

Adult Eating Disorder Admission Guideline

Key Points

- This document aims to support admissions for patients where the intent is for re-feeding/medical stabilisation.
- Adults admitted with Eating Disorders are often at high risk of death from starvation & organ failure.
- A multi-disciplinary approach is vital to ensure safe care for these patients, and should include gastroenterologists, psychiatrists, nursing staff and dietitians.
- Patients deemed at high risk of sudden death who refuse treatment should be considered for detention under the framework of the Mental Health Act and treatment given in their best interests.
- Thorough assessment of risk and adequate monitoring of these patients is vital to mitigate the risks & ensure adequate provision of care.
- Adequate follow-up care should be arranged for these patients – whether under community eating disorder services or via transfer to a specialist inpatient unit.
- Nutrition is the lifesaving treatment that should be administered as a clinical priority. See Appendix B for a sample meal plan and Appendix C for the out of hours NG feeding regimen.

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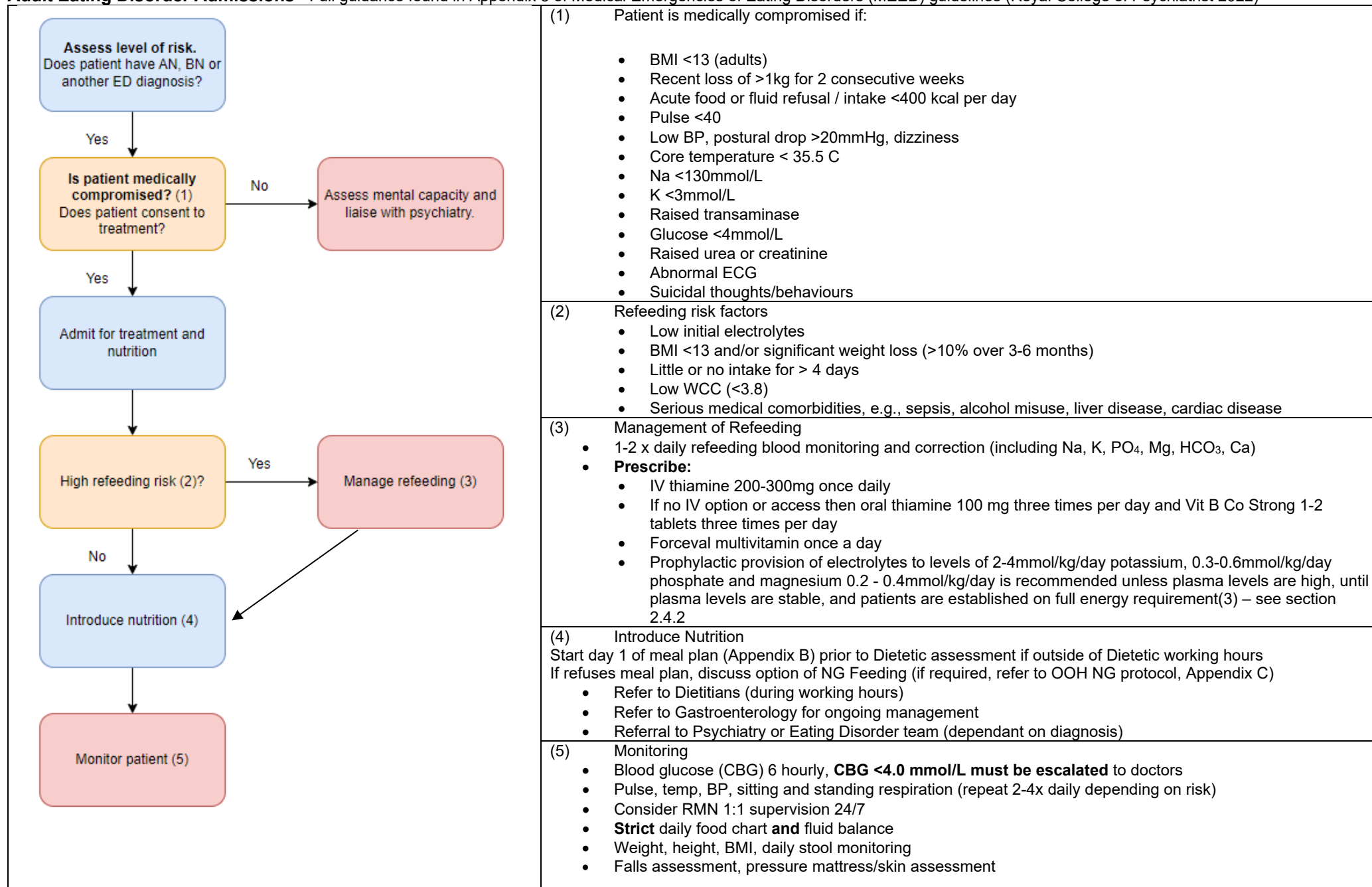
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Abbreviations

AN	Anorexia Nervosa
BN	Bulimia Nervosa
HDU	High Dependency Unit
MCA	Mental Capacity Assessment
MDT	Multidisciplinary team
MEED	Medical Emergencies in Eating Disorders
MHA 1983	Mental Health Act 1983
NGT	Nasogastric tube
OOH	Out of hours
SEDU	Specialist Eating Disorder Unit

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Adult Eating Disorder Admissions - Full guidance found in Appendix 3 of Medical Emergencies of Eating Disorders (MEED) guidelines (Royal College of Psychiatrist 2022)


1 INTRODUCTION

This document is designed to offer guidance to doctors, registered nurses, Allied Health Professionals (AHPs) and psychiatric liaison services involved in the management of seriously ill adult patients with eating disorders when they are admitted to an acute medical setting. It aims to provide a local framework to support safe initiation of care on admission to hospital and should be used in conjunction with the Medical Emergencies in Eating Disorders (MEED): Guidance on Recognition and Management College Report (Royal College of Psychiatrists 2022) ⁽¹⁾.

