“Eating Disorders are Everybody’s Business”

Admission and inpatient treatment for youth and adults with eating disorders in Western Australia
Index of contents

Section 1 – Overview
Background, Objectives, General principles of care
Malnutrition, precipitous weight loss and the relevance of starvation syndrome
Refeeding syndrome

Section 2 – Screening and identification
Screening
Emergency Department
Clinician guide for assessing medical risk
Table 1 - Indicators for consideration for psychiatric and medical admission for adults
Weight restoration – rate of increase
Family/carer involvement
Lack of insight regarding need for treatment
Community referral

Section 3 – Management principles
Medical and nutritional management principles
Table 2 – Initial medical management
Table 3 - Ongoing medical management
Table 4 – Admission goals and treatment
Table 5 – BMI-related guide to inpatient management of physical activity

Section 4 – Management Guidelines
Ward management
Nursing management – initial
Nursing management – ongoing
Nutritional management - initial
Table 6 – default 6000kJ oral meal plan
Table 7 – default 6000kJ oral liquid meal plan
Nutritional management – ongoing
Table 8 – Summary of initial nutritional management
Table 9 – Summary of ongoing nutritional management
Mental Health management (including peer support)

Section 5 – Further Guidelines
Weighing
Inpatient leave guideline
Supportive Meal Therapy
Use of 1:1 specials and physical restraint
Criteria for discharge from medical inpatient settings
Management in adult inpatient mental health settings
Management in Community settings

Section 6 - Resources
Local/national and guidelines
Starvation Syndrome handout
Appendix I: ICD-10 diagnostic codes for eating disorders
Appendix II: References
Appendix III: Sample 6000kJ oral meal plan
Appendix IV: Sample 6000kJ oral liquid meal plan
Appendix V: BMI Banding
Clinician guide for assessing medical risk
Acknowledgments

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These guidelines draw heavily on those developed by New South Wales/CEDD, RANZCP and the Royal Brisbane and Women’s Hospital Eating Disorders Outreach Service (RBWH EDOS).

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SECTION 1- OVERVIEW

Background

- Eating disorders comprise a complex group of illnesses that can be life-threatening and can present with a range of serious physical health issues.
- They are also serious mental disorders, often with psychiatric comorbidities.
- Treatment needs to be conducted in a collaborative and compassionate manner.
- Comprehensive physical and mental health assessment is required, regardless of presenting weight. Very underweight people can present initially with no obvious medical instability, while people who are not underweight may be severely medically compromised if they have fasted for a long period and/or lost a large amount of weight within a short time.
- Eating disorders can affect people of all ages. Although the peak onset is in the teens, over half of people presenting with eating disorders are aged over 25. Males are also affected.
- Early intervention and optimisation of nutrition are fundamental to improving outcomes for people with eating disorders.
- The West Australian Eating Disorder Outreach and Consultation Service (WAEDOCS) has been established to build capacity in the identification, assessment and management of eating disorders and to guide health professionals on the best-practice management of youth and adults presenting with an eating disorder. This will be done via provision of training, mentoring, support, clinical consultation and service guidance, to increase clinicians’ skills and confidence to facilitate optimal treatment for all eating disorder patients.

Objectives

The aim of these guidelines is to provide recommendations to assist treating teams to:

- Identify and manage the medical and psychological risks and needs of youth and adults with severe eating disorders.
- Optimise treatment: improving prognosis, shortening illness duration and reducing morbidity and mortality.
- Promote coordinated and integrated care with a smooth transition across medical, mental health, specialist and community services with family involvement whenever possible.

General Principles of Care

- Patients aged ≥16 years presenting for inpatient treatment for a severe eating disorder requiring medical stabilisation will be medically stabilised at their local general hospital.
- Where possible, transfer to a mental health inpatient unit will occur once medical stability has been reached, following collaborative care planning between services and the family.
- Optimal care requires treatment of sufficient duration to reverse the cognitive effects of starvation syndrome. This may necessitate a longer initial length of stay. Early intervention has the potential to reduce length of stay and facilitates engagement with care at a point when cognitions associated with eating disorders are less rigid.
Malnutrition, Precipitous Weight Loss and the relevance of “Starvation Syndrome”

- Malnutrition can occur as an outcome of many physical and mental illnesses across all ages.
- Severe malnutrition and associated “starvation syndrome” can itself cause a number of physical and psychological effects that perpetuate the cycle of insufficient nutrition and impaired self-assessment of nutritional state.
- This ability to accurately self-assess nutritional state and medical risk often improves only as nutrition normalises. Treatment of starvation syndrome is generally required BEFORE people with eating disorders can engage effectively with structured psychological therapies.
- We know from the Keys (1950) starvation study that prolonged malnutrition alone results in:
  - physical symptoms, e.g., reduced body mass and metabolism; hormonal disturbance
  - psychological symptoms, e.g., anxiety, depression, irritability, labile mood, heightened rigidity and obsessional thinking, impaired concentration and decision-making
  - social withdrawal and lack of interest in surroundings
  - preoccupation with food

(See page 44 or http://www.cci.health.wa.gov.au/docs/starvation%20syndrome%20(2).pdf)

- Diagnostic clarity may be difficult at presentation in a malnourished individual. Caution should be exercised in making a definitive diagnosis regarding mental health comorbidities as these may shift with restoration of nutrition.
- Treatment of starvation and optimisation of nutrition may improve physical and psychological well-being in people presenting with malnutrition resulting from many health problems.
- Reassessment following nutritional restoration will enable distinction between those with persistent abnormal cognitions regarding fear of weight gain, suggestive of a primary eating disorder, and those with disordered eating due to other causes.
- Some people may present in the “healthy” weight range but exhibit starvation and other cognitive features of eating disorders, including distorted body image and fear of weight gain (Atypical Anorexia). These individuals may have lost a large amount of weight in a short time (including after bariatric surgery) and may be at high medical risk. Likewise patients presenting with purging behaviours (e.g., self-induced vomiting and/or laxative abuse) may also be at very high risk of adverse medical outcomes, whatever their weight.

- Anorexia Nervosa (AN) is a severe mental illness with serious medical co-morbidities and high risk of mortality as a result of malnutrition and/or purging, and high risk of suicide. A cardinal feature of AN is an intense fear of weight gain which manifests as an intense ambivalence regarding increasing nutrition. Clear and frequent explanations regarding medical risk are an important part of treatment engagement.
- People with AN may exhibit behaviours that appear out of character for them, and perplexing to their families. They often engage in behaviours that appear to be oppositional (e.g., hiding food, pulling out a naso-gastric tube, asking relatives to bring in laxatives) but actually reflect their intense fear of eating and weight regain. These behaviours often reduce with nutritional restoration, provided that the cognitive effects of starvation are also reversed.
- Many individuals with AN carry a vulnerability of genetics and/or temperament (e.g., perfectionism, obsessiveness, anxiety) but the illness can be precipitated by weight loss from ANY cause, including physical ill health or dieting for any reason.
- Many patients with AN can be treated in the community, in conjunction with medical monitoring via a General Practitioner. National / international guidelines suggest admission when BMI falls below 14kg/m², or when other markers of medical instability occur (see Table 1).
Refeeding Syndrome

What is it?
Refeeding syndrome is the potentially fatal shift in fluids and electrolytes that can occur following re-introduction of nutrition in patients who are malnourished from consuming a reduced caloric intake for a prolonged period. It is important to note that this syndrome may not occur in every starved patient, however due to the potential seriousness and its unpredictability, clinicians should be aware that every malnourished patient may be at risk.

How does it develop?
During starvation the body switches from using carbohydrates as its main source of energy to using protein and fat, with the aim of preserving lean muscle mass. There is also depletion of phosphate, potassium and magnesium stores, however the serum concentrations may remain normal. There will also be a reduction in renal excretion. As a result of the starvation state, the cell volume of muscles and various organs such as the heart, brain and liver can decrease.

When carbohydrate or adequate nutrition is re-introduced, the body reverts to using carbohydrate as its main source of energy. This can precipitate fluctuations in insulin levels and associated rebound hypoglycaemia. Minerals (e.g., phosphate, magnesium) and vitamins (e.g., thiamine) are required for normal metabolism of nutritional intake, and as these are taken up into the cells there is a further decrease in their serum levels. The clinical complications of refeeding syndrome include hypophosphataemia, hypokalaemia, hypomagnesaemia, altered glucose metabolism and fluid balance abnormalities, manifesting in the following symptoms:
- Sensory disturbances, confusion (delirium), irritability
- Neuromuscular weakness
- Renal and metabolic disturbances
- Hepatic changes
- Haematological and gastrointestinal problems
- Impaired muscle contraction (including heart, respiratory and gastrointestinal muscles)
- Reduced oxygenation of tissues, ventilation difficulties
- Cardiac arrhythmias
- Cardiac/respiratory arrest
- Untimely death

What are the risk factors for refeeding?

The National Institute for Health and Care Excellence (NICE) guidelines indicate that if a patient displays the following criteria they are at a high risk of refeeding:

| ≥ 1 of: | • BMI less than 16kg/m²  
|        | • Unintentional weight loss greater than 15% within 3 – 6 months  
|        | • Little to no nutritional intake for more than 10 days  
|        | • Low levels of potassium, phosphate or magnesium prior to feeding |
| ≥ 2 of: | • BMI less than 18.5kg/m²  
|        | • Unintentional weight loss greater than 10% within 3 – 6 months  
|        | • Little to no nutritional intake for more than 5 days  
|        | • A history of alcohol abuse or drugs including insulin, chemotherapy, antacids or diuretics |
Refeeding Eating Disorders Safely

Historically clinicians followed the principle of “starting low and going slow”, with the concern that restoring nutrition too quickly could precipitate refeeding syndrome. However it is now generally agreed that this protocol can be counterproductive and lead to “underfeeding syndrome” which is characterised by poor weight gain, further medical deterioration and in some cases even death.

There is emerging evidence that it is possible to refeed more aggressively with a higher initial caloric intake without triggering hypophosphataemia. It should be noted that more research has been done on commencing higher initial caloric intake in adolescents than in adults and this research may not be applicable to adults. It can be inferred that an adult with an eating disorder may have been more severely malnourished for a longer period of time which might place them at a higher risk of refeeding syndrome.

Despite the conflicting evidence it is important to provide nutrition more quickly than has been recommended historically and clinical practice suggests this can be done safely provided there is prophylactic supplementation to prevent hypophosphataemia. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) recommend commencing initial caloric refeeding for adults with an eating disorders at 6000kJ/day (1440kcal/day) and increasing by 2000kJ (480kcal) every 2 – 3 days until adequate intake to meet the patient's needs for weight restoration has been achieved.
SECTION 2- SCREENING AND IDENTIFICATION

Screening for eating disorders

An eating disorder should be screened for if a comorbid condition is present or any physical signs have been detected (See Table 1 below).

The SCOFF is an evidence-based tool to screen for an eating disorder. Two or more positive answers raise the likelihood of an eating disorder and suggest the need for further questioning.

SCOFF
1. Do you ever make yourself Sick because you feel uncomfortably full?
2. Do you ever worry you have lost Control over how much you eat?
3. Have you recently lost Over 6.3 kg in a three month period?
4. Do you believe yourself to be Fat when others say you are too thin?
5. Would you say that Food dominates your life?

Emergency Department

Patients who present to the Emergency Department with a suspected eating disorder should be given the tests outlined below (Table 1) and admitted when indicators are observed. Clinical judgement should be exercised regarding other factors associated with increased risk, such as comorbid substance abuse, Type 1 diabetes, deliberate self-harm and/or suicidal ideation. See below for common presentations and Page 54 for a printable two-page poster assessing medical risk.

Indicators for consideration for psychiatric and medical admission for adults

Patients at risk of medical and/or psychological compromise should be admitted to hospital (immediately if any of the signs listed in Table 1 are present).

- Some people may present in the “healthy” weight range but exhibit starvation and other cognitive features of eating disorders, including distorted body image and fear of weight gain (Atypical Anorexia Nervosa).
- Many people with severe malnutrition/purging present in a compensated state and may not exhibit the full extent of their medical instability at the point of initial presentation; with refeeding they may become more unstable in the first days/weeks of an admission. Because of their intense fear of weight regain, patients may manipulate weight/height measurement, which can result in an artificially high BMI calculation. This can present risks for patients managed in stand-alone mental health units, where 24 hour medical monitoring/management may not be available. This is another reason that BMI should never be the sole measure of medical stability.
- WAEDOCS recommends that all patients requiring admission are initially admitted medically for assessment and stabilisation, with in-reach support by Mental Health teams and guidance from WAEDOCS.
- Simply attaining BMI >14kg/m² or stabilisation of medical parameters does NOT constitute criteria for discharge from a medical OR mental health setting. Those requiring admission for severe malnutrition should continue nutritional rehabilitation as inpatients until tolerating full oral diet without need for supervision or use of compensatory strategies.
Could your patient have an Eating Disorder?
WAEDOCS Clinicians Guide for Assessing Medical Risk

**General**
- Hypothermia
- Dehydration
- Collapse
- Cyanosis of the extremities
- Perihepal oedema

**Have you measured?**
- Weight
- Height
- BMI (=weight + height²)
- HR/BP (postural)
- Temperature

**Evidence of Starvation**
- Weight loss
- Hypotension
- Malnourished
- Underweight
- Early satiety

**Central Nervous System (CNS)**
- Poor insight
- Irritability
- Cognitive rigidity
- Impaired cognition
- Preoccupation with food / bowels
- Delirium
- Seizures

**Cardiovascular (CVS)**
- Postural tachycardia
- Hypotension
- Bradycardia
- Arrhythmias +/- prolonged QTC interval
- Cardiac failure

**Gastrointestinal / Renal / Hepatic**
- Recurrent vomiting / purging
- Oesophageal tears
- Abdominal distension
- Constipation / Diarrhoea
- Rectal prolapse
- Chronic renal impairment, stones
- Liver impairment

**Skeletal**
- Osteoporosis / Non-union fractures
- Bone pain / deformity
- Muscle weakness

**Integumentary System**
- Dry skin
- Brittle nails
- Dry hair
- Lanugo
- Dorsal finger callouses (Russel's sign)

**Ear, Nose, Throat (ENT)**
- Dental caries
- Gingivitis
- Parotid enlargement

**Respiratory**
- Pneumonia
- Effusions

**Haematological**
- Hypokalaemia
- Anaemia
- Neutropenia
- Deranged electrolytes / LFTs

**Note:** Signs and symptoms above in bold are the most common indicators.
**Table 1. Indicators for consideration for psychiatric and medical admission for adults**  
RANZCP Clinical Practice Guidelines for the Treatment of Eating Disorders (2014)

