Anorexia Nervosa/Eating Disorders - Summary Clinical Guideline

Reference no.: CG-T/2024/153

Anorexia nervosa has one of the highest mortalities of any psychiatric condition. Patients may be admitted to University Hospitals of Derby and Burton NHS Foundation Trust as a result of other problems, e.g. trauma, pneumonia, or as a result of severe malnutrition.

On admission to RDH

1) Refer all patients to Ward Dietitian. This includes patients with known Eating Disorder admitted via ED / MAU and patients admitted with other problems, e.g. trauma, pneumonia
2) Refer to nutrition team consultant/gastroenterology consultant
3) Refer to Eating Disorders Service (if open to service) or liaison psychiatry team if not known/open to Eating Disorders Service
4) Undertake risk assessment: how ill is the patient?

Appropriate Ward

- Where patients are admitted for feeding/medical treatment of malnutrition this should be to ward 305 RDH/ward 8 QHB
- Where patients are admitted for other reasons, e.g. trauma, pneumonia, initial care may be provided on specialist ward. Consideration should be given to subsequently moving patient to ward 305/ward 8 at the discretion of the nutrition/gastroenterology consultant when the condition has stabilised.

Risk Assessment

- BMI (weight kg/height m^2): Low risk >15
  Medium risk 13–14.9
  High risk <13
- Recent weight loss over 2 consecutive weeks

Physical examination

- low pulse, blood pressure and core temperature
- muscle power reduced
- Sit up–Squat–Stand (SUSS) test

2. Sit-up: patient lies down flat on the floor and sits up without, if possible, using their hands.
3. Squat– Stand: patient squats down and rises without, if possible, using their hands. Scoring (for Sit-up and Squat–Stand tests separately)
0: Unable, 1: Able only using hands to help 2: Able with noticeable difficulty 3: Able with no difficulty

Baseline Investigations

- FBC
- Urea and electrolytes/ LFTs
- Phosphate, calcium, magnesium, albumin, CRP
- Glucose (by BM stix and/or laboratory method)
- Zinc, copper, selenium
- Iron profile, vitamin B12 and folate
- Vitamin A/D/E and carotene
- Thyroid function
- ECG

Daily Investigations

- U+Es, phosphate, calcium, magnesium – daily for 1 week,
- Glucose by BM stix before main meals

Correcting electrolyte abnormalities

Do NOT stop feeding patient when electrolyte abnormalities occur.

Monitor for refeeding syndrome (particularly phosphate) and correct as per the Trust's refeeding guideline.

- administering supplementary thiamine/B vitamins (PO or IV according to risk level)

Additional treatment

- monitoring and replacement of electrolytes as indicated and as per trust guidelines.
- gradually increasing nutritional intake as directed by the dietitian.

Nursing assessment and care formulation

- Fluids: closely monitor fluid intake as patients may drink large amounts of fluid causing fluid overload and electrolyte disturbances
- Supervised showers and washes: owing to patients compromised physical state to monitor for abnormal behaviours
- Supervised toilet visits: owing to patients compromised physical state and to monitor for abnormal behaviours
- Meals: patients encouraged to take appropriate diet as advised by the dietician and to supplement oral nutrition using nasogastric feeding if necessary
- Leave: no ward leave permitted
- Physical observations: patient are vulnerable to hypothermia and hypoglycaemia; as well as carrying out physical observations ensure room is kept warm
- Staff should ensure that if there are more than one patient with anorexia on the ward, they should not be placed in the same bay
- Avoid placing patients in side rooms, unless 1:1 supervision is available

Discharge or transfer to SEDU

- No patient with an Eating Disorder should be discharged from UHDB without discussion with Nutrition Team Consultant/ Gastroenterology consultant.