The guidance refers to patients over the age of 18 years old. If the patient is under 18 years of age, please refer to the [Paediatric Oral and Enteral Feeding](#) guideline.

Eating Disorders are severe psychiatric illnesses that can present with life-threatening physical emergencies caused by undernutrition and severe dietary restriction; and/or compensatory behaviours, such as bingeing, purging, laxative and diuretic misuse and overexercising. Often, individuals with eating disorders present with complex medical, social and/or psychological needs ⁽²⁾.

Hospital admissions for Eating Disorders have increased by 84% in the last 5 years ⁽³⁾. Individuals with eating disorders have significantly elevated mortality rates, with the highest rates occurring in those with Anorexia Nervosa (AN)⁽⁴⁾.

Refeeding syndrome occurs when there is a sudden reversal of prolonged starvation by the reintroduction of nutrition via oral, enteral or parenteral routes and this can have fatal consequences ⁽⁵⁾. Cardiovascular and neurological disturbances can occur as a result of rapid electrolyte shifts resulting in deranged phosphate, potassium and magnesium levels. Respiratory failure, liver dysfunction, central nervous system abnormalities, myopathy and rhabdomyolysis are also recognised complications.

2 DEFINITIONS

- 2.1 **Anorexia Nervosa (AN)** is a psychological condition in which individuals manipulate their energy intake/energy expenditure to keep their weight as low as possible. It is often associated with a distorted perception of body image and/or a poor relationship with food. Those diagnosed with AN may also exhibit purging behaviours, but the key difference between AN and BN is that this is done with the intent to lose weight/keep weight as low as possible.
- 2.2 **Bulimia Nervosa (BN)** is a psychological condition associated with binge/purging behaviours. The key difference between BN & AN is that those with BN do not purge with the intent to lose weight. This guideline is not suitable for use with those with a diagnosis of Bulimia Nervosa.
- 2.3 **Refeeding syndrome** is a physiological response to an increased nutritional intake (primarily following introduction of carbohydrates) in a starved individual. It can be life-threatening due to electrolyte derangements & can also result in encephalopathy due to B vitamin deficiencies. The response can be managed with slow introduction of nutrients alongside adequate electrolyte monitoring and B vitamin replacement.
- 2.4 **A Nasogastric Tube (NGT)** is a reliable route of feed administration in patients with severe starvation syndrome, as it provides a measured form of calories during the

refeeding process. A tube is placed through the nares into the stomach & feed is administered through this tube. It is important that local guidelines are followed for tube placement, confirmation & checking of position of the tube.

- 2.5 **Mental capacity** is the ability of an individual to weigh up, retain & make decisions on information regarding their care. Those with severe psychological condition (e.g AN) may lack capacity due to their disordered psychological processing & thus treatment may be given in their best interests under the Mental Health Act. Decisions regarding capacity are situation & decision specific, however. Therefore, someone with AN refusing treatment may not automatically lack capacity & thus decisions should be made on an individual basis & as an MDT.
- 2.6 The **Mental Health Act 1983⁽⁷⁾ (MHA)** is a legal document designed for use in the healthcare settings where patients suffer with a mental health condition (e.g., AN). In some situations where patients are deemed to lack capacity based on their mental health status, patients can be detained under the mental health act & be treated in their best interests. This is often when a patient's decisions are likely to cause direct harm to themselves or others (in this case, death from starvation).
- 2.7 A **Mental Capacity Assessment (MCA)** is a key piece of documentation used to objectively assess an individual's capacity. Capacity assessments should be formally documented in the medical notes.

3 DUTIES AND RESPONSIBILITIES

Medical staff

- Assess and manage risk as per Trust and MEED guidance.
- Without delay refer to Psychiatry Liaison Service and Dietetic Teams.
- Before discharging a patient from the emergency department, seek an opinion from a Consultant Psychiatrist, specialist clinician from Adult Eating Disorders Service, or the referring clinician.
- Refer to Diabetes Specialist Nurses/Endocrinology team to support in the management of those with Type 1 Diabetes.
- Prior to feeding, determine risk of developing refeeding syndrome.
- Ensure refeeding bloods are monitored daily and prescribe vitamins and electrolyte replacement as per Trust and MEED guidance. For very high-risk patients, assess whether twice daily bloods or cardiac monitoring is necessary.
- Assess if a HDU bed is required for monitoring and electrolyte correction while feeding is established.
- Start refeeding as per Trust and MEED guidance for non-specialists in eating disorders until dietetic assessment takes place.
- Daily clinical assessment for complications of refeeding syndrome.
- If patient refuses treatment, assess capacity under the Mental Health Acts, or if not appropriate, the Mental Capacity Act. Inform nearest relative if patient is detained. Arrange discharge as soon as possible and consult with psychiatric experts

Psychiatric Liaison Service

- Refer to the Adult Eating Disorder Team if patient is not already known to the service.
- Support medical, nursing and dietetic teams with guidance around compulsory treatment and mental health legislation, including restraint.
- Advise when supervision from a Registered Mental Health Nurse (RMN) is appropriate.
- Assess for behavioural manifestations of eating disorders and bring to the attention of the clinical team.
- Where appropriate, provide advice on medication to reduce anxiety in patients undergoing medical stabilisation.
- Support in the management of comorbid mental health conditions, risk of self-harm and suicidal ideation.

Dietitian

(General working hours Monday – Friday, 0830 - 1630)

- FHFT acute dietitians are not specialist in eating disorders. The acute dietetic team will seek advice from the specialist eating disorder team where appropriate.
- Assess and monitor refeeding risk.
- Preparation of meal plan and/or enteral feeding regimen based on estimated nutritional requirements.
- Develop individualised care plan in collaboration with the patient and MDT.
- Regular communication with the MDT.
- Monitor patient's adherence to Dietetic care plan and make appropriate adjustments as required.