<table>
<thead>
<tr>
<th>Psychiatric or Medical Admission a</th>
<th>Acute Medical Admission b</th>
<th>Indicated (level of acuity can usually be managed in either setting)</th>
<th>Is Required (level of acuity usually requires a medical ward)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid weight loss</td>
<td></td>
<td>Rapid weight loss (i.e. 1kg/week over several weeks) or grossly inadequate nutritional intake (&lt;100kcal daily) or continued weight loss despite community treatment</td>
<td></td>
</tr>
<tr>
<td>Re-feeding Risk</td>
<td></td>
<td>High (if markers below are present)</td>
<td>Extreme (if the markers below are present)</td>
</tr>
<tr>
<td>Systolic BP</td>
<td>&lt;90 mmHg</td>
<td>&lt;80 mmHg</td>
<td></td>
</tr>
<tr>
<td>Postural BP</td>
<td>&gt;10 mmHg drop with standing</td>
<td>&gt;20 mmHg drop with standing</td>
<td></td>
</tr>
<tr>
<td>Heart rate</td>
<td></td>
<td>&lt;40 bpm or &gt; 120 bpm or postural tachycardia &gt; 20 beats/min</td>
<td></td>
</tr>
<tr>
<td>Temperature</td>
<td>&lt;35.5°C or cold/blue extremities</td>
<td>&lt;35°C or cold/blue extremities</td>
<td></td>
</tr>
<tr>
<td>12-lead ECG</td>
<td></td>
<td>Any arrhythmia including QTc prolongation, nonspecific ST or T-wave changes including inversion or biphasic waves</td>
<td></td>
</tr>
<tr>
<td>Blood sugar</td>
<td>Below normal range*</td>
<td>&lt; 2.5 mmol/L</td>
<td></td>
</tr>
<tr>
<td>Sodium</td>
<td>&lt;130 mmol/L*</td>
<td>&lt;125 mmol/L</td>
<td></td>
</tr>
<tr>
<td>Potassium</td>
<td>Below normal range*</td>
<td>&lt;3.0 mmol/L</td>
<td></td>
</tr>
<tr>
<td>Magnesium</td>
<td>Below normal range*</td>
<td>Below normal range*</td>
<td></td>
</tr>
<tr>
<td>Phosphate</td>
<td>Below normal range*</td>
<td>Below normal range*</td>
<td></td>
</tr>
<tr>
<td>Albumin</td>
<td>Below normal range</td>
<td>&lt;30 g/L</td>
<td></td>
</tr>
<tr>
<td>Liver enzymes</td>
<td>Mildly elevated</td>
<td>Markedly elevated (AST or ALD &gt;500)*</td>
<td></td>
</tr>
<tr>
<td>Neutrophils</td>
<td>&lt;1.5 × 10⁹/L</td>
<td>&lt;1.0 × 10⁹/L</td>
<td></td>
</tr>
<tr>
<td>eGFR</td>
<td></td>
<td>&lt;60ml/min/1.73m² or rapidly dropping (25% drop within a week)</td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td>Body Mass Index (BMI) &lt;16kg/m²***</td>
<td>Body Mass Index (BMI) &lt;14kg/m²***</td>
<td></td>
</tr>
<tr>
<td></td>
<td>BMI &lt;14kg/m² (&gt; 85% ideal body wt 16-18yrs)</td>
<td>BMI &lt;12kg/m² (&gt;85%ideal body wt 16-18yrs)</td>
<td></td>
</tr>
<tr>
<td>Risk assessment</td>
<td>- Suicidal ideation; Active self-harm; Moderate to high agitation and distress</td>
<td>- Other psychiatric condition requiring hospitalisation</td>
<td></td>
</tr>
<tr>
<td>Severe ED symptoms</td>
<td>- Bulimia Nervosa with hypokalaemiaand/or without control of vomiting; Vomiting &gt;4 times daily</td>
<td>- Excessive daily laxative use</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>- Not responding to outpatient treatment</td>
<td>- Aversive family relationships or severe family strain or stress</td>
<td></td>
</tr>
</tbody>
</table>

**Starvation Syndrome can occur at any weight therefore weight should not be the deciding factor for admission location or use of the Mental Health Act.**

**a** Patients who are not as unwell as indicated above may still require admission to a psychiatric or other inpatient facility.

**b** Medical admission refers to admission to a medical ward, short stay medical assessment unit or similar.

**c** Any biochemical abnormality which has not responded to adequate replacement within the first 24 hours of admission should be reviewed by a medical registrar urgently

**c** This additional information is taken from NSW Health/CEDD Guideline for Inpatient Management of Eating Disorders in General Medical and Psychiatric Setting in NSW (2014).
Weight restoration – rate of increase and goal

Research is currently limited regarding the appropriate amount of weight gain for best outcome in the treatment of eating disorders, therefore most guidelines have been based on clinical experience.

People with AN need a higher energy intake to promote weight gain as their rest energy expenditure can be greatly increased during refeeding. Some literature suggests that a rate of weight regain of more than 0.8kg/week during an inpatient stay is associated with better outcomes and higher energy intakes have resulted in a reduced length of stay. WAEDOCS recommends aiming for 1 to 1.5kg weight restoration per week for undernourished patients.

Family/carer involvement

- Involve the patient’s family whenever possible, as families can be a valuable resource for both patients and clinicians. Parents/carers/family members are typically the people with the highest dedication to and investment in the patient, and are the clinicians’ best ally.
- Understand that supporting a loved one with an eating disorder can be highly distressing and confusing, leaving family members feeling afraid, frustrated and guilty. This anxiety can be easily misunderstood as negative or harmful, so make sure you do not judge the family members(s) just because they are showing signs of severe stress.
- Involving family members at admission can be beneficial. Listen carefully to the people who are close to the patient and interview them in a caring, compassionate and non-judgemental way. You may gather vital information/history that the patient has not told you, or that provides a perspective different from that which the patient has given. Appreciate that patients with eating disorders, because of their lack of insight, often provide contradictory reports and are angry at family members.
- Provide family members with full information/rationale regarding the treatment process.
- Make sure families are given some basic psycho-education about eating disorders and starvation, especially if they are new to dealing with an eating disorder. They may not have understood the severity and complexity of the mental and physical aspects of the illness. Once included in the treatment process and reassured that they are not to blame, family members come on board as support and company for the patient. This can ease the burden on clinical staff and may lead to better outcomes.
- Up-skill family members regarding provision of meal support, since upon discharge their support becomes pivotal. This is particularly relevant when a patient is young, but even adult patients will require a period of encouragement, validation and homecare from partners, family or people close to them.
- Collaborating with and involving parents/carers/family members in the development of discharge and relapse prevention plans will enable family to provide their loved one with necessary support upon discharge.
Lack of Insight Regarding Need for Treatment

There are occasions where the patient is severely ill with a potentially life-threatening condition, and refusing medically necessary care. Where a person’s judgement and illness are thought to be impaired secondary to their eating disorder, it may be necessary to use the Mental Health Act.

Any registered medical practitioner or authorised mental health practitioner can complete a Form 1A Referral for Assessment by a Psychiatrist. The referral destination may be a general medical hospital if initial medical stabilisation is required. Given the potential impact of acute medical morbidity on decision-making, it is suggested that General Practitioners contact their local hospital and ask to be put through to the Mental Health Acute Care Team for advice and assistance with using Mental Health Act 2014.

A psychiatrist can determine if the person should be detained under the Mental Health Act 2014 for further treatment by completing Form 6A Inpatient Treatment Order in an Authorised Hospital or Form 6B Inpatient Treatment Order in General Hospital, which is valid for a period of up to 28 days and can be extended. Weekly reports must be provided to the Chief Psychiatrist (or delegate) regarding the patient’s status and treatment provided.

To be considered for involuntary treatment, a person must meet all of the criteria:

1. “The person is experiencing a mental illness for which the person is in need of treatment”
   Eating disorders are mental illnesses.

2. “Because of the mental illness there is a significant risk to health and safety / or a significant risk of harm to the person”
   Eating disorders have a mortality of up to 20%. People with AN have the highest mortality rate of any psychiatric condition, predominantly as a result of malnutrition and suicide, The RANZCP clinical guidelines for the treatment of eating disorders recommend immediate inpatient treatment if any of the criteria in Table A are met in relation to a suspected or diagnosed eating disorder or malnutrition.

3. “The person does not demonstrate that they have the capacity to make treatment decisions”
   Generally treatment for people with eating disorders should be based upon collaborative, person-centred decision-making, where safe, empirically supported treatment options are discussed with the individual and their family. However, the Minnesota Semi-starvation Study (Keys 1950) demonstrated that loss of 25% of body weight led to profound cognitive changes in all subjects, including obsessive preoccupation with food and eating, with loss of perspective and insight. These changes were only reversed when weight was restored.

   The WA Department of Health Consent Policy (2011) defines capacity as “the extent to which a person is able to make reasonable judgements about their treatment and personal welfare”. Additional information regarding assessment of decision-making capacity is available within the Clinician’s Guide to the Mental Health Act 2014:

4. “There is no less restrictive way to provide the treatment that the person needs”
   People with eating disorders exhibit cognitive distortions regarding perception of their body and the need for nutrition. Thus they may acknowledge a need for treatment but struggle to engage consistently with treatment and/or engage in use of compensatory measures.
Inpatient admission for medical monitoring during supervised nutritional restoration and reversal of the effects of starvation syndrome is a key component of treatment for many people with severe eating disorders.

Assessment of decision-making with respect to setting and restriction of care should take into account an individual’s ability, or lack thereof, to engage safely with treatment in that setting. As insight and decision-making often improve with nutrition, the need for ongoing use of the mental health act should be regularly reviewed, recognising however, that the cognitive effects of starvation syndrome can persist well beyond the physiological effects and can perpetuate ambivalence regarding engagement with treatment.

People with particularly complex or severe illnesses may be appropriate for care under a Community Treatment Order following a period of inpatient nutritional restoration. The aim of this is to enable close monitoring for deterioration and re-engagement with physical and mental health care at the earliest opportunity to improve outcome.

All involuntary persons must have access to mental health advocacy services as per the 2014 Mental Health Act.


**Community Referral**

- Where patients have a BMI >16kg/m², are medically and psychologically stable and a hospital admission is not indicated, they should be referred to their GP for support to improve nutrition to BMI > 18kg/m². Regular monitoring for physical and psychological morbidity associated with eating disorders is strongly recommended, aiming to facilitate early medical assessment and / or inpatient admission in the event of clinical deterioration.
- Referral to an specialist eating disorder service is recommended if available locally or the patient is located in the Perth metropolitan area - e.g., Hollywood Private Hospital (if privately insured) or Centre for Clinical Interventions (CCI). It should be noted that the waitlist for structured psychological therapy through CCI can be up to 6 months, and an interim plan for community follow-up may be required. WAEDOCS can assist with education for private and community psychologists regarding supporting people with eating disorders.
- For those people unable to access CCI, there are online workbooks designed as self-help resources: http://www.cci.health.wa.gov.au/resources/infopax.cfm?Info_ID=48 which can also be worked on with a clinician. In the absence of specialised resources, multidisciplinary coordinated community care should be instituted via collaboration between their General Practitioner, dietitian and/or the local Mental Health team with input from other medical specialists, psychological and health professionals as required and as available.
- Exploration of the person’s ability to self-assess risk and capacity to engage with further treatment should also form part of the risk assessment and should inform decision-making regarding setting of care and / or need for assertive follow-up.
SECTION 3- MANAGEMENT PRINCIPLES

Medical and Nutritional Management Principles

The goals of inpatient treatment include (in the following order):

- Medical stabilisation
- Prevention and treatment of re-feeding syndrome
- Safe nutritional and weight restoration
- Reversal of cognitive effects of starvation prior to outpatient psychotherapy

A comprehensive patient assessment should be conducted including history of recent nutritional diet, current BMI and a risk assessment for re-feeding syndrome.

Re-feeding syndrome can be defined as the occurrence of severe fluid and electrolyte shifts and their associated complications in malnourished patients undergoing feeding. Careful patient monitoring is required when reinstituting nutrition to patients who are starved or severely malnourished.

To minimise the risk of Refeeding:

- The patient will require daily medical monitoring for at least the first 7-10 days of re-feeding
- Supplement and correct any electrolyte and vitamin deficiencies (min of 10 days). In addition, all patients should receive:
  - Thiamine 300mg OD daily
  - Vitamin B complex 1 tablet OD
  - Multivitamin and Mineral 1 tablet OD
  - Phosphate- Sandoz 500mg BD daily
- On admission obtain bloods for FBC, U&E’s, LFT’s, Ca^{2+}, PO_{4}, Mg^{2+}, B12 / folate and other investigations as indicated by clinical findings.
- Daily monitoring of electrolytes and mineral levels and replace deficiencies until goal energy intake is reached.
- ECG on admission and continue daily until goal energy intake is reached.
- BSLs QID (1-2 hours post prandial irrespective of feeding route) and 0200. Low glycogen stores and an abnormal insulin response may lead to low morning, overnight and post meal BSLs and are associated with an increased risk of cardiac arrhythmia.
- Hypoglycaemic episodes often occur in the early re-feeding stage of severely malnourished clients. Low BGLs (<4.0mmol/l) should be managed according to the 2012 Australian Commission on Safety and Quality in Health Care User Guide to National Insulin Subcutaneous Order and Blood Glucose Record: Adult
  [http://www.safetyandquality.gov.au/wp-content/uploads/2012/06/National-Subcutaneous-Insulin-Pilot-Project-Insulin-Form-User-Guide.pdf](http://www.safetyandquality.gov.au/wp-content/uploads/2012/06/National-Subcutaneous-Insulin-Pilot-Project-Insulin-Form-User-Guide.pdf) However, in view of the risk of excess simple carbohydrate precipitating re-feeding syndrome and rebound hypoglycaemia in these patients secondary to inadequate glycogen stores, wherever the above document recommends giving a fast acting carbohydrate, a slow acting carbohydrate (e.g. One of the following: Tetrapak of Ensure Plus /glass of milk and crackers) should be given in addition at the same time.
- If rehydration is required, refrain from using IV Dextrose to minimise rebound hypoglycaemia
**Safe Nutritional Restoration**

- The route of nutrition restoration will depend on medical stability and BMI. Consult the facility dietitian for safest route.
- Initial continuous enteral feeding is indicated if:
  - Severely medically unstable regardless of BMI OR
  - Unable to tolerate any oral diet OR
  - Medical co-morbidities complicated by an eating disorder OR
  - BMI <13.5kg/m²

- However the patient may be able to commence oral diet or a combination of oral diet if:
  - Medically stable AND
  - Able to tolerate any oral diet AND
  - BMI >13.5kg/m²

- The patient should be commenced on a 6000kJ/day enteral feeding

**BMI Banding**

- There are different ways to demonstrate nutrition restoration including monitoring the patient's weight, however discussing weight with a patient is not encouraged as it can be a source of distress for the patient and continue to drive eating disorder behaviours.
- Weight as an absolute marker of nutrition restoration should be used in combination with other parameters such as BSL, laboratory results and general observations. Weight can, however, be affected by other factors such as fluid shifts and be misinterpreted by the patient.
- A suggested and possibly more sensitive marker is to use “BMI banding”.
- It generally takes about 3 weeks to increase a patient’s BMI by 1 band.
- Feedback regarding the patient’s weight must not include actual numbers, but rather include information regarding the clients “BMI range”.
- There are 3 ways of giving feedback to the patient regarding BMI range:
  1. **“Steady / Stable”**
     - The patient’s weight has remained in the current BMI range.
     - The patient’s weight has gone above / below the current range but only once.
  2. **“Moved Up”**
     - Patient’s weight has been above the previous BMI range for two consecutive weights.
  3. **“Moved Down”**
     - The patient’s weight has been below the previous BMI range for two consecutive weights.

