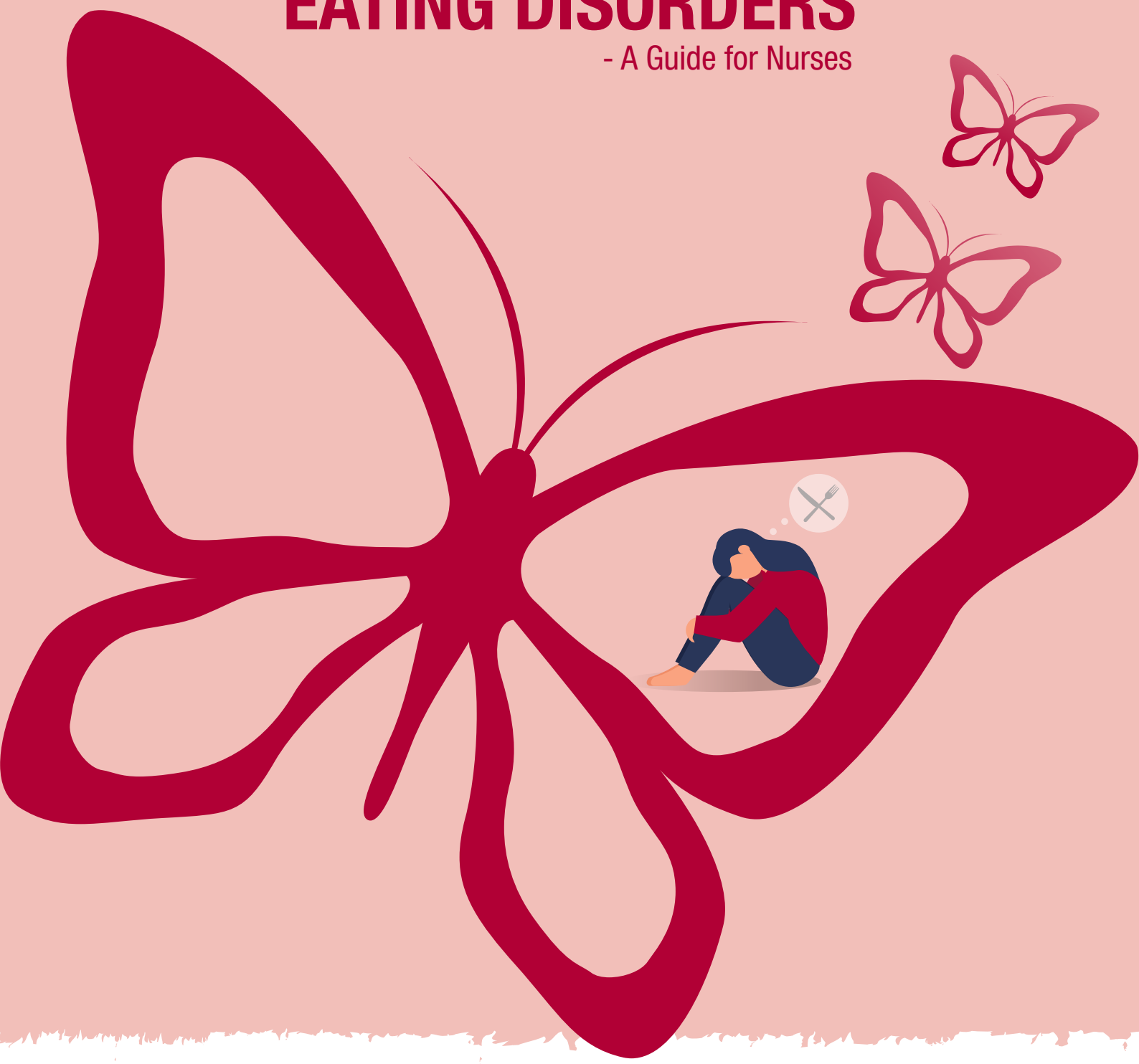
Oifig an Stiúrthóra Seirbhísí Altranais & Cnáimhseachais | Office of the Nursing & Midwifery Services Director

A Guidance Document to provide Nurses with evidence based information to aid decision making regarding the safe and holistic assessment and management of eating disorders in healthcare services.

EATING DISORDERS

- A Guide for Nurses



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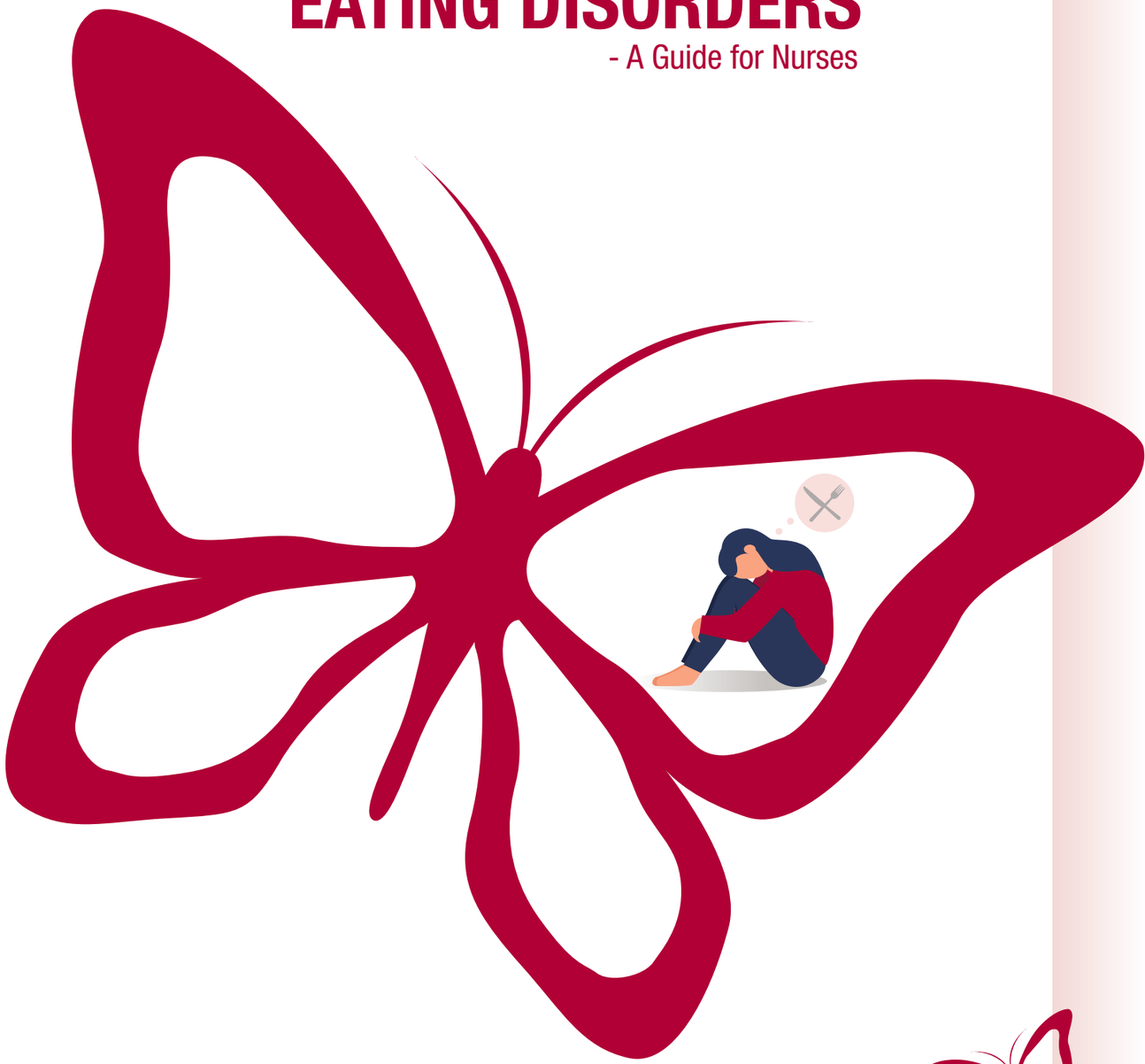