Nursing staff

- Ensure accurate handover of Dietetic care plans.
- Measure weight at appropriate intervals as set out by the MDT.
- Complete risk assessment for tissue viability / pressure mattress.
- Complete capillary blood glucose (CBG) monitoring 6 hourly, until directed otherwise by the medical/dietetics teams.
- Monitor and document compensatory behaviours, such as over-exercising, purging or other methods of avoiding weight gain, bingeing, self-harm, and of violent or other disturbed behaviours.
- Strict completion of accurate food and fluid charts and/or enteral feeding provision
- Regular communication with the MDT.

Adult Eating Disorder Service

- Provide handover (to A&E clinicians, Gastroenterologist and Dietitians as appropriate) for patients already known to service and outline intended aims of the admission.
- Provide advice and guidance to acute medical managing team including ward visits in line with clinical need and resource.
- Eating disorder specialist dietitian to provide advice and guidance to acute dietitians where appropriate.
- Communicate discharge follow up plan or submit Specialist Eating Disorder Unit (SEDU) referral.

- Support acute medical, nursing and dietetic teams with guidance around compulsory treatment and mental health legislation. This will be provided in collaboration with Liaison Psychiatry team.

Pharmacy

- Advise on possible interactions between medication and enteral feeding.
- Advise on suitable medication formulations based on enteral route availability.
- Identify dose adjustments of medications required for patients with low body weights.

Bed managers

- Coordinate transfer to appropriate ward depending on clinical need i.e. gastroenterology ward or HDU

4 THE GUIDELINE

4.1 Medical assessment of risk

A copy of the framework developed by MEED can be found in Appendix A. The framework is intended to guide level of concern and requires clinical judgement for its interpretation. It is designed to aid decisions on emergency management such as admissions for monitoring and refeeding.

Please refer to the relevant sections for detailed management guidance regarding these potential life-threatening complications:

- Electrolyte disturbances (see section 4.2)
- Hypoglycaemia (see section 4.3)
- Cardiac arrhythmias (see section 4.4)

4.2 Electrolyte management in refeeding syndrome

Correction of electrolyte disturbances prior to or alongside introduction of nutrition is important, with particular attention given to phosphate, potassium, calciums and magnesium.

Once feeding has been initiated, there is a risk of refeeding syndrome occurring. This can occur within 72 hours after feeding is commenced, with a range of 1–5 days⁽⁶⁾, but in some cases it can occur late (in one study up to 18 days) and therefore close monitoring is advised.

Clinical and laboratory features of refeeding syndrome:

- Severely low electrolyte concentrations
- Peripheral oedema or acute circulatory fluid overload
- Disturbance to organ function including respiratory failure, cardiac failure or pulmonary oedema, raised liver transaminases.

NB. Not all features need to be present.

Daily or twice daily (in the highest risk and/or unstable patients) monitoring of plasma urea and electrolytes (U&E), Magnesium, phosphate, potassium and adjusted calcium should be carried out until patient is at goal rate of nutrition support. Frequency can then be reduced as per clinical need to daily or 2-3 times a week⁽¹⁵⁾.

4.2.1 Prophylactic electrolyte provision

Prophylactic electrolyte provision is recommended to be prescribed unless plasma levels are high and patients are established on full energy requirement ⁽¹⁶⁾. This should be prescribed on initiation of feeding.

Prophylactic oral electrolyte replacement can avoid the need for IV preparations which can be associated with very large amounts of fluid and sodium.

Prophylactic dosing of electrolytes:

- Potassium: 2-4mmol/kg/day
- Phosphate: 0.3-0.6mmol/kg/day
- Magnesium 0.2 mmol/kg/day (for IV replacement)
- Magnesium: 0.4mmol/kg/day (for oral replacement)

Suggested prophylactic oral electrolyte provision for patients weighing 30-40kg and at high risk of refeeding problems with normal renal function:

Electrolyte	Example preparation	Typical Dose	Provision/day (mmol)
Potassium	Sando K (12 mmol/tablet)	2 tablets tds	72 mmol K
Phosphate	Phosphate Sandoz tablet (16 mmol/tablet)	1 tablet bd	32 mmol PO ₄
Magnesium	Magnaspartate powder (10 mmol/sachet)	1 sachet bd	20 mmol Mg
	Neomag chewable tablet (4 mmol/tablet)	2 tablets bd	16 mmol Mg

4.2.2 Electrolyte replacement

Intravenous electrolyte replacement may be required if the gut is not functioning properly or is inaccessible or where plasma levels are very low for example:

- Potassium < 2.5
- Phosphate < 0.4
- Magnesium < 0.4

When IV electrolyte provision is deemed necessary, it is recommended that where possible patients are transferred to a high dependency or similar unit for provision of concentrated electrolytes. Where non-concentrated electrolytes are used, glucose 5% is the preferred diluent but the total calorie provision of this approach should be considered.

Extreme caution should be taken when giving IV electrolytes in NaCl 0.9% due to the risk of sodium and fluid overload. In those with hyponatraemia due to purging or diarrhoea, NaCl 0.9% can be considered. Also consider the sodium content of medications – discuss with pharmacy for further advice.

4.2.3 Potassium

Caution should be taken in patients with renal insufficiency and those who are habitually vomiting.

The need for supplementation should be reviewed regularly and any amendments made to the patient's drug chart accordingly.

Potassium Deficiency	Mild 3.0 – 3.5 mmol/L	Moderate 2.5 - 3 mmol/L	Severe <2.5 mmol/L
Oral/enteral Sando K 12mmol/tab	Two TDS (72 mmol)	Three TDS (108 mmol)	Not appropriate
Intravenous supplementation	Ready-prepared infusions with 20mmol/l OR 40 mmol/l potassium		Specialist areas only

4.2.4 Phosphate

Caution should be taken in patients with renal insufficiency.

The need for supplementation should be reviewed regularly and any amendments made to the patient's drug chart accordingly.