For a printable version of the BMI banding for the patient’s nursing file, please see Appendix V.
Table 2. Summary of Initial Medical Management  
(A Guide for the First 24 Hours after Initial Presentation)

<table>
<thead>
<tr>
<th>Medical Parameters</th>
<th>Pharmacological Measures</th>
<th>Nutritional Management</th>
<th>Starvation Syndrome</th>
</tr>
</thead>
</table>
| Reduce the risk of refeeding with daily medical monitoring | Commence daily supplementation:  
  - 300mg Thiamine OD  
  - 1 Multivitamin & Mineral Supplement OD  
  - 1 B Complex Supplement OD  
  - 500mg Phosphate Sandoz BD | Route of Nutrition Restoration will depend on medical stability and BMI. Consult the facility dietitian | Occurs when there has been a restriction in energy intake and / or precipitous weight loss. Signs include:  
  - Physical Symptoms, e.g., loss of body mass, lowered metabolism, hormonal disturbance, “fullness” on eating  
  - Psychological symptoms e.g., anxiety, depression, irritability, labile mood, heightened rigidity and obsessional thinking, impaired concentration and decision-making  
  - Social withdrawal & lack of interest in surroundings  
  - Preoccupation with food | Provide patient / family with a Handout on Starvation Syndrome available from CCI Website |
| Monitor the following blood tests  
  - U+E / Mg²⁺ / PO₄ (daily)  
  - FBP / B12 / folate / Ca⁺²  
  - Other investigations as indicated by clinical findings | Replace potassium and magnesium levels once refeeding commenced if below acceptable range | Initial continuous NGT feeding is indicated if:  
  - Medically unstable regardless of BMI  
  - Unable to tolerate any oral diet  
  - Medical co-morbidities complicated by an eating disorder (ED)  
  - BMI <13.5kg/m² |  
  OR  
  OR  
  OR  
  OR  |
| QID Observations including lying & standing heart rate and BP | | May be able to commence oral diet or a combination of oral diet and enteral feeding if:  
  - If medically stable  
  - Able to tolerate oral diet  
  - If BMI >13.5kg/m² |  
  AND  
  AND  |
<p>| ECG on admission | | | |
| BSLs QID (1-2 hrs. post prandial irrespective of feeding route ) and 0200 | | | |
| Manage any hypoglycaemic events. Low BGLs (&lt;4.0mmol/l) should be managed according to The 2012 Australian Commission on Safety and Quality in Heath Care User Guide to National Insulin Subcutaneous Order and Blood Glucose Record: Adult or facility protocol then a slow acting carbohydrate (e.g., One of: 200ml Tetrapak Ensure Plus or 250ml glass milk and 3 crackers) should be given in addition at the same time. | | | |
| If rehydration required refrain from using IV Dextrose to minimise rebound hypoglycaemia | | | |</p>
<table>
<thead>
<tr>
<th>Medical Parameters</th>
<th>Pharmacological Measures</th>
<th>Nutritional Management</th>
<th>Starvation Syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue daily monitoring of electrolytes and mineral levels and replace deficiencies until goal energy intake is reached or for at least 7 – 10 days post commencement of nutrition rehabilitation</td>
<td>Continue supplementation until refeeding syndrome risk has resolved:</td>
<td>Continue to progress with nutrition rehabilitation with the assistance of the facility dietitian.</td>
<td>The signs of Starvation Syndrome will continue to improve with ongoing nutrition rehabilitation</td>
</tr>
<tr>
<td></td>
<td>o 300mg Thiamine OD</td>
<td>• If NGT feeding was indicated, consider moving to a transitional regime (a combination of oral and enteral feeding) if:</td>
<td>Cognitive effects of Starvation Syndrome are unlikely to resolve completely during admission (insight and judgement may fluctuate re: need for further treatment).</td>
</tr>
<tr>
<td></td>
<td>o 1 Multivitamin &amp; Mineral Supplement OD</td>
<td>o Refeeding syndrome risk has resolved AND  AND Medically stable &gt;48 hours AND Able to tolerate oral diet AND Resolving cognitions related to starvation syndrome AND BMI &gt;13.5kg/m²</td>
<td>Starvation Syndrome needs to be substantially improved before the patient can successfully engage in structured psychological treatment (ideally BMI &gt;16kg/m²)</td>
</tr>
<tr>
<td></td>
<td>o 1 B Complex Supplement OD</td>
<td>If a transitional regimen was commenced, aim for full oral diet +/- nutritional supplements (i.e. 3 meals, 3 snacks and 3 nutritional supplements per day (or individualised protocol after discussion with facility dietitian or WAEDOCS).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o 500mg Phosphate Sandoz BD</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Replace potassium and magnesium levels if below acceptable range</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>--------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue daily ECG</td>
<td>--------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue QID Observations including lying &amp; standing heart rate and BP</td>
<td>--------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue BSLs QID (1-2 hrs. post prandial irrespective of feeding route) and 0200</td>
<td>--------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue to manage any hypoglycaemic events. Low BGLs (&lt;4.0mmol/l) should be managed according to The 2012 Australian Commission on Safety and Quality in Health Care User Guide to National Insulin Subcutaneous Order and Blood Glucose Record: Adult or facility protocol then a slow acting carbohydrate (e.g. One of the following: 200ml tetrapak Ensure Plus or 250ml glass of milk and 3 crackers) should be given in addition at the same time.</td>
<td>--------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4. Admission Goals and Treatment

This guidance is to ensure consistency and transparency in line with goals and tx, to optimise nutritional and psychological recovery. Starvation affects insight, decision making and ability to engage with treatment. Reversal of starvation should therefore be the key intervention. If the Mental Health Act (MHA) is required, WAEDOCS recommend the patients remain in hospital until their BMI reaches 18.

### Acutely Medically Compromised

<table>
<thead>
<tr>
<th>Clinical Recommendations / Treatment</th>
<th>Observe For</th>
<th>Recommended Destination</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medically unstable regardless of BMI (WAEDOCS Clinician’s Guide)</td>
<td>• Cardiac arrhythmias</td>
<td>• Medical Admission with Psychiatric input</td>
</tr>
<tr>
<td>• Unable to tolerate any oral diet</td>
<td>• Thromboembolism</td>
<td></td>
</tr>
<tr>
<td>• Medical co-morbidities complicated by eating disorder</td>
<td>• Re-feeding Syndrome</td>
<td></td>
</tr>
<tr>
<td>• Or BMI &lt;13.5kg/m²</td>
<td>• Skin integrity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• High falls risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Distress / use of compensatory behs</td>
<td></td>
</tr>
</tbody>
</table>

### Progressing Towards Medical Stability

<table>
<thead>
<tr>
<th>Clinical Recommendations/ Treatment</th>
<th>Observe For</th>
<th>Recommended destination</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Commence oral diet however may still require a combination of NGT feeding and oral diet (See WAEDOCS Dietetic Guidelines)</td>
<td>• High falls risk</td>
<td>• Option of either medical or psychiatry admission</td>
</tr>
<tr>
<td>• Meal supervision for 60 mins after meals, 30 mins after snacks; may need close supervision to contain compensatory behaviours (purging/excessive exercise)</td>
<td>• Hypoglycaemic rebound</td>
<td></td>
</tr>
<tr>
<td>• Limited supervised physical activity (See WAEDOCS guidelines for physical activity)</td>
<td>• Dizziness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Weight loss</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Compensatory strategies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Distress / self harm ideation secondary to nutritional gain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Medical Admission with Psychiatric input</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Consider Psych ward</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Work towards discharge to community setting (if tolerating full oral diet and eating disorder cognitions manageable)</td>
<td></td>
</tr>
</tbody>
</table>
Table 5. BMI-related Guide for inpatient management of physical activity

Decisions for physical activity should be agreed upon by the Multi-Disciplinary Team and patient/carer, considering individual patient’s nutritional reserves and their ability to tolerate suggested activities. This guide should be utilised in conjunction with WAEDOCS Inpatient Leave Guidelines.

<table>
<thead>
<tr>
<th>BMI Band</th>
<th>Recommended Physical Activity</th>
<th>Criteria for physical activity</th>
<th>Associated risk factors</th>
</tr>
</thead>
</table>
| BMI <13.5kg/m² | • Bed rest recommended (toilet privileges will be dependent upon medical stability) | • Medical stabilisation is overriding priority (high risk of cardiac arrhythmias / sudden death) | • Thromboembolism  
• Muscle wasting/contractures  
• Refeeding Oedema  
• Skin integrity  
• High falls risk (↓ BP, Muscle wasting) |
| BMI 13.5 – 15kg/m² | • Lying and sitting exercises (gentle stretches) 5 mins 2x daily  
• Toilet privileges  
• Seated showering 1x per day  
• Gentle walk 10 mins 1x daily within ward (if medically stable) | Supervised - Medical stability for 7 days  
• Blood Pressure ≥ 90  
• Heart Rate ≥ 50 and no significant postural tachycardia (i.e., <20bpm)  
• Blood Sugar Levels ≥4  
• Electrolytes in normal range  
• Consuming 100% of nutrition  
• Efforts to reduce compensatory behs | • High falls risk (↓ BP, Muscle wasting)  
• Hypoglycaemic rebound  
• Dizziness  
• Weight loss |
| BMI 15 – 17kg/m² | • Non aerobic stretch and tone exercises (5 mins 2x daily)  
• Toilet privileges  
• Showering 1x per day  
• Gentle walk 10 min 2x daily within ward environment | Supervision - dependent on ability to self-manage compensatory behaviours  
• Medical Stability  
• Assessment of muscle strength  
• Walking with defined purpose, not pacing | • Dizziness  
• Falls risk (↓ BP)  
• Joint stiffness  
• Muscle tears/stress  
• Fractures  
• Weight loss |
| BMI >17kg/m² | • No aerobic exercise until BMI> 19kg/m²  
• Gentle walking (10 mins 3x / daily) off ward or  
• Mindful exercises - Yoga, Gentle Pilates, Tai Chi, (max 20 mins daily)  
• Independent showering 1x daily | Unsupervised in preparation for discharge  
• Medical stability  
• Walking with a defined purpose (wandering, pacing not permitted). | • Dizziness  
• Falls risk (↓ BP)  
• Dehydration  
• Joint stiffness  
• Injuries to muscle, joints, tendons, ligament  
• Stress fractures  
• Weight loss |

Adapted from 1. Physiotherapy Guidance Notes for Exercise and Physical Activity in Adult Patients with Anorexia and Bulimia Nervosa  
Judith Bentley, MSc, MCSP, Patricia Caddy, MCSP, Lynn Hammond, MCSP, Yvonne Hull, MCSP, Maggie Ward, MCSP (2011) 2.Royal Brisbane and Women’s Hospital- A guide to admission and inpatient treatment for people with eating disorders at the Royal Brisbane and Women’s Hospital  
SECTION 4 – MANAGEMENT GUIDELINES

Ward Management - Initial

Eating disorders are complex illnesses affecting both physical and mental health. Starvation syndrome can occur at any weight as a result of calorie restriction and can affect insight and body perception. Associated rigid beliefs around food and eating worsen as nutrition deteriorates; making it difficult for people to assess their own health risks or recognize the need to engage with treatment.

Improving outcomes for people with Eating Disorders requires sufficient treatment for reversal of the effects of starvation syndrome, by increasing calorific intake and containing compensatory behaviours, before addressing the psychological aspects. For people with more severe illnesses, this may require lengthy inpatient treatment to reverse starvation syndrome such that outpatient treatment can continue successfully.

Goals of Care

The goals of care in the medical inpatient setting are:

- Medical stabilisation: provide safe initial medical management
- Prevention and treatment of re-feeding syndrome: providing close ongoing medical monitoring for emergence of physical health complications related to malnutrition or re-feeding.
- Nutritional and weight restoration with the goal of reversing cognitive effects of starvation syndrome; if possible via oral diet alone without need for direct supervision at meal times by the time of discharge.

Additionally:

- Introduce best-practice psychoeducation for patient and family / carers regarding eating disorders and their management
- Commence collaboration with mental health unit or community care team regarding discharge planning

All patients admitted to medical wards should receive assessment by the local consultant liaison psychiatric (C/L) team. WAEDOCS can also provide ongoing advice and support to the treating medical team as required.

The local C/L team and/or WAEDOCS should ensure adequate regular and frequent support is provided to the medical team to assist them with behavioural and psychological management.

WAEDOCS can be contacted to provide advice and support for the medical and C/L team via face-to-face meetings or by tele/video-conference.

Recommendations

- A consistent multi-disciplinary team (MDT) approach is essential to minimise the potential for “splitting” between the patient and individual members of the team.
- Weekly MDT meetings, where plan of care is agreed upon (no negotiation between these meetings unless medically indicated). The patient should be present to voice their perspective and be included in collaborative decision-making where possible. Parents/other family members should be invited (with the patient’s permission if aged ≥18), especially if the patient is living with them.
• A clear plan for the purpose of admission and identification of medical risk factors will assist both the patient and health professionals to understand restrictions that may be put in place e.g. physical activity allowances.

• Collaborative, transparent and non-judgemental application of the care plan involving the patient and, wherever possible and appropriate, the family will be most successful.

• Where possible, a core group of experienced nursing staff should manage these patients.

• Patients with eating disorders require a consistent, understanding, non-judgmental, and non-punitive approach to management. They often elicit intense negative reactions from staff. Opportunities for debriefing, discussing adherence to the care plan and strategies for distress tolerance techniques for staff and patient need to be readily available.

• Limiting activity on the ward is important from time of admission as it is harder to enforce as admission progresses (See Table 5: BMI related guidelines for inpatient management of physical activity in patients).
  ▪ The amount and frequency of activity should be clearly identified and time limits applied.
  ▪ The amount of activity can be increased with weight restoration, and should be reduced if there is weight loss or lack of progress.
  ▪ Consider a referral to ward physiotherapist for low impact activities such as yoga stretches instead of walking

• Supervision is a priority at all times. Any unobserved time, including time in bathroom and shower, may be used for “eating disordered” behaviours to compensate for food ingestion, e.g., purging food or exercise (including excessive fidgeting or moving about whilst on bed rest; sit-ups etc.). When supervision is limited, locating the patient as close to the nurses’ station as possible is ideal (supervision and bed rest is strongly advised post-meal as outlined in nursing management).

• On admission, and preferably with patient consent search belongings for laxatives, diuretics, diet pills, chewing gum, water bottles, and small weights. This is to be repeated after any leave from the ward.

• A behavioural management plan for each patient may be created outlining specific guidelines regarding activity, level of observation, access to bathroom, challenging behaviours (purging, tampering with nasogastric feeds, incidental exercise etc.), meal support, helpful/unhelpful phrases and leave arrangements etc.

• It is important for staff to be aware and sensitive to families and carers, as this is a highly stressful and often distressing experience for all involved. Families often benefit from education regarding the medical management of malnutrition and starvation syndrome, and frequent updates on the treatment plan. Communication must be consistent (so it should be established early in the admission, who in the team will deliver this).

**Ward Management - Ongoing**

• Focus should remain on achieving medical and physical stability.
• Continue to improve nutritional status and weight restoration towards healthy levels.
• Goal of reversing the cognitive effects of starvation prior to outpatient psychotherapy.
Nursing Management - Initial

Nursing staff play a key role in the management of people with eating disorders and are a major source of support and encouragement during the difficult process of early nutritional rehabilitation. Agreed care plans need to be delivered with compassion and firmness regarding non-negotiables, in a non-punitve, non-judgemental manner.

