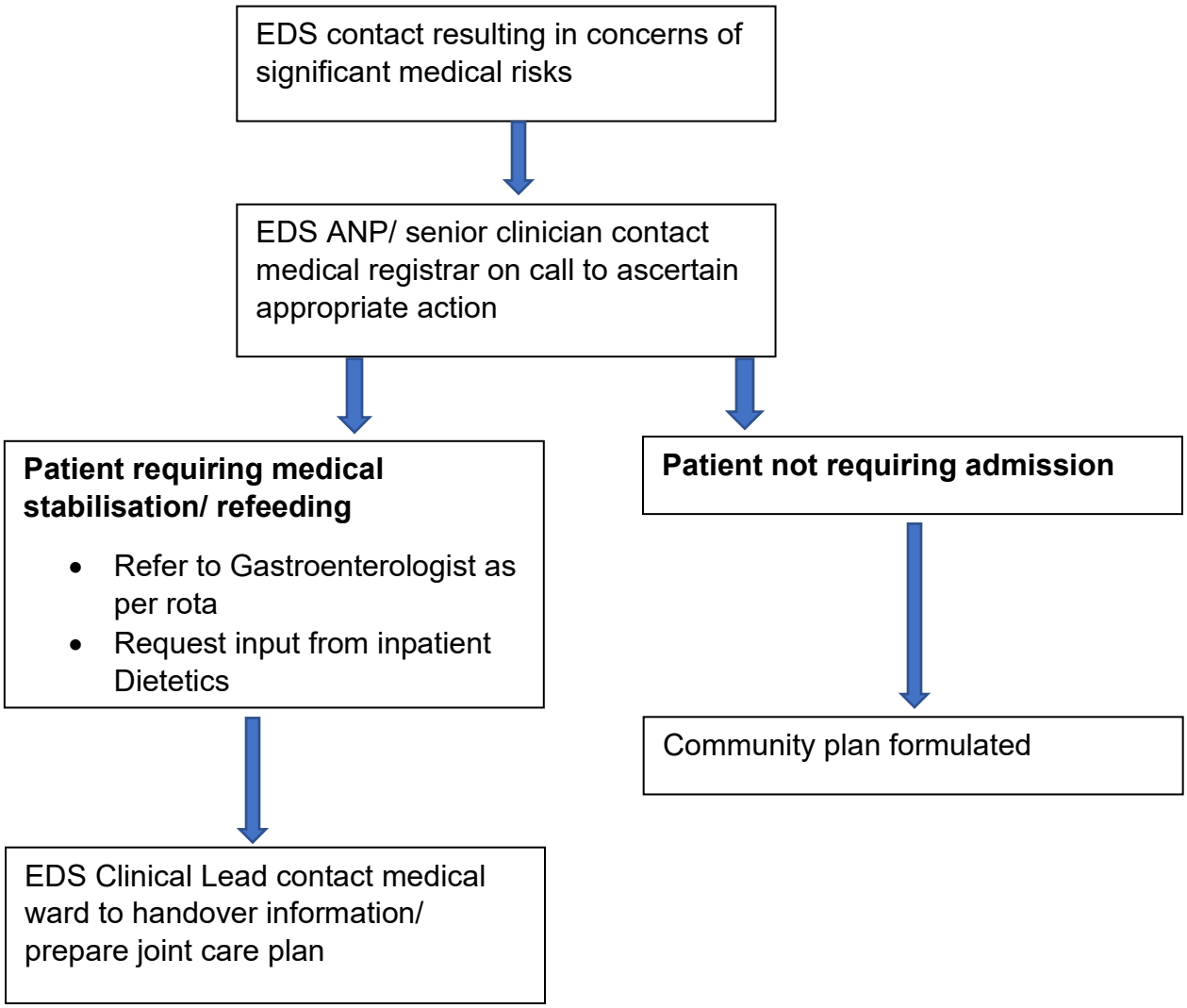
Appendix 4 - Potential Indications of Abnormal Blood Results (MEED, 2022)

