Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

MEED Policy (Medical emergencies in eating disorders) for ages 16 years and over in adult areas

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Target audience:	Trust wide

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 1	16th Sept 2024	• This is a new procedural document, please read in full	Kate Carville Hannah Stirland Jennifer Wood

Contents

1. INTRODUCTION

To provide a standardised approach to the admission and management of adults requiring hospitalisation due to an eating disorder at Doncaster and Bassetlaw Teaching Hospitals (DBTH). This includes admission criteria, risk assessment, key components of the safe management and guidance for liaison with the RDASH and Notts Healthcare Community Eating Disorder Team (CEDS).

2. PURPOSE

This document is for use by all members of the multidisciplinary team involved in the delivery of inpatient care to adults with eating disorders. It primarily focuses on those who have a suspected eating disorder. Some patients with a confirmed or suspected eating disorder who are suffering from similar behaviour and risk issues should also be managed according to the principles in this procedure.

Young people over the age of 16 will be referred to and managed as per this policy by adult services.

3. DUTIES AND RESPONSIBILITIES

This policy should be undertaken by the medical, nursing and allied healthcare professionals trust wide. The framework is also intended to be used by the wider multidisciplinary team members including RDASH/Notts Healthcare Mental Health Liaison teams and CEDS team with a view to standardise practice for inpatients.

4. PROCEDURE

A range of eating disorders may present in adults and the majority will be managed in the community by the RDASH/Notts healthcare CEDS team. In the situation where a referral is made for hospital assessment this may be directly via CEDS, primary care or presentation to the Emergency Department. Occasionally admission may also occur from Medical Outpatients.

A decision regarding the need for admission should be based on a thorough clinical assessment and guided by the completion of MEED risk assessment (Appendix 1) which provides a structured approach to examination for patients with a known or suspected eating disorder.

4.1 Admission criteria

Follow the DBTH guidance for assessing and managing patients with known or suspected eating disorders who may require admission to hospital (Appendix 2)

Community patients can be referred by CEDS to the consultant gastroenterologist via switchboard or to the Gastro secretaries' at dbth.gastrosec@nhs.net

Once discussed by a clinician the decision to review the patient in the outpatient clinic will be agreed and an appointment given.

Emergency patients attending ED or the Acute Medical Unit will be escalated by the medical registrar on call to the gastro team for consideration of admission.

4.2 First 24 hours

Once admitted to the ward the **Eating Disorder Assessment document** (Appendix 3) should be completed in addition to the nursing admission.

Within the first 24 hours of admission the following actions are required:

- A physical examination and assessment including a focused history by the doctor.
- A MEED risk assessment if not already documented (Appendix 1) by the doctor.
- Weight, height and %BMI calculation (BMI in >16y) documented on dedicated chart (Appendix 4)
- Admission blood tests* urine dipstick and β-HCG if amenorrhoea
- Blood glucose and treatment if <4mmols
- 12-lead ECG with QTc calculation AND if abnormal (arrhythmia or QTc >450ms) strict bed rest with continuous cardiac monitoring
- Treatment of immediate medical needs/electrolyte disturbance
- Review by a Gastroenterology Consultant within 24hrs
- Completion of Personal Expectation Plan by the CEDS and Mental health teams.

- Starting meal plan agreed and commenced without delay (see appendix 4)
- Intake/Meal chart commenced
- Drug card prescription or Well Sky for supplementary vitamins**
- Nutritional team and Dietician electronic referral AND phone call via switch board to request urgent review
- Referral/contact with CEDS (whether first presentation or already known) and agreement about first MDT review

***First* presentation AND not already had screening bloods in community**: see DBTH guidance (appendix 2)

Following admission, agreement with CEDS should be sought regarding the frequency of MDT meetings required. These should occur at least weekly and follow the standard MDT Review Form document (Appendix 5).

4.3 Nursing Responsibilities

The nursing and healthcare team play a vital role in the management of patients with eating disorders and provide ongoing consultation with all members of the MDT. They have the opportunity to develop rapport with the patient and family providing compassionate care and emotional support at a time of significant stress.