Trust may take some time to establish, as eating disorders can cause people to act in a manner not in keeping with their usual values. Distress in eating disorder patients is common, as their avoidance of nutrition is directly challenged and they are often terrified of rapid weight gain. Behaviours such as restricting and purging may have emerged as a means of regulating or “numbing” unpleasant emotional states. New skills and strategies for tolerating and managing distress/anxiety may need to be taught to the patient.

Some patients require frequent reminders that the aim of nutritional support is to reduce the risk of medical harm, as memory/cognition are both affected after starvation and the eating disorder may drive unhelpful beliefs that the medical risk is lower than it really is.

The management of the family is important during this stressful time. Families will require detailed information and frequent updates, wherever possible with an outline and rationale for the care plan and the clinical milestones needed. Establish who in the team will be responsible for this. It can be helpful for a family member to attend a portion of ward round each week to reduce “splitting”. It will be natural for the family to be sympathetic to appeals from their loved one for an alteration in treatment plan. Consistency of staff approach and clear agreement of the care plan across all disciplines is essential.

Suggested Nursing Management Plan

No leave off the ward due to medical risk.

Observations:

- **Blood pressure and pulse** QID lying & standing. Staff should notify RMO if:
  - Pulse is below 50bpm,
  - Systolic BP below 90 or if:
  - Significant postural drop of more than 10mmHg or postural tachycardia > 20 bpm
  - Temp below 35.5c
- BSL’s QID (1-2 hours after meals - risk of hypoglycaemic rebound; glycogen stores and abnormal insulin response may lead to post meal low BSL’s and low BSL’S morning and night) early morning and 2 am
- Treat blood glucose levels of <4.0mmol/l as per Medical Management.
- Daily ECG to observe for cardiac instability (increased QT interval and / or other arrhythmias)
- Patient requires full bed rest if medically unstable
- Accurate assessment of the patient’s nutritional status and eating behaviours:
  - **Weight**: Measure and record weight & urine specific gravity the morning after admission at 6.30am after voiding, and repeat as per individual management plan determined by the treating team, using the same set of scales for each weight measure (Do NOT tell the patient their weight as day to day fluctuations can cause anxiety and drive compensatory behaviours. They can be informed of their BMI band – see Page 12.)
  - **Height**: should be recorded accurately as soon after admission as possible, without shoes, feet flat on the floor with patient standing at full height
  - **Bowel chart**: record bowel activity (or lack of) daily as patient will have reduced gut motility
**Nutritional intake:** Record all offered food & fluids as well as all consumed intake including fluids. Check all meals against the meal plan: patient should only be allowed to choose food items from the meal plan at this stage; see nutritional management plan.

- Request family members to assist with the management plan, by NOT bringing in food, diet drinks/lollies and medications (as these may have a laxative effect) from home or allowing patient to exercise.
- Monitor and contain eating disorder behaviours:
  - **Visual observations** - minimum frequency 15 minute intervals. It is often more effective, particularly on medical wards, to provide 1:1 constant supervision. Shared room versus single room to be decided on an individual basis.
  - **Toilet needs** - must be attended prior to meals. If not on 1:1 special, patients must have post meal supervision for 60 mins after meals and snacks. During this time they must not attend the toilet or shower.
  - **Exercise** - limit physical activity (may require bed rest to reduce energy expenditure, or due to risk of collapse/arrhythmia - as per individual management plan).
  - **Vomiting/chewing and spitting into cup/napkin** - support at meals and post meals. When risk high supervise in toilet and shower.
  - **Laxatives/diuretics** - Senna based laxatives should not be prescribed. Manage constipation as clinically indicated, e.g., with stool softeners. No laxatives from home, and supervise toilet use. No diet chewing gums or lollies as many contain sorbitol (potential laxative effect).
  - **Inappropriate fluid intake** - monitor fluid intake for under or over drinking.

**Nasogastric Tube Feeding**

- The decision to insert a NG tube for the purpose of feeding/medications should be made following careful assessment of the risks and benefits.
- Management by this method may evoke strong reactions from the patient based on potential fear of losing control of weight gain or previous intrusive unpleasant experiences.
- Where appropriate, patients and next of kin should be involved in the decision making process with verbal informed consent being sought after discussion of risks and benefits.
- Recommended tube size (10-12 French) with insertion performed in a gentle, compassionate and supportive manner by competent nursing/medical staff.
- Ideally the person should be on a 1:1 nursing special to limit tampering with feeds.
- A lockable pump prevents patients switching off the device/altering the settings.
- The NG tubing should be visible to nursing staff at all times, not covered by clothing or bed linen; this will prevent kinking or holes being put into the tube.
- NG feeding and resultant weight gain will likely be a source of great anxiety for the patient and may result in sabotaging behaviour as weight increases. NG feeding rates should be concealed from the patient. The NG tube should be sealed with tape and the seal initialled so any tampering can be identified if the seal is broken. Clear documentation of when the feed started and when it is due to finish is required to prevent tampering of feeds.

**Management of Weighing**

- Weighing is non-negotiable. See Section 5 for Weighing Guideline.
Nursing Management - Ongoing

Leave guidelines are provided to help guide decisions (see guidelines Section 5)

Observations (to continue as clinically indicated)
- QID lying and standing blood pressure. Staff should notify RMO if:
  - Pulse is below 60bpm or postural tachycardia > 20bpm,
  - Temp below 35.5c, and/or;
  - Systolic BP below 90, or if;
  - Significant postural drop of more than 10mmHg.
- BSL’s to continue if clinically indicated.
- ECG to continue as clinically indicated

Monitor and contain eating disorder behaviours
- Visual observations to be reviewed according to risk of eating disorder behaviours.
- Exercise: Monitor and contain excessive physical activity.
- Vomiting /chewing and spitting into cup/napkin: Support at meals and post meals. All toilet needs should be attended to prior to meals; and when risk is high, supervise in toilet and shower.
- Laxatives/diuretics: Manage constipation as clinically indicated with stool softeners; No laxatives from home; consider supervised toilet use.
- Inappropriate fluid intake: Monitor fluid intake for under or over drinking.
- Restriction: If possible, supervision during and after meals to observe and record intake.
- Request family members to assist with the management plan, by NOT bringing in food and medications (laxatives) from home, NOT visiting during meal times, NOT allowing patient to exercise.

Nutritional status and eating - continue to monitor
Weight: Measure / record weight and urine specific gravity twice weekly at 6.30am after voiding.
Bowel chart: Record bowel activity (or lack of) daily as patient will have reduced gut motility.
Intake: Check all meals against the meal plan; and record all offered food and fluids, as well as all consumed intake including fluids.

Management of Anaemia / Neutropaenia
- Is usually reversible with nutrition and there are few serious complications
- Check iron, B12/Folate if not already done
- Discuss with a medical registrar if neutrophils are consistently <1.0
- Does not require transfusion unless platelets or Hb is critically low, or active bleeding.
- Transfusion only in consultation with a medical registrar
- Explain that low blood cells are an indicator of malnutrition as it suppresses bone marrow function, but it will improve as their nutrition and BMI improve

Constipation
- Commonly occurs in drastic weight loss as the reduced caloric intake leads to reflex hypofunctioning of the colon, or to slowed colonic transit.
- Frequently follows cessation of laxatives.

Laxative Abuse
- The most widely abused laxatives are from the stimulant class (e.g., Senna based).
- In prolonged laxative use, return to normal bowel function can take an extended time, and on rare occasions can have serious outcomes.
Nutritional Management - Initial

The goal of nutrition is to minimise any risk of refeeding syndrome and promote safe, adequate nutritional restoration within the shortest timeframe thereby reducing length of admission. Providing nutrition is not negotiable however the route of how the nutrition is provided can vary. The evidence of whether to feed a patient orally or enterally on initial presentation is limited and is largely based on research in adolescents rather than in adults. However, clinical experience suggests that it is very difficult for people who are severely malnourished (eg. BMI <13.5kg/m^2) to tolerate sufficient oral diet to treat their underlying nutritional deficit.

Recommencement of nutrition in a person with an eating disorder can be associated with a high level of emotional distress / anxiety as well as physical discomfort. An empathic approach which acknowledges the distress and maintains clear communication regarding the essential requirement for nutrition to treat underlying medical risk should be demonstrated by all staff.

The following guidelines can be implemented until the person is able to be assessed by your facility dietitian.

Refeeding Syndrome Risk

- If the person is at risk of refeeding syndrome (see Section 1 to determine Refeeding Syndrome risk) then the person must have daily checks U+E, PO4, Mg and supplementation if low
- It is recommended that the person commence prophylactic phosphate at 500mg twice daily

Oral vs Enteral Feeding

Although oral diet is the preferred way to commence nutrition restoration, the patient may find it too difficult to consume nutrition orally or may be too unwell. If so, follow instructions below for enteral feeding.

- Continuous 24 hour enteral feeding is the safest way of treating the complications of malnutrition when the patient is critically ill. Delivering a constant and controlled supply of carbohydrate is less likely to cause reactive hypoglycaemia, and feeding patients overnight can help keep their heart rate and blood sugar level at a safer level.
- It is recommended that an enteral feeding tube is inserted immediately for feeding in any of the following circumstances:
  a. When the patient is unable to tolerate sufficient oral diet and/or nutritional supplements to meet nutritional goals
  b. On initial presentation there is cardiac instability and/or abnormal electrolytes,
  c. BMI is <13.5kg/m^2
- In other circumstances, oral feeding may be offered. It is acknowledged that asking a patient to consume a 6000kJ initial oral meal plan (see Table 6 for a sample oral meal plan or Appendix III for a printable copy that can be placed in the patient’s nursing file) will be challenging especially if they have been consuming less than 6000kJ prior to admission. If physical safety does not warrant enteral feeding, the patient should be given 24 hours to demonstrate ability to consume the required intake with supervision. If after 24 hours they are unable to comply then it is recommended that an enteral feeding tube be inserted for nutrition restoration.
Enteral Feeding

- Insertion of a nasogastric tube must be done with skill and compassion. See Ongoing Nutritional Management below for details of enteral feeding progression.
- A nasogastric tube is preferred however if not feasible, a nasojejunal feeding tube (NJT) can be used. Total Parenteral Nutrition (TPN) should only be used if the GI tract is non-functional. See Nasogatric Tube (page 22) for enteral feeding tube insertion.
- It is recommended to commence 24 hour continuous feeding with a nutritionally complete, lower carbohydrate (40 – 50% of energy), low fibre, energy dense feed (6.3kJ/ml or 1.5kcal/ml recommended e.g. Ensure Plus or Isosource 1.5). A recommended starting rate of 40ml/hour over 24 hours with 60ml water flush every 4 hours be commenced to reduce to incidence of refeeding syndrome (see Section 1 for an overview of refeeding syndrome).
- Fluid requirements for the patient can vary and will depend on medical stability. Fluid intake should be calculated according to age and weight. Generally this is 35 – 45ml/kg/day and includes all methods of delivery of fluids (i.e. orally, enterally and IVH).

Oral diet

- It is recommended to start at 6000kJ/day. See below for a sample meal plan or Appendix III for a printable version for the patient’s nursing file. To minimise the risk of refeeding it is preferable to initially provide a diet lower in carbohydrates (40 – 50% energy)
- The patient must consume 100% of all meals and snacks prescribed. If the patient is unable to consume 100% then s/he will need to consume a high protein liquid medical nutritional supplement. It is recommended that a nutritionally complete 6.3kJ/day (1.5kcal/day) supplement be used e.g. Ensure Plus or Fortisip. If <100% of the main meal is finished provide 1 packet as a top up and if <100% of the snack is completed then provide ½ packet of supplement of choice as a top up.
- If the patient is unable to tolerate a full diet but able to tolerate liquids, then it is recommended that an oral high energy oral liquid meal plan be followed. See Table 7 for a sample meal plan or Appendix IV for a printable copy that can be placed in the patient’s nursing file. If it has been determined that an enteral feeding tube is required then this meal plan can also be used while the patient is awaiting insertion.
- An additional Medical Nutritional Supplement may be required as a late supper (2200 – 0000) to avoid low BSL levels especially overnight as per facility hypoglycaemia guidelines.
- No extra purchased or home supplied food is to be consumed.
- Strictly no “diet” or artificially sweetened products e.g. drinks, sugar substitutes, lollies, chewing gum or diet foods are allowed as they can promote a laxative effective and/or suppress appetite.
- The patient has 30 minutes to complete all main meals and 15 minutes for snacks. If the patient is unable to complete within the respective timeframe then they should be provided with a top up supplement as stated above.
- The patient must remain seated for 60 minutes post meal and 30 minutes post snacks including no bathroom access.
- Limit fluids for minimum 30 minutes prior to main meals and 15 minutes prior snacks to aid hunger.
- All oral intake should be supervised and accurately documented.
- See Supportive Meal Therapy Guidelines in Section 5 for further details on managing meals.
- For a summary of initial Nutritional Management, see Table 8.
### Table 6: Default 6000kJ Oral Meal Plan

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
<th>Medical Nutritional Supplement if &lt;100% Prescribed Meal / Snack Completed</th>
</tr>
</thead>
</table>
| **BREAKFAST (08.00 – 08.30)** | • 1 Portion Pack Cereal (Cornflakes™ or Rice Bubbles™)  
• 150ml Hilo Milk  
• 1 Portion Pack Tinned Fruit in Natural Juice | 200ml bottle Fortisip (no fibre) OR  
200ml tetrapack Sustagen (Ready to Drink) |
| **MORNING TEA (10.00 – 10.15)** | • 200ml UHT Flavoured Milk  
• 1 Piece Fresh Fruit | 100ml bottle Fortisip (no fibre) OR  
200ml tetrapack Sustagen (Ready to Drink) |
| **LUNCH (12.00 – 12.30)** | • **Hot** Main Meal (standard portion / serve size)  
(must include carbohydrate portion e.g. potato / rice / couscous / pasta) | 200ml bottle Fortisip (no fibre) OR  
200ml tetrapack Sustagen (Ready to Drink) |
| **AFTERNOON TEA (15.00 – 15.15)** | • 200ml UHT flavoured milk | 100ml bottle Fortisip (no fibre) OR  
200ml tetrapack Sustagen (Ready to Drink) |
| **DINNER (17.00 – 17.30)** | • **Hot** Main Meal (standard portion / serve size)  
(must include carbohydrate portion e.g. potato / rice / couscous / pasta) | 200ml bottle Fortisip (no fibre) OR  
200ml tetrapack Sustagen (Ready to Drink) |
| **SUPPER (20.00 – 20.15)** | • 200ml UHT flavoured milk | 200ml bottle Fortisip (no fibre) OR  
200ml tetrapack Sustagen (Ready to Drink) |

For a printable version of the above meal plan for the patient’s nursing file, please see Appendix III.
# Table 7: Default 6000kJ Oral Liquid Meal Plan

This oral liquid meal plan can be started prior to review by your facility dietitian.

