

Paediatric Eating Disorders Guidelines

Key Points

- Eating Disorders
- This document aims to support admissions for patients under 18 years old age, where the intent is for re-feeding/medical stabilisation.
- Thorough assessment of risk and adequate monitoring of these patients is vital to mitigate the risks & ensure adequate provision of care.
- Refeeding syndrome guidelines
- Meal plans
- Oral Nutritional Supplements
- Adapted from the ALPINE guidelines

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Abbreviations

AN	Anorexia Nervosa
ED	Eating Disorder
MEED	Medical Emergencies in Eating Disorders
NGT	Naso-gastric Tube
RS	Refeeding Syndrome

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1. Introduction

Children and young people with anorexia nervosa, bulimia nervosa or disordered eating, that significantly restrict their intake of food/fluid are admitted to the Paediatric Ward when they are seriously **medically** unwell. They are admitted to be medically stabilised until they are safe for discharge for continuing care either in the community or to a Psychiatric Inpatient Unit (Tier 4). Significant psychological intervention at this stage is not desirable or effective.

The aims for admission are:

1. Physical and nutritional assessment
2. Attain physiological stability by managing the complications of malnutrition
3. Commence appropriate refeeding whilst managing the complications
4. Initiate nutritional recovery

There is no set length of time for patients with eating disorders to stay on the ward as this will vary greatly from case to case.

Most young people admitted to hospital with an eating disorder will come in because of one or more MEED red criteria (see appendix 1).

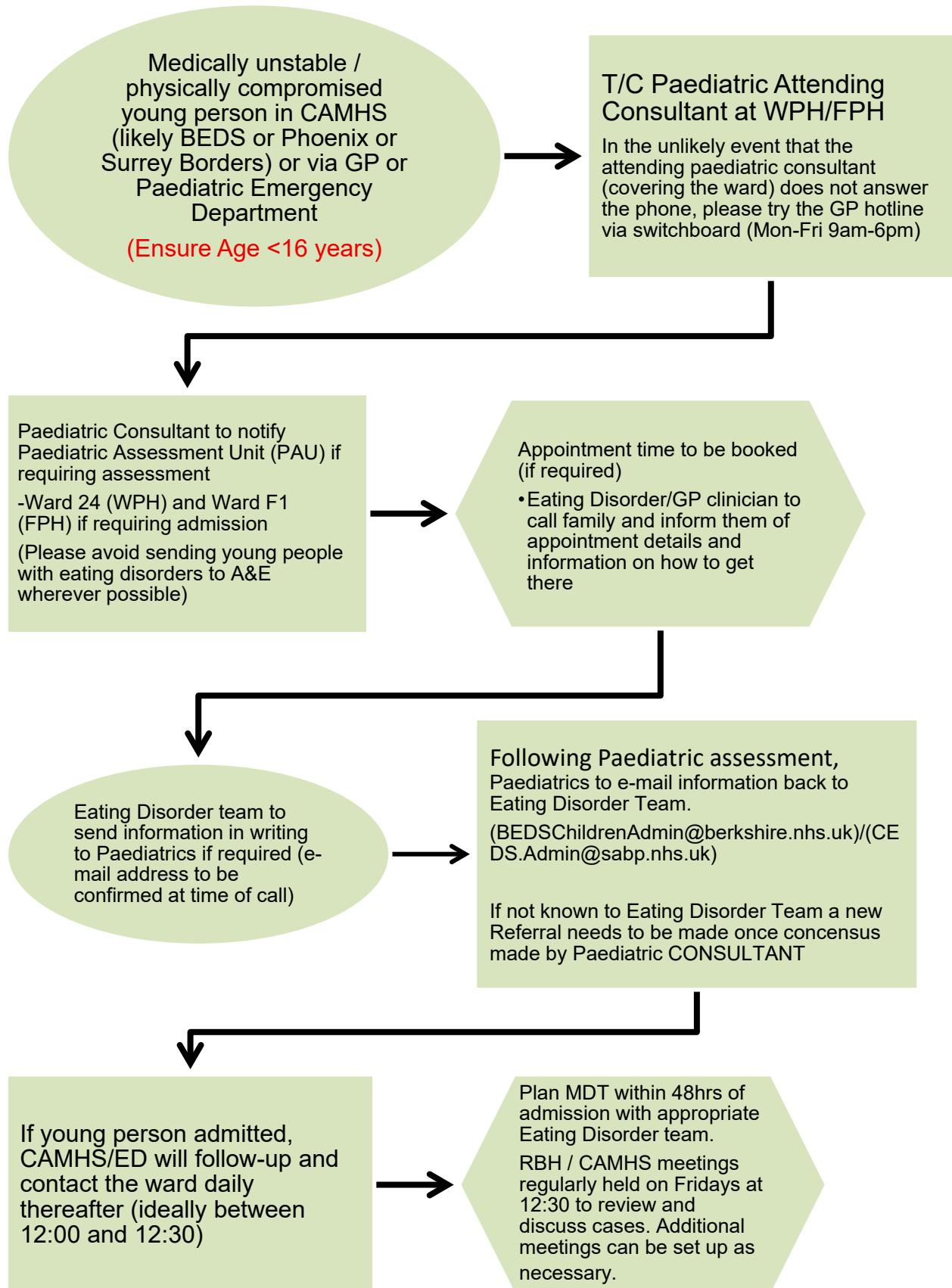
It would be unusual for them to be in a general paediatric bed for less than a week, or more than 2 weeks unless this has been decided by senior clinicians.

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. Pathway for Acute Admission of Eating Disorder Patients
- 2.8 A **Blind weight** is a weight which is not shared with the patient. On request the patient should be asked to stand on the scale with their back to display, this should be documented but not discussed with them. Ideally these weights should be first thing in the morning, after going to the toilet in the lightest clothing possible

3. Pathway for the acute admission of Eating Disorders Patients



For patients known to the Berkshire Eating Disorder Service (BEDS) admissions will be organised between WPH Paediatric Consultants and the BEDS team who meet weekly on a Friday to identify any patients who need an acute admission.