Specific responsibilities include:

- Support patient safety, considering the most appropriate bed location (should facilitate level of supervision required), promoting an environment that supports rest and recovery.
- Standard observations including 12 hourly lying and standing BP/HR if there are cardiovascular amber/red flags (Appendix 1)
- 4 x daily blood sugars, escalate if <4mmols
- Administration of prescribed medication, and oral nutritional supplements.
- Provision of meals and snacks including timely consumption and supervision with these meals.
- Lead on twice weekly weight monitoring (Mon and Thurs).
- Ensure supervision and/or enhanced observation is provided as per MDT decision seeking support from NHSP as required and ensuring a Safe and Supportive assessment is completed.
- Closely monitor activity levels and support the patient in keeping to their agreed personal expectation plan. Consider distance to the toilet from bed and size of bathroom.

- Insert nasogastric tube if required under the direction of medical/CEDS team.
- If the patient is not compliant to discuss further actions with MDT.

4.4 Medical Responsibilities

The aim of inpatient admission is to

- Monitor and maintain the patient physiological parameters, indicating when they are at physical risk from their eating disorder within the MDT.
- Monitor and treat any physical complications of their eating disorder
- Provide nutritional rehabilitation, balancing the risk of refeeding syndrome with over-cautious underfeeding.
- Manage behavioural manifestations such as compulsive exercise
- Utilise the Mental Health Act (MHA) to support refeeding where clinically necessary.
- Arrange transfer back to the community or for specialist care as soon as clinically safe to do so.

4.5 Dietitian Responsibilities

- To assess the severity of malnutrition and risk of refeeding syndrome
- To monitor biochemistry to continually assess this risk of refeeding syndrome and with support of the MDT to correct any abnormalities
- To work on building a trusting relationship with the patient to support safe refeeding
- To suggest appropriate meal plans to safely build up to meeting the patients nutritional requirements
- Alongside the MDT to consider artificial feeding routes as appropriate and provide safe feeding regimes for this
- To continually review regarding compliance and behaviours, liaising with the MDT to make changes to the nutritional plan as required
- To refer on and handover to relevant services on discharge

4.6 Senior Doctor

The admitting consultant should remain the lead consultant for the duration of admission, unless otherwise specified, seeking advice from the Eating Disorder consultant as and when required.

Senior Doctor to explain to the patient.

This consultation should gently raise levels of anxiety in families in which there is denial or minimisation of the seriousness of the ED.

- The disease is the problem not the patient.
- The disease itself is altering their brain and thought processes making it even harder to eat as time progresses.

- Nutritional intake is not an option; it is a necessity as the patient is seriously unwell.
- Food = Medicine and is essential for physical stabilisation.
- Until the patient is stable they will struggle to access and engage with psychological therapies.
- The patient has a choice as to whether nutrition is solid food or a liquid meal replacement drink.
- Reassure patient and the families that the strong urge to resist weight gain becomes less powerful as nutrition increases.

4.7 Daily ward rounds

- Before seeing at the bedside, review:
  - Vitals and lying/standing BP
  - Refeeding bloods
  - Intake chart/adherence to the meal plan
- Patients should be reviewed daily and examined as clinically necessary.
- for signs of refeeding syndrome: oedema, resting tachycardia (differentials include anxiety, sepsis, arrhythmia (if suspected do ECG, CRP, gas in addition to routine bloods), confusion or altered conscious state (check glucose and consider refeeding syndrome or Wernicke's).
- Complete of the MEED risk assessment once weekly in readiness for MDT assessment (Appendix 1 and 5).
- Centre any discussion around the decisions made from the weekly MEED MDT.
- **Avoid** discussion about weight or calorie intake.
- **Avoid** reassuring patients that their bloods are normal (electrolytes often remain normal unless a patient is purging and the sickest of patients can maintain normal blood parameters).

4.8 Discharge Planning

Length of stay is governed by the time taken to restore medical stability, usually 2-3 weeks. Some patients are able to be discharged to the community under CEDS, whilst others require transfer to a Specialist Eating Disorder Unit (SEDU). The MDT should discuss discharge at each weekly meeting and are best placed to determine a safe course for ongoing treatment on a case-by-case basis.

Prior to confirming medical fitness for discharge patients must
:

- Correct electrolytes (may still require supplements)
- Maintain temperature >36.5^{o}C
- Improve/stabilise syncopal symptoms
- QTc, BP and HR can take weeks to fully normalise and may still be out of range but should show an improving trend. In the case of prolonged QTc follow-up ECG should be arranged.

No particular target weight should be required for discharge but caution should be applied in discharging any patient with a %BMI <70 (even if nutritional reintroduction has occurred).