<table>
<thead>
<tr>
<th>Time of Day</th>
<th>Meal Plan Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BREAKFAST (08.00 – 08.30)</strong></td>
<td>- 200ml bottle / tetrapak Ensure Plus OR Fortisip (no fibre) OR Resource Protein</td>
</tr>
<tr>
<td><strong>MORNING TEA (10.00 – 10.15)</strong></td>
<td>- 100ml Ensure Plus OR Fortisip (no fibre) OR 200ml bottle Resource Protein</td>
</tr>
<tr>
<td><strong>LUNCH (12.00 – 12.30)</strong></td>
<td>- 200ml bottle / tetrapak Ensure Plus OR Fortisip (no fibre) OR Resource Protein</td>
</tr>
<tr>
<td><strong>AFTERNOON TEA (15.00 – 15.15)</strong></td>
<td>- 100ml Ensure Plus OR Fortisip (no fibre) OR 200ml bottle Resource Protein</td>
</tr>
<tr>
<td><strong>DINNER (17.00 – 17.30)</strong></td>
<td>- 200ml bottle / tetrapak Ensure Plus OR Fortisip (no fibre) OR Resource Protein</td>
</tr>
<tr>
<td><strong>SUPPER (20.00 – 20.15)</strong></td>
<td>- 200ml bottle / tetrapak Ensure Plus OR Fortisip (no fibre) OR Resource Protein</td>
</tr>
</tbody>
</table>

For a printable version of the above meal plan for the patient’s nursing file, please see Appendix IV.
Nutritional Management - Ongoing

Once nutritional restoration has been commenced, the goal is to continue to provide nutrition until the target energy intake has been reached to promote and adequate rate of weight restoration.

Refeeding Syndrome Risk

- The person will remain at risk of refeeding syndrome approximately 7 – 10 days post commencement of nutrition restoration
- Continue to liaise with the medical team to monitor U+E, Mg and PO₄ levels, BSL levels
- If potassium, magnesium and phosphate levels continue to decrease after supplementing DO NOT increase the rate of enteral nutrition or calories through oral diet. Continue to supplement the electrolyte/s and leave the feed / oral diet at the current rate until the electrolyte/s levels return to within the acceptable reference range.

Nutrition Restoration

- If U+E, Mg¹², PO₄ levels are within the acceptable reference range, then the oral diet or enteral feeds should be progressed in 2000kJ aliquots (480kcal) every 2 – 3 days until the the target rate of weight gain has been achieved as per goal energy intake. A specific rate and target goal devised with a clinical dietitian (ideally with eating disorders experience) is always preferable. The goal energy intake is calculated following equation:
  \[ 120kJ/kg\, \text{current weight} \times 1.4\, \text{(activity factor)} \times 1.5\, \text{(repletion factor)} \]
- Patients are expected to consume 100% of all meals and snacks or enteral feeds prescribed to meet a target weight rate of 1 – 1.5kg per week
- If <1kg per week weight gain is being demonstrated then assess and manage any compensatory behaviours and/or continue to increase the energy intake by 2000kJ (480kcal) until desired rate of weight gain is achieved. Note that metabolic requirements also rise as nutrition improves and a “plateau” in weight gain may signal a need for increased energy intake rather than signalling use of compensatory strategies (although this should also be considered).
- If a patient is struggling to adhere to the feeding regime it is likely a 1:1 nursing special will be initially required. Ideally this nurse should have received additional education in care of a person with an eating disorder. WAEDOCS can provide phone and face to face advice.
- Ensure the current nutritional management plan is available for all staff and the patient
- Strictly no “diet” or artificially sweetened products e.g. drinks, sugar substitutes, lollies, chewing gum or diet foods are allowed as they can promote a laxative effective and/or suppress appetite
- Limit caffeinated beverages to 3 cups daily (1 teaspoon coffee powder per cup or a 3 minute steep for black tea). Green tea (including decaffeinated) and herbal teas are not permitted

Oral Diet

- Incremental meal plans are available on request from the WAEDOCS dietitian
- It is essential that only food on the meal plan is consumed i.e., No extra purchased or home supplied food is permitted. All family members/friends should also be aware of this
- The ideal feeding method is oral however many patients at this level of severity require some component of enteral feeding for optimal treatment.
If oral feeding fails to increase weight as prescribed by the treating team, then it is recommended that enteral feeding be commenced.

- The patient must remain seated and supervised for 60 minutes post meal and 30 minutes post snacks including no bathroom access.
- Limit fluids for minimum 30 minutes prior to main meals and 15 minutes prior snacks to aid hunger.
- Continue to document all oral intake on an appropriate oral nutrition intake chart.
- See Meal Support Guidelines in Section 5 for further details on managing meal times.
- Once a target rate of weight gain has been achieved continue with the meal plan until the target BMI for discharge has been reached.
- A snack may be required during the night or late supper (2200 – 0000) to avoid low BSL levels especially overnight as per facility hypoglycaemic guidelines.

**Enteral Feeding**

- Continue to increase the rate of enteral feeding by 2000kJ (480kcal) every 2 – 3 days until target rate of weight gain of 1 – 1.5kg/week is reached.
- However if the target rate of weight gain is not achieved when goal energy intake is reached, continue to increase energy intake by 2000kJ/day (480kcal) until target rate of weight gain is achieved. This can sometimes be greater than 12000kJ/day (~2900kcal).
- 7 – 10 days post commencement of feeds, the patient can be progressed to a nutritionally complete, high fibre, energy dense feed (recommend 6.3kJ/ml or 1.5kcal/ml e.g Jevity Hical or Fortisip Multifibre) at the same rate. However caution should be exercised as a high quantity of fibre (above AI) can be reached once goal energy intake has been achieved. It is important to monitor the patient’s bowel actions / movements.
- Once the risk of refeeding syndrome has been minimised, enteral feeding can also be changed from continuous to bolus / intermittent feeding. Bolus feeding can be useful to help decrease a patient’s anxiety levels which may be high with a feeding running continuously. Your facility dietitian will be able to advise on an appropriate bolus feeding plan.

**Transitional Feeding (moving from Enteral Feeding to Oral diet)**

- If enteral feeding has been used, there will come a time when it is suitable to transition the patient to oral diet. However this should be done in consultation with the multidisciplinary team as substantial meal support will likely be required.
- An important factor in beginning transition is that the patient should be medically stable.
- There are various ways in which transition to an oral diet can occur, these include:
  a. Oral diet during the day and enteral feeding overnight.
  b. Commencing a staged re-introduction of oral diet with weaning of enteral feeds e.g. commence with 1 meal daily and ongoing full enteral feeds with progression towards more oral diet and less enteral feeding.
  c. Commencement of full oral diet and ceasing enteral feeding however the enteral feeding tube remains in place for 2 – 3 days while the patient demonstrates that they are able to finish 100% of all prescribed meals and medical nutritional supplements.
- The facility dietitian can identify which is the best way for transitional feeding to occur.
- Prior to discharge the patient should be able to demonstrate that they are able to maintain their nutrition via minimum 3 meals, 3 snacks and 3 medical nutritional supplements per day (or individualised protocol after discussion with dietitian or WAEDOCS). Your facility dietitian will be able to advise the patient on an appropriate meal plan for discharge.
- For a summary of Ongoing Nutrition Management, see Table 9.
Table 8: Summary of Initial Nutritional Management

<table>
<thead>
<tr>
<th>Medical Monitoring</th>
<th>Pharmacologic Measures</th>
<th>Route of Nutritional Rehabilitation</th>
<th>Nutritional Requirements*</th>
<th>Starvation Syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce the risk of refeeding with daily medical monitoring</td>
<td>At high risk of refeeding syndrome.</td>
<td>Route of nutrition restoration will depend on medical stability and BMI.</td>
<td>Energy</td>
<td>When there has been a restriction in energy intake &amp; precipitous weight loss. Signs include:</td>
</tr>
<tr>
<td>Daily monitoring of FBC / U+E / Mg&lt;sup&gt;2+&lt;/sup&gt; / PO&lt;sub&gt;4&lt;/sub&gt; / Ca&lt;sup&gt;2+&lt;/sup&gt;</td>
<td>Commence daily supplementation:</td>
<td></td>
<td></td>
<td>• Physical Symptoms, e.g. loss of body mass, ↓metabolism, hormonal disturbance</td>
</tr>
<tr>
<td>QID Observations including lying &amp; standing heart rate and BP</td>
<td>• 300mg Thiamine OD</td>
<td></td>
<td>Protein</td>
<td>• Psychological symptoms e.g. anxiety, depression, irritability, labile mood, heightened rigidity and obsessional thinking, impaired concentration and decision-making</td>
</tr>
<tr>
<td></td>
<td>• 1 Multivitamin &amp; Mineral Supplement OD</td>
<td></td>
<td></td>
<td>• Social withdrawal &amp; lack of interest in surroundings</td>
</tr>
<tr>
<td></td>
<td>• 1 B Complex Supplement OD</td>
<td></td>
<td></td>
<td>• Preoccupation with food</td>
</tr>
<tr>
<td>ECG on admission</td>
<td>• 500mg Phosphate Sandoz BD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BSLs QID (1-2 hours post prandial irrespective of feeding route) + 0200</td>
<td>Replace potassium and magnesium levels once refeeding commenced if below reference range</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manage any hypoglycaemic events. Low BGLs (&lt;4.0mmol/l) should be managed according to The 2012 Australian Commission on Safety and Quality in Heath Care User Guide to National Insulin Subcutaneous Order and Blood Glucose Record: Adult or facility protocol then a slow acting carbohydrate (e.g. One of the following: 200ml Tetrapak of Ensure Plus / 250ml glass milk and 3 crackers) should be given in addition at the same time. If rehydration required refrain from using IV Dextrose</td>
<td>May be able to commence full oral or transitional diet if:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Medically unstable regardless of BMI</td>
<td></td>
<td>Energy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unable to tolerate oral diet OR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Medical co-morbidities complicated by ED OR</td>
<td></td>
<td>Protein</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• BMI &lt;13.5kg/m&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Energy</td>
<td>120kJ/kg x 1.4 (activity factor) x 1.5 (repletion factor)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Start at 6000kJ/day irrespective of nutritional route</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protein</td>
<td>0.8 – 1g/kg/day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carbohydrate</td>
<td>If at ↑risk of refeeding aim for 40 – 50% of CHO from total energy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>35 – 45ml/kg/day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluid</td>
<td>Use current body wt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td>For &gt;18 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16 – 18 years use %IBW</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 9: A Summary of Ongoing Nutritional Management

<table>
<thead>
<tr>
<th>Medical Monitoring</th>
<th>Pharmacological Measures</th>
<th>Route of Nutritional Rehabilitation</th>
<th>Nutritional Requirements*</th>
<th>Starvation Syndrome</th>
</tr>
</thead>
</table>
| Continue daily monitoring of electrolytes and mineral levels and replace deficiencies until goal energy intake is reached **or** for at least 7 – 10 days post commencement of nutrition rehabilitation | Continue supplementation until refeeding syndrome risk has resolved  
• 300mg Thiamine OD  
• 1 Multivitamin & Mineral Supplement OD  
• 1 B Complex Supplement OD  
• 500mg Phosphate Sandoz BD | Continue to progress with nutrition rehabilitation with the assistance of the facility dietitian.  
*Refeeding syndrome risk has resolved AND Medically stable >48 hours AND Able to tolerate any oral diet AND Resolving cognitions related to starvation syndrome AND BMI >13.5kg/m² | Energy  
• Increase by 2000kJ every 2 – 3 days until target rate of weight gain reached  
• Aim for 10,000 – 12,000kJ/day | Starvation Syndrome signs will continue to resolve with ongoing nutrition rehabilitation  
• Cognitive effects of Starvation Syndrome are unlikely to resolve completely during admission (insight and judgement may fluctuate re: need for further treatment). |
| **Continue daily ECG**                                  | **Replace potassium and magnesium levels if below reference range** | **If a transitional regimen was commenced, aim for full oral diet +/- nutritional supplements (i.e. 3 meals, 3 snacks and 3 nutritional supplements per day (or individualised protocol after discussion with facility dietitian or WAEDOCS).** | **Fluid**  
○ As per medical team, but may need extra fluid if experiencing constipation | **Target Rate of Weight Gain**  
• Aim 1 – 1.5kg per week |
| **Continue QID Observations** including lying & standing heart rate and BP | **Continue to manage any hypoglycaemic events.** Low BGLs (<4.0mmol/l) should be managed according to The 2012 Australian Commission on Safety and Quality in Health Care User Guide to National Insulin Subcutaneous Order and Blood Glucose Record: Adult or facility protocol then a slow acting carbohydrate (e.g. One of the following: 200ml Tetrapak of Ensure Plus / 250ml glass milk and 3 crackers) should be given in addition at the same time. | **If NGT feeding was indicated, consider moving to a transitional regime if the following is present:**  
• Refeeding syndrome risk has resolved AND Medically stable >48 hours AND Able to tolerate any oral diet AND Resolving cognitions related to starvation syndrome AND BMI >13.5kg/m² | **Important to note that Starvation Syndrome needs to be resolved before the patient can successfully engage in psychological treatment.** | 
| **Continue BSLs QID** (1-2 hours post prandial irrespective of feeding route) + 0200 |                                                                                   |                                                                                   |                                                                                   |                                                                                   |

*For a detailed explanation of Nutritional Requirements please refer to the Dietetics Protocol available from the WAEDOCS Dietitian.
Mental Health Management

Caring for people with eating disorders often involves managing feelings and behaviour related to their fear of weight regain, as well as other comorbid conditions such as maladaptive personality traits, depression, anxiety and substance abuse.

It is important not to get involved in negotiations regarding nutritional management. Remind the patient that any changes to nutritional management plan will only be made at the MDT meeting and that any questions will be addressed at that time.

A clinical psychologist, if available, should visit the patient; ideally within 48 hours.

Mental health clinicians such as mental health nurses, clinical psychologists and psychiatrists have an important role in helping people manage their psychological distress and comorbid psychiatric conditions. It is understood that not all locations will have a mental health unit or access to mental health clinicians. The following is a guide for supporting patients by helping them manage the psychological distress commonly seen in eating disorders:

- Engage with the patient and assess level of distress. Facilitate a therapeutic relationship that encourages ventilation of stress and anxiety related to the renourishment plan and weight restoration; family dynamics; suicidal and self-harm thoughts or feelings of inadequacy.
- Balance compassion with firmness. Convey an appreciation of the patient’s distress / fear of weight restoration and any concerns about being in hospital (which may be against their will) while reiterating the seriousness of their physical condition and the importance of following the treatment plan, since their physical state of starvation needs to be addressed before structured psychological therapy is likely to be effective.
- Provide psycho-education regarding:
  - Anorexia nervosa (AN): explain that AN is a severe mental disorder involving a) seriously low weight; b) intense fear of weight gain; and c) disturbance of body image/denial of the seriousness of the low weight.
- Promote anxiety management strategies to use especially around meal times and improving sleep.
- Encourage patients to develop a sense of self-control, and connect feelings to events and actions within the boundaries of collaborative goal setting.
- Support the family in understanding and managing the eating disorder in relation to patient behaviours which may maintain the illness and interrupt the treatment process.
- Use Cognitive Behaviour Therapy (CBT) principles: connecting thoughts, feelings, behaviours and physiological state.
- Be aware that structured psychological therapies for eating disorders are most likely to be successful once starvation syndrome has been treated. Weight restoration is needed (often to approximately BMI 16.5kg/m²) to optimise engagement with and success of psychological treatments.
Specific support from Mental Health Nurse

Mental Health nurses are a key resource within the multi-disciplinary team. In addition to the supportive and collaborative role provided in the course of the comprehensive assessment, management and follow-up, Mental health nurses can:

- Act as resource for staff in medical in-patient settings in providing education and insight into the mental health aspect of the treatment, e.g., regulations governing involuntary admissions and restraint that are consistent with the Mental Health Act (2014), promoting a stance that provides firm limits around unhelpful illness behaviours but is supportive and compassionate towards the patient.
- Undertake community visits as required for assessment, psychoeducation or follow-up support, not just for patients and their families but all stakeholders, including GPs and other care providers.
- Provide support for community mental health staff to manage patients when they are transferred to a community setting, particularly maintaining regular follow-up to enable early identification of deterioration, and facilitation of readmission to improve chance of recovery.
- Provide assertive outreach for people with more complex / high risk illnesses who may be ambivalent about engaging with care, and facilitate involuntary admissions of clients under Mental Health Act 2014 as needed and when decided by the MDT.
- Promote close partnership with mental health settings and mental health staff in general, facilitating provision of effective assessment, management and follow-up care to people with eating disorders, through education on the complex nature of the illness and evidence-based practice.