Blood results	
Hypoglycaemia	Severe restriction, Starvation, Malnutrition
Hypokalaemia	Vomiting, Laxative abuse, diuretic abuse
Hyponatraemia	Water loading to falsify weight Laxative misuse Diuretic misuse
↑ T3/T4 ↓ TSH	Thyroxine misuse
Normocytic anaemia Leucopenia	Bone marrow hypoplasia
Hypophosphataemia Hypomagnesaemia Hypocalcaemia Hypokalaemia	Re-feeding syndrome
↑ Creatine Kinase ↑ Liver function tests	Proximal myopathy

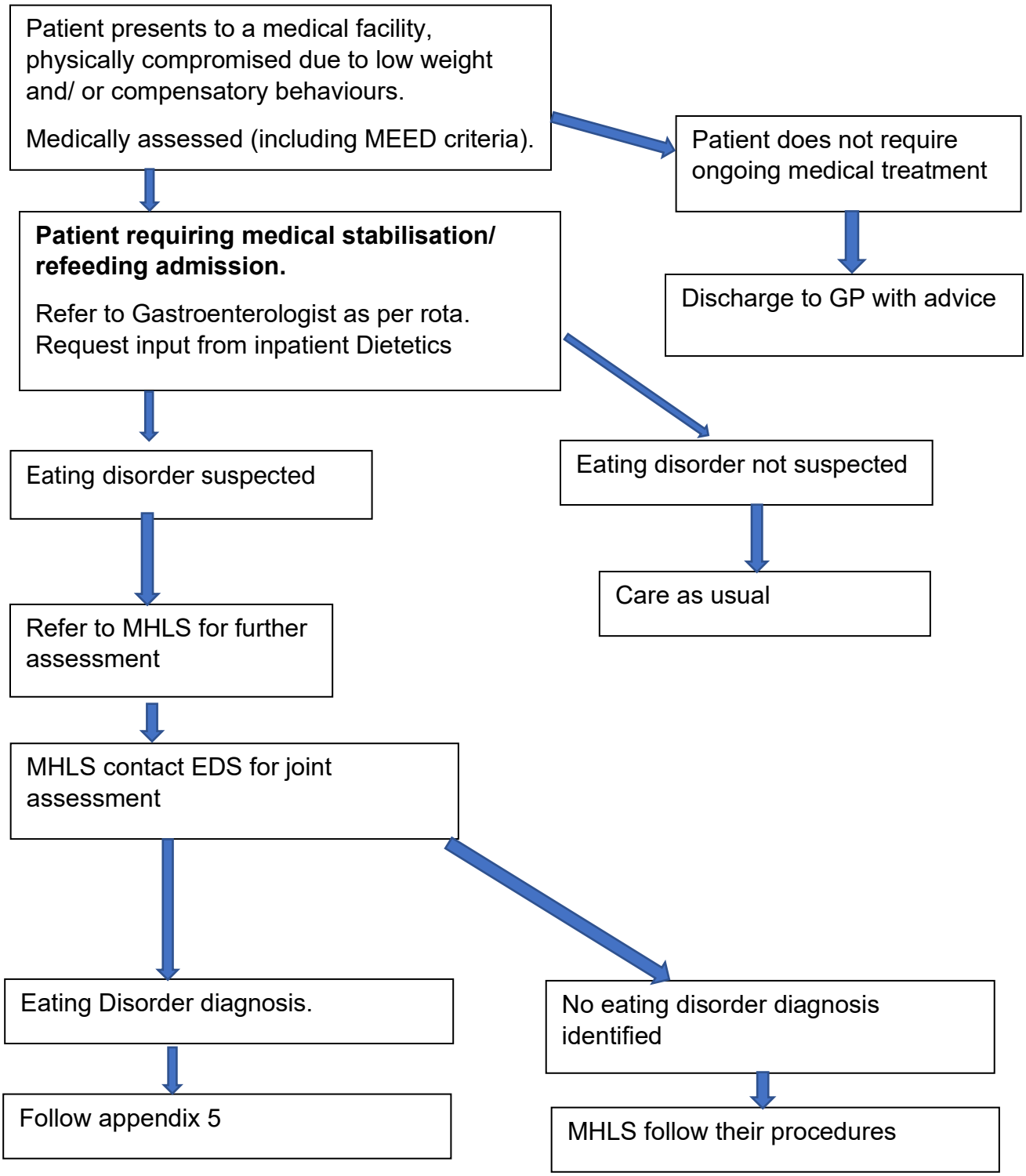
Appendix 5 Urgent Admission: Pathway to Medical Ward for Refeeding Admission (Planned Admission known by EDS)