PATIENTS LACKING CAPACITY

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.
- Any interventions applied must be completed in the least restrictive manner
- Further information can be found in the MCA policy, and the Code of Practice, both available on the Extranet.

It has been established in the Courts that patients with a severe eating disorder causing malnutrition LACK CAPACITY to make safe judgements about the treatment of their eating disorder, even though they appear to have full capacity.

If a patient who has been admitted for treatment of medical complications of an eating disorder wishes to self-discharge, that patient MUST be detained by clinical staff until the patient has been reviewed by a member of the Psychiatry team who can decide whether the patient has impaired capacity.

There is no single definition of Best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

5 TRAINING/SUPPORT

All staff working in acute adult areas including the Emergency Department, gastroenterology ward, endocrine ward and Acute Medical Assessment must complete the following eLearning via the eLearning for health website;
'Eating disorders in acute medical settings'.

Staff will also attend the two day reducing restrictive interventions training.
Additional training and support can be provided by the consultant gastroenterologist for nutrition, the Nutrition Nurses and psychiatric liaison team.

6 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Staff training compliance for completion of eLearning for health 'Eating disorders in acute medical settings'.	SSR, Matron, DDN, DN and Education teams re. compliance figures	Quarterly	REST Training figures, escalated to Divisional and corporate governance groups to monitor compliance
Staff attendance and completion of the two day reducing restrictive interventions training	SSR, Matron, DDN, DN and Education teams re. compliance figures	Quarterly	REST Training figures, escalated to Divisional and corporate governance groups to monitor compliance
Compliance and adherence with the MHA and MCA.	SSR, Matron, DDN, DN	When MHA is applied but audit completed annually	Completion of appropriate paperwork as part of routine screening/audit process. Case notes review – directly address incomplete or inaccurate documentation. Discussion at local and Trust wide governance
Compliance with MEED guidance as described in the policy	Responsible Consultant (J Wood) and Audit and effectiveness team – Medicine	Annually	Contemporaneous and retrospective case note review for adherence to the standards set under the policy and national standards for access to MH provision and CEDS. Feedback through audit and effectiveness and governance processes.

7 DEFINITIONS

Anorexia nervosa

- Restriction of energy intake relative to requirements leading to a low body weight where %BMI <85% or where BMI<17.5 (in patients >16y).
- Intense fear of weight gain or behaviour that interferes with weight gain such as purging or excessive exercise.
- Disturbance in body weight or shape perception leading to distorted body image and persistent lack of recognition of seriousness of low body weight.

Atypical Anorexia Nervosa

- All the above criteria are met but despite significant weight loss, the individual's weight remains within or above the normal range.

Bulimia Nervosa

- Frequent (≥1/week for ≥3 months) uncontrolled binge eating followed by recurrent and inappropriate, self-induced purging behaviour in order to avoid weight gain (vomiting, laxative or diuretic abuse, fasting or excessive exercise, omission of insulin in T1DM).

Abbreviations

DSM-5	Diagnostic and statistical manual of mental disorders
BMI	Body mass index
ARFID	Avoidant restrictive food intake disorder
CEDS	Community eating disorder service
OPD	Outpatient department
RDASH	Rotherham Doncaster and South Humber
ED	Eating disorder
DBTH	Doncaster and Bassetlaw Teaching Hospitals
OCD	Obsessive Compulsive Disorder
eMARF	Electronic multiagency referral form
MEED	Managing Emergencies in Eating Disorders
β-HCG	Beta – human chorionic gonadotropin
ECG	Electrocardiogram
PEP	Personal expectation plan
OD	Once daily
BD	Twice daily
Bpm	Beats per minute
sBP	Systolic blood pressure
dBP	Diastolic blood pressure

HR	Heart rate
SUSS	Sit up Squat Stand Test
WHO	World Health Organisation
MHA	Mental Health Act
MCA	Mental Capacity Act
SEDU	Specialist Eating Disorder Unit
PPI	Proton Pump Inhibitor

8 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix ?)

9 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Medical Emergencies in Eating Disorders (MEED) Guidance on recognition and management. May 2022

10 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.
For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website:
https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

11 REFERENCES

NICE guideline NG69 Eating Disorders Recognition and Treatment 2017

Fuller S.J. Philpot U and working group (2020) The development of a consensus based guidelines for dietetic practice in nasogastric tube feeding under restraint for patients with anorexia nervosa using a modified Delphi process. J Hum Nutr Diet https://10.1111/jhn.12731

Department of Constitutional Affairs Mental Capacity Act (2005): Code of Practice, 2007 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Medical emergencies in eating disorders (MEED) Guidance on recognition and management (2022), Royal college of psychiatrists, CR233 https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2022-college-reports/cr233

APPENDIX 1 MEED RISK ASSESSMENT

Risk Assessment- can be used for all age groups - Please complete the Risk Assessment at admission and then at least weekly until discharge.