- They will arrive to the ward/ PAU and avoid A&E
- The aim would be to reduce unexpected 'out of hours' admissions and waiting in A&E

For patients who fall outside of this area, or for those not known to an ED service then they will likely be admitted from A&E.

4. Ambulatory approach for Eating Disorders at Frimley Park

Given the increasing global incidence of eating disorders and recent data indicating that affected children are experiencing higher rates of institutionalisation alongside a reduction in high-level tier beds for severe cases, we have prioritised the mental health of both the child and family by allowing ambulation when possible.

Where clinically appropriate and safe, we advocate for permitting ambulation with daily blood monitoring and regular clinical review to ensure compliance and safety.

The decision to commence ambulation rests solely with the Paediatric Consultant on Duty, who will make this determination following their own patient assessment and if they deem it safe for daily outpatient blood monitoring and review.

- The patient must demonstrate willingness to have support at home to ensure compliance.
- Boundaries and agreements should be clearly established with the patient.
- A meal plan will be provided to the parent/guardian to support adherence.
- Initial investigations must fall within acceptable parameters.
- Baseline blood results are required to be normal.
- The patient must be haemodynamically stable.
- An escalation plan should be in place, including hospital admission if concerns arise during the ambulation period.

If decision to ambulate is made ensure eating disorder team is made aware once possible by email.

Do NOT REASSURE that their risk is low as this will compound the dismissive nature of their eating disorder cognitions and increase their perception that change is not necessary, or even worse that they need to try harder with their restrictions!

Do EMPHASISE the severity of the problem.

Plan:

- Daily Bloods for 5 days
 - After 24hrs ensure book phlebotomy for midday to ensure if difficulties vascular team can help
 - CACOU (Monday to Friday)

- PAU (Saturday to Sunday)
- Arrange Clinical review at end of 5 days with a Blind Weight at time
- Discharge letter done at end of day 5 to ensure summary details and blood results with follow-up with eating disorder team
- Arrange for refeeding bloods with GP for Day 7-10 (The results are for review by the GP and Eating Disorder Team)
- Follow-up is with Eating Disorder Team not Paediatric Services and they are to ensure this is arranged in a timely manner for Outpatient review urgently.

5. Assessment

On admission the following features should be assessed and documented on Epic:

5.1 History:

- IF not known to have eating disorder HEADSSS assessment is quite helpful
 - *Home, Education/Employment, Activities, Drugs, Sex and relationships Self harm and depression Safety and abuse.*
 - <https://cks.nice.org.uk/topics/eating-disorders/diagnosis/assessment/>
 - The SCOFF questionnaire — **two or more positive answers** to the following questions are suggestive of anorexia nervosa or bulimia nervosa.
 - 'Do you ever make yourself sick because you feel uncomfortably full?'
 - 'Do you worry that you have lost control over how much you eat?'
 - 'Have you recently lost more than one stone in a 3-month period?'
 - 'Do you believe yourself to be fat when others say you are too thin?'
 - 'Would you say that food dominates your life?'
- Take General Paediatric History to exclude if cause of weight and restricted eating is due to a medical cause.
 - History should assess for red flags to exclude:
 - Brain tumour (Red flags from Better safe than Tumour website),
 - Inflammatory bowel disease,
 - Diabetes,
 - Coeliac disease,
 - Thyroid dysfunction.
 - Lymphoma/Leukaemia
- Eating/dieting behaviour:
 - Amount of weight loss (maximum and minimum weight with dates)
 - Rate of weight loss
 - Dietary intake
 - Discuss previous oral intake
 - Discuss any specific fears
 - Fluid intake
 - Caffeine intake
 - Purging, vomiting, laxatives, diuretics

- Exercise
- Family compensation
- Recent social changes or Stressors-Family separation, death, school bullying
- Co-morbid conditions
- Menstrual History-LMP
- Medical complications – assess for dyspepsia, acute pancreatitis, central abdominal pain (can be a feature of superior mesenteric artery syndrome)
- Suicidal ideation
- CAMHS involvement-Known Autistic or ADHD or assigned social worker
- Family History

5.2 Examination:

- Height and weight **(ALWAYS BLIND WEIGHT)**
 - calculate percentage BMI (weight-for-height) and document,
 - plot weight, height and BMI on a centile chart (available on Epic)
- Heart rate – r/o Bradycardia, postural tachycardia
- Lying and standing blood pressure – hypotension (refer to standardised chart), postural drop
- Temperature - hypothermia – beware of $<35^{\circ}\text{C}$
 - a) Cold peripheries (need for extra sock and thick clothing)
- General Paediatric examination to ensure no neurological, abdominal, cardiovascular and respiratory concerns
 - a) Abnormal reflexes or trousseau sign (hypocalcaemia)
- Hydration
 - a) normal or raised heart rate can be sign of dehydration,
 - b) assess clinically, (take creatinine and urea with caution as there may be a low creatinine from poor muscle mass and a raised urea from catabolism)
- Features of malnutrition
 - a) lanugo hair,
 - b) dry skin,
 - c) pressure sores
- Evidence of purging
 - a) enamel erosion,
 - b) swollen parotid gland,
 - c) calluses on fingers
- Pubertal stage if needed (no menarche history)
- Peripheral oedema – linked to severity of acute malnutrition

5.3 Investigations:

- ECG
 - a) rule out other causes of bradycardia, arrhythmia, QTc (using Bazetts formula $QTc = QT/\sqrt{RR}$)
 - b) <https://www.mdcalc.com/calc/48/corrected-qt-interval-qt-c>
 - c) Prolonged QTc
 - Under 15 years of age >460ms
 - Over 15 years of age male >450ms; females >460ms
- Blood sugar
 - a) Blood glucose less than 3 approach as advised by PIER guidelines
 - b) <https://www.piernetwork.org/guideline-eating-disorders.html>
 - a) Please note unless the patient is experiencing a seizure or coma it can be dangerous and inappropriate to treat low BSL with dextrose alone, in the context of malnutrition, as it can increase risk of precipitating refeeding syndrome.
 - b) Only treat low blood sugar if symptomatic, and if emergency treatment needed, please treat with FOOD or FEED.
 - c) Ensure give IV thiamine if decision for IV glucose is given
- Full blood count - do not forget the possibility of other diagnosis (e.g. leukaemia, lymphoma, infection)
- Urea and electrolytes, creatinine, calcium, phosphate, magnesium, liver function tests, bone profile, Vitamin D –particularly looking for hypokalaemia, hyponatraemia, hypocalcaemia, hypomagnesaemia and hypophosphatemia.
- Venous blood gas – a metabolic acidosis would be expected with purging
- Urinalysis – pH, specific gravity (may be low if water loaded) and ketones
 - a) Consider urine pregnancy test for females after discussion with patient
- Thyroid function test
- Coeliac screen- repeat after 6 months if needed as restricted diet would have affected the accuracy of test