Phosphate Deficiency	Mild 0.65 – 0.79 mmol/L	Moderate 0.4 – 0.64 mmol/L	Severe <0.4 mmol/L
Oral/enteral supplementation	Phosphate-Sandoz (16.1mmol PO ₄ ³⁻ /tablet) 1 tablet BD (32mmol)	Phosphate-Sandoz (16.1mmol PO ₄ ³⁻ /tablet) 2 tablets BD (64mmol)	Not appropriate
Intravenous supplementation	Phosphate polyfusor (50mmol/ 500mls) 90mls over 12hrs (= 9mmol phosphate) rate = 7.5ml/hr		2-5ml/kg over 6-12 hours

Adjusted calcium (adj Ca) can drop in refeeding as a result of phosphate provision. When adj Ca <2.0 mmol/L, seek advice a member of the nutrition support team.

4.2.5 Magnesium

Caution should be taken in patients with renal insufficiency.

The need for supplementation should be reviewed regularly and any amendments made to the patient's drug chart accordingly.

Magnesium Deficiency	Mild 0.5 – 0.7 mmol/L	Moderate 0.4 – 0.5 mmol/L	Severe <0.4 mmol/L
Oral supplementation	Magnesium Glycerophosphate (4mmol Mg+ /tablet), unlicensed 2 tablets TDS (24mmol)		Not appropriate
Intravenous supplementation	Magnesium sulphate 8mmol in 250ml glucose 5% (or sodium chloride 0.9%) over 2-3hrs		Magnesium sulphate 20mmol in 250ml in glucose 5% (or sodium chloride 0.9%) over at least 2.5 hours. If symptoms severe e.g. serious arrhythmias (especially if hypokalemia), give 8 mmol (2g) over 10-15 mins. Repeat if necessary, with continuous ECG monitoring.

4.3 Hypoglycaemia

Malnutrition can be associated with hypoglycaemia due to limited substrates for gluconeogenesis and glycogenolysis. Glucose monitoring is advised for all patients four times a day until the patient is at goal rate of nutrition support and blood glucose has normalised. Frequency can then be reduced to twice daily if blood glucose levels are stable ⁽¹⁵⁾. If there is a change in infusion time or feed rate, increase to four times daily for 48 hours and then reduce back down to twice daily if blood glucose levels are stable.

Please refer to the FHFT clinical guidance for '[Hospital management of hypoglycaemia in adults with/without diabetes mellitus](#)' for further advice.

Recommendations for the management of hypoglycaemia include checking for additional (e.g., sepsis) or alternative (Addison's disease, insulin abuse) diagnoses.

4.4 Cardiac arrhythmias

All patients require daily ECG monitoring to check for arrhythmias associated with electrolyte disturbances.

4.5 Nutrition guidance

4.5.1 Introduction of nutrition

A referral to the Dietetics team should be made at the earliest opportunity. Please raise an 'Inpatient Consult to Dietetics' on EPIC.

Nutrition is the lifesaving treatment that should be administered as a clinical priority. Patients should not be started on fewer calories than they were consuming prior to admission due to the risk of underfeeding.

4.5.2 Meal plan

The preferred method of feeding is oral via a prescribed meal plan.

- In hours, this will be prescribed by a Dietitian.
- Out of hours, please see Appendix B.

The meal plan should comprise of solid food. If meals and/or snacks are not completed, then nutritionally complete supplements (*Fortisip Compact*) in measured volumes should be offered to the patient to meet nutritional requirements – please see Appendix B for recommended volumes of nutritional supplements.

Please pre portion the meals prior to being served to prevent any complications. All food and fluid ingested (including amounts) should be strictly documented on food charts.

Specific dietary requests such as vegan diets or lactose intolerance should be considered and planned for via the MDT. If the patient is under the care of the Adult Eating Disorder Service, information on special diets should be included in the handover and shared with the acute team.

NB. The meal plan stipulates daily calorie intake and therefore caution should be used when sharing this information with patients.

4.5.3 Commencing nutrition

High physical risk of refeeding and/or a BMI <13 (as outlined on page 3 of this document):

- Cautious refeeding at around 10kcal/kg per day with energy provision built up rapidly to meet or exceed requirements by around day 4 and a maximum of day 7 ⁽¹⁵⁾.
- Increases in feeding should not be withheld unless K <2.5mmol/l, Mg <0.4 mmol/l or PO4 <0.4 mmol/l, provided that electrolytes are supplemented as recommended in section 4.2 of this document.
- If electrolytes are significantly deranged on presentation, an HDU bed may be the most appropriate care area for correction while feeding is established.

Low physical risk of refeeding:

- A starting intake of 30–35kcal/kg/day is advised, with increases of 200–300kcal/day every 2–3 days (MEED, 2022)

Steady calorie increases should be continued until weight gain of 0.5 – 1kg (MEED, 2022) is achieved or meeting ~60kcal/kg/day. Weight gain of up to 2kg/week is considered safe as long as there is close physical monitoring.

Fluctuations in weight due to rehydration and replenishment of glycogen storage are common. Clinicians should monitor for occurrence of peripheral oedema.

4.5.4 Enteral Feeding

If after 24 hours of initiating the meal plan there has been insufficient intake, NGT feeding should be considered in collaboration with the patient (as much as possible). Factors such as baseline medical risk including life-threatening weight loss that exposes the patient to immediate danger, clinical or biochemical instability, duration of feeding and an assessment of the likelihood that the behaviour will change (based on history), should be taken into account.

If the patient refuses to consent, the application of the relevant legal framework should be considered, i.e., a Mental Health Act assessment or use of Mental Capacity Act & DOLS in an emergency, in order to deliver life-saving treatment.

If NG feeding is required out of Dietetic working hours, please refer to Appendix C.