	RED Risk to life Admission essential	**AMBER** Impending risk to life may need admission	**Green** Low risk to life
Weight loss	More than 1kg/week for 2 weeks Rapid weight loss even if obese	500 – 999g/week Undernourished patient	Less than 500g/week or fluctuating weight
BMI	**Over 18 year old** BMI less than 13 **Under 18 year old** BMI less than 70% of mean BMI for age	**Over 18 year old** BMI between 13 and 14.9 **Under 18 year old** BMI 70-80% mean % BMI	**Over 18 year old** BMI >15 **Under 18 year old** BMI >80% mean BMI
Heart rate (awake)	Less than 40/min	40-50/min	>50/min
CVS	Standing BP <90mm systolic (over 18 year old) Standing BP<0.4th centile for age Postural drop >20mm Hg systolic BP Heart rate increases by >30 beats/min on standing (35 beats/min if age less than 16 years	Standing systolic BP >90 mm with occasional syncope Postural drop systolic BP >15 mm on standing or heart rate increases >30 beats per min on standing (35 beats/min if age 16 year old or less)	Normal standing systolic BP for age and gender Normal orthostatic cardiovascular changes, normal heart rhythm
Hydration Status	Fluid refusal Severely dehydrated Poor urine output, dry mouth, postural drop, reduced skin turgor, sunken eyes, tachypnoea or tachycardia	Severe fluid restriction Mild dehydration (5-10%) With dry mouth, reduced urine output, normal skin turgor, peripheral oedema	Minimal fluid restriction Less than 5% dehydration. May have concerns about negative fluid balance

Temperature (degrees centigrade)	Less than 35.5 tympanic or less than 35.0 axilla	Less than 36	More than 36
Muscle function (SUSS test)	Unable to sit up from lying flat unable to get up from squat needs upper limbs to help get up	Unable to sit up from lying or only able to get up with difficulty	Able to sit up from lying Able to rise from a squat without using arms
Handgrip strength (IN DBTH only available through dieticians)	Male <30.5 kg Female<17.5	Male<38 Kg Female <23 Kg	Male >38 Kg Female >23 Kg
Mid arm circumference cm	Less than 18	18-20	>20
Other clinical	Diabetic ketoacidosis Confusion Other medical co-morbidities such as sepsis	Pressure sores	Poor concentration Poor cognitive flexibility (resisting new ideas)
ECG changes	**Over 18 year old** QTc >450ms (female) or > 430 ms (male) **Under 18 year old** QTc >460ms (f) or 450 (m) Any other significant ECG abnormality	**Over 18 year or under 18 year old** prolonged QTc but patient is on medication which causes prolong QTc NO other ECG abnormalities present	Normal QTc for age and sex

Hospital Number: (Affix patient label here) Name: Date of Birth:	Ward:
Date/time of assessment:	Signature of Assessor:

APPENDIX 2 DBTH GUIDANCE FOR ASSESSING AND MANAGING PATIENTS WITH KNOWN OR SUSPECTED EATING DISORDERS WHO MAY REQUIRE ADMISSION TO HOSPITAL

Guidance for assessing and managing patients with known or suspected eating disorders who may require admission to hospital

These guidelines have been prepared with reference to the report 'Medical Emergencies in Patients with Eating Disorders – MEED', produced for the Royal College of Psychiatrists May 2022, report CR233. This report can be downloaded in full from the web site of Royal College of Psychiatrists by searching for MEED.

Recognising patients with medical complications of an eating disorder, who need to be admitted to hospital because of deteriorating physical health

Patients with an eating disorder have a psychiatric illness. The illness when severe carries a mortality rate up to 20%. The clinical team (Emergency Department and Acute Medicine) need to be able to recognise patients with life – threatening complications and admitting these patients to hospital to commence re-feeding.

Where the patient's risk assessment indicates admission is needed but the patient refuses hospital admission, the patient should be detained until a psychiatrist can decide whether the patient requires a compulsory admission.