6. Biochemistry and Monitoring

Refeeding syndrome is complex and life-threatening. Simply put, it occurs when the starving body gets a carbohydrate load that stimulates insulin production. This can very quickly drain the body's supplies of electrolyte and co-factors, requiring senior consideration and intervention

Before increasing food intake await the initial blood results (as per MEED) :

- If very low plasma electrolyte concentrations (i.e. phosphate <0.9mmol/l potassium <3mmol/l, magnesium <0.7mmol/l or adjusted calcium <2.0 mmol/l) the increase in food intake may result in further drops.

- They should, therefore, be corrected before increasing food intake
- Do not ascend the meal plan if electrolytes become abnormal
- Oral supplementation should be considered at the same time as feeding

<https://www.sort.nhs.uk/Media/Guidelines/Electrolytereplacementguidelines.pdf>

BLOOD GLUCOSE < 3mmol/l

- ☐ Unless the patient is experiencing a seizure or coma it can be dangerous and inappropriate to treat low BM with dextrose alone, in the context of malnutrition
- ☐ Only treat low blood sugar if symptomatic
- ☐ If emergency treatment needed, please treat with FOOD or FEED.
- ☐ If treating with IV glucose is needed ensure thiamine also given preferably first
- ☐ Watch for refeeding syndrome and urgently treat electrolyte abnormalities.

HYPOPHOSPHATEMIA (< 0.9mmol/l)-Epic wont turn RED below 0.7mmol/l

- ☐ Exclude other causes of low phosphate i.e. Vitamin D deficiency and hypoparathyroidism
- ☐ Intravenous phosphate is rarely given unless less than 0.65mmol/L and requires HDU/PICU monitoring (see SORT link for advice)
- ☐ ALWAYS Check on Ward and Pharmacy dosage/concentration of phosphate Sandoz used
 - One Phosphate-Sandoz tablet usually contains 16.1mmoles phosphate
- ☐ See BNFC for dosing and *Phosphate Sandoz®*
 - 2–3 mmol/kg daily in 2–4 divided doses, dose to be adjusted as necessary; maximum 97 mmol per day (for children over 5 years (if younger 48mmol/day)
 - Usually Correct orally with a stat dose — Phosphate-Sandoz 2 tablets
 - Commence 1 tablet 3 times per day regular Phosphate-Sandoz
- ☐ Recheck levels in 12hrs after stat dose

HYPOMAGNESAEMIA (<0.7mmol/l)

- ☐ Stop meal accession plan
- ☐ Replace orally with Magnesium supplements
- ☐ Oral magnesium: 0.2 mmol/kg every 8 hours (over 40kg, max dose = 8 mmol) Magnesium glycerophosphate 4 mmol tablets/chewable
- ☐ For younger children the 5mmol/5ml oral solution is available
- ☐ **In hyperphosphataemia use magnesium oxide.** Caution: oral magnesium is poorly absorbed and can cause diarrhoea.(this is not routinely available and would need to be bought in)
- ☐ Intravenous Magnesium should only be used if the level is less than 0.5mmol/l and rarely as needs PICU/HDU and SORT discussion

HYPOKALAEMIA (K<3mmol/l)

- ☐ If asymptomatic
 - Replace orally or via NGT
 - Daily requirement (2 -3mmols/kg/day)

- Oral potassium chloride: 0.5-1mmol/kg twice daily initially, adjusted to requirements.
- If symptomatic with arrhythmia (usually when less than 2.5mmol/l)
 - *Symptoms of hypokalaemia: ECG changes include flattening of the T wave, appearance of U waves*
 - ECG and transfer to HDU
 - CONSULTANT lead management and discuss with PICU/SORT
 - Intravenous replacement (SEE SORT Drug advise)

5.1 Medication: (MEED page 84)

- Oral thiamine 200mg po od
- Sanatogen A-Z multivitamins or Forceval (one tablet/capsule once daily)
- Seek advice from pharmacy for patients under 12 years of age.
- Duration is for 10 days minimum but if concerns raised throughout consider extending for 14 days

5.2 Monitoring:

1. Vital signs:

- Heart rate
- Blood pressure(lying and sitting) twice daily for minimum 3 days if values acceptable but if abnormal continue but adjust based on clinical concern
- Respiratory rate
- GCS or level of consciousness should be monitored every 6 hours for the first 72 hours then twice daily
- Twice daily temperature
- Bedside blood glucose twice daily-*if low on admission or if patient is symptomatic*

2. Blood tests:

- Daily electrolytes for the first 72 hours as a minimum, unless unstable then there may need to be more frequent,
- Attempt up to 5 days daily to coincide with meal plans
- Repeat bloods on Day 7 and Day 10-14 (due to the risk of late re-feeding syndrome). **If Discharged ensure booked with GP and results to be followed by Eating Disorder Team or GP**
- Weekly full blood counts if neutropenic as takes several weeks to improve
- Weekly blood gas if concerns about purging

3. Weighing:

- The young person should be weighed twice a week at the same time,
- On the same scales, in a hospital gown, before breakfast and after going to the toilet.
- Weights on Admission then at days 4 and 7 since admission
- There is no benefit to measuring more than twice a week

- Weight trends are more important than individual measurements.
- **DO NOT disclose the weight (or even the trend) to the young person.**
- **BLIND WEIGHTS ONLY**

4. Bed rest:

- No use of the toilet for 30 minutes after meal or snack time
- If symptomatic (dizzy etc), must be accompanied to toilet in case of postural hypotension/collapse
- WHEELCHAIR access only for movement to toilet
- Senior clinician to decide whether young person can mobilise off the ward but would not advise
- If there are any attempts to engage in exercise e.g. prolonged standing, pacing, 'crunches', young person is to be told firmly to stop.