Appendix 6 Emergency/ Unplanned Admissions for Patients Known to EDS



Appendix 7 Emergency Admissions Not Known to EDS



Appendix 8 - Enteral Tube Feeding a Patient Under Restraint Procedure - Flowchart for the management of food refusal in a patient detained under the Mental Health Act when restraint feeding is being considered

Patient refuses food (but may be taking fluids) and is assessed as medically and psychiatrically compromised

- ✓ Actively encourage oral intake
- ✓ Frequent food & fluid offers
- ✓ Undertake routine nutrition risk screening & associated actions
- ✓ Refer to dietetics
- ✓ Contact RRPT
- ✓ Commence Person centred support plan

RC convenes an urgent MDT to agree plan

Undertake & Act on Monitoring:
- ✓ Bloods: biochemistry as advised by team
- ✓ Strict food intake chart (document offered & consumed)
- ✓ Strict fluid balance
- ✓ Weight: frequency as advised by team
- ✓ Any other monitoring as agreed by team

MDT decision made to NG feed to mitigate significant risk to medical compromise:
- ✓ Physical restraint is only used as a last resort when all reasonable steps have been taken to negotiate & persuade the patient to consume adequate oral intake and / or accept a voluntary NG feeding tube, and these strategies have failed;
- ✓ MDT undertakes & documents an individual patient risk assessment in relation to feeding with restraint;
- ✓ MDT agree & document the plan for NG feeding with restraint including the aim of NG feeding, the refeeding plan, responsibilities for interventions and monitoring, and review is scheduled;
- ✓ A person-centred support & care plan is agreed in collaboration with the patient and family, as appropriate;
- ✓ The associated staffing and training needs are identified and a plan agreed

Each occasion NG feeding with restraint is required / undertaken:
- Risk assess the patient's current clinical condition in relation to the potential stress associated with NG feeding with restraint, this is a continuous process during feeding;
- Datix each occasion restraint is used;
- Document in clinical notes;
- Team and patient debrief

Regular MDT review. Review after each incident of restraint

Appendix 9 - Request Proforma for refeeding/medical stabilisation admission for eating disorders

Name of referrer/Profession	
Email and Telephone number	

Personal Details	
Full name:	Previous surnames:
Address:	Date of Birth:
	NHS No:
	Gender:
	Religion:
	Ethnicity:
Postcode:	Relationship status:
Legal status:	Dependents:
	First language:
Mobile:	Other contact:
GP and address:	GP: telephone:

Family/Carer Involvement			
	Comments	**Yes**	**No**
Does the person agree to family carer involvement?		☐	☐
Contact for next of Kin			