Risk Assessment- can be used for all age groups

	RED Risk to life Admission essential	**AMBER** Impending risk to life may need admission	**Green** Low risk to life
Weight loss	More than 1kg/week for 2 weeks Rapid weight loss even if obese	500 – 999g/week Undernourished patient	Less than 500g/week or fluctuating weight
BMI	**Over 18 year old** BMI less than 13 **Under 18 year old** BMI less than 70% of mean BMI for age	**Over 18 year old** BMI between 13 and 14.9 **Under 18 year old** BMI 70-80% mean % BMI	**Over 18 year old** BMI >15 **Under 18 year old** BMI >80% mean BMI
Heart rate (awake)	Less than 40/min	40-50/min	>50/min
CVS	Standing BP <90mm systolic (over 18 year old)	Standing systolic BP >90 mm with occasional syncope	Normal standing systolic BP for age and gender

	Standing BP<0.4th centile for age Postural drop >20mm Hg systolic BP Heart rate increases by >30 beats/min on standing (35 beats/min if age less than 16 years	Postural drop systolic BP >15 mm on standing or heart rate increases >30 beats per min on standing (35 beats/min if age 16 year old or less)	Normal orthostatic cardiovascular changes, normal heart rhythm
Hydration Status	Fluid refusal Severely dehydrated Poor urine output, dry mouth, postural drop, reduced skin turgor, sunken eyes, tachypnoea or tachycardia	Severe fluid restriction Mild dehydration (5-10%) With dry mouth, reduced urine output, normal skin turgor, peripheral oedema	Minimal fluid restriction Less than 5% dehydration. May have concerns about negative fluid balance
Temperature (degrees centigrade)	Less than 35.5 tympanic or less than 35.0 axilla	Less than 36	More than 36
Muscle function (SUSS test)	Unable to sit up from lying flat unable to get up from squat needs upper limbs to help get up	Unable to sit up from lying or only able to get up with difficulty	Able to sit up from lying Able to rise from a squat without using arms
Handgrip strength (IN DBTH only available through dieticians)	Male <30.5 kg Female<17.5	Male<38 Kg Female <23 Kg	Male >38 Kg Female >23 Kg
Mid arm circumference cm	Less than 18	18-20	>20
Other clinical	Diabetic ketoacidosis Confusion Other medical co-morbidities such as sepsis	Pressure sores	Poor concentration Poor cognitive flexibility (resisting new ideas)

ECG changes	**Over 18 year old** QTc >450ms (female) or > 430 ms (male) **Under 18 year old** QTc >460ms (f) or 450 (m) Any other significant ECG abnormality	**Over 18 year or under 18 year old** prolonged QTc but patient is on medication which causes prolong QTc NO other ECG abnormalities present	Normal QTc for age and sex

Other Assessments - Blood Results

Electrolyte derangement
Admit to medical ward if potassium less than 2.5 mmol/l
Admit if low sodium (think of water loading to disguise weight loss)
Admit if low calcium or low magnesium or low phosphate
Electrolytes will need to be replaced intravenously because of risk of re-feeding syndrome. Patients will require assessment by Psychiatry and Dietetics- it is NOT sufficient to correct the electrolyte deficiencies and discharge the patient back to the community.

Hypoglycemia
Admit to medical ward if blood glucose is less than 3 mmol/l

These patients have very low glycogen stores. Prolonged treatment with intravenous glucose 10% may be required to treat the hypoglycaemia until oral or enteral carbohydrate intake can be re-established

Haematology
Admit if:
Anaemia Hb <100g/l
Low WCC- remember to screen for sepsis

Other Indications for admission- likely to require enteral feeding
Acute food refusal
Estimated calorie intake less than 500 kCal/day for 2 days
TIDE
Type 1 diabetes and eating disorder= diabetic with fear of weight gain or altered body image, restricting insulin to lose weight or other compensatory behaviours e.g. ketogenic diet

Red flags to recognise TIDE:

- Erratic blood glucose (with high HbA1C >86 mmol/mol)
- Multiple hospital admissions with poor diabetic control
- Recurrent Diabetic ketoacidosis

- Recurrent severe hypoglycaemia
- Over exercising
- Impaired hypoglycaemia awareness
- Extreme dietary restriction or binge eating
- Mental health co-morbidity
- Secrecy about diabetes management
- Disengagement with diabetes management, failure to request repeat prescriptions

Management

Avoid confrontation: patient and family have been dealing with the illness for a long time.