7. Feeding protocol for IP treatment of ED on Paediatric Ward

For meal plans- see appendix – only offer the meal plan WITHOUT CALORIE INFORMATION to parents/caregivers if requested.

- Mealtimes are set out by nursing staff
- Young person should sit in a chair at the bedside, wearing short sleeves, hair tied back, no other items on meal tray that could be used to hide food.
- Parents are to be present at mealtimes unless agreed otherwise, and they are the main providers of support for the young person. Initially the parents may need support to achieve this. Parents may find it helpful to eat their meal along with the young person too.
- Allow some expression of feelings while firmly encouraging young person to eat.
- Mealtimes and snacks supervised by parents. Allow patient to express feelings as necessary, supporting them to eat for about 30 minutes. If the young person has not eaten their meal in 15 minutes, then allow another 15 minutes with minimal interaction with nursing staff. Snacks should take no longer than 15 minutes and meals no longer than 30 minutes.
- At the end of this time, remove any uneaten food and avoid negative comments. Offer the recommended supplement drink to replace lost calories – do not offer portions
- Ask the young person what interaction they would like over the mealtime. In general, avoid praise if the patient has finished their meal as many young people with anorexia nervosa experience this negatively. Saying "thank you for eating your meal" may be more acceptable.
- Parents can bring in snacks for the young person **provided these are agreed with the Dietitian/senior clinician.**

8. NGT Feeding

Any decision about NG feeding should be jointly made by Paediatricians, CAMHS and a Dietitian.

DO NOT USE NGT AS A THREAT OR PLACE AT BEDSIDE FOR INTIMIDATION.

<https://www.bda.uk.com/static/c449030d-3147-4563-90d8d6aa3854f8f0/Naso-Gastric-Tube-feeding-under-restraint.pdf>

1. Depends on:
 - Medical emergency
 - Weight loss or lack of weight gain
 - Decision by Consultant Paediatrician in liaison with the local eating disorder team and the Dietitian
2. Indications:
 - Severe acute complications
 - Failure to halt weight loss or restore any weight within the usual management guidelines placing the young person's health at risk
 - Must be undertaken in conjunction with the Dietitian
3. Methods:
 - Staff should continue to offer food as per meal plan and communicate a high expectation that the food will be eaten.
 - a) If food is refused or no attempt is made to eat or complete the meal in the time limits set, then a bolus feed is to be given via the nasogastric tube (this will equate to more calories than they would have eaten).
 - NG feeding should be seen as a short-term measure until medically safe to remove the tube
 - Ideally the feeds should be boluses around the time of normal meal times to mimic physiological demand and so the choice can be offered on each occasion (Are you going to eat, drink or be fed this time?)
 - The nasogastric tube to be passed and then left in situ.
 - The ng feeding meal plan should be one meal plan higher than that expected to be eaten orally
 - Bolus feed would be the recommended method unless otherwise indicated.
 - If the young person does eat then they need to comply fully with the daily meal plan until the next joint Paeds, CAMHS and Dietitian review, when a decision will be made as to whether the tube can be removed.
4. NG tube feeding depends on the competence or capacity of the patient to consent.
 - a) Refusal requires the appropriate legal framework, usually the Mental Health Act.
 - b) Discussion concerning these issues with the young person and their family will be documented in the notes.

9. Discharge Planning

1. **No target weight gain** will be given but on average weight gain should be about 0.5-1kg per week, and to be at least sufficient to allow discharge without a risk of early re-admission

2. The parents will have been joining the young person at meals so they will have learned appropriate portion sizes and food types that are recommended
3. Parents should feel confident and able to continue feeding their young person at discharge
4. The Dietitian/CAMHS/EDT will provide the family with an eating plan to follow once discharged
5. CAMHS/EDT will arrange outpatient follow-up with their team
6. The young person should be walking short distances without supervision before discharge
7. An appropriate professional in the community from CAMHS/EDT will be monitoring the patient's weight, initially weekly
8. The date of discharge will be agreed between the core team and the family. The aim is to discharge the patient home. However, if they are not making sufficient progress for discharge, CAMHS/EDT may arrange transfer to an age-appropriate psychiatric inpatient unit with experience in treating anorexia nervosa
9. Factors to consider when planning discharge are
 - The original rationale for admission, i.e. physical compromise
 - The current physical health and any continuing medical requirements
 - Nutritional status, method of feeding and monitoring
 - Family and individual's needs, circumstances and preference
 - Success of periods of leave home (if there are concerns about discharge, consider trial of leave)

10. Contact Details for local ED units

Surrey and Hampshire Surrey and Borders Partnership NHS Foundation Trust North East Hampshire CAMHS: Children's Eating Disorders Service The Meadows Day Hospital, The Meadows, Horton Lane, Epsom, KT19 8PB, United Kingdom	Phone: 0137 221 6633 Email: ceds.admin@sabp.nhs.uk Online referral portal: https://mindworksrequestforsupport.sabp.nhs.uk/ Out of hours: Surrey and Borders Partnership NHS Foundation Trust Switchboard – 0300 5555 222
Berkshire: Berkshire Eating Disorders Service (BEDS) Berkshire Healthcare NHS Foundation Trust 1st Floor Nicholsons House Nicholsons Walk Maidenhead, SL6 1LD	Phone: 0118 904 3010 Email: BEDSchildrenadmin@berkshire.nhs.uk Out of hours: CAMHS team – 0118 904 3444 Urgent Care line – 0300 247 000 Both available 24/7 and will go to a mental health practitioner
South Bucks: Sue Nicholls Centre Bierton Road Aylesbury Buckinghamshire HP20 1EG Saffron House Easton Street High Wycombe HP11 1NH	Phone: 01865 901 951 Email: BucksCAMHSSPA@oxfordhealth.nhs.uk