4.5.5 Fluid intake

- Accurate documentation on fluid balance charts is extremely important to aid clinical assessment.
- It is recommended that patients have a maximum of 30-35ml/kg/day from all sources of fluid including oral, enteral (feed and flushes) and IV routes.
- Please be aware that patient's may drink excessively to alter their weight and therefore close monitoring and/or restriction of fluids may be required.

4.6 Refusal of treatment

Treatment against the patient's consent should only ever be done within an appropriate legal framework, such as the Mental Health Act or equivalent legislation.

Capacity to consent should be assessed as per the Mental Capacity Act 2005 (8). Medical treatment, especially urgent and lifesaving treatment, is likely to be a best interest's decision if the patient lacks capacity. It is important that assessments of capacity should carefully look at the ability of patients to 'use and weigh' information for the decision in question and the impact of AN on this.

Please refer to the FHFT trust policy 'Mental Capacity and Deprivation of Liberty Safeguards (DoLs)' for further information.

In cases where someone's psychiatric diagnosis is impairing their capacity and it is difficult to assess, please discuss with the Psychiatric Liaison Team.

If a patient is repeatedly objecting treatment or wanting to leave hospital and they are at risk, then they may require the framework of the Mental Health Act. If patients are detained under the Mental Health Act (MHA 1983), their treatment for medical stabilisation takes place under the care of their Responsible Clinician. If a patient is detained under the MHA 1983, their care should be administered even if they object. If a patient is under MHA 1983 this overrides use of the MCA for treatment.

4.7 Ward monitoring

Please monitor the following:

- Pulse, temperature, sitting and standing blood pressure, respiration rate (repeat 2-4 times daily depending on risk).
- Continue 6 hourly blood glucose measurement until directed by treating team.
- Weight in kg on admission, then twice weekly or as per MDT recommendation.
- Height in metres (measured not reported).
- Skin assessment / pressure mattress if required.
- Complete falls assessment
- Daily **strict** food record charts including intake of enteral feed.
- 1:1 mealtime supervision.
- Accurate fluid balance chart.
- Document any compensatory behaviours, such as over-exercising, purging or other methods of avoiding weight gain.
- Discourage bathroom use for 30 minutes after mealtimes.

Weight is best monitored before breakfast and after using the toilet, wearing underwear or light clothing only. Staff should remain vigilant about compensatory behaviours such as water-loading and concealing objects or weights, which can result in unexpected changes in weight. Access to scales may need to be restricted to eliminate the opportunity for the patient to frequently weigh themselves. Staff should avoid openly discussing a patient's weight upon the weight being taken.

A specialist Registered Mental Health Nurse (RMN) may be required for vigilant observation and specialist support to enable the patient to adhere to the care plan. Psychiatry Liaison should be contacted for advice.

4.8 Out of hours guidance

Clinical and refeeding risk should be assessed using the flowchart outlined on page 3. MEEDs risk assessment framework for assessing the impending risk to life can also be found in Appendix A. Guidance on the management of refeeding can be found in the flowchart on page 3 and in section 4.2. Refeeding bloods including plasma urea and electrolytes, magnesium, phosphate and adjusted calcium should be carried out daily (or twice daily in the highest risk and/or unstable patients).

The following should be prescribed:

- IV thiamine 200-300mg once daily
- If no IV option or access then oral thiamine 100 mg three times per day and Vit B Co Strong 1-2 tablets three times per day
- Forceval multivitamin once a day
- Prophylactic provision of electrolytes to levels of 2-4mmol/kg/day potassium, 0.3-0.6mmol/kg/day phosphate and magnesium 0.2 – 0.4mmol/kg/day is recommended unless plasma levels are high, until plasma levels are stable, and patients are established on full energy requirement (3) – see section 2.4.2

A sample meal plan can be found in Appendix B and should be commenced out of hours prior to Dietetic assessment. Please note the meal plan stipulates daily calorie intake and therefore caution should be used when sharing this information with patients.

If after 24 hours of initiating the meal plan there has been insufficient intake, NGT feeding should be considered in collaboration with the patient (as much as possible). If NG feeding is required out of Dietetic working hours, please refer to Appendix C.

5.0 TRAINING

Training on the content and implementation of the guideline will be provided to the relevant staff, including a consultant from the Nutrition Support Team, a consultant psychiatrist, and a Dietitian.

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APPENDIX A - MEED'S RISK ASSESSMENT FRAMEWORK FOR ASSESSING THE IMPENDING RISK TO LIFE (Based on RCP, 2022, pp. 31-35¹)

- Important: risk parameters for adults cannot be applied to children & young people without adjusting for age and gender
- This risk assessment guide cannot replace proper clinical evaluation, but a patient with one or more red ratings or two or more amber ratings should probably be considered high risk

	 Red: High impending risk to life	 Amber: High concern for impending risk to life	 Green: Low impending risk to life
Medical History and examination			
Weight Loss	Recent loss of weight of ≥ 1 kg/week for 2 weeks (consecutive) in an undernourished patient ¹ Rapid weight loss at any weight, e.g. in obesity or ARFID	Recent loss of weight of 500–999g/week for 2 consecutive weeks in an undernourished patient	Recent weight loss of < 500 g/week or fluctuating weight
BMI and weight	• Under 18 years: %mBMI² $< 70\%$ • Over 18: BMI < 13	• Under 18: %mBMI 70–80% • Over 18: BMI 13–14.9	• Under 18: %mBMI $> 80\%$¹ • Over 18: BMI > 15
HR (awake)	< 40	40-50	> 50
Cardiovascular health ^{4 5}	Standing systolic BP below 0.4th centile for age or less than 90 if 18+, associated with recurrent syncope and postural drop in systolic BP of > 20 mmHg or increase in HR of over 30bpm (35bpm in < 16 years)	Standing systolic BP < 0.4 th centile or < 90 if 18+ associated with occasional syncope; postural drop in systolic BP of > 15 mmHg or increase in HR of up to 30bpm (35bpm in < 16 years)	• Normal standing systolic BP for age and gender with reference to centile charts • Normal orthostatic Cardiovascular changes • Normal heart rhythm