Acknowledge family's concerns: FEAST has information sheets to support families of patients with eating disorders.

Involve Psychiatry and Dietetic services ON THE DAY OF ADMISSION. Patients with medical emergencies due to eating disorder need to be discussed with consultant psychiatrist or the Access team on the day of admission, to agree a joint management plan and strategies to manage difficult behaviour.

Mental Capacity

Eating disorders are a Mental Health problem and the patient can be detained under the mental health act. The decision to detain a patient under the mental health act can only be made by a consultant psychiatrist.

It has been established in the Courts that patients with a severe eating disorder causing malnutrition LACK CAPACITY to make safe judgements about the treatment of their eating disorder, even though they appear to have full capacity.
If a patient who has been admitted for treatment of medical complications of an eating disorder wishes to self-discharge, that patient MUST be detained by clinical staff until the patient has been reviewed by a member of the Psychiatry team who can decide whether the patient has impaired capacity.

If the patient cannot recognise the need to be in hospital to treat the malnutrition or other medical complications, it should be assumed that the patient lacks capacity to weigh up the information because of their mental illness. This is the grounds for requesting a psychiatric assessment of their mental capacity.

Managing behavioural issues

Patients with a severe eating disorder have severe anxiety around eating or gaining weight. This can lead to disruptive behaviours. The clinical team need to be aware of the risk that the patient will try to jeopardise the re-feeding. Ideally these patients should be managed on a ward where the staff are alert and trained to recognise these disruptive behaviours (Gastroenterology and endocrine wards at DRI, Gastroenterology ward at Bassetlaw).

The nursing and medical team need to watch for micro-exercising (isometric exercises while on bed rest), concealing food, emptying feed into toilet or waste bins, falsifying weight e.g. excessive water drinking, concealing weights under clothes. The clinical team need to remain empathic to the patient while challenging these disruptive behaviours. There should be regular (ideally daily) support from the Psychiatry team to discuss how to manage these behaviours.

It is essential that the whole clinical team and the family or carers have an agreed approach to these behaviours so that the patient and family are managed consistently.

When starting re-feeding, it is best to advise patient and family that the patient will remain on bed rest, in a warm environment, with supervision when the patient goes to the toilet or the shower. Access to fluids should be restricted to avoid water-loading.

Patient will need to remain in bed for 1 hour after meals (so will need to go to toilet before the meal). They will be observed by the nursing team at all times (not suitable for side room unless there are infection control issues).

If the family wish to bring in food, this must be handed to the nursing team who will discuss with the dietician whether the food should be included in the meal plan.

All food and drink consumed must be documented by the nursing team (not patient or carers).

Remember these patients have a high risk of anxiety, distressing thoughts and suicidal thoughts. The team needs to remain empathic and maintain a consistent approach.

Discharge from Acute Hospital

Treating the altered thinking present in a patient with a severe eating disorder requires a prolonged period of psychiatric or psychological support. Once the patient's malnutrition, dehydration and electrolyte problems have been addressed, the medical, psychiatric and dietetic teams need to agree on an appropriate discharge destination. Ideally these patients should be transferred to an inpatient bed in an eating disorders unit but at present there are insufficient of these specialist beds. It is helpful to set targets (weight, BMI, calorie intake, behaviour targets etc.) which can help to demonstrate progress towards discharge and can be used after discharge for outpatient monitoring or progress.

APPENDIX 3 – ASSESSMENT TOOL

ASSESSMENT TOOL (to be completed on admission to ward)
Reason for admission? (including name of admitting Consultant)
Source of admission? CEDS ☐ OPD ☐ Emergency Department ☐ Readmission/open access ☐ **If unknown to CEDS, please REFER NOW rdash.ceds@nhs.net or by phoning 03000 212 349**
Coexisting mental health diagnosis in addition to ED (OCD/depression/anxiety etc)?
Risks to self and others? (please provide detail where applicable) Self-harm (cutting or poisoning) ☐ Suicidal ideation ☐ Risk of absconding ☐ Mealtime-associated violence/aggression ☐ Other ☐ Detail……
Known safeguarding concern (including contact details of social worker if applicable)? **Has a safeguarding referral been completed?**
Who has parental responsibility? For 16-18 yrs old (full name and contact number/s)
Accompanying caregiver and relationship? If yes referral to be made.
Nominated caregiver for primary communication during admission?
Education setting (school/college) if 16-18 yr old? Known learning disability?