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Foreword

Dear Colleagues

It gives me great pleasure to present Eating Disorders - A Guide for Nurses, A Guidance Document to provide Nurses with evidence based information to aid decision making regarding the safe and holistic assessment and management of eating disorders in healthcare services.

The National Clinical Programme for Eating Disorders (2018) is a key component for the Clinical Design & Innovation (CDI) Division. This programme applies to HSE Mental Health Services for children, adolescents and adults with eating disorders throughout all clinical stages of the disorder working collaboratively with other relevant clinical programmes in terms of presentations in other settings.

The purpose of this Guidance document is to provide Nurses with evidence based information to aid decision making regarding the safe and holistic assessment and management of eating disorders in healthcare services. The vision of this document is that adults with eating disorders will receive evidenced-based quality nursing care to promote their recovery.

It is set within the context of working within a multi-disciplinary team (MDT) across all public healthcare environments applying to services working with adults at all stages of their eating disorder from screening and early intervention through to recovery.

I would like to express our sincere appreciation to the members of the Steering Group who have given their time, commitment and expertise to develop and complete this important resource for nurses.

Dr Geraldine Shaw
Nursing and Midwifery Services Director & Assistant National Director
Office of the Nursing & Midwifery Services Director
Clinical Programme Implementation and Professional Development

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This document has been colour coded and divided into 5 sections:

1. Introduction and Background
2. Definition and Screening for Eating Disorders
3. Assessment of People with Eating Disorders
4. Anorexia, other Eating Disorders and Management of Common Complaints
5. Potential Requirements to Deliver Services

Glossary and Acronyms

AN	Anorexia Nervosa
AFRID	Avoidant Restrictive Food Intake Disorder
BED	Binge Eating Disorder
BEE	Basal Energy Expenditure
BGL	Blood Glucose Level
BMI	Body Mass Index
BPM	Beats per Minute
BN	Bulimia Nervosa
CAT	Cognitive Analytical Therapy
CBT-E	Cognitive Behavioural Therapy-Enhanced
CBT-ED	Eating Disorder Focused Cognitive Behavioural Therapy
CMHT	Community Mental Health Team
CRP	C-reactive protein
CVS	Cardiovascular System
DBT	Dialectical Behavioural Therapy
ECG	Electrocardiography
FBC	Full Blood Count
FBT	Family Based Therapy
FPT	Focal Psychodynamic Therapy
FT- AN	Anorexia Nervosa Focused Family Therapy
FT- BN	Bulimia Nervosa Focused Family Therapy
GP	General Practitioner
HDU	High Dependency Unit
ICP	Integrated Care Plan
ICU	Intensive Care Unit
IPT	Interpersonal Psychotherapy
IV	Intravenous
KCI	Potassium Chloride
LFT	Liver Function Test
MDT	Multidisciplinary Team
MANTRA	Maudsley Model of Treatment for Adults with Anorexia Nervosa
MARSIPAN	Management of Really Sick Patients with Anorexia Nervosa
NICE	National Institute for Health and Care Excellence
MUST	Malnutrition Universal Screening Tool
NG	Nasogastric
ORS	Oral Rehydration Solution
OSFED	Other Specified Food and Eating Disorders
PICU	Psychiatric Intensive Care Unit
POCT	Point of Care Testing
SE- AN	Severe and Enduring Anorexia Nervosa
SEED	Severe and Enduring Eating Disorder
SSCM	Specialist and Supportive Clinical Management
SUSS	Sit-up Squat Stand Test
TFT	Thyroid Function Test
U&E	Urea and Electrolytes

Mission, Vision and Core Values

The National Clinical Programme for Eating Disorders (2018) is a key component for the Clinical Design & Innovation (CDI) Division. This programme applies to HSE Mental Health Services for children, adolescents and adults with eating disorders throughout all clinical stages of the disorder working collaboratively with other relevant clinical programmes in terms of presentations in other settings. The eating disorder services in Ireland provide vital care to all people who experience eating disorders, which include: Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorders, Avoidant Restrictive Food Intake Disorder and Other Specified Feeding and Eating Disorders. The mission of this guiding document is to provide evidence-based information to nurses to equip them with a holistic understanding of eating disorders to enable them to assess, manage and engage therapeutically with adults experiencing an eating disorder.

The vision of this document is that adults with eating disorders will receive evidenced-based quality nursing care to promote their recovery. The values initiative led by the Chief Nursing Officer, Department of Health, in partnership with the Office of the Nursing and Midwifery Services Director (ONMSD) HSE, and the Nursing and Midwifery Board of Ireland (2016) identified and agreed Compassion, Care and Commitment as the three core values that underpin their practice in Ireland.

The HSE aims to provide people with the very best outcomes by living our values of Care, Compassion, Trust and Learning. Our values influence our attitudes and behaviour towards those to whom we provide services and with whom we have professional contact.

Introduction

"Eating disorders are behavioural conditions characterised by severe and persistent disturbance in eating behaviours and associated distressing thoughts and emotions. They can be very serious conditions affecting physical, psychological and social function. Types of eating disorders include anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant restrictive food intake disorder and other specified feeding and eating disorder" (APA 2021).

Eating Disorders are multifaceted illness which do not discriminate based on diversity- despite common misconception they present in all ages, genders, cultural and racial milieu (Morrisey & Oberlin 2019). Eating Disorders may present in numerous different ways-from the stereotypical emaciated presentation to the not so obvious- this in turn can elicit challenges for identification, assessment, diagnosis and treatment in clinical practice (Bodywhys 2013). Treatment of Eating Disorders can become more challenging as the illness progresses leading to serious physical and mental health complications and potentially fatal outcomes (Royal College of Psychiatrists 2022). Eating Disorders- especially Anorexia Nervosa- are associated with higher morbidity and mortality rates than any other mental illness (HSE 2018, St Patricks Mental Health Services 2022). Co-morbid mental illness such as depression, obsessive compulsive disorder and personality disorders are common and there is a significant risk of suicide in people experiencing eating disorders (RCSI 2016, Very Well Mind 2021).