Peer Support

‘Peer support’ refers to the particular support provided by someone who has been through a similar experience. In the case of eating disorders, peer support workers have been found to be an effective adjunct to treatment, because of their in-depth knowledge and understanding of the eating disorder process and what it takes to recover. Essentially, a well-trained peer support worker acts as a ‘recovery coach’ for patients. By providing a role model for life after the eating disorder, s/he can urge them to engage with treatment and resist the distorted thoughts associated with the illness, focussing on other strategies to improve well-being. WAEDOCS has a Peer Support Clinician who can assist with training.

As this type of support is becoming increasingly accepted within mental health services, many clinical settings may already have staff on their team who could provide this service. Peer support should be integrated into a multi-disciplinary team in order to be effective, and the role should be clearly defined to meet the particular needs and resources of each service. Peer support workers do not perform clinical duties, nor are they qualified as psychologists. It is recommended that peer support workers receive specific training and supervision in the management of eating disorders, and ideally they will have had previous personal experience in that area.

Exposure to someone who has recovered from an eating disorder can be a key factor in recovery. For this reason it is considered a worthwhile adjunct to the treatment plan wherever possible.
SECTION 5 – FURTHER GUIDELINES

Weighing guideline

Weighing is non-negotiable.

The following process for weighing is recommended to ensure the patient knows what to expect and that they experience accurate and private weight recordings. This process can also assist in minimising the focus on weight during treatment for both team and patient.

Structure for weighing is as follows

- Admission weight to be recorded on the morning after admission, thereafter scheduled bi-weekly or as per nursing care plan.
- Routinely bi-weekly weight on Monday and Thursday mornings, or Tuesday and Friday mornings.
- When returning from overnight leave on a weigh day, patient is to be weighed the following day.
- Additional random weighs will occur as identified on the patient’s individual management plan and may be indicated if falsification of weight is suspected (water loading, salt loading, secreting weights in underwear) and water loading is confirmed by ward test of specific gravity. Concerns should be shared with team and documented.

Weighing procedure recommended for patients is as follows

- Weights are recorded at 0630, after first morning void, and prior to oral intake
- Patients should be weighed wearing a hospital gown with underwear only and hair accessories removed
- Provide a specimen jar to patient to collect urine prior to weighing. Urine specific gravity to be checked and recorded.
- Ensure consistency by using the same set of scales each time.
- Ensure patient’s privacy and dignity is respected during the weighing process.
- Record weight in progress notes and plot on weight chart.
- As weighing is often extremely anxiety provoking for the patient, distraction and distress tolerance methods should be utilised (e.g. engaging in light conversation during the weight, encouraging them to do crosswords etc. afterwards).
- Weight information to only be fed back to patient by dietitian, consultant physician or psychiatrist once per week during the multi-disciplinary team case conference. Progress will be relayed in terms of “BMI Band”, rather than an absolute measure.
- This is generally conveyed as the lower BMI band until 2 consecutive weights have exhibited stable movement to the next band. Under NO circumstances should weight in kilograms be disclosed to patient by staff.
Inpatient Leave Guideline

The WAEDOCS leave programme is designed to facilitate recovery by introducing time off the ward in increments, starting with escorted leave and gradually increasing to unescorted leave. However there are periods in the patient’s treatment where leave places patients at a high risk of physical complications and should not be offered. This document should be used in conjunction with WAEDOCS BMI related guidelines for inpatient management of physical activity.

Stage 1- No leave
- Whilst medically unstable and/or psychologically unsafe (refer to RANZCP 2014 Clinical Practice Guidelines (CPGs) for the treatment of Eating Disorders)
- BMI < 13.5kg/m² and /or
- If unable to progress towards treatment goals
- If unable to contain compensatory behaviours

Stage 2 - Escorted leave is appropriate if:
- Post 7-10 days of adequate nutrient intake and when risk of re-feeding syndrome is minimised
- Medically and psychologically stable (RANZCP 2014 CPGs / WAEDOCS physical activity guidelines)
- Progressing towards treatment goals
- Demonstrating ability to contain compensatory behaviours
- Patient is in a wheelchair accompanied by a suitable nursing staff escort
- BMI Band 13.5 – 15kg/m² - 30 minutes escorted

Stage 3- Unescorted leave is appropriate when:
- The individual has the ability to use their leave in a way consistent with the treatment goals
- Able to self- manage urge to engage in compensatory behaviours
- For progression towards discharge
- BMI band 15-17kg/m² - 30 minutes unescorted

Stage 4 - BMI Band >17kg/m²
Leave will be extended incrementally to accommodate discharge planning. The following leave progression is recommended to enable the patient to demonstrate adequate intake during leave.
- Leave to eat meal within the inpatient setting accompanied by family member/support person
- Leave to purchase food in preparation for discharge or trial eating in a challenging environment (e.g., restaurant or family function)
- Leave to trial overnight stay (or weekend) at home prior to discharge
- If indicated, extended leave pre discharge to monitor weight maintenance and transition to community.

N.B. If the patient is under the Mental Health Act (2014) they may require ongoing 1:1 escorted leave irrespective of their BMI or medical stability.
Supportive Meal Therapy (SMT) Guidelines

Introduction

Supportive Meal Therapy (SMT) is a critical component in the management of eating disorders. During SMT, patients have an opportunity to consume and retain the prescribed amount of nutrition which supports the treatment plan and the discharge goals. Patients will generally be prescribed 3 main meals and 3 snacks by the dietitian – all of which require one-on-one SMT. SMT is essentially provided in two phases – the supervised meal, and post meal supervision.

Where 1:1 supervised meal and post-meal supervision is not available, it is recommended that patients consume their meal seated in the sight of nursing staff, e.g., outside the nursing station. They should remain there and not be allowed to visit the toilet for the post-meal supervision period (60 mins after main meals and and 30 minutes after snacks).

The Supervised Meal

- The primary purpose of the supervised meal is to support the completion of all prescribed meals and snacks within the allocated time frames, being 30 mins for meals and 15 mins for snacks. These time frames provide the patient with boundaries around meal times that are consistent with those of a normalised eating pattern, while limiting opportunities for food hoarding and other disordered eating behaviours.
- Ensure the patient has been to the toilet before the meal/snack (as they will not be allowed to go to the toilet for 60 minutes post-meal and 30 minutes post-snack)
- A calm and supportive environment can be facilitated by engaging in general conversation and avoiding discussions about food, dieting and weight.
- Empathetically encourage the patient to complete the meal. It is important to validate the patient’s struggle and acknowledge how challenging it may be. Patients should be encouraged to complete 100% of the meal plan, with all plates and containers etc being checked by staff to assess compliance.
- Discuss inappropriate eating behaviours with the patient on a one on one basis after the meal has been completed. Should the patient continue to engage in disordered behaviours during future meals, the behaviour should be addressed once only in real time using a concerned/non-threatening manner and in a non-confrontational tone.
- Provide patients with time updates throughout the meal to help with their pacing of the meal.
- At the end of the meal period, the meal tray and all items must be removed. If the patient has taken less than 100% of the meal, the corresponding meal replacement supplement as prescribed on the meal plan must be provided and consumed within a 10 minute period.
- If the patient takes less than 100% of the prescribed meal replacement supplement, the balance may be delivered via nasogastric bolus as per the treating team’s directions.

Post Meal Supervision

The main goals of post meal supervision are to:

- Support the patient in managing emotions and anxiety post meals.
- Support the patient in an effort to limit or prevent various compensatory behaviours such as purging and exercising.

Patients have post meal supervision for 60 mins after main meals and and 30 minutes after snacks, during which time they must remain supervised and not attend to the toilet or shower.
During post meal supervision, it is important to

- Accurately document all foods and fluids consumed on the food record chart.
- Engage the patient in distraction activities and/or provide one on one support to manage anxiety and eating disorder cognitions after the meal. Examples of post meal activities include
  - Participating in groups on the ward (skill development).
  - Listening to relaxation music or participating in relaxation activities.
  - Watching television or listening to music (iPod etc.).
  - Reading suitable books, magazines or newspapers.
  - Journaling or writing in a diary.
  - Playing board games or cards.

What to and what not to do/say when providing Supportive Meal Therapy

Briefly, the primary purpose of SMT is to support the completion of all prescribed meals and snacks within the allocated time frames (or to support naso-gastric feeding). Staff have to balance the task aspect (supervising refeeding) with a compassionate stance, acknowledging the distress that the patient is likely to be experiencing.

Staff should:

- Empathically encourage the patient to complete the meal or tolerate the NG feed;
- Remind the patient that any changes to nutritional management will only be made at the MDT meeting and that any questions will be addressed at that time;
- Validate the patient’s struggle; acknowledge how challenging/anxiety-provoking it may be;
- Engage the patient in distracting activities (e.g., cards) or chat (e.g., about movies);
- For meals served, check all plates and containers etc. to assess the individual’s intake;
- Use “nutritional restoration” rather than “weight gain” (which will be heard as “getting fat”).

Staff should NOT:

- Engage in conversation regarding calories or nutrients (e.g., fat content) of the meal/feed;
- Engage in arguments about why the patient does/does not need the meal/feed, or whether s/he needs to be in hospital;
- Discuss their own weight loss/dieting efforts or ask for dieting tips;
- Discuss the patient’s weight;
- Allow the patient to go to the toilet for 60 minutes after completing meal (30 for snack).
- Engage in discussion about how much weight s/he is gaining/how fat s/he feels;
- Say “you’re looking really well now” or anything about gaining weight (which will be interpreted as “I look fat now”);
- Say “Just eat” or “the quicker you do it, the faster you can go home”;
- Make jokes about the patient, their weight, their eating.

Important Note - It can be stressful for staff to sit for long periods with a patient who is distressed by refeeding. Such patients often attempt to persuade staff to cease the nutrition plan (meals or naso-gastric feeding), sometimes with very convincing arguments as to why they do not need to be in hospital. Remaining calm and refusing to engage in such discussions is vital, as is maintaining a balance between compassion (validating their distress) and firmness (reiterating the need for hospital care).
Use of 1:1 specials and physical restraint.

In both medical and mental health settings, treatment of an eating disorder may entail insertion of a nasogastric tube (NGT) for continuous nutrition as an urgent medical intervention for some patients (e.g. BMI <13.5kg/m², recurrent hypoglycaemia, significant cardiac instability) or where ongoing restriction, purging or other compensatory strategies have meant that oral diet / supplements have been insufficient for nutritional improvement.

The medical reasoning for nasogastric feeding should be clearly explained to all patients prior to NGT insertion with language focussing on the need to treat the medical risks associated with severe underlying malnutrition, rather than “weight gain”. Insertion should be managed with compassion and an understanding that this procedure may be experienced as traumatic or may activate traumatic memories.

Many patients will require 1:1 supervision from a nurse during the initial stages of admission for treatment of an eating disorder, to reduce risks associated with compensatory behaviours, such as purging, excessive exercise, disposing of food / supplements (including tampering with nasogastric feeds) water loading and/or abuse of laxative medications. The rationale for 1:1 supervision should also be explained clearly to all patients.

Staff providing 1:1 specials should ideally be trained in supporting a person with an eating disorder, including strategies for meal support and awareness of the need for compassion (to provide acknowledgement of suffering), whilst also providing firm limits around the eating disorder and reminders regarding the importance of improving nutrition to reduce medical risk.

In a very small number of patients there may need to be consideration for short term use of physical restraint where repeated NGT removal by the patient is associated with increased risk of complications / delay in urgent medical treatment.

This is not a replacement for 1:1 nursing and would need to be discussed with the guardian and / or chief psychiatrist for those under the mental health act, and reviewed every 24 hours.

Patients who are struggling to contain compensatory behaviours despite 1:1 support should be given clear explanations regarding the point at which physical restraint will be instituted if they are unable to tolerate / cannot be safely fed by their preferred means. They should also be clearly informed regarding the point at which restraint would be ceased if this has been required e.g., 24 hours without attempts to remove NGT.

Feeling disempowered can escalate the symptoms of the illness, so all care should be delivered with compassion and follow a clear and consistent plan among the team. It is important to provide as much clarity as possible for staff, patients and families around this issue and the rationale for the intervention, to reduce the stress for all involved associated with feeling overwhelmed or uncertain.
Criteria for Transfer/Discharge from medical inpatient settings

If a patient with an eating disorder has required a medical admission, the following criteria should be met before transfer/discharge from that medical ward:

1. The risk of refeeding syndrome has passed (up to 2 weeks from commencement of refeeding)

1.1 The first two weeks of refeeding pose the greatest risk to the patient with an eating disorder. Potential biochemical abnormalities include hypokalaemia, hypophosphatemia, hypomagnesaemia and hypocalcaemia: thus patients must be monitored for electrolyte disturbances on a daily basis and urgent replacement instituted if indicated. A cardiovascular review and ECG should also be performed daily as clinically indicated to detect cardiovascular manifestations of refeeding syndrome. A routine daily thiamine supplement (300 mg orally) in the first three days of treatment is essential.

1.2 Some patients rapidly develop peripheral oedema and cardiac failure, and this should be suspected in the presence of rapid weight gain. The risk of heart failure in refeeding syndrome is reduced by gradual realimentation. WAEDOCS is also able to provide written guidelines, advice and support to the treating team in all aspects of treatment including management of refeeding syndrome and medical complications associated with eating disorders. See “Nutritional Management” in Section 4 and WAEDOCS RMO Guidelines.

1.3 There should be clear evidence that the patient has received adequate nutrition evidenced by medical stabilisation, and be receiving full energy requirements with demonstration of weight restoration at a rate of 1-1.5kg / week (See “Nutritional Management” in Section 3).

2. All patients should be medically stable for a minimum of 72 hours prior to transfer to a mental health unit

2.1 Many patients with eating disorders present initially in a “compensated” state of malnutrition / chronic dehydration and can deteriorate significantly during nutrition restoration. Electrolyte disturbances such as hyponatraemia, hypocalcaemia, and hypochloraemia may reflect ongoing vomiting or laxative abuse, water loading, or total body deficit due to chronic starvation. Although phosphate and magnesium levels may initially present within the normal range, they often drop precipitously during refeeding. Thiamine deficiency is common and can be expected to worsen during refeeding, and requires replacement from the time of admission (see appendix: Initial Management Guidelines).