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Appendix 1 - 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 <500g/week or fluctuating weight
BMI and weight	• Under 18 years: %mBMI² <70% • Over 18: BMI <13	• Under 18: %mBMI 70–80%	• Under 18: %mBMI >80%³ • Over 18: BMI >15

		- Over 18: BMI 13–14.9	
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 >20mmHg or increase in HR of over 30bpm (35bpm in <16 years)	Standing systolic BP <0.4th centile or <90 if 18+ associated with occasional syncope; postural drop in systolic BP of >15mmHg or increase in HR of up to 30bpm (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	- Minimal fluid restriction - No more than mild dehydration (<5%): may have dry mouth or concerns about risk of dehydration with negative fluid balance

		skin turgor, some tachypnoea, some tachycardia, peripheral oedema	
Temperature	<35.5°C tympanic or 35.0°C axillary	<36°C	>36°C
Muscular function6: 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 strength7	Male <30.5kg, Female <17.5kg (3rd percentile)	Male <38kg, Female <23kg (5th percentile)	Male >38kg, Female >23kg
Muscular function: MUAC8	<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,	Non-life-threatening physical compromise, e.g. mild haematemesis, pressure sores	Evidence of physical compromise, e.g. poor cognitive flexibility, poor concentration

	significant alcohol consumption		
	 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 abnormalities	• Hypophosphataemia and falling phosphate		

	• Hypokalaemia (<2.5mmol/L) • Hypoalbuminaemia • Hypoglycaemia (<3mmol/L) • Hyponatraemia • Hypocalcaemia • Transaminases >3x normal range • Inpatients with diabetes mellitus: HbA1C >10% (86mmol/mol)		
Haematology	• Low white cell count • Haemoglobin <10g/L		
Disordered eating behaviours	Acute food refusal or estimated calorie intake <500kcal/day for 2+ days		

	 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 2 - Meal Plans (without calories displayed)

2a Meal Plan for inpatients

2b Ambulatory meal plan

Calorie amounts (kcal/day):

Day 1&2 – 1400

Day 3 – 1600

Day 4 – 1800

Day 5 – 2000

Day 6 – 2200

Day 7 – 2400

Inpt plan	Day 1 & 2 (unless started at Breakfast when you can move on after 24hrs)		Day 3 –	
	Suggested Food – all items must be offered	Alternative	Suggested Food – all items must be offered	Alternative
Breakfast	Cereal (e.g. 2 Weetabix/2 packs) & 100ml milk +1 piece of fruit or 2 cartons of fruit juice	1 Fortisip compact	Cereal (e.g. 2 Weetabix/2 packs) & 100ml milk +1 piece of fruit or 2 cartons of fruit juice	1 Fortisip compact
10.00	Large banana or 2 biscuits	70mls Fortisip compact	3 biscuits and a piece of fruit or carton of fruit juice	100mls Fortisip compact
Lunch	Full portion (Carbohydrate, Protein & veg) and light dessert Or 2 slices bread with sandwich filling and either light dessert or pkt of crisps	1 Fortisip compact	Full portion (Carbohydrate, Protein & veg) and light dessert Or 2 slices bread with sandwich filling and either light dessert or pkt of crisps	1 Fortisip compact
3.00	2 biscuits	70mls Fortisip compact	3 biscuits/ packet of crisps (not Quavers) and a piece of fruit or 2 cartons of fruit juice	100mls Fortisip compact
Tea	Full portion main (Carbohydrate, Protein & veg) and light dessert	1 Fortisip compact	Full portion main (Carbohydrate, Protein & veg) and light dessert	1 Fortisip compact
8.00	1 Glass milk or ward milkshake or ward yoghurt	70ml Fortisip compact	1 Glass milk or ward milkshake or ward yoghurt + 1 biscuit	100ml Fortisip compact

IMPORTANT DAILY MANAGEMENT- PLEASE READ

- | | |
|--|--|
| <ul style="list-style-type: none"> • If unable to manage food within time frame e.g. 30 minutes for main meals, 15 minutes for snacks, offer supplement drink (10 minutes to drink), if unable to manage give via NG tube. Do not offer parts of Fortisip Compact – if meal is not completely finished give full amount as per plan • Main meals can be ordered off main hospital menus for a hot meal, or sandwiches from ward trolley • 1 glass of milk = 150ml whole or 200ml semi skimmed • Aim for approximately 8 glasses of fluid in total (2000 ml) • Caffeinated drinks to be limited to 1-2 per day, e.g. 1 cup (~200ml) tea/coffee or ~200ml Pepsi Max/Diet Coke | <ul style="list-style-type: none"> • Light dessert: e.g. yoghurt, ice cream, custard, instant whip, jelly, mousse • No toilet trips for 30 minutes post meals • Please keep food & fluid intake charts • Check refeeding bloods before moving to next day of feeding plan • Please check weight twice a week in the morning, before breakfast and after going to the toilet (no shoes and gown) • Do not disclose to patient ahead of time when they will be weighed |
|--|--|