	 Red: High impending risk to life	 Amber: High concern for impending risk to life	 Green: Low impending risk to life
Assessment of hydration status	- Fluid refusal - Severe dehydration (10%): reduced urine output, dry mouth, postural BP drop (see above), decreased skin turgor, sunken eyes, tachypnoea, tachycardia	- Severe fluid restriction - Moderate dehydration (5–10%): reduced urine output, dry mouth, postural BP drop (see above), normal skin turgor, some tachypnoea, some tachycardia, peripheral oedema	- Minimal fluid restriction - No more than mild dehydration (<5%): may have dry mouth or concerns about risk of dehydration with negative fluid balance
Temperature	<35.5°C tympanic or 35.0°C axillary	<36°C	>36°C
Muscular function¹: SUSS Test	Unable to sit up from lying flat, or to get up from squat at all or only by using upper limbs to help (Score 0 or 1)	Unable to sit up or stand from squat without noticeable difficulty (Score 2)	Able to sit up from lying flat and stand from squat with no difficulty (Score 3)
Muscular function: Hand grip strength²	Male <30.5kg, Female <17.5kg (3rd percentile)	Male <38kg, Female <23kg (5th percentile)	Male >38kg, Female >23kg
Muscular function: MUAC³	<18cm (approx. BMI<13)	18–20cm (approx. BMI<15.5)	>20cm (approx. BMI >15.5)
Other clinical state	Life-threatening medical condition, e.g. severe haematemesis, acute confusion, severe cognitive slowing, diabetic ketoacidosis, upper gastrointestinal perforation, significant alcohol consumption	Non-life-threatening physical compromise, e.g. mild haematemesis, pressure sores	Evidence of physical compromise, e.g. poor cognitive flexibility, poor concentration

	 Red: High impending risk to life	 Amber: High concern for impending risk to life	 Green: Low impending risk to life
ECG abnormalities	• <18 years: QTc >460ms (female), 450ms (male) • 18+ years: QTc >450ms (females), 430ms (males) • Or any other significant ECG abnormality	• <18 years: QTc >460ms (female), 450ms (male) • 18+ years: QTc >450ms (females), >430ms (males) • And no other ECG anomaly • Taking medication known to prolong QTc interval	• <18 years: QTc <460ms (female), 450ms (male) • 18+ years: QTc <450ms (females), <430ms (males)
Biochemical abnormalities¹	• Hypophosphataemia and falling phosphate • Hypokalaemia (<2.5mmol/L) • Hypoalbuminaemia • Hypoglycaemia (<3mmol/L) • Hyponatraemia • Hypocalcaemia • Transaminases >3x normal range • Inpatients with diabetes mellitus: HbA1C >10% (86mmol/mol)		
Haematology	• Low white cell count • Haemoglobin <10g/L		
Disordered eating behaviours	Acute food refusal or estimated calorie intake <500kcal/day for 2+ days		

¹ Patients losing weight at higher BMI should be assessed for other signs of medical instability and weight loss strategies to determine risk

² AKA weight for height percentage

³ NB. these do not denote a healthy weight but rather a weight above which other parameters in this framework may better reflect risk

⁴ See Balijepalli et al. (2014)⁷

⁵ See NHLBI (2004)⁸

	 Red: High impending risk to life	 Amber: High concern for impending risk to life	 Green: Low impending risk to life
Engagement with management plan	- Physical struggles with staff or parents/carers over nutrition or reduction of exercise - Harm to self - Poor insight or motivation - Fear leading to resistance to weight gain - Staff or parents/carers unable to implement meal plan prescribed	- Poor insight or motivation - Resistance to weight gain - Staff or parents/carers unable to implement meal plan prescribed - Some insight and motivation to tackle eating problems - Fear leading to some ambivalence but not actively resisting	- Some insight and motivation to tackle eating problems - May be ambivalent but not actively resisting
Activity and exercise	High levels of dysfunctional exercise in the context of malnutrition (>2h/day)	Moderate levels of dysfunctional exercise in the context of malnutrition (>1h/day)	Mild levels of or no dysfunctional exercise in the context of malnutrition (<1h/day)
Purging behaviours	Multiple daily episodes of vomiting and/or laxative abuse	Regular (>=3x per week) vomiting and/or laxative abuse	
Self-harm and suicide	Self-poisoning, suicidal ideas with moderate to high risk of completed suicide	Cutting or similar behaviours, suicidal ideas with low risk of completed suicide	

Key:

°C = degrees Celsius; ARFID = avoidant restrictive food intake disorder; BMI = body mass index; BP = blood pressure; bpm = beats per minute; cm = centimetre; ECG = electrocardiogram; g = grams; h = hour; HR = heart rate; kcal = kilocalories; kg = kilogram; L = litre; mmHg = millimetres of mercury; mmol = millimole; mol = mole; ms = millisecond; QTc = corrected QT interval; SUSS Test = Sit Up-Stand-Squat Test.

APPENDIX B: SAMPLE MEAL PLAN (TO BE COMMENCED PRIOR TO DIETETIC ASSESSMENT)

Date	Day 1		Day 2	
	Suggested Food – all items must be offered	Alternative	Suggested Food – all items must be offered	Alternative
Breakfast	Cereal (e.g. 2 weetabix) AND 1 glass of milk ¹	100ml Fortisip Compact	Cereal (e.g. 2 weetabix) and 1 glass of milk ¹	100ml Fortisip Compact
10.00	1 glass of milk ¹ OR 1 ward yoghurt	40ml Fortisip Compact	1 glass of milk ¹ OR 1 ward yoghurt	40ml Fortisip Compact
Lunch	Quarter portion of main meal (carbohydrate, protein and vegetables) OR quarter of ward sandwich	30ml Fortisip Compact	Half portion of main meal (carbohydrate, protein and vegetables) OR half ward sandwich	60ml Fortisip Compact
3.00	1 portion of fruit OR 2 cartons of fruit juice ²	40ml Fortisip Compact	1 portion of fruit ² OR 2 cartons of fruit juice	40ml Fortisip Compact
Tea	Quarter portion of main meal (carbohydrate, protein, vegetables) OR half ward sandwich	30ml Fortisip Compact	Half portion of main meal (carbohydrate, protein, vegetables) OR half ward sandwich	60ml Fortisip Compact
8.00	1 glass of milk ¹ OR 1 ward yoghurt	40ml Fortisip Compact	1 glass of milk ¹ OR 1 ward yoghurt	40ml Fortisip Compact

¹ 1 glass of milk – 150ml whole or 200ml semi skimmed milk or 250ml unsweetened soya milk .