Reason for referral

Weight	**Result**	**Date**
Past 5 Weights (kg)		
Height (M)		
Current BMI Kg/M^2		

Clinical Information/ MEED RISK	RED MEED risk	Amber MEED risk	Green MEED risk	Not known	Comments
weight loss	☐ Recent loss of weight of ≥1kg/week for 2 weeks (consecutive) in an undernourished patient	☐ Recent loss of weight of 500–999g/week for 2 consecutive weeks in an undernourished patient	☐ Recent weight loss of <500g/week or fluctuating weight	☐	
BMI and weight	☐ Under 18 years: %mBMI <70% Over 18: BMI <13	☐ Under 18: %m BMI 70–80% Over 18: BMI 13–14.9	☐ Under 18: %mBMI >80% Over 18: BMI >15	☐	
HR (waking)	☐ <40	☐ 40 - 50	☐ >50	☐	
Cardiovascular health	☐ Standing systolic BP below 0.4th centile for age or less than 90 if 18+, associated with recurrent syncope and postural drop in systolic BP of >20mmHg or increase in HR of over 30bpm	☐ Standing systolic BP <0.4th centile or <90 if 18+ associated with occasional syncope; postural drop in systolic BP of >15mmHg or increase in HR of up to 30bpm	☐ Normal standing systolic BP. Normal orthostatic cardiovascular changes. Normal heart rhythm.	☐	
Assessment of hydration status	☐Fluid refusal. Severe dehydration (10%)	☐ Severe fluid restriction. Moderate dehydration (5–10%)	☐ Minimal fluid restriction ☐ No more than mild dehydration (<5%)	☐	
Temperature	☐ <35.5°C tympanic or 35.0°C axillary	☐ <36°C	☐ <36°C	☐	
Muscular function - SUSS Test	☐ Score 0 or 1	☐ Score 2	☐ Score 3	☐	

ECG abnormality	☐ <18 years: QTc >460ms (female), 450ms (male) 18+ years: QTc >450ms (females), 430ms (males) Or any other significant ECG abnormality	☐ <18 years: QTc >460ms (female), 450ms (male) 18+ years: QTc >450ms (females), >430ms (males). And no other ECG anomaly Taking medication known to prolong QTc interval	☐ <18 years: QTc <460ms (female), 450ms (male) 18+ years: QTc <450ms (females), <430ms (males)	☐	
Biochemical abnormalities	· Hypophosphataemia and falling phosphate. Hypokalaemia (<2.5mmol/L) Hypoalbuminaemia Hypoglycaemia (<3mmol/L). Hyponatraemia Hypocalcaemia Transaminases >3x normal range Inpatients with diabetes mellitus: HbA1C >10% (86mmol/mol)			·	
Haematology	· Low white cell count. Haemoglobin <10g/L			·	
Disordered Eating	· Acute food refusal or estimated calorie intake <500kcal/day for 2+ days			·	
Activity and exercise	· High levels of dysfunctional exercise in the context of malnutrition (>2h/day)	· Moderate levels of dysfunctional exercise in the context of malnutrition (>1h/day)	· Mild levels of or no dysfunctional exercise in the context of malnutrition (<1h/day)	·	
Purging behaviours	· Multiple daily episodes of vomiting and/or laxative abuse	· Regular (=>3x per week) vomiting and/or laxative abuse		·	

Self-harm and suicide	▪ Self-poisoning, suicidal ideas with moderate to high risk of completed suicide	▪ Cutting or similar behaviours, suicidal ideas with low risk of completed suicide		▪	
Engagement with management plan	▪ Physical struggles with staff or parents/carers over nutrition or reduction of exercise Harm to self Poor insight or motivation Fear leading to resistance to weight gain Staff or parents/carers unable to implement meal plan prescribed	▪ Poor insight or motivation Resistance to weight gain Staff or parents/carers unable to implement meal plan prescribed Some insight and motivation to tackle eating problems Fear leading to some ambivalence but not actively resisting	▪ Some insight and motivation to tackle eating problems May be ambivalent but not actively resisting	▪	

Medical information		Current (tick)	Past (tick)
Co-morbidities physical and mental			
Current Medication/compliance			
Relevant clinical information/medical history			
Current alcohol or substance misuse issues			

Risk Factors	
Date of recent risk assessment:	Completed by:
Details of recent risk assessment: (attach a copy if available) **In process of being completed.**	
Risk to self? (including history of self-harm/suicidal ideation) Risk to others? (please provide details)	

History of Eating Disorder

History:	Diagnosis	Tick
	Anorexia Nervosa	
	ARFID	
	Bulimia Nervosa	
	OSFED	
	Other	