Despite prolonged starvation, hypoalbuminaemia is rare in anorexia, and should prompt a search for occult infection. Haematological complications result from bone marrow suppression and include anaemia, thrombocytopenia and neutropenia (common in anorexia). This can be associated with impaired immune function and increased vulnerability to infections.

2.2 Cardiovascular complications include sinus bradycardia, hypotension, impaired myocardial performance, mitral valve prolapse and sudden death. ECG abnormalities in eating disorders particularly anorexia include bradycardia, low QRS, P and T wave voltages, ventricular tachyarrhythmia, non-specific ST-T changes, presence of U waves and prolongation of the QTc interval. QTc interval prolongation has been suggested to increase the risk of sudden cardiac death. Ventricular arrhythmias are a major cause of death in anorexic patients.
2.3 Orthostatic pulse or blood pressure changes suggest significant intravascular depletion and place patients at significant risk of syncope. As severely malnourished patients are typically unable to mount an adequate immune response, findings of tachycardia, pyrexia or clear localising signs may be absent on clinical examination.

3. Patients should be at a BMI of at least 14kg/m² (>85% IBW for adolescents) before transfer to a mental health ward.

Although transfer can occur below this if there is agreement between the medical and mental health units and the patient has been stable for at least 72 hours as evidenced by:

- Systolic BP 90mm or above (>80MM if reviewed and agreed in conjunction with psychiatrist in charge of the mental health ward / unit).
- Heart rate >50 and <100 bpm
- No significant postural tachycardia or hypotension
- Normal ECG
- Normal electrolytes

4. Patients may be discharged home under certain conditions.

4.1 Where there is no mental health unit, discharge to the home setting will require a higher level of medical stability. All patients should be linked into appropriate medical and mental health follow-up with a a documented individualised treatment plan developed in consultation with the patient and agreed to by follow-up agencies prior to discharge. A detailed discharge summary provided must be provided to the receiving service(s). WAEDOCS can assist treating teams to identify and facilitate referral to appropriate services if required.

4.2 Ideally, patients should be at a BMI of at least 16kg/m² (>85% IBW for adolescents) before transfer to community based services.

4.3 In order to provide patients with an opportunity to utilise community treatment, it is recommended that the patients should meet each of the following six criteria prior to discharge:

1. BMI ≥ 16kg/m². (Potentially higher for those with a history of recurrent presentations with severe malnutrition.)
3. Psychologically safe.
4. Demonstrated adequate nutritional intake during leave (i.e. 3 meals, 3 snacks and 3 nutritional supplements per day or individualised protocol after discussion with dietitian or WAEDOCS).
5. Have an established community treatment plan:
   a. Weekly GP follow-up for weighing and bloods for four weeks, and ongoing as clinically indicated.
   b. Assigned a case manager from the local mental health service.
   c. Community Dietetic support
6. Have an established early intervention plan.
   a. Identified readmission weight with a goal of providing for a voluntary solution-focussed admission.
   b. Voluntary or involuntarily readmission should be facilitated if BMI ≤ 14kg/m², or medically compromised. (NB. Readmission at higher BMI is appropriate for some patients with complex / high risk illnesses to prevent rapid deterioration)
Management in adult inpatient mental health settings

The receiving inpatient mental health treatment team should be consulted and have input into the treatment plan prior to admission.

The mental health treatment team should have timely access to advice and support from the department of medicine including transfer back to a medical bed if necessary. All treating teams can access WAEDOCS for advice throughout treatment.

If the patient is admitted directly to the Mental Health Unit, monitoring and treatment of refeeding syndrome should be undertaken in the first two weeks as per the guidelines for medical admission.

The goals of care in the mental health inpatient setting are to:

- Provide safe initial medical management if direct admission as outlined above.
- Build upon nutritional gains and reversal of cognitive effects of starvation syndrome – working toward sustaining a BMI >18kg/m² via oral diet alone without need for direct supervision at meal times by the time of discharge.
- Provide close ongoing medical monitoring for emergence of physical health complications related to malnutrition or refeeding.
- Identify unhelpful patterns of distress management which may drive disordered eating cognitions and compensatory behaviours, and develop alternate strategies for managing distress intolerance such as mindfulness based approaches.
- Identify and commence treatment of clear mental health comorbidities and/or substance dependence/abuse.
- Continue process of best-practice psychoeducation for patient and family/carers regarding eating disorders and their management.
- Encourage development of self-generated recovery goals and a healthy living plan. This may include motivational interviewing techniques, identifying future life goals and listing the pros and cons of recovery.
- Commence collaboration with community care team regarding discharge planning.

Discharge criteria: as for the Medical Inpatient Setting – see above.

N.B. Some patients with Severe and Enduring Eating Disorders (SEED) may have different goals of care for nutritional restoration during inpatient admissions reflecting a more chronic illness course. However, this diagnosis should not be made without a robust process to determine prior access to best-practice care over a sustained period, ideally entailing formal second opinion from WAEDOCS or a senior mental health practitioner with specialised experience in the management of eating disorders.
Management in Community Settings

The role of a community mental health service in the care of a person with an eating disorder will depend on the setting of the service and the specific needs of the person. Care may include:

- **Initial assessment** – including confirmation of diagnosis and clarification of other mental health comorbidities, and awareness of criteria for inpatient management
- **Psycho-education** – provision of high quality information to people with eating disorders and their carers/families regarding the nature of eating disorders, particularly the role of both nutritional and psychological treatment and the impact of starvation syndrome (see Page 44 for Starvation handout)
- **Care co-ordination** including referral to emergency/specialist medical or psychological care
- **Monitoring and engagement** (including weighing, other physical monitoring or tracking medical monitoring/attendance in collaboration with the GP, medical specialist, CCI or private psychologist/psychiatrist). Dietetic support for adequate nutrition and hydration.
- **Treatment of other mental health comorbidities** – including assessment and management of suicidal ideation and risk (particularly post inpatient admission for nutritional restoration)
- **Assertive follow-up on discharge following inpatient admission for nutritional restoration**, to enable early identification of clinical deterioration and rapid readmission where appropriate. This includes legislated follow-up under a community treatment order (CTO).
- **Transition engagement and follow-up for younger patients with eating disorders as they move between child and adolescent and youth/adult services.**

In rural and regional areas, the community mental health service may work closely with the GP, dietitian and/or other health service providers and may play multiple key roles in care provision. In the metropolitan area, people with eating disorders may also access initial psychoeducation and structured psychological interventions through their GP, CCI or the private sector.

The Important Role of Community Mental Health Services in Monitoring Complex / High Risk Patients with Eating Disorders

- **In the metropolitan area**, referral to community mental health services is often reserved for those with particularly complex or high risk illnesses. The assertive outreach capability of the community mental health team plays a key role in optimising care and reducing morbidity and mortality.
- **For many high risk individuals**, community engagement and monitoring, with a plan for rapid facilitation of medical admission at the first sign of nutritional deterioration, represents an essential component of treating starvation syndrome and can result in reduced need for hospitalisation, reduced length of inpatient stay and reduced duration of illness.
- **Access to these ongoing pathways for assertive outreach from community mental health** is often crucial for supporting other health providers such as GPs, clinical psychologists and/or dieticians who may be struggling to maintain engagement with complex and high risk patients.
- **Community Mental Health Services** should develop collaborative links with catchment area inpatient medical units, mental health units and consultation liaison psychiatry services to optimise safe and timely transitions between settings of care. WAEDOCS can assist with facilitating this process.
Section 6 - Resources

General Resources

Local

CCI – Outpatient psychological service, treating people aged 16 and above. Parent/carer groups and website.
223 James Street, Northbridge, WA 6003.
Tel: 08 9227 4399 Fax: 08 9328 5911 Email: info.cci@health.wa.gov.au

Web-based self-help modules for eating disorders:

Web-based handouts for eating disorders:


PMH - multi-disciplinary team, treating children and adolescents up to and including age 15.

National

Butterfly Foundation - National Support Line: 1800 ED HOPE (1800 33 4673)
www.thebutterflyfoundation.org.au

National Eating Disorders Collaboration (NEDC) www.nedc.com.au

Victorian Centre for Excellence in Eating Disorders (CEED) www.ceed.org.au

Centre for Dieting Disorders (CEDD) www.cedd.org.au

Guidelines

https://www.ranzcp.org/Files/Resources/Publications/CPG/Clinician/Eating-Disorders-CPG.aspx

Royal Brisbane and Women’s Hospital- A guide to admission and inpatient treatment for people with eating disorders at the Royal Brisbane and Women’s Hospital

Guidelines for the Inpatient Management of Adult Eating Disorders in General Medical and Psychiatric Settings in NSW
Key resources for people with eating disorders and their families

- www.eatingdisorders.org.au
- www.whfs.org.au/services/bep
- www.cci.health.wa.gov.au
- www.nedc.com.au
- www.health.wa.gov.au/services
Starvation Syndrome Handout

The effects of starvation on the human body are well documented. When starved of calories, the human body responds with “Starvation Syndrome”. People with Anorexia Nervosa suffer from starvation as a result of severely restricting their calorie intake. People with Bulimia Nervosa suffer from starvation by engaging in restriction and purging behaviour (which also reduces caloric absorption) and irregular intake of vital nutrients.

The Minnesota Experiment

In the 1940s, there was an experiment involving 32 fit young men who had been drafted into the United States army. They were conscientious objectors to military service and had volunteered to do humanitarian work. They became subjects of a year-long experiment. This involved:

- 3 months of normal eating (3600cal)
- 6 months where rations were cut by 50% (1800cal)
- 3 months of full rations (3600cal)

For the first three months, when they were receiving normal rations, the men engaged in normal behaviours, getting along well with one another, playing games and followed the war on the radio and in newspapers. After six months of half rations (semi-starvation), the men experienced not only the expected physical changes, but dramatic mental changes too.

**Physical changes:** On average, the men lost 25% of their body weight, both fat and muscle. Their heart muscle also reduced by 20% and slowed down. Their basal metabolic rate slowed down so that their bodies could conserve energy—about 600 calories per day. Body temperature decreased so they felt cold all the time. Many reported dizziness and momentary blackouts. They lost strength and were constantly tired. Hair often fell out and their hair and skin were dry. Many suffered from fluid retention. Their hormone levels decreased, resulting in loss of sexual desire and performance.

**Personality changes:** The men became depressed and apathetic, self-centered and less interested in life going on around them. Their mental alertness decreased and they became moody and irritable, restless and anxious. They reported poor concentration and decision making. Their thinking became more rigid and they obsessed more.

**Social changes:** The men lost their sense of humour and became sarcastic with one another. Group spirit deteriorated and social interaction became stilted. When they talked to each other it was mainly about food.

**Food preoccupation:** The change in attitude to food was one of the most surprising outcomes of the study. The men became preoccupied with food, including having persistent thoughts and dreams about food. There was a change in mealtime behaviours, including toying with food, or being ritualistic about the way they ate and taking longer to finish a meal. They even collected recipes—unusual in males during the 1940s!

These symptoms are experienced by anyone who is starved of calories. If you recognise these symptoms in your own life, it is important to remember that they all stem from one thing: starvation.
Recovery from Starvation
The men in the Minnesota Experiment recovered from their physical and mental symptoms once they were given regular rations, although it took some men a while to normalise their eating. Many men reporting feeling full and some developed binge eating. Their mood remained low for a while and usual social behaviours took longer to return.

How is this relevant to eating disorders?
We now believe that ANY kind of weight loss (from dieting or even having a stomach bug) can push someone into developing an eating disorder.

People with anorexia nervosa and anyone who has lost a lot of weight will probably be suffering from full-scale starvation syndrome. Starvation does not just affect weight and food; it affects all aspects of your psychological and social functioning.

However, there are some major differences. The men in the Minnesota Study wanted to eat, they weren’t afraid of regaining weight, whereas people with anorexia nervosa are terrified of eating and weight regain. So anyone with anorexia nervosa will be suffering from BOTH starvation AND an eating disorder.

We need to remember that eating disorders are mental illnesses, and the most relevant point about anorexia nervosa is the intense fear of weight regain. This is NOT merely the commonly held fear of gaining weight experienced by many women and some men. It is a fundamental characteristic of anorexia nervosa, and it is usually a fear so strong that it keeps people ill and underweight.

Having an intense fear of weight regain makes starvation syndrome in someone with an eating disorder different from starvation in the men in the Minnesota Experiment. And the paradox is that the only way out of anorexia nervosa is first getting out of starvation mode —which means gaining weight, the scariest thing for someone with anorexia nervosa!

Getting out of starvation
The fear of weight regain is something that your therapist will understand. He or she will be very empathic, but will be encouraging you to relearn to eat, since it is not helpful for them to support you to remain in a state of starvation.

The physical and mental changes you have experienced will also be reversed when you increase and normalise your food intake, giving your body the energy it needs. The mental changes often take longer. Through regular and healthy eating, your body can regain its strength and fight these symptoms of starvation. You may need to consult a medical practitioner, psychologist, dietitian or other health professional for support with this.

Your brain will not function as it should without adequate nutrition. A starved brain will have problems processing and regulating emotions, which means your moods and reactions to situations might be unpredictable.

You will find that you feel stronger and have more energy when you return to a weight that is healthy for you. Your hormones and your heart will be functioning in a healthy way, but for a while you may still feel anxious about food. Your brain will take longer to return to its former levels of functioning, but it will catch up!
Appendix I: ICD-10-AM EATING DISORDER

DIAGNOSIS CODES

F50 Eating Disorders

Excludes: Anorexia NOS (R63.0)

Feeding:
• difficulties and mismanagement (R63.3)
• disorder of infancy or childhood (F98.2)
• polyphagia (R63.2)

F50.0 Anorexia nervosa

A disorder characterised by deliberate weight loss, induced and sustained by the patient. It occurs most commonly in adolescent girls and young women, but adolescent boys and young men may also be affected, as may children approaching puberty and older women up to the menopause. The disorder is associated with a specific psychopathology whereby a dread of fatness and flabbiness of body contour persists as an intrusive overvalued idea, and the patients impose a low weight threshold on themselves. There is usually undernutrition of varying severity with secondary endocrine and metabolic changes and disturbances of bodily function. The symptoms include restricted dietary choice, excessive exercise, induced vomiting and purgation, and use of appetite suppressants and diuretics.

Excludes: loss of appetite:
• NOS (R63.0)
• psychogenic (F50.8)

F50.1 Atypical anorexia nervosa

Disorders that fulfil some of the features of anorexia nervosa but in which the overall clinical picture does not justify that diagnosis. For instance, one of the key symptoms, such as amenorrhoea or marked dread of being fat, may be absent in the presence of marked weight loss and weight-reducing behaviour. This diagnosis should not be made in the presence of known physical disorders associated with weight loss.

F50.2 Bulimia nervosa

A syndrome characterised by repeated bouts of overeating and an excessive preoccupation with the control of body weight, leading to a pattern of overeating followed by vomiting or use of purgatives. This disorder shares many psychological features with anorexia nervosa, including an overconcern with body shape and weight. Repeated vomiting is likely to give rise to disturbances of body electrolytes and physical complications. There is often, but not always, a history of an earlier episode of anorexia nervosa, the interval ranging from a few months to several years.