² 1 portion of fruit = 1 piece of fruit (80g) or 2 juice pots (85ml each).

³Light dessert: yoghurt or icecream or custard or mousse. Avoid low fat options.

IMPORTANT DAILY MANAGEMENT- PLEASE READ**Nursing notes:**

- Please keep strict food and fluid charts.
- Avoid toilet trips for 30 minutes post meal or snack.
- Check refeeding bloods before moving to the next day of the feeding plan.
- Check weight twice a week in the morning, before breakfast and after using the toilet. Wearing light clothing and no shoes.
- Do not disclose to patient ahead of time when they will be weighed.

Meal plan notes:

- Main meals should be ordered from the standard hospital menu. Salads should be avoided.
- Sandwiches, biscuits, yoghurt, milk should be in the ward kitchen.
- Main meals will not be premeasured by catering. Ward staff should portion meals at bedside.
- Oral nutritional supplement (ONS) can be taken as an alternative to the suggested food. If unable to manage food within the time frame (30 minutes for main meals and 15 minutes for snacks) offer the alternative ONS.
- If they only complete a part of the specified food item they must also take the alternative to make up the deficit. Please titrate the specified amount of the alternative oral nutritional supplement (ONS) based on amount of food item eaten. 0% of food item eaten = give full portion of alternative ONS, 25% of food item eaten = give 75% of alternative ONS, 50% of food item eaten = give 50% of alternative ONS, 75% of food item eaten = 25% of alternative ONS.
- Give 10 minutes to complete the alternative ONS orally but if unable to manage give via nasogastric tube.
- Aim for approximately 8 glasses of fluid per day (2000ml). Caffeinated drinks should be limited to 2 cups per day (1 cup = 200ml).

	Day 3		Day 4	
	Suggested Food – all items must be offered	Alternative	Suggested Food – all items must be offered	Alternative
Breakfast	Cereal (e.g. 2 weetabix) and 1 glass of milk ¹	100ml Fortisip Compact	Cereal (e.g. 2 weetabix) and 1 glass of milk ¹	100ml Fortisip Compact
10.00	1 glass of milk ¹ OR 1 ward yoghurt	40ml Fortisip Compact	1 glass of milk ¹ OR 1 ward yoghurt	40ml Fortisip Compact
Lunch	Full portion of main meal (carbohydrate, protein and vegetables) OR ward sandwich	125ml Fortisip Compact	Full portion of main meal (carbohydrate, protein and vegetables) OR ward sandwich AND light dessert ³	150ml Fortisip Compact
3.00	1 portion of fruit OR 2 cartons of fruit juice ²	40ml Fortisip Compact	1 portion of fruit OR 2 cartons of fruit juice ²	40ml Fortisip Compact
Tea	Full portion of main meal (carbohydrate, protein, vegetables) OR ward sandwich	125ml Fortisip Compact	Full portion of main meal (carbohydrate, protein and vegetables) OR ward sandwich AND light dessert ³	150ml Fortisip Compact
8.00	1 glass of milk ¹ OR 1 ward yoghurt	40ml Fortisip Compact	1 glass of milk ¹ OR 1 ward yoghurt	40ml Fortisip Compact

¹ 1 glass of milk – 150ml whole or 200ml semi skimmed milk or 250ml unsweetened soya milk

² 1 portion of fruit = 1 piece of fruit (80g) or 2 juice pots (85ml each).

³Light dessert: yoghurt or icecream or custard or mousse. Avoid low fat options.

IMPORTANT DAILY MANAGEMENT- PLEASE READ

Nursing notes:

- Please keep strict food and fluid charts
- Avoid toilet trips for 30 minutes post meal or snack.
- Check refeeding bloods before moving to the next day of the feeding plan
- Check weight twice a week in the morning, before breakfast and after using the toilet. Wearing light clothing and no shoes.
- Do not disclose to patient ahead of time when they will be weighed.

Meal plan notes:

- Main meals should be ordered from the standard hospital menu. Salads should be avoided.
- Sandwiches, biscuits, yoghurt, milk should be in the ward kitchen.
- Main meals will not be premeasured by catering. Ward staff should portion meals at bedside.
- Oral nutritional supplement (ONS) can be taken as an alternative to the suggested food. If unable to manage food within the time frame (30 minutes for main meals and 15 minutes for snacks) offer the alternative ONS.
- If they only complete a part of the specified food item they must also take the alternative to make up the deficit. Please titrate the specified amount of the alternative oral nutritional supplement (ONS) based on amount of food item eaten. 0% of food item eaten = give full portion of alternative ONS, 25% of food item eaten = give 75% of alternative ONS, 50% of food item eaten = give 50% of alternative ONS, 75% of food item eaten = 25% of alternative ONS.
- Give 10 minutes to complete the alternative ONS orally but if unable to manage give via nasogastric tube.
- Aim for approximately 8 glasses of fluid per day (2000ml). Caffeinated drinks should be limited to 2 cups per day (1 cup = 200ml).