APPENDIX 4 – MEAL PLAN

Day 1- 1200kcal (appropriate for most patients to commence on admission)

Breakfast	Medium bowl cereal e.g. 2 Weetabix with 200ml semi-skimmed milk	*200ml Fortisip
Mid-morning snack	1 piece fruit (apple, banana, orange)	*100ml Fortisip
Lunch	To include: -Sandwich (2 slices bread and margarine) or medium-sized baked potato and margarine with -At least one protein filling: tuna/salmon/chicken/ ham/egg/beans	*200ml Fortisip
Mid-afternoon snack	2 biscuits *or* cereal bar *or* yoghurt (can choose from 200kcal snack list)	*100ml Fortisip
Tea	Hot main meal to include: -Carbohydrate and protein for example baked potato and cheese, pasta bolognaise, omelette with filling AND 2 slices of bread	*200ml Fortisip

Day 2- 1500kcal

Breakfast	Medium bowl cereal e.g. 2 Weetabix with 200ml semi-skimmed milk	*200ml Fortisip
Mid-morning snack	2 biscuits *or* cereal bar *or* yoghurt (can choose from 200kcal snack list)	*125ml Fortisip
Lunch	To include: -Sandwich (2 slices bread and margarine) or medium-sized baked potato and margarine with -At least one protein filling: tuna/salmon/chicken/ ham/egg/beans AND 1 piece fruit (apple/banana/orange)	*200ml Fortisip
Mid-afternoon snack	2 biscuits *or* cereal bar (can choose from 150-200kcal snack list) AND 200ml semi skimmed milk	*125ml Fortisip
Tea	Hot main meal to include: -Carbohydrate and protein for example baked potato and cheese, pasta bolognaise, omelette with filling AND 2 slices of bread	*200ml Fortisip
Supper/Snack	2 biscuits *or* cereal bar (can choose from 200kcal snack list)	*125ml Fortisip

Day 3- 1800kcal

Breakfast	Medium bowl cereal e.g. 2 Weetabix with 200ml semi-skimmed milk AND 100ml fruit juice	*200ml Fortisip
Mid-morning snack	1 piece fruit (apple/orange/banana)	*200ml Fortisip
Lunch	To include: -Sandwich (2 slices bread and margarine) or medium-sized baked potato and margarine with -At least one protein filling: tuna/salmon/chicken/ ham/egg/beans AND 1 yogurt (thick and creamy)	*200ml Fortisip
Mid-afternoon snack	2 biscuits *or* cereal bar (can choose from 150-200kcal snack list)	*200ml Fortisip
Tea	Hot main meal to include: -Carbohydrate and protein for example baked potato and cheese, pasta bolognaise, omelette with filling AND 2 slices of bread AND 1 piece of fruit (apple, banana, orange)	*200ml Fortisip
Supper/Snack	2 biscuits *or* cereal bar (can choose from 200kcal snack list) AND 200ml semi-skimmed milk	*200ml Fortisip

*If meal or snack not taken in full, offer equivalent amount of 1.5kcal/ml nutritional supplement e.g. Fortisip which can be obtained from stock.

If at least 50% meal/snack eaten, half liquid supplement can be given otherwise offer full amount.

Include 200–300 mL fluid at each meal or snack.

Meal will be removed after agreed time and supplement drink of Fortisip provided if unfinished. 200ml of Fortisip to be provided if meal not finished, 100ml if half eaten

APPENDIX 5 – MDT REVIEW FORM

MDT REVIEW FORM
Minimum frequency weekly

Name……

Date of review / /

Current length of stay…….....days

MHA status……

Attendees……

……

……

Weight in kg (and change from previous week)	
Current update Include compliance with meal plan and progress	
Behaviours of concern	
Current therapeutic input	
Current medication Including side effects or changes needed?	
Current risks Include to self, others or environmental factors	
Physical health update	

Home leave? How are we maintaining links to home?	
Discharge planning Include expected length of stay, where will discharge be to?	

APPENDIX 6 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Policy	Trust wide	Hannah Stirland	New	11.03.2024

1) Who is responsible for this policy? Name of Division/Directorate: Medicine

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? MEED policy

3) Are there any associated objectives? Legislation, targets national expectation, standards: NICE guidance for caring and managing patients with ED

4) What factors contribute or detract from achieving intended outcomes? – None

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? [any actions to be taken] N/A

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (☐) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: June 2026

Checked by: Lorna Ball **Date: 11.03.2024**