Other Psychiatric Co-morbidities:

Previous admissions:

Current management plan in the community:

Consent		
Tick as appropriate	Yes	No
Has the patient got capacity to consent to this admission		
Has the patient given consent to admission		

Consent Received By: (Print name)	Signature:
Date:	Time:
Is there any restriction on sharing information?	☐ **YES** ☐ **NO**
Details:	

Dietary Information	
Intolerances/allergies/ meal pattern/ supplement use. Cultural or religious diets/vegetarian/vegan. NG feeding history	

Primary community contact or care coordinator	Social worker
Name: Job Title: Organisation:	Name: Job Title: Organisation:

Telephone: Email:	Telephone: Email:
Psychiatrist	**Dietitian**
Name: Address: Telephone: Email:	Name: Address: Telephone: Email:
Nearest relative (under the MHA) if different next of kin	**Other**
Name: Job Title: Organisation: Telephone: Email:	Name: Job Title: Organisation: Telephone: Email:

Appendix 10 - Care Plan

Name (DoB) NHS:

The admission is for 10-14 days for medical stabilisation/refeeding.

Status: Informal/formal

Pen picture

History

Diagnosis/previous admissions

Current presentation

Weight

Rate of weight loss

BMI

Height

blood test results (- FBC, U&E, Phosphate, T4, TSH, B12, Folate, LFT, Calcium, Magnesium),
BP sitting and standing,
Pulse sitting and standing,
temperature
ECG

Compensatory behaviours –

Mental health -

self-harm or suicidal ideation risks -

Admission to medical bed

The current admission is for medical stabilisation and refeeding. It is anticipated that ***Name*** will attempt to comply with the meal plan, however, **she/he** may also attempt to negotiate specifics around portion sizes, food items and/or try to delay meals/snacks. It is anticipated that ***Name*** will be able to manage food intake and not require NG feeding.

- ★ However, due to risks of re-feeding if meal plan is declined and supplement drink alternative is declined, to arrange urgent MDT meeting with relevant professionals to review need for NG feeding.

Objectives for admission: -

1. To manage refeeding risks, monitor medical condition, support weight gain and to help *Name* to restore a more regular pattern of eating.
2. To assess for and eliminate any compensatory behaviours (e.g. exercise).
3. To monitor mood and liaise with eating disorder and community teams as needed.

Meal Plan Guidance

- ***Name*** requires a Specialist Re-feeding Nutrition and Hydration plan to be devised by acute/in-patient Dietetics team (please liaise with *Name*). This will be reviewed by Dietitian and the Multidisciplinary team will be updated of changes.
- ***Name*** is **Pescetarian/vegan/ etc**
- ***Name*** to be supported to order meals and snacks as stated in meal plan.
- ***Name*** to be prompted to use the toilet prior to commencing her meals.
- Mealtimes to be 'protected' - try to limit disturbances.
- All meals to be administered as per the meal plan and at the time documented in the meal plan. Staff to prompt.
- No negotiations to be agreed without prior consultation with dietetics.
- ***Name*** to complete all of her meals and snacks.
- Staff to observe all meal times.
- Staff to provide post meal support and observation
- Staff to provide pre and post meal support - distraction/coping strategies.
- **If meal plan not adhered to, Name to be offered equivalent/top up via supplement drink.**
- **If food and Supplement drink refused, NG feeding to be offered. If refused MDT meeting to be arranged.**
- Be aware of any attempts to hide food to avoid eating it.
- ***Name*** not to visit the toilet one-hour post meals; staff to remind her of this at each mealtime.
- Staff to observe ***Name*** post meals and at other times for any signs that **she/he** may be compensating for dietary intake – e.g. exercising (overtly or covertly).
- *Name* to be encouraged and prompted to sit down and rest if standing or pacing/walking.