APPENDIX C: OUT OF HOURS ENTERAL RE-FEEDING REGIMEN

Department of Nutrition and Dietetics

Emergency Nasogastric Feeding Regimen for patients admitted with Anorexia Nervosa and assessed to be at extremely high risk of refeeding syndrome.

Actions required prior to commencing feed

- Check urea and electrolytes, phosphate, magnesium, potassium and calcium daily. Correct as appropriate and commence with feed unless:
 - Potassium <2.5mmol/l, phosphate <0.5mmol/l, magnesium <0.5mmol/l, then correct levels prior to commencing feed
- Administer IV thiamine 200-300mg 30 minutes prior to commencing feed. Continue daily until advised to stop.
- Confirm position of NGT as per NG care pathway

Ensure patient does not have any allergies or intolerances to any ingredients in the feed. Note that it contains: **MILK, SOYA & FISH**. (Please avoid starting the feed if the patient reports reactions to either and maintain hydration via IV).

Starting regimen – Day 1

Weight	Feed Presentation	Rate (mls/hr)	Duration (hours)	Rest (hours)	Providing	Notes
20-25kg	Nutrison (1kcal/ml)	12	20	4	240kcal	50ml water flush (or sterile water if applicable) pre and post feed & with medication
25-30kg	Nutrison (1kcal/ml)	15	20	4	300kcal	50ml water flush (or sterile water if applicable) pre and post feed & with medication
30-35kg	Nutrison (1kcal/ml)	17	20	4	340kcal	50ml water flush (or sterile water if applicable) pre and post feed & with medication
35-40kg	Nutrison (1kcal/ml)	20	20	4	400kcal	50ml water flush (or sterile water if applicable) pre and post feed & with medication
40-45kg	Nutrison (1kcal/ml)	23	20	4	460kcal	50ml water flush (or sterile water if applicable) pre and post feed & with medication

If the patient weighs > 45kg, please follow the FHFT standard out of hours protocol as outlined in the [Oral and Enteral Feeding \(Adult\)](#) guidelines.

Day 2 regimen

DO NOT PROCEED TO DAY 2 UNTIL BLOODS CHECKED, ABNORMALITIES CORRECTED AND IV THIAMINE ADMINISTERED 30 MINUTES PRIOR TO FEED

Weight	Feed Presentation	Rate (mls/hr)	Duration (hours)	Rest (hours)	Providing	Notes
20-25kg	Nutrison (1kcal/ml)	18	20	4	360kcal	50ml water flush (or sterile water if applicable) pre and post feed & with medication
25-30kg	Nutrison (1kcal/ml)	22	20	4	440kcal	50ml water flush (or sterile water if applicable) pre and post feed & with medication
30-35kg	Nutrison (1kcal/ml)	25	20	4	500kcal	50ml water flush (or sterile water if applicable) pre and post feed & with medication
35-40kg	Nutrison (1kcal/ml)	29	20	4	580kcal	50ml water flush (or sterile water if applicable) pre and post feed & with medication
40-45kg	Nutrison (1kcal/ml)	34	20	4	680kcal	50ml water flush (or sterile water if applicable) pre and post feed & with medication

APPENDIX D – USEFUL PROMPTS AND PHRASES

Adopted from Psychosocial Studies Association developed by patients with Eating Disorders [General-Patient-Guide-to-the-ED-World-R.-Hursey-September-2017.pdf](https://www.psychosocial-studies-association.org/General-Patient-Guide-to-the-ED-World-R.-Hursey-September-2017.pdf) ([psychosocial-studies-association.org](https://www.psychosocial-studies-association.org/)) ⁽⁹⁾

DO:

- Help patients to separate their illness and their identity so that patients feel less ground down with the day-to-day work of battling the illness.
- Provide correct practical aspects of treatment (e.g., correct food & portioning, food being on time, having the suitable equipment) as this can help to reduce feelings of being out of control for patients.
- Ask individual patients what helps them to feel safe as this will vary between patients.
- Keep boundaries and be firm (as it is this that keeps patients safe), while at the same time be firm in a way which can help people to move forward and feel cared for.
- Prioritise the timings of meals & snacks to reduce delays as often as possible.

DON'T's:

- Don't encourage patients to "do it for your family". Patients already feel acutely guilty about this, so such comments burden the sufferer further. It also increases the self-blame guilt.
- Avoid using phrases such as "why don't you get better for your family or children?", "what about the starving children of the world?", "look at what you have in your life" and "don't you want X things in the future?"
- Comment on the patient's food choice. It emphasises that they have made a choice which increases a patient's guilt and inability to have it again. This is especially so if people are trying new foods or they are having an item that they may feel is not a "proper ED choice." (e.g., cheese, chocolate).

FULL VERSION CONTROL RECORD

Version:	1.0
Guidelines Lead(s):	Natasha Richardson (Gastroenterology Dietitian, cross-site) Dr Amrutha Ramu (Gastroenterologist & Nutrition consultant, FPH)
Contributor(s):	Laura Mulford (Gastroenterology Dietitian, FPH) David Lang (Gastroenterology Pharmacist, FPH)
Lead Director / Chief of Service:	Melanie Van Limborch – Chief of Nursing and Midwifery
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Key words:	Anorexia nervosa, eating disorder, anorexia, bulimia, refeeding, NGT, meal plan

This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert.

Caution is advised when using guidelines after the review date. This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version Control Sheet

Version	Date	Guideline Lead(s)	Status	Comment
0.1	Jan 2024	Natasha Richardson	Draft	New guideline
1.0	March 2025	Natasha Richardson	Final	Ratified Clinical Governance (13/03/2025) and approved at the Drugs and Therapeutic Committee (08/05/2025)

Related Documents

Document Type	Document Name
Guideline	Oral and Enteral Feeding (Adult)
Guideline	Hospital Management of Hypoglycaemia in Adults With or Without Diabetes

Policy	MCA and DoLS, available at https://ourplace.xfph-tr.nhs.uk/our-trust/trust-policies (intranet link, requires FH network access)
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