The National Clinical Programme for Eating Disorders was prioritised within the Health Service Executive's (HSE's) National Clinical Programme for Mental Health to develop and improve its eating disorder service provision in Ireland. The Model of Care (2018) outlines the HSE's vision for its eating disorder services in Ireland into the future. This framework acknowledges that the demand for inpatient services disorders is significant and that many adults who require hospitalisation may receive treatment in non-eating disorders specialist wards.

The purpose of this current framework document is to provide Nurses with evidence based information to aid decision making regarding the safe and holistic assessment and management of eating disorders in healthcare services. The framework document is based on national / international best practice including (HSE 2018; Joint Commissioning Panel for Mental Health 2013, NICE 2017; NICE 2018; Royal Australian and New Zealand College of Psychiatrists (RANZCP) 2014; Royal College of Pathologists, Royal College of Physicians & Royal College of Psychiatrists 2014).

Guiding Documents and Evidence Based Practice

Diagnostic and Statistical Manual of Mental Disorders (DSM-5), (5th edition, 2013)

The DSM-5 is the standard classification of mental disorders used by mental health professionals in the United States (U.S.) and contains a listing of diagnostic criteria for every psychiatric disorder recognized by the U.S. healthcare system. The previous edition, DSM-IV-TR, has been used by professionals in a wide array of contexts, including psychiatrists and other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, counsellors, as well as by clinicians and researchers of many different orientations. DSM is used in clinical settings as well as with community populations. In addition to supplying detailed descriptions of diagnostic criteria, DSM is also a necessary tool for collecting and communicating accurate public health statistics about the diagnosis of psychiatric disorders (American Psychiatric Association, 2013).

Medical Emergencies in Eating Disorders: Guidance on Recognition and Management (2022) (Replacing MARSIPAN and Junior MARSIPAN)

In 2017 the Parliamentary Health Service Ombudsman (PHSO) published the report "Ignoring the alarms: How NHS eating disorder services are failing patients". (https://www.ombudsman.org.uk/publications/ignoring-alarms-how-nhs-eating-disorder-services-are-failing-patients)

On the basis of this report the PHSO made several recommendations and in 2019 work began on reviewing and updating current guidance with the specific intention to assimilate guidance for children, adolescents and adults and to provide guidance on the management of other eating disorders. This latest guidance document supersedes all previous versions including the MARSIPAN and Junior MARSIPAN (2015) Guidelines.

There has been a substantial increase in presentation and admission of children and young people with restrictive eating patterns to accident and emergency departments during the COVID-19 pandemic, and figures for adult presentations (when available) are likely to follow a similar narrative.

"The aim of this guidance is to make preventable deaths due to eating disorders a thing of the past" (RC Psych 2022) and the intentions are to address presentations in eating disorder patients that feasibly result in admissions to medical care. This guidance document emphasises the importance of medical management of eating disorder presentations- incorporating both medical and psychiatric care.

This updated version of Medical Emergencies in Eating Disorders: Guidance on Recognition and Management (2022) provides clinicians with:

- Advice on the assessment and management of all eating disorders that may result in the person presenting as a medical emergency;
- An new risk assessment tool for people with eating disorders of all ages based on a traffic light system; (RCPsych 2022 p31)
- A review and amalgamation of the evidence which informed the guidelines, including evaluations of international guidance on the medical management of eating disorders;
- "Summery sheets/ brief reference guidance" targeted at specific interest groups-(general practitioners, nurses, psychiatrists, dietitians, people with eating disorders and their families)
- Up to date clinical practice guidance on the medical, nutritional and psychiatric care of people with eating disorders in medical settings;
- Advice for commissioners on the services required for very ill people with eating disorders (RCPsych 2022).

Eating Disorders: recognition and treatment National Institute for Health and Care Excellence NG69 (NICE guideline 2017)

Eating disorders: recognition and treatment is a guideline which covers assessment, treatment, monitoring and inpatient care for children, young people and adults with eating disorders. It aims to improve the care people receive by detailing the most effective treatments for anorexia nervosa, binge eating disorder and bulimia nervosa.

National Institute for Health and Care Excellence (NICE 2018) Quality Standard (QS175)

This standard is based on NG69 and outlines six quality statements for Eating Disorders:

Statement 1	People with suspected eating disorders who are referred to an eating disorder service start assessment and treatment within 4 weeks for children and young people or a locally agreed timeframe for adults.
Statement 2	People with eating disorders have a discussion with a healthcare professional about their options for psychological treatment.
Statement 3	People with binge eating disorder participate in a guided self-help programme as first line psychological treatment.
Statement 4	Children and young people with bulimia nervosa are offered bulimia-nervosa-focused family therapy (FT-BN).
Statement 5	People with eating disorders who are being supported by more than one service have a care plan that explains how the services will work together.
Statement 6	People with eating disorders who are moving between services have their risks assessed.

Adult Eating Disorders: community, inpatient and intensive day patient care. Guidance for commissioners and providers (2019)

A guidance document prepared by: NHS England with NICE and the National Collaborating Centre for Mental Health.

Position statement on early intervention for eating disorders (2019) RCPsych.

This position statement sets out the Royal College of Psychiatrists' view, with supporting evidence, that early intervention for eating disorders (EDs) is essential. It also makes recommendations for actions to improve service provision in this area.

National Clinical Programme for Eating Disorders

Model of Care 8 Themes

1. Enhanced Service Structure	**5. Evidence based treatement**
2. Resources required to deliver the service	**6. Effective team working**
3. Patient -centred care and recovery	**7. Skilled workforce developement**
4. Intergrated care	**8. Evaluation of effectiveness**

Aim, Objectives and Scope of the Guidance Document

Aim:

The National Group was established to develop a guidance document to provide advice and guidance to nurses working with adults with eating disorders in a variety of settings. The aim of this document is to provide practical information to Nurses on key components of the National Clinical Programme for Eating Disorders.

Objectives:

- To equip Nurses with a holistic understanding of eating disorders in the adult population.
- To provide evidenced based information to aid decision making regarding the safe and holistic assessment and management of eating disorders in line with national and international guidelines.
- To provide Nurses with a better understanding with the clinical, psychological and behavioural symptoms of an eating disorder.
- To provide better outcomes for adults who experience eating disorders.
- To provide clarity regarding effective nursing care and improve consistency across the health services.

Scope:

This document sets to outline nursing principles / practice regarding eating disorders for adults. It applies to the delivery of eating disorder services across primary, community mental health, day and inpatient services including acute hospital services. Key eating disorders requiring mental health treatment and as described in DSM-5 are included. It is set within the context of working within a multi-disciplinary team (MDT) across all public healthcare environments applying to services working with adults at all stages of their eating disorder from screening and early intervention through to recovery.