Date	Day 4 –		Day 5 –	
	Suggested Food – all items must be offered	Alternative	Suggested Food – all items must be offered	Alternative
Breakfast	Cereal (e.g. 2 Weetabix/2 packs) & 100ml milk +1 piece of fruit or 2 cartons of fruit juice + ½ slice toast and spread and jam	1 Fortisip compact + 25 ml Fortisip compact	Cereal (e.g. 2 Weetabix/2 packs) & 100ml milk +1 piece of fruit or 2 cartons of fruit juice + ½ slice toast and spread and jam	1 Fortisip compact + 55 ml Fortisip compact
10.00	3 biscuits/ packet of crisps (not Quavers) and a piece of fruit or 2 cartons of fruit juice	100ml Fortisip compact	3 biscuits/ packet of crisps (not Quavers) and a piece of fruit or 2 cartons of fruit juice	100ml Fortisip compact
Lunch	Full portion (Carbohydrate, Protein & veg) and light dessert Or 2 slices bread with sandwich filling and either light dessert or pkt of crisps	1 Fortisip compact + 25 ml Fortisip compact	Full portion (Carbohydrate, Protein & veg) and light dessert Or 2 slices bread with sandwich filling and either ward yoghurt or icecream	1 Fortisip compact + 55 ml Fortisip compact
3.00	1 Glass milk or ward milkshake or ward yoghurt +1 portion fruit	100ml Fortisip compact	2 crackers and a portion of cheese and butter and a drink eg water/squash	100ml Fortisip compact
Tea	Full portion main (Carbohydrate, Protein & veg) and light dessert	1 Fortisip compact + 25 ml Fortisip compact	Full portion main (Carbohydrate, Protein & veg) and light dessert	1 Fortisip compact + 55 ml Fortisip compact
8.00	1 Glass milk or ward milkshake or ward yoghurt + 2 biscuits	100ml Fortisip compact	1 Glass milk or ward milkshake or ward yoghurt + 2 biscuits	100ml Fortisip compact

IMPORTANT DAILY MANAGEMENT- PLEASE READ

- | | |
|--|--|
| <ul style="list-style-type: none"> • If unable to manage food within time frame e.g. 30 minutes for main meals, 15 minutes for snacks, offer supplement drink (10 minutes to drink), if unable to manage give via NG tube. Do not offer parts of Fortisip Compact – if meal is not completely finished give full amount as per plan • Main meals can be ordered off main hospital menus for a hot meal, or sandwiches from ward trolley • 1 glass of milk = 150ml whole or 200ml semi skimmed • Aim for approximately 8 glasses of fluid in total (2000 ml) • Caffeinated drinks to be limited to 1-2 per day, e.g. 1 cup (~200ml) tea/coffee or ~200ml Pepsi Max/Diet Coke | <ul style="list-style-type: none"> • Light dessert: e.g. yoghurt, ice cream, custard, instant whip, jelly, mousse • No toilet trips for 30 minutes post meals • Please keep food & fluid intake charts • Check refeeding bloods before moving to next day of feeding plan • Please check weight twice a week in the morning, before breakfast and after going to the toilet (no shoes and gown) • Do not disclose to patient ahead of time when they will be weighed |
|--|--|

Date	Day 6–		Day 7	
	Suggested Food – all items must be offered	Alternative	Suggested Food – all items must be offered	Alternative
Breakfast	Cereal (e.g. 2 Weetabix/2 packs) & 100ml milk +1 piece of fruit or 2 cartons of fruit juice + ½ slice toast and spread and jam	1 Fortisip compact + 55ml Fortisip compact	Cereal (e.g. 2 Weetabix/2 packs) & 100ml milk +1 piece of fruit or 2 cartons of fruit juice + a slice toast and spread and jam	1 Fortisip compact + 85ml Fortisip compact
10.00	3 biscuits/ packet of crisps (not Quavers) and a piece of fruit or 2 cartons of fruit juice	1 Fortisip compact	3 biscuits/ packet of crisps (not Quavers) and a piece of fruit or 2 cartons of fruit juice	1 Fortisip compact
Lunch	Full portion (Carbohydrate, Protein & veg) and a light dessert Or 2 slices bread with sandwich filling and a proper pudding eg crumble and custard	1 Fortisip compact + 55ml Fortisip compact	Full portion (Carbohydrate, Protein & veg) and a light dessert Or 2 slices bread with sandwich filling and a proper pudding eg crumble and custard	1 Fortisip compact + 85ml Fortisip compact
3.00	2 crackers and a portion of cheese and butter and a drink eg water/squash	1 Fortisip compact	2 crackers and a portion of cheese and butter and a drink eg water/squash	1 Fortisip compact
Tea	Full portion main (Carbohydrate, Protein & veg) and light dessert eg ward yoghurt/ice cream	1 Fortisip compact + 55ml Fortisip compact	Full portion main (Carbohydrate, Protein & veg) and proper pudding eg crumble and custard	1 Fortisip compact + 85ml Fortisip compact
8.00	1 Glass milk or ward milkshake or ward yoghurt + ½ a ward sandwich	1 Fortisip compact	1 Glass milk or ward milkshake or ward yoghurt + ½ a ward sandwich	1 Fortisip compact

IMPORTANT DAILY MANAGEMENT- PLEASE READ

- | | |
|--|--|
| <ul style="list-style-type: none"> • If unable to manage food within time frame e.g. 30 minutes for main meals, 15 minutes for snacks, offer supplement drink (10 minutes to drink), if unable to manage give via NG tube. Do not offer parts of Fortisip Compact – if meal is not completely finished give full amount as per plan • Main meals can be ordered off main hospital menus for a hot meal, or sandwiches from ward trolley • 1 glass of milk = 150ml whole or 200ml semi skimmed • Aim for approximately 8 glasses of fluid in total (2000 ml) • Caffeinated drinks to be limited to 1-2 per day, e.g. 1 cup (~200ml) tea/coffee or ~200ml Pepsi Max/Diet Coke | <ul style="list-style-type: none"> • Light dessert: e.g. yoghurt, ice cream, custard, instant whip, jelly, mousse • No toilet trips for 30 minutes post meals • Please keep food & fluid intake charts • Check refeeding bloods before moving to next day of feeding plan • Please check weight twice a week in the morning, before breakfast and after going to the toilet (no shoes and gown) • Do not disclose to patient ahead of time when they will be weighed |
|--|--|

Eating Plan - To have three meals and three snacks daily.