Bulimia NOS
Hyperorexia nervosa
F50.3  Atypical bulimia nervosa
Disorders that fulfil some of the features of bulimia nervosa, but in which the overall clinical picture does not justify that diagnosis. For instance, there may be recurrent bouts of overeating and overuse of purgatives without significant weight change, or the typical overconcern about body shape and weight may be absent.

F50.4  Overeating associated with other psychological disturbances
Overeating due to stressful events, such as bereavement, accident, childbirth, etc.
Psychogenic overeating
Excludes: obesity (E66.-)

F50.5  Vomiting associated with other psychological disturbances
Repeated vomiting that occurs in dissociative disorders (F44.-) and hypochondriacal disorder (F45.2), and that is not solely due to conditions classified outside this chapter. This subcategory may also be used in addition to O21.- (excessive vomiting in pregnancy) when emotional factors are predominant in the causation of recurrent nausea and vomiting in pregnancy.
Psychogenic vomiting
Excludes: nausea (R11)
   vomiting NOS (R11)

F50.8  Other eating disorders
Pica in adults
Psychogenic loss of appetite
Excludes: pica of infancy and childhood (F98.3)

F50.9  Eating disorder, unspecified
Appendix II: References


North Metropolitan Health Service (2014) A comprehensive specialist eating disorders service for youths and adults in Western Australia


Wakefield, W., Williams, H (2009) DAA Practice Recommendations for the Nutritional Management of Anorexia Nervosa in Adults


Ellis, L.B. (1946) Electrocardiographic abnormalities in severe malnutrition. British Heart Journal: 8; 53


Golden, NH., Keane-Miller, C., Sainana, KL., Kapphahn, CJ., (2013) Higher caloric intake in hospitalized adolescents with anorexia nervosa is associated with reduced length of stay and no increase rate of refeeding syndrome. J Adol Health:53(5); 573-8


Kohn, MR., Madden, S., Clarke, SD. (2011) Refeeding in anorexia nervosa; increased safety and efficiency through understanding the pathophysiology of protein calorie malnutrition. Curr Opin Pediatr:23:390-394


Royal Brisbane and Women’s Hospital A guide to admission and inpatient treatment for people with eating disorders at the Royal Brisbane and Women’s Hospital


Whitelaw, M., Gilbertson, H., Lam, P., Sawyer, SM. (2010) Does aggressive refeeding in hospitalised adolescents with anorexia nervosa result in increased hypophosphatemia? J Adol Health:46;577-582

Appendix III: Sample 6000kJ Oral Meal Plan

WA Eating Disorders Outreach & Consultation Service

Nutritional Management Oral Meal Plan (Step 1A)

This meal plan can be started prior to review by your facility dietitian and provides ~6000kJ

<table>
<thead>
<tr>
<th>PATIENT DETAILS (use sticker if available)</th>
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<tbody>
<tr>
<td>UMRN</td>
</tr>
<tr>
<td>Surname</td>
</tr>
<tr>
<td>Given Names</td>
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<tr>
<td>D.O.B.</td>
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<td>Sex</td>
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<td>Address</td>
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Medical Nutritional Supplement if <100% Prescribed Meal / Snack Completed

**BREAKFAST (08.00 – 08.30)**
- 1 Portion Pack Cereal (Cornflakes™ or Rice Bubbles)
- 150ml Hilo Milk
- 1 Portion Pack Tinned Fruit in Natural Juice

200ml bottle Fortisip (no fibre) OR 200ml tetrapak Sustagen (Ready to Drink)

**MORNING TEA (10.00 – 10.15)**
- 200ml UHT Flavoured Milk
- 1 Piece Fresh Fruit

100ml Fortisip (no fibre) OR 200ml tetrapak Sustagen (Ready to Drink)

**LUNCH (12.00 – 12.30)**
- **Hot** Main Meal (standard serve / portion size)
  (must include carbohydrate portion e.g. potato / rice / couscous / pasta)

200ml bottle Fortisip (no fibre) OR 200ml tetrapak Sustagen (Ready to Drink)

**AFTERNOON TEA (15.00 – 15.15)**
- 200ml UHT flavoured milk

100ml Fortisip (no fibre) OR 200ml tetrapak Sustagen (Ready to Drink)

**DINNER (17.00 – 17.30)**
- **Hot** Main Meal (standard serve / portion size)
  (must include carbohydrate portion e.g. potato / rice / couscous / pasta)

200ml bottle Fortisip (no fibre) OR 200ml tetrapak Sustagen (Ready to Drink)

**SUPPER (20.00 – 20.15)**
- 200ml UHT flavoured milk

200ml bottle Fortisip (no fibre) OR 200ml tetrapak Sustagen (Ready to Drink)

**Notes:**
- Nutritional content is approximate and will vary based on hot main meal choice and region
- The patient has **30 minutes** to complete the main meal and **15 minutes** for snacks. A Medical Nutritional Supplement is to be provided if <**100%** of the prescribed meal or snack is consumed
- Patient to remain seated and supervised for **60 minutes** post meals and **30 minutes** post snacks
- An additional Medical Nutritional Supplement may be required during the night or late supper (2200 – 0000) to avoid low BSL levels especially overnight as per facility hypoglycaemia guidelines
**Appendix IV: Sample Oral Liquid Meal Plan**

**PATIENT DETAILS (use sticker if available)**

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<thead>
<tr>
<th>UMRN</th>
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<th>Given Names</th>
<th>D.O.B.</th>
<th>Sex</th>
<th>Address</th>
</tr>
</thead>
</table>

This oral liquid meal plan can be started prior to review by your facility dietitian.

**BREAKFAST (08.00 – 08.30)**
- 200ml bottle / tetrapak Ensure Plus **OR** Fortisip (no fibre) **OR** Resource Protein

**MORNING TEA (10.00 – 10.15)**
- 100ml Ensure Plus **OR** Fortisip (no fibre) **OR**
- 200ml bottle Resource Protein

**LUNCH (12.00 – 12.30)**
- 200ml bottle / tetrapak Ensure Plus **OR** Fortisip (no fibre) **OR** Resource Protein

**AFTERNOON TEA (15.00 – 15.15)**
- 100ml Ensure Plus **OR** Fortisip (no fibre) **OR**
- 200ml bottle Resource Protein

**DINNER (17.00 – 17.30)**
- 200ml bottle / tetrapak Ensure Plus **OR** Fortisip (no fibre) **OR** Resource Protein

**SUPPER (20.00 – 20.15)**
- 200ml bottle / tetrapak Ensure Plus **OR** Fortisip (no fibre) **OR** Resource Protein

**Notes:**
- The patient has **30 minutes** to complete the Medical Nutritional Supplement at a main meal time and **15 minutes** at a snack time.
- Patient to remain seated and supervised for **60 minutes** post meals and **30 minutes** post snacks.
- If the patient is struggling to complete the above meal plan then it is recommended that enteral feeding be considered.
- An additional Medical Nutritional Supplement may be required during the night or late supper (2200 – 0000) to avoid low BSL levels especially overnight as per facility hypoglycaemia guidelines.
### Appendix V: BMI Banding Chart

**WA Eating Disorders Outreach & Consultation Service**

**BMI / Weight Chart**

<table>
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<th>Date</th>
<th>Wt</th>
<th>BMI</th>
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#### PATIENT DETAILS (use sticker if available)

- **UMRN**
- **Surname**
- **Given Names**
- **D.O.B.**
- **Sex**
- **Address**

#### Instructions for inpatients:
- Dressed in hospital gown and underwear, no shoes
- First thing in the morning (e.g. 6.30am) after voiding
- Specific Gravity <1.010 indicates dilute urine

#### Goal Weight: ________ kg

#### Goal BMI: ______________ kg/m$^2$

To complete insert BMI on dotted line

BMI = weight (kg) ÷ height$^2$ (m)

#### Weight (kg)

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**Acknowledgement:** Used with Permission from Queensland Eating Disorders Outreach Service   Developed: May 2016
NOTES FOR USING BMI CHART

Admission Weight

- Admission weight and height is to be recorded in the space located in the top left hand side of the weight chart document.

- The BMI (Body Mass Index) is then calculated and disclosed to the patient

\[
\text{BMI} = \frac{\text{Weight (kg)}}{\text{Height squared (m}^2\text{)}}
\]

E.g. Weight 35kg and Height 1.70m

\[
35.0 \div (1.70 \times 1.70) = \text{BMI 12.1}
\]

Subsequent Weights

- Subsequent weights are to be recorded by plotting the patient’s weight on the weight chart document.

- Feedback regarding the patient’s weight must not include actual numbers, but rather include information regarding the clients ‘BMI range’. This essentially includes three options

4. Steady / Stable
   - The patient’s weight has remained in the current BMI range
   - The patient’s weight has gone above / below the current range but is a one off

5. Moved Up
   - Patient’s weight has been above the current BMI range for four consecutive weights

6. Moved Down
   - The patient’s weight has been below the current BMI range for four consecutive weights
Could your patient have an Eating Disorder?
WAEDOCS Clinicians Guide for Assessing Medical Risk

General
- HYPOTHERMIA
- DEHYDRATION
- COLLAPSE
- Cyanosis of the extremities
- Peripheral oedema

Have you measured?
- Weight
- Height
- BMI (=weight + height^2)
- HR/BP (postural)
- Temperature

Ear, Nose, Throat (ENT)
- Dental caries
- Gingivitis
- Parotid enlargement

Respiratory
- Pneumonia
- Effusions

Integumentary System
- Dry skin
- Brittle nails
- Dry hair
- Lanugo
- Dorsal finger callouses (Russell's sign)

Skeletal
- Osteoporosis / Non-union fractures
- Bone pain / deformity
- Muscle weakness

Haematological
- HYPOKALAEMIA
- ANAEMIA
- Neutropenia
- Deranged electrolytes / LFTs

Evidence of Starvation
- WEIGHT LOSS
- HYPOTENSION
- Malnourished
- Underweight
- Early satiety

Central Nervous System (CNS)
- POOR INSIGHT
- IRRITABILITY
- COGNITIVE RIGIDITY
- IMPAIRED COGNITION
- Preoccupation with food / bowels
- Delirium
- Seizures

Cardiovascular (CVS)
- POSTURAL TACHYCARDIA
- HYPOTENSION
- BRADYCARDIA
- ARRHYTHMIAS +/- PROLONGED QT INTERVAL
- Cardiac Failure

Gastrointestinal / Renal / Hepatic
- RECURRENT VOMITING / PURGING
- Oesophageal tears
- Abdominal distension
- Constipation / Diarrhoea
- Rectal prolapse
- Chronic renal impairment, stones
- Liver impairment

Endocrine
- HYPOGLYCAEMIA
- Thyroid abnormalities
- Amenorrhoea / Anovulation

Note: Signs and symptoms above in bold are the most common indicators
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Psychiatric or Medical Admission a Indicates (level of acuity can usually be managed in either setting)</th>
<th>Acute Medical Admission b Is Required (level of acuity usually requires a medical ward)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid weight loss</td>
<td>Rapid weight loss (i.e. 1kg/week over several weeks) or grossly inadequate nutritional intake (&lt;100kcal daily) or continued weight loss despite community treatment</td>
<td></td>
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<tr>
<td>Re-feeding Risk</td>
<td>High (if markers below are present)</td>
<td>Extreme (if the markers below are present)</td>
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<tr>
<td>Systolic BP</td>
<td>&lt;90 mmHg</td>
<td>&lt;80 mmHg</td>
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<tr>
<td>Postural BP</td>
<td>&gt;10 mmHg drop with standing</td>
<td>&gt;20 mmHg drop with standing</td>
</tr>
<tr>
<td>Heart rate</td>
<td>&lt;40 bpm or &gt; 120 bpm or postural tachycardia &gt; 20 beats/min</td>
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<tr>
<td>Temperature</td>
<td>&lt;35.5°C or cold/blue extremities</td>
<td>&lt;35°C or cold/blue extremities</td>
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<tr>
<td>12-lead ECG</td>
<td>Any arrhythmia including QTc prolongation, nonspecific ST or T-wave changes including inversion or biphasic waves</td>
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<tr>
<td>Blood sugar</td>
<td>Below normal range*</td>
<td>&lt; 2.5 mmol/L</td>
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<tr>
<td>Sodium</td>
<td>&lt;130 mmol/L</td>
<td>&lt;125 mmol/L</td>
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<tr>
<td>Potassium</td>
<td>Below normal range*</td>
<td>&lt;3.0 mmol/L</td>
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<tr>
<td>Magnesium</td>
<td>Below normal range*</td>
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<tr>
<td>Phosphate</td>
<td>Below normal range*</td>
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<tr>
<td>Albumin</td>
<td>Below normal range</td>
<td>&lt;30 g/L</td>
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<tr>
<td>Liver enzymes</td>
<td>Mildly elevated</td>
<td>Markedly elevated (AST or ALD &gt;500)*</td>
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<tr>
<td>Neutrophils</td>
<td>&lt;1.5 x 10^9/L</td>
<td>&lt;1.0 x 10^9/L</td>
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<tr>
<td>eGFR</td>
<td>&lt;60ml/min/1.73m² or rapidly dropping (25% drop within a week)</td>
<td></td>
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<tr>
<td>Weight (Body Mass Index (BMI) &lt;16kg/m²)**</td>
<td>(Body Mass Index (BMI) &lt;14kg/m²)**</td>
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<tr>
<td>BMI &lt;14kg/m² (&gt; 85% Ideal Body Weight 16 – 18 years)</td>
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<tr>
<td>Risk assessment</td>
<td>- Suicidal ideation, Active self-harm, Moderate to high agitation and distress,</td>
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<td>- Other psychiatric condition requiring hospitalisation</td>
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<tr>
<td>Severe ED symptoms</td>
<td>- Bulimia Nervosa without control of vomiting, Vomiting &gt;4 times per day, Bulimia Nervosa with hypokalaemia,</td>
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<td>- Excessive daily laxative use</td>
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<td>Other</td>
<td>- Not responding to outpatient treatment;</td>
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<td>- Aversive family relationships or severe family stress or strain</td>
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</tbody>
</table>

Starvation Syndrome can occur at any weight therefore weight should not be the deciding factor for admission location or use of the Mental Health Act.

* Patients who are not as unwell as indicated above may still require admission to a psychiatric or other inpatient facility.

b Medical admission refers to admission to a medical ward, short stay medical assessment unit or similar.

* Please note, any biochemical abnormality which has not responded to adequate replacement within the first 24 hours of admission should be reviewed by a medical registrar urgently

** This additional information is taken from NSW Health and CEDD Guideline for Inpatient Management of Eating Disorders in General Medical and Psychiatric Setting in NSW (2014).

Source: RANZCP Clinical Practice Guidelines for the Treatment of Eating Disorders 2014

What to do next?

Ensure the patient is reviewed by the appropriate team and transferred to the appropriate location (General Medicine / Speciality / Mental Health / Community with Mental Health follow up)

For further support call WA Eating Disorders Outreach and Consultation Team (WAEDOCS) on 1300 629 208 Monday – Friday 9am – 4pm
Enquires regarding this document
should be directed to WAEDOCS on 1300 620 208