The focus of this document is not to replace initiatives already in place but to build on and compliment them, ensuring provision of a quality, safe service which offers value for money. This evidenced based information may be used to develop a guideline for nurses working with adults with eating disorders to inform and promote best practice.

As previously mentioned eating disorders are multifaceted and the person suffering from an eating disorder may present with physical and/or psychological symptoms of same that may not always be initially obvious (Bodywhys 2018).
There are numerous healthcare settings in which people with eating disorders may present- however the primary reason for their presentation to the specific health care setting may not always be to treat their eating disorder.

Presentations in dental clinics, primary care areas such as general practitioner surgeries with non-specific physical health issues and referrals sought by concerned family members are not unusual.

An increased awareness of signs and symptoms associated with eating disorders can aid Nurses to utilise evidence based information to aid decision making regarding the safe and holistic assessment and management of eating disorders in their own clinical areas and healthcare services.

It is not uncommon for people with eating disorders to experience overlapping symptoms. Diagnosis can change dependent on presenting signs and symptoms; therefore an increased awareness of the signs and symptoms associated with each disorder can aid nurses and midwifes in assessment and treatment decisions (BEAT 2022).

Examples of physical symptoms associated with eating disorders include:

Frequent changes in weight/weight loss	**Failure to gain expected weight in a child or adolescent who is still growing and developing**
Wanting to lose weight when normal or underweight	**Dry, discoloured skin or fine hair growing on their face and body**
Poor circulation, fluid retention	**Difficulty sleeping, or concentrating**
Calluses	**Enlarged salivary glands**
Digestive problems such as cramps, wind, constipation, diarrhoea	**Loss of, or irregular periods**
Unexplained infertility	**Feeling weak, dizzy or tired**
Cardiac arrhythmias	**A sore throat or mouth ulcers**
Erosion of tooth enamel, tooth decay	**Muscle weakness** (Bodywhys 2018 p 6)

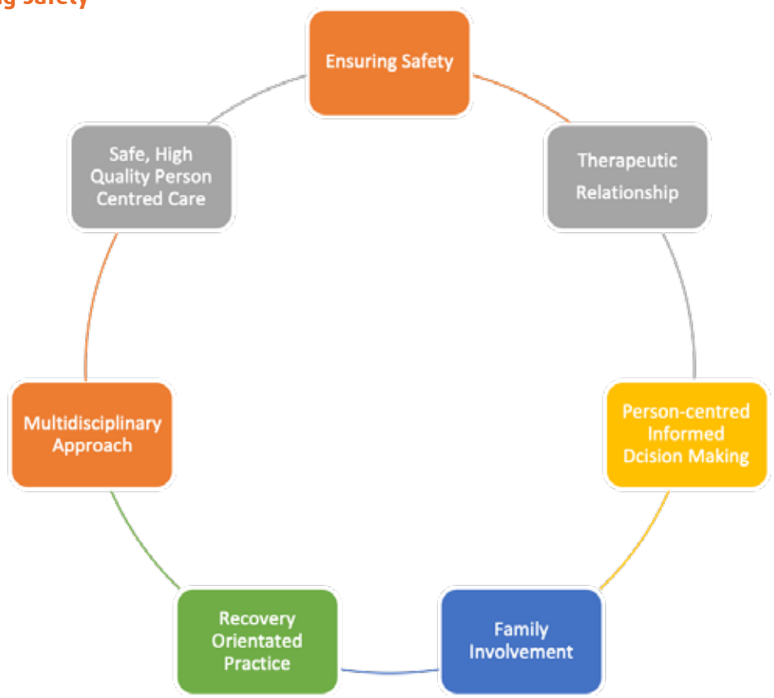
Service Delivery:

People diagnosed with an eating disorder receive care from generalist and specialist nurses in a range of care settings and environments. Regardless of the setting the nurse's role can be complex and is vitally important in the recovery process. In all care settings nurses, when equipped with knowledge and skills, have an important role to play in recognising early signs and symptoms of eating disorders and in their prompt intervention and treatment. Nursing care is delivered within a MDT and includes prevention, screening, assessment, interventions, education, coordination and evaluation of care.

General Principles for Nurses

The following seven general principles for Nurses will support the delivery of safe, high quality person centred care in collaboration with the person with an ED.

Ensuring Safety



The primary focus of care for adults with an ED is to ensure that they are provided with safe and evidenced based care. This includes a bio psychosocial approach to care.

The Therapeutic Relationship

The nurse plays a crucial role in creating and fostering a therapeutic alliance built on the principles of collaboration, person focus, empowerment and recovery (Zugai *et al.* 2015). (Appendix 3)

The therapeutic relationship can be influenced by several factors such as experiences, attitudes and perceptions by the nurse and the person with the eating disorder. Other fundamental skills are listening and questioning techniques. These methods are all used to help elicit and reinforce change and commitment talk in helping resolve the ambivalence commonly found in eating disorders.

Person-centred Informed Decision-Making

The person and their family / carers (where appropriate) should be at the centre of care and informed decision-making. Where consent to treatment is an issue (child or adult) the appropriate legal framework should be considered (HSE 2018). Further information regarding legal and ethical considerations associated with treatment of Eating Disorders in Ireland can be obtained in Section 13 of the Eating Disorder Service HSE Model of Care for Ireland (2018). https://www.hse.ie/eng/services/list/4/mental-health-services/national-clinical-programme-for-eating-disorders/ed-moc.pdf

Family Involvement

Family involvement can support recovery in both adults and children with eating disorders (HSE 2018). Family Based Therapy is regarded as a fundamental component of treatment in children with eating disorders (Morrissey & Oberlin 2019). Family members and significant others (where appropriate) should be involved in the assessment and treatment process. Living with a person with an eating disorder can be a significant stressor for family members, therefore it is important to provide them with support and information. Bodywhys currently offers the PiLaR programme to family members of people with eating disorders. This is a programme for families of people with eating disorders offering information, support and particle advice to help support their loved ones on in their recovery. This programme is delivered in support of the HSE's Stepped Model of Care for Eating Disorders. (Bodywhys 2022) Please see (https://www.bodywhys.ie/supporting-someone/pilar-programme-for-families/) for more information.

Recovery Oriented Practice

Care for people with eating disorders should be provided within a framework that supports the values of recovery-oriented care. 'Recovery' is different for each individual affected by an eating disorder and will mean different things to different people. Research has shown that earlier treatment leads to better outcomes and in the case of anorexia nervosa the best outcomes are usually achieved when weight restoration to a healthy weight range (BMI 20-25) is achieved and maintained alongside psychological change. Higgins (2016) highlights the importance of providing a recovery service founded on hope, connection, meaning and empowerment. Recovery-oriented practice encapsulates care that:

Recognises and embraces the possibilities for recovery.