Day 1 & 2

Breakfast: 2 portions of cereal
200mls semi-skimmed milk/ 150mls whole milk
1 item from the 'fruit' list

Mid-morning: 250mls of water or squash
1 item from the 'fruit' list

Lunch: 1 item from the 'bread & alternatives' list
1 item from the 'meat & alternatives' list
1 item from the 'fruit or vegetables' list
1 item from the 'cheese or yoghurt' list
250mls of water or squash

Mid-afternoon: 250mls of water or squash
1 item from the 'Snack' list

Evening meal: 1 item from the 'bread & alternatives' list
2 items from the 'meat & alternatives' list
1 item from the 'vegetables' list
1 item from the 'fruit' list
250mls of water or squash

Before bed: 200mls semi-skimmed milk/ 150mls whole milk

Fortisip Compact Alternative (if meals refused or not completed)

Meals: 125mls Fortisip Compact
Snacks 70mls Fortisip Compact

Day 3 –

Breakfast: 2 portions of cereal
250mls semi-skimmed milk/ 200mls Whole Milk
1 item from the 'fruit' list

Mid-morning: 250mls of water or squash
1 item from the 'fruit' list

Lunch: 1 item from the 'bread & alternatives' list
1 item from the 'meat & alternatives' list
1 item from the 'fruit or vegetables' list
1 item from the 'cheese or yoghurt' list
250mls of water or squash

Mid-afternoon: 250mls of water or squash
1 item from the 'Snack' list

Evening meal: 1 item from the 'bread & alternatives' list
2 items from the 'meat & alternatives' list
1 item from the 'vegetables' list
1 item from the 'fruit' list
1 item from the 'cheese or yoghurt' list
250mls of water or squash

Before bed: 250mls semi-skimmed milk / 200mls whole milk
1 item from the 'fruit' list

Fortisip Compact Alternative (if meals refused or not completed)

Meals: 125mls Fortisip Compact
Snacks 100mls Fortisip Compact

Day 4 –

Breakfast: 2 portions of cereal
250mls semi-skimmed milk/ 200mls whole Milk
1 item from the 'fruit' list

Mid-morning: 250mls of water or squash
1 item from the 'fruit' list

Lunch: 2 item from the 'bread & alternatives' list
1 item from the 'meat & alternatives' list
1 item from the 'fruit or vegetables' list
1 item from the 'cheese or yoghurt' list
250mls of water or squash

Mid-afternoon: 250mls of water or squash
1 item from the 'Snack' list

Evening meal: 1 item from the 'bread & alternatives' list
2 items from the 'meat & alternatives' list
1 item from the 'vegetables' list
1 item from the 'fruit' list
1 item from the 'cheese or yoghurt' list
250mls of water or squash

Before bed: 250mls semi-skimmed milk / 200mls whole milk
1 item from the 'fruit' list

Fortisip Compact Alternative (if meals refused or not completed)

Meals: 150mls Fortisip Compact
Snacks 100mls Fortisip Compact

Day 5 -

Breakfast: 2 portions of cereal
250mls semi-skimmed milk/ 200mls whole Milk
1 slice of bread and butter/spread
1 item from the 'fruit' list

Mid-morning: 250mls of water or squash
1 item from the 'fruit' list

Lunch: 2 item from the 'bread & alternatives' list
2 item from the 'meat & alternatives' list
1 item from the 'fruit or vegetables' list
1 item from the 'cheese or yoghurt' list
250mls of water or squash

Mid-afternoon: 250mls of water or squash
1 item from the 'Snack' list

Evening meal: 2 item from the 'bread & alternatives' list
2 items from the 'meat & alternatives' list
1 item from the 'vegetables' list
1 item from the 'fruit' list
1 item from the 'cheese or yoghurt' list
250mls of water or squash

Before bed: 250mls semi-skimmed milk / 200mls whole milk
1 digestive or 2 rich tea biscuits

Fortisip Compact Alternative (if meals refused or not completed)

Meals: 180mls Fortisip Compact
Snacks 100mls Fortisip Compact

Day 6

Breakfast: 2 portions of cereal
250mls semi-skimmed milk/ 200mls whole Milk
1 slice of bread and butter/spread
250mls fruit juice

Mid-morning: 250mls of water or squash
1 item from the 'fruit' list

Lunch: 2 item from the 'bread & alternatives' list
2 item from the 'meat & alternatives' list
1 item from the 'fruit or vegetables' list
1 item from the 'cheese or yoghurt' list
250mls of water or squash

Mid-afternoon: 250mls of water or squash
1 item from the 'fruit' **and** 'Snack' list

Evening meal: 2 item from the 'bread & alternatives' list
2 items from the 'meat & alternatives' list
1 item from the 'vegetables' list
1 item from the 'fruit' list
1 item from the 'cheese or yoghurt' list
250mls of water or squash

Before bed: 250mls semi-skimmed milk / 200mls whole milk
1 digestive or 2 rich tea biscuits

Fortisip Compact Alternative (if meals refused or not completed)

Meals: 180mls Fortisip Compact
Snacks 125mls Fortisip Compact

Day 7

Breakfast: 2 portions of cereal
250mls semi-skimmed milk/ 200mls whole Milk
1 slice of bread and butter/spread
250mls fruit juice

Mid-morning: 250mls of water or squash
1 item from the 'fruit' list

Lunch: 2 item from the 'bread & alternatives' list
2 item from the 'meat & alternatives' list
1 item from the 'fruit or vegetables' list
1 item from the 'cheese or yoghurt' list
250mls of water or squash

Mid-afternoon: 250mls of water or squash
1 item from the 'fruit' **and** 'Snack' list

Evening meal: 2 item from the 'bread & alternatives' list
2 items from the 'meat & alternatives' list
2 item from the 'vegetables' list
1 item from the 'fruit' list
1 item from the 'cheese or yoghurt' list
250mls of water or squash

Before bed: 250mls semi-skimmed milk / 200mls whole milk
1 digestive or 2 rich tea biscuits

Fortisip Compact Alternative (if meals refused or not completed)

Meals: 210mls Fortisip Compact
Snacks 125mls Fortisip Compact

Recommended portion sizes at each meal:

Food Group	Recommended Portion Sizes	
Cereal	1 Weetabix <u>or</u> 1 Shredded Wheat <u>or</u>	2 heaped tablespoons Oatibix, All-Bran, Bran-flakes, Cornflakes, Frosties, Rice Krispies, Muesli, or Coco Pops
Bread & Alternatives	1 medium slice Bread <u>or</u> ½ large Bagel <u>or</u> ½ large / 1 small Bread Roll <u>or</u> 70g cooked Pasta <u>or</u> 75g cooked Rice <u>or</u>	140g Boiled New Potatoes <u>or</u> 80g Jacket Potato with Skin <u>or</u> 130g Jacket Potato without Skin <u>or</u> 65g Chips <u>or</u> 100g Mashed Potato
Meat & Alternatives	1 thick slice Ham (60g) <u>or</u> ½ fillet Chicken/Turkey Breast (50g) <u>or</u> 1 heaped tablespoon Minced Meat (30g) <u>or</u>	½ fillet White Fish <u>or</u> ½ small fillet Salmon <u>or</u> 3 Fish Fingers <u>or</u> 90g Baked Beans <u>or</u>

	1 standard sized Sausage <u>or</u>	1 egg (hardboiled, poached or omelette)
Milk, Cheese & Yoghurt	250ml semi-skimmed milk <u>or</u> 200mls whole milk <u>or</u> 1 pot Yoghurt (125g) (not diet or low fat) <u>or</u>	30g Cheddar Cheese 1 pot Custard (150g)
Vegetables	1 dessert bowlful Mixed Salad 1 large / 2 medium Tomatoes	7 Cherry Tomatoes 2 heaped tablespoons Cooked Vegetables
Fruit	1 medium Apple, Pear, or Orange 1 small Banana 1 teacupful Grapes	2 medium Satsumas ½ large Tin Fruit
Snacks	1 slice of toast + 10g of spread (not low fat) <u>or</u> 4 crackers + 30g Cheddar cheese <u>or</u> 1 scone + 10g spread (not low fat) <u>or</u>	40g breakfast cereal + 250mls semi-skimmed milk <u>or</u> 3 digestives

Appendix 3 - Useful prompts and phrases (Hursey, R 2016)

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).

Appendix 4: Checklist for Paediatric Eating Disorders Patients (WPH only)

Point	Responsibility	Yes/No/NA Date
BEDS team aware of patient	Admitting team to contact BEDS in working hours (details below) Out of hours notify CAMHS if concerns (details below) <i>Thereafter BEDS/CAMHS will also call daily for updates</i> **	
BEDS team have generated plan for admission, and likely plan for discharge – <i>must be documented in medical notes and ideally single point of contact from ED team highlighted.</i>	BEDS team to find ward Registrar to discuss case and make arrangements for transferring their notes into Epic (see below)	
Vitamins prescribed as per local guidelines	Ward medical team	
Oral nutritional supplements to be available on ward	Dietitian	
<u>Discharge Criteria</u>		
Completed minimum day 5 meal plan (decision to discharge before this under advice of BEDS only)	Ward medical team and dietitian	
Stable weight (minimum criteria; no further loss)	Ward medical team	
Cardio vascularly stable (ECG normal, HR >40, no symptomatic postural hypotension)	Ward medical team	
Refeeding bloods normalising (i.e. improving and outside of critical levels – see MEED)	Ward medical team	
If bloods not normalised at time of discharge, must not be critical level/falling and repeat bloods and supplementation must be arranged at discharge	Ward medical team	
If having repeat bloods – medical follow up (e.g. CACOU/OP or PAU weekend) must be organised and explained to family	Ward medical team including adding bloods to chase list	

No new behavioural, mental health or safeguarding concerns since last discussion with BEDS – <i>if so will need separate discharge planning</i>	Ward medical team	
BEDS aware of discharge that day; Inform BEDS in their morning call or via on-call numbers (below)	Ward medical team **	
Sent home with meal plan and BEDS notified with copy of meal plan for discharge	Dietitian	
Patient and parent know BEDS follow up arrangements AND have BEDS contact details including OOH contact number	BEDS **	

Useful contacts:

Beds duty telephone number: 0118 9043010

BEDS email ; BEDSchildrenadmin@berkshire.nhs.uk

Named consultant for Eating Disorder's email (for internal use see EPIC smartphrase) use if Epic messenger not available who will assist when on site (**)

For out of hours concerns about patient (e.g. treatment non adherence), if patient refuses to attend or discharges against medical advice then;

1. Within normal working hours contact on call BEDS team on: 0118 904 3010
2. Outside of working hours contact on call CAMHS team on;

- Main enquiries number – 01189043444
- Urgent care line – 03002470000

Both available 24/7. Out of hours this would go straight to a mental health practitioner.

Agreed actions for BEDS team reviewing child on ward:

- Will find Registrar (or Consultant if registrar not available) to discuss assessment and updated plan
- Will write assessment to be filed into Epic; to be emailed to doctor for transferring to Epic
- Will include clarity on what aspects of diagnosis and management have been discussed with family and what aspects are responsibility of ward team
- Will provide name/contact of most appropriate BEDS team member to contact

Full version control record

Version:	1.1
Guidelines Lead(s):	Joanna Slade, Paediatric Dietitian WPH Dr Frances Morrison, Consultant Paediatrician WPH Emma Brackley Paediatric Dietitian FPH Dr Leo Poulouse, Consultant Paediatrician FPH All Dietitians working across WPH & FPH Helen Sowerbutts, Consultant Paediatrician WPH
Contributor(s):	Angela Yannoulis Clinical Director for paediatrics
Lead Director / Chief of Service:	30/10/2025
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Review Date:	Rashmi Selli, Principal Pharmacist 16/12/2025
Pharmaceutical dosing advice and formulary compliance checked by:	
Key words:	Paeds Eating Disorders, Paed Refeeding Syndrome

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 NHS Foundation 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 History

Version	Date	Guideline Lead(s)	Status	Comment
Previous 5	Sept 2020	Emma Brackley Joanna Slade Emily Gilbert Mary Jenkins		Was previously part of the paediatric oral and enteral feeding guidance
1.0	January 2026	Joanna Slade, Dr Frances Morrison, Emma Brackley, Dr Leo Poulouse	Final	Split from paediatric oral and enteral feeding guidance to be stand alone. Paediatric Clinical Governance 21st January 2026

1.1	January 2026	Helen Sowerbutts, Consultant Paediatrician WPH	Interim	Initials removed from appendix 4 14/04/2026
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Related Documents

Document Type	Document Name