Recording and Monitoring

- Complete the **Food and Fluid chart**.
- Ensure any exercising, observed attempts to conceal food are documented.
- ***Name*** to be **weighed** twice a week after going to the toilet and before breakfast and drinks. Wearing minimal clothing. - *Be aware of potential water loading and wearing several layers of clothes pre weighing.*
- *Name* also to be randomly weighed on occasions to check for weight manipulation
- **Refeeding blood monitoring** to be completed on a daily basis. These are to include U&Es, LFTs, Phosphate and Magnesium.
- **Physical observations twice daily, including**:
- Sitting and Standing blood pressure,

- Sitting and Standing pulse
- blood sugars 4 hours initially, daily once stable
- **Communication** – ensure nursing handovers and update MDT.

Personal care – Supervised washes are recommended until medically stable. Consider use of commode.

Patient mobilising – to prevent over activity and promote treatment encourage bed rest and a wheelchair should be used when mobilising on ward supported by staff. This includes short distances. Risk assessment for tissue viability. To be reviewed once medically stable.

Time off ward – If ***Name*** wishes to have time off the ward **he/she** must be in a wheelchair at all times and to be accompanied with staff. If ***Name*** refuses, please contact member of Eating Disorders Service.

Requesting discharge – if ***Name*** requests **her/his** discharge and insists on leaving against medical advice, please use the Mental Health Act (e.g. Section 5, 2). Please contact Mental Health Liaison team **email**

and Approved Mental Health Practitioners (AMPH) **email/contacts**

The Eating Disorders team will support *Name* and the Ward Team during admission and will aim to visit daily Monday to Friday for updates, to support with meals where possible (9-4:30pm) and to help resolve any issues that may arise. The Eating Disorders Service will also be available by telephone (01267 229700).

If concerns regarding *Name* mood/mental health arise outside of normal office hours, please contact on call psychiatrist or refer to Mental health Liaison team: …..

Eating Disorder Service - Monday to Friday 9am to 5pm - …
Name, Eating Disorders Clinical Lead
Name, Service manager, EDS
Name, Care coordinator

Appendix 11 - Care Planning Guidance

	Intervention	Rationale
Activity	• Bed rest until medically stable • Risk assessment for Tissue Viability • Ensure pressure mattress. • Monitor for signs of compensatory activity (muscle clenching, pacing etc.)	Required in view of compromised state
Fluids	• Input and output to be measured • Consider limiting access to water supply e.g. turn off water supply in room • Be aware of the potential to fluid overload during some aspects of personal care e.g. Teeth brushing, hand washing, going to the toilet.	Often patients drink large amounts of fluid causing dangerous fluid overloading and electrolyte disturbance
Personal Care	• Supervised bathroom use recommended until medically stable. • Consider the use of a commode.	Due to patient's compromised physical state e.g. Low BP and temperature. Also to monitor for abnormal behaviours. A commode will assist in monitoring fluid balance.
Nutrition	• Post-meal supervision for 60 minutes	Required if vomiting and/or other compensatory behaviours are suspected
Leave	• All leave to be agreed between the medical team and EDS	Due to patient's compromised physical state close medical supervision is needed.
Communication	• Consider placing the patient in the bed next to the nursing station • Do not leave weight charts within easy patient access • Ensure regular feedback and MDT liaison Ensure consistency of the nursing boundaries between shifts/care givers.	Observe any abnormal behaviour. Ensure patients feel safe and approaches are consistent.