1. Focuses on the strengths and capabilities of people experiencing the issues.
2. Maximises self-determination & self-management of mental health & wellbeing.
3. Assists families to understand the challenges and opportunities arising from their family member's experiences.
4. Provides evidence-informed treatment, therapy, rehabilitation and psychosocial support that helps people to achieve the best outcomes for their mental health, physical health and wellbeing.
5. Works in partnership with consumer organisations and a broad cross-section of services and community groups.
6. Embraces and supports the development of new models of peer-run programs and services.
7. Maximises choice, supports positive risk-taking and promotes safety.
8. The National Framework for Recovery in Mental Health (2017) principles should be applied when caring for someone with an Eating Disorder in a mental health setting. (Appendix 4)

A Multidisciplinary Approach

A Multi-disciplinary team approach must be supported to ensure the individual gets access to the combined medical, nursing, dietician and psychological interventions required to maximise the chances of a full recovery (NICE 2017).

Delivery of Safe, High Quality, Person Centred Care

Early recognition and diagnosis of eating disorders is linked to successful recovery with improved outcomes noted for persons diagnosed at 19 years of age or younger (van Son *et al.* 2010). Therefore, the importance of assessment for eating disorders by primary care providers cannot be underestimated. People with eating disorders often present to primary care more frequently prior to diagnosis and may seek help for other issues- often not acknowledging disordered eating (Bodywhys 2013).

An awareness of the appropriate care pathways is essential, to effectively manage transitions between primary care, mental health and medical services when needed and to ensure people with eating disorders are being cared for by the medical and/or mental health teams with the expertise to best provide the expert level of care dependent on their current presentation and care needs (HSE 2018).

When engaging with people who experience eating disorders, Snell *et al.* (2010) identifies the importance of developing a therapeutic connection, sharing knowledge, maintaining a hopeful presence, conveying availability to the person, supporting the steps taken by the person toward overcoming their fear of letting go of the disorder and managing the resistance of the eating disorder. The nurse's professional knowledge, ability to withstand the emotional work involved and own level of self-awareness are key factors when working with persons with eating disorders (Snell *et al.* 2010).

Zugai *et al.* (2015) and Linville *et al.* (2012) identify nurses as holding a highly influential role in inpatient care stating that day to day nursing interaction is responsible for a significant aspect of inpatient experience. Through careful interaction nurses can alleviate feelings of boredom and isolation, facilitate good peer relationships and relieve the stress associated with eating and gaining weight (Zugai *et al.* 2015).

Sensitive interpersonal skills, effective communication skills, a supportive and non-judgemental approach, a commitment to care by being emotionally involved and available are considered essential elements of the therapeutic alliance to positively influence recovery (Zugai *et al.* 2015).

What is an Eating Disorder?

Eating disorders are moderate to severe illnesses that are characterised by disturbances in thinking and behaviour around food, eating and body weight or shape, and are diagnosed according to specific psychological, behavioural and physiological characteristics. Incidence of these disorders typically begins in childhood, peaks in the adolescent years but can occur in later life. Research indicates that the overall prevalence of eating disorders is increasing.

The DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 2013) outlines six types of disordered eating patterns:

1. Anorexia Nervosa (AN)

AN is a serious illness associated with significant morbidity and mortality. The illness is characterised by a refusal to maintain a minimally normal weight for age and height, intense fear of weight gain, body image disturbance and denial of illness severity.

2. Bulimia Nervosa (BN)

BN is a moderate to severe illness that is predominantly characterised by recurrent episodes on bingeing and purging behaviour.

3. Binge Eating Disorder (BED)

BED is characterized by repeated episodes of binge eating without the use of purging or other compensatory measures following the binge. You cannot tell by looking at someone whether they have BED; people struggling with this disorder may be normal weight, overweight or obese.

4. Avoidant Restrictive Food Intake Disorder (ARFID)

ARFID is characterised by individuals who have developed some type of problem with eating (or for very young children, a problem with feeding). As a result of the eating problem, the person isn't able to eat enough to get adequate calories or nutrition through their diet.

5. Other Specified Feeding or Eating Disorders (OSFED)

OSFED is also a moderate to severe illness and may include eating disorders of clinical significance that do not meet the criteria for AN or BN. OSFED and USFED may be as severe as AN or BN.

6. Unspecified Feeding or Eating Disorders (USFED)

USFED applies to where behaviours cause significant distress or impairment of functioning, but do not meet the full criteria of any of the other feeding or eating disorder criteria.

Screening for an Eating Disorder

Early intervention is a cornerstone of the HSE model of care in terms of reducing the mortality and morbidity associated with ED's.

Statistics published by the Health Research Board (HRB)

Adults

On average, patients with eating disorders stayed in hospital for 39.3 days (based on discharges in 2018). Out of 157 patients, 154 were female (98%), 3 were male (2%). 67 patients were first time admissions, 90 were readmissions (total 157).151 admissions were voluntary, 6 were involuntary (total 157) (Health Research Board, Activities of Irish Psychiatric Units 2018).

Persons with an eating disorder will often not disclose eating disorder symptoms at presentation but will present for treatment for a variety of other, often related, physical signs and symptoms (as listed).

Indicator for Eating Disorder Assessment

Hallmark Signs of an Eating Disorder	Physical Signs of an Eating Disorder	Comorbid Presentations
• Low body weight or failure to achieve expected weight gains • Fear of weight gain • Body image disturbances • Severe body dissatisfaction and drive for thinness • Preoccupation with food, weight and shape • Restricted dietary intake • Self-induced vomiting • Misuse of laxatives, diuretics or appetite suppressants • Excessive exercise • Amenorrhoea, Oligomenorrhoea or failure to reach menarche • Loss of sexual interest • Binge eating episodes involving loss of control over eating and eating unusually large amounts of food	• Dehydration • Hypothermia • Syncope (e.g. low BP, postural drop) • Cardiac arrhythmias (Bradycardia) • Suicide attempts • Overwhelming infection • Renal failure (e.g. elevated creatinine) • Bone marrow suppression • GIT dysfunction • Acute massive gastric dilatation from bingeing • Enlarged Parotid Glands from purging • Electrolyte imbalance (e.g. potassium, sodium) • Dorsal hand calluses from inducing purging	• Major Depressive Disorder • Anxiety Disorders • Obsessive Compulsive Disorder • Substance abuse / dependence • Self-harm and suicidal ideation

NSW HEALTH Guidelines for the Inpatient Management of Adult Eating Disorders in General Medical and Psychiatric Settings in NSW 2014

The SCOFF Test

Early detection in patients with unexplained weight loss improves prognosis and may be aided by use of the SCOFF questionnaire, developed by John Morgan at Leeds Partnerships NHS Foundation Trust. This questionnaire uses five simple screening questions and has been validated in specialist and primary care settings. It has a sensitivity of 100% and specificity of 90% for anorexia nervosa. Though not diagnostic, a score of 2 or more positive answers should raise your index of suspicion of a case, highlighting the need for a comprehensive assessment for an eating disorder and consultation with an eating disorder expert or mental health clinician.

S	Do you make yourself **Sick** because you feel uncomfortably full?
C	Do you worry you have lost **Control** over how much you eat?
O	Have you recently lost more than **One** stone (6.35kg) in a three-month period?
F	Do you believe yourself to be **Fat** when others say you are too thin?
F	Would you say **Food** dominates your life?

(Morgan *et al.* 1999)

Primary Care

People with eating disorders should be assessed and receive treatment at the earliest opportunity (NICE 2017). The GP is often responsible for the initial assessment and co-ordination of care including determining the need for emergency medical or psychiatric assessment. The GP's initial assessment should include the physical, psychological and social aspects and a comprehensive assessment of risk to self. Following assessment, the GP should agree the next steps with the person and assess the need for further referral to the Community Mental Health Team (CMHT), Specialist Eating Disorder Service or the need for emergency medical or psychiatric assessment.

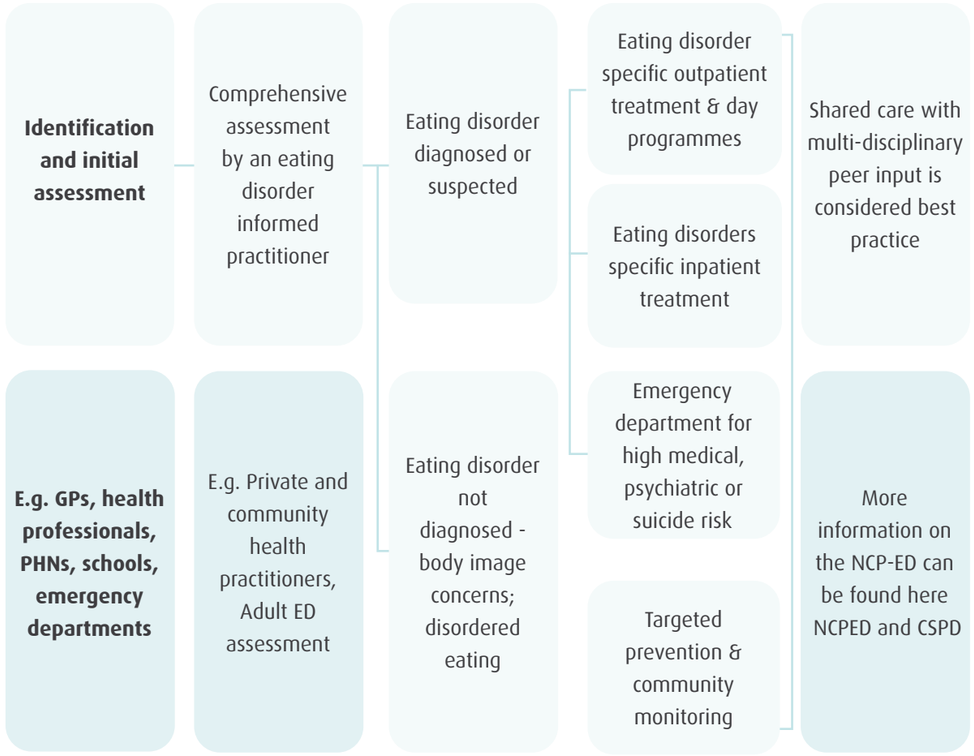
The aim is to promote openness and disclosure amongst persons who may be ambivalent about seeking help. Obtaining a formal diagnosis is a major step to getting the right treatment for a person. In order to assess suitability and thereafter triage appropriately, it is key that referrals where eating disorder are a concern, contain certain information:

BMI weight (kg)/height2 (m2)

Low risk 15–17.5	Medium risk 13–15	High risk <13

- Rate of weight loss
- Extent of physical risk
- Duration of difficulties
- Extent of familial support
- The person's thinking around changing eating behaviours
- Current behaviour patterns relating to eating and associated behaviours for instance: number of meals per day, composition of meals, presence and rate of binge eating, self-induced vomiting, laxative / diuretic use, extent of substance misuse or self-medication, excessive use of exercise.

Referral



Limitations of BMI as a risk marker for Anorexia Nervosa

- potential for deceit
- less reliable if rapid change in weight
- less reliable at extremes of height
- higher risk for each BMI range for men (taller)
- children have a BMI range which changes developmentally
- less reliable if bulimic features
- less reliable if fluid restriction
- less reliable if physical comorbidity
- BMI not critical with regards to risks associated with fluid and electrolyte balance.

All persons are at medical risk to some degree with weight being only one aspect of risk. In terms of medical-checks the following are recommended at the **point of assessment**:

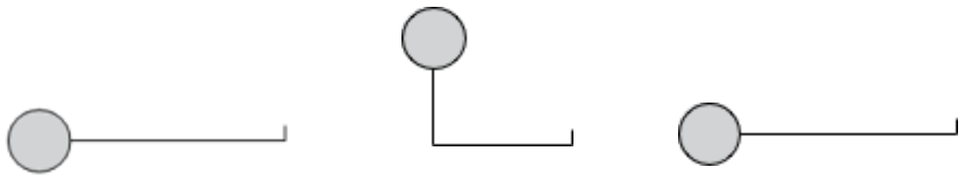
- Pulse
- Blood pressure (lying and standing)
- Temperature
- Respiration
- FBC, U&E, Potassium, Magnesium, LFT, TFT, Creatinine, Glucose, Calcium
- Urinalysis
- ECG if BMI < 15kgs/ mÐ
- Vomiting / laxative use
- Peripheral circulation
- Sit-Up Squat-Stand (SUSS) test (see below)
- Muscle power reduced.

Increase concern if:

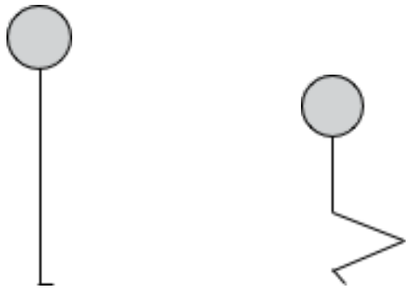
- Blood in vomit
- Rapid weight loss - 0.5 kgs per week over an 8-week period
- Excessive exercising at a low weight (due to cardiac risk)
- Purging leading to electrolyte imbalance
- Dehydration (signs of decompensation: dizziness / fainting; assess skin turgidity, electrolyte levels, lying and standing blood pressure).

SUSS (Sit up – Squat – Stand Test) from Robinson (2012)

1. Sit-up: patient lies down flat on the floor and sits up without, if possible, using their hands



2. 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 when using hands to help
2	Able with noticeable difficulty
3	Able with no difficulty

Nurses Role

Nurses in the hospital or primary care setting are in a crucial position to screen for and detect eating disorders, hence the importance for nurses to have an awareness of the indicators for eating disorder assessment. According to NICE (2017) if an eating disorder is detected early, outpatient treatment in the form of psychotherapy and support can be very effective. Evidence based outpatient treatment approaches include Cognitive Behavioural Therapy (CBT-e), Interpersonal Psychotherapy (IPT), Specialist Supportive Clinical Management (SSCM) and Maudsley Model of Treatment for Adults with Anorexia Nervosa (MANTRA) (Appendix 5).