Appendix 12 - Management of Behaviours

Problem	Consider
Suspected fluid loading (if weight is rapidly increasing)	• Spot weight checks • Consider 24-hour supervision or support for patient • Liaise with EDS for further management strategies
Suspected self-induced vomiting (particularly if weight is not increasing despite compliance with feeding plan)	• Ensure patient is being supervised post meals • Consider 24-hour supervision or support for patient • Liaise with EDS for further management strategies
Patients wishing to negotiate regarding food or fluid intake	• Food and fluid intake is non-negotiable, especially during first 10 days of refeeding • Boundaries should be maintained at all times. • Once the patient is medically stable and consistently gaining weight some aspects of diet plan can be re-negotiated.
Snack or parts of meal are missed	• Replace with ONS as per contingency on meal plan
Patient wanting laxatives	• Check history of laxative misuse and stool chart • Offer education about altered gut function in starvation, and support in tolerating some GI symptoms
Patient is overactive (e.g. pacing or standing up frequently)	• Consider 24-hour supervision/support for patient. • Liaise with EDS for further management strategies. • Wheelchair to be used for mobilising on ward / when leaving ward and to be accompanied by staff. • Consider short (5 min), supervised walks once medically stable.
Patient is tampering with feed, hiding food or pulling feeding tube out	• Consider 24-hour supervision/support for patient • Liaise with EDS for further management strategies

Appendix 13 - Assessment of Musculoskeletal Strength

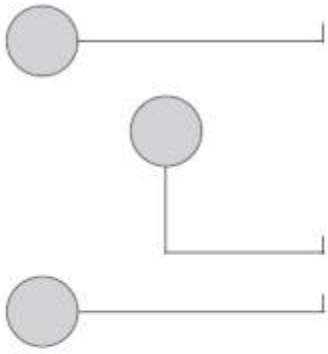
SUSS (Sit-Up / Squat-Stand) test

Part 1: Sit-Up:

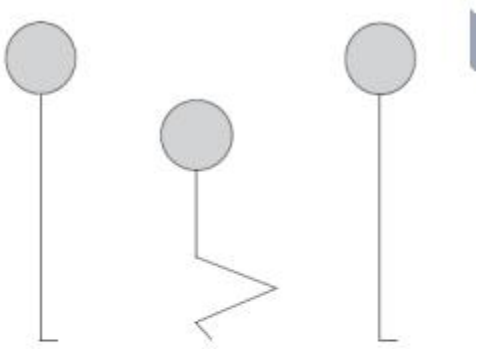
The patient lies flat on a firm surface such as the floor and has to sit up without, if possible using hands (see diagram on the left below)

Part 2: Squat-Stand:

The patient is asked to squat down on haunches and is asked to stand up without using arms as levers if at all possible (see diagram below):



1. Sit-up: patient lies down flat on the floor and sits up without, if possible, using their hands.



2. Squat–Stand: patient squats down and rises without, if possible, using their hands.

Scoring (for Sit-up and Squat–Stand tests separately)
0: Unable
1: Able only using hands to help
2: Able with noticeable difficulty
3: Able with no difficulty

(Robinson, 2009)

Appendix 14 - RISH: Additional Information

Traditionally, those with a **RISH** presentation were categorised under **Atypical AN**, **Other Specified Feeding and Eating Disorder** (OSFED) or **'disordered eating'.**
RISH is a **formulation-driven term** that aims to describe the subset of patients who present with restricted intake (both foods and fluids) as a method of indirect self-harm.
The term RISH was coined following studies driven by child and adolescent psychiatrist Clare Fenton, and further validated by a national working group exploring
research and practice-based suggestions (2025).

RISH is one specific subset of disordered eating. Other disordered eating presentations include neurodivergent eating difference and disordered eating secondary to life events

Treatment Recommendations from RISH Guidance

- Treating RISH as Anorexia Nervosa can cause psychological and medical harm.
- Although not an eating disorder, **MEED guidelines provide a framework** for assessing physical risk.
- Targeted eating disorder treatment delivered by EDS is not recommended as it is more likely to maintain the difficulties.
- Being discharged or declined by EDS can be highly invalidating- sensitive management of assessment process is required.
- Active management of team anxieties and splitting via frequent discussions within the team and inter-team.
- Positive risk taking should be considered.
- Treatment planning should be informed by approaches approved for treating emotional dysregulation, e.g. DBT, CAT, attachment models and systemic frameworks.

See RISH guidance for full details (RESTRICTIVE INTAKE SELF-HARM (RISH) - Practice considerations for the management of RISH across care settings and age)