The nurses role will include supporting psychological based therapies, psycho-education regarding effects of the eating disorder, assessment of risk, promoting recovery and hope, involving family and carers, observing for co-morbidities. If the person is medically and psychologically stable and does not require hospitalisation, the person can be managed by attending the GP and referral to an eating disorder specialist, dietician or local Community Mental Health Team (CMHT). People admitted to hospital, attending an outpatient clinic for the first time or having care in a community setting should be screened for the risk of malnutrition using a validated screening tool for example: the Malnutrition Universal Screening Tool (MUST). (https://www.hse.ie/eng/staff/pcrs/online-services/musttool.pdf)

Screening is important to enable early and effective interventions that prevent and treat malnutrition. Routine nutritional screening should include screening for the risk of refeeding syndrome.

Refeeding Syndrome

Refeeding Syndrome "is potentially a fatal condition defined by severe electrolyte and fluid shifts as a result of a rapid reintroduction of nutrition after a period of inadequate nutritional intake. The route of nutrition does not affect the risk of refeeding, therefore oral, enteral and parenteral nutrition can precipitate refeeding in severely starved patients" (NHS 2019).

Symptoms of Refeeding Syndrome may include:

Hypokalaemia	Cardiac Arrhythmias	Weakness
Hypomagnesaemia	Fluid Imbalances	Confusion
Hypophosphataemia	Pulmonary Oedema	Breathing difficulties
Encephalopathy	Cardiac Failure	Hypertension
Hyperglycaemia	Fatigue	Seizures
Coma	Death	

(HSE 2018, NHS 2019, Norman 2021)

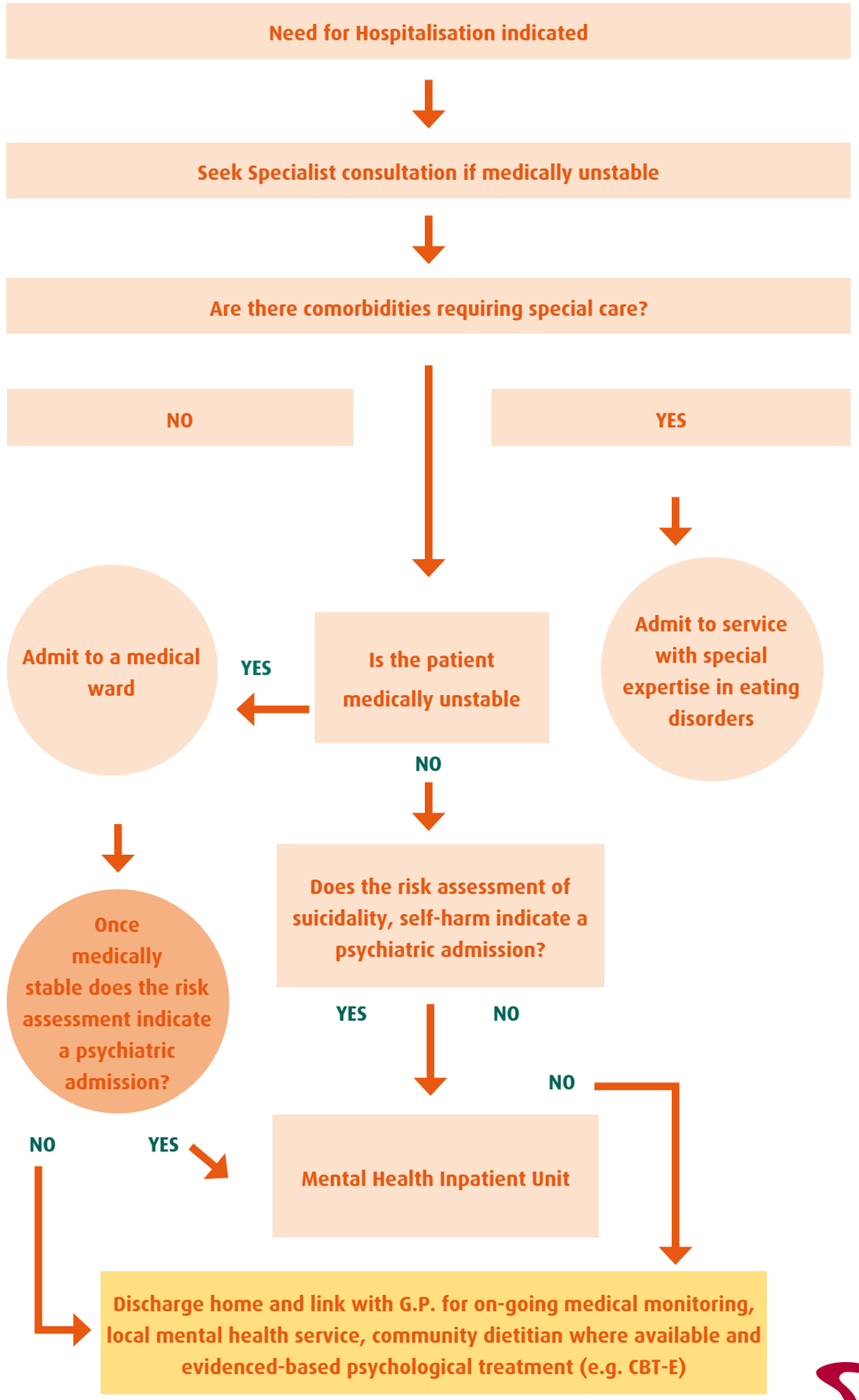
Screening on admission to acute care will result in early identification of patients at risk of refeeding syndrome, enabling the immediate implementation of a refeeding syndrome protocol, and effective nutritional intervention (Irish Society for Clinical Nutrition and Metabolism 2010).

Emergency Department Referral

It is important to be aware that people with an eating disorder can arrive to services already very unwell and can deteriorate quickly. Any person presenting with weight loss with or without amenorrhea may have AN, especially if there are signs of weight preoccupation, lack of concern about weight loss or compensatory behaviours such as vomiting (RCPsych 2022). Co morbid psychiatric illnesses are seen in up to 80% of persons with an eating disorder and therefore should be screened for in addition to the physical manifestations of the disorder. The HSE National Clinical Programme for Eating Disorders (2018) advocates for onward referral to Emergency Department for a full multidisciplinary assessment when:

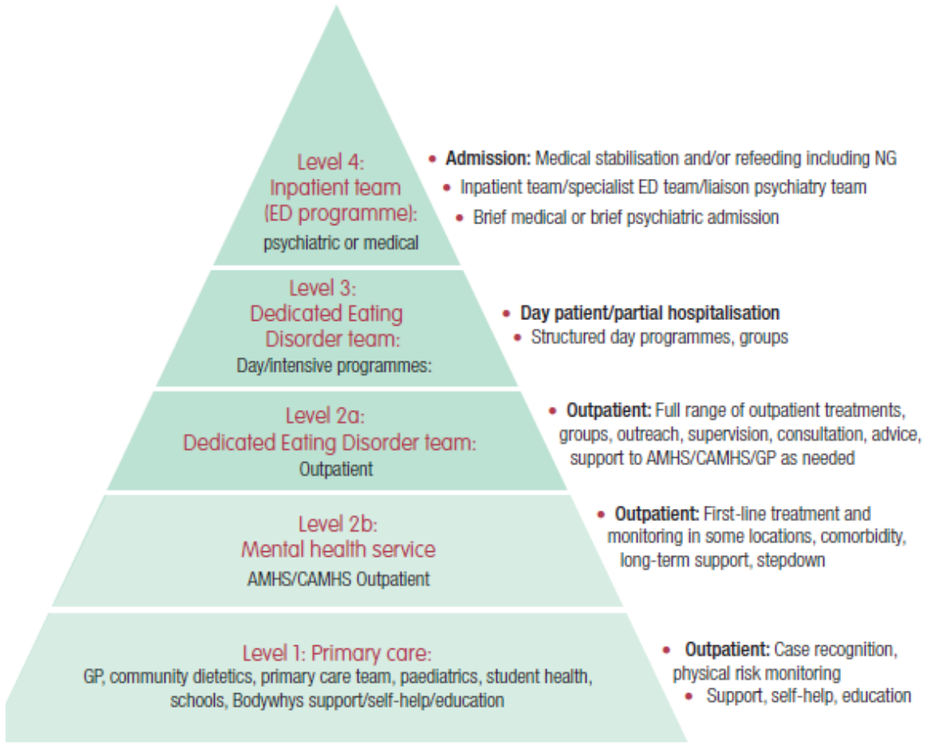
- Case recognition and physical health status/ deteriorating physical health indicate full ED assessment is required;
- Medical admission is required if a person with an eating disorder is identified as being at substantial risk of physical harm or death as a result of their eating disorder.

See Appendix 1



HSE Stepped Model of Care for ED

Figure 9.1: HSE stepped model of care for eating disorders



Assessment of Patients with Eating Disorders

The initial clinical evaluation of patients with a possible eating disorder includes a psychiatric/mental health and general medical history, mental status and physical examination, and focused laboratory tests.

Establishing rapport with the patient can help elicit more information. At the beginning of the interview, simple questions about the patient's age, occupation, marital status, and referral source can put the patient at ease. In addition, directed and focused questions about eating disorder psychopathology may be helpful for patients who do not respond to open-ended questions. Conveying a non-judgmental, supportive, and knowledgeable attitude also helps. Collateral information should be sought from family members, who may more accurately report the patient's nutritional and exercise habits, and at times be the only informants to report the presence of vomitus in the house, finding laxatives or diuretics, or the patient regularly departing to the bathroom after meals. Assessment of the family also engages them to support efforts at nutritional rehabilitation and other aspects of recovery.

Inpatient Care in Medical or Mental Health Setting

It is essential in the first 24 hours that an appropriate assessment is conducted and an initial plan is developed and implemented. The majority of persons admitted for inpatient treatment will be critically ill upon admission, therefore, there must be clear guidelines addressing medical, nutritional and nursing management from the beginning. The HSE NCP-ED has endorsed the MARSIPAN guidelines for adults with AN (RCPsych2014). (These guidelines have been recently updated and a new guidance document replacing same titled *Medical Emergencies in Eating Disorders: Guidance on Recognition and Management* (RCPsych 2022) has been drafted by the Royal College of Psychiatrists). In addition, MDT management of the person should commence immediately. A united approach in delivering care is critical. In patient admission should be long enough to restore medical stability, improve homeostasis and begin nutritional rehabilitation. Thorough assessment will lead to a working diagnosis or diagnoses, risk assessment and case formulation setting immediate treatment priorities. The case formulation should include preliminary hypotheses about predisposing, precipitating and maintaining factors, as well as noting the individual's strengths and protective factors (Hay *et al.* 2014).

The key priorities of inpatient treatment include:

- Improvement in nutritional status
- Weight restoration- main goal of treatment- "Food is medicine" (HSE 2018 p43)
- Treating physical complications
- Medical and physical stability
- Avoid refeeding syndrome
- Normalisation of eating behaviours prior to step down to a day programme, out person programme
- Engagement in psychological work may be limited when a person is too physically or cognitively unwell to engage in same (HSE 2018); however psychological input will benefit the treatment team and assist the person with distress tolerance.

The first 24 hours

Nursing Management plan for the first 24hrs of admission should include:

- Blood tests
- Conduct a thorough physical and psychological assessment
- Obtain a history of the ED (length of illness, interventions to date and family member/carer involvement
- 4 hourly physical observations (note the critical time in body temperature is between 12:00 – 04:00 hours) lying & standing blood pressure and pulse 2 minutes apart.
- Complete risk assessment and document
- Develop nursing ward programme with guidelines on activity levels and if possible, this should be done in collaboration with the persons family and/or carers
- Medical / physical / psychiatric consultation
- Liaise with family and carers
- Develop meal plan and refeeding regime, in consultation with the dietician.

Clinical Assessment

1. History
2. Risk Assessment
3. Compensatory Mechanism
4. Attitudes to weight and shape
5. Current Diet
6. Menstrual Cycle\Bone Health
7. Physical Symptoms/Examination
8. Mental Health
9. Current Medication

History

During assessment, patients should be asked about when they first experienced any eating disorder symptoms, including significant concerns about weight and shape. Usually this will be the start of the prodromal period.

- First contact with specialist eating disorder treatment/services.
- When did issues with food/weight begin?

Clinical onset - point at which symptoms meet diagnostic thresholds, e.g., onset of regular binge/purge behaviours plus weight/shape concerns or dietary restriction with significant weight loss.

- Patients own complaint – nature of the eating disorder
- Previous admissions/outpatients/day programmes
- Past medical and psychiatric/mental health history
- Personal history - early childhood, experiences of neglect and abuse, relationships (with parents, peers and significant others)
- Pre – morbid personality (e.g. introverted/extroverted, perfectionist)
- Current living arrangements
- Family history (include history of ED, mental/physical illness
- Ask about restricting eating and drinking habits
- Highest/Lowest Adult weight
- Ideal weight
- History of weight change since the onset of an ED
- Are there any eating rituals present?

Risk Assessment

People with eating disorders, in particular those with anorexia nervosa, are at high risk in terms of their own health and safety. They have the highest mortality of any psychiatric illness. Twenty percent of people with anorexia nervosa will die by suicide (HSE 2018). Increased mortality from physical health complications is also a significant issue in all eating disorders- people diagnosed with anorexia nervosa are 5.86 times more likely to experience premature death as a result of physical complications of the illness and a direct result of starvation- than the general population. Adolescents with anorexia nervosa are 10 times more likely to die prematurely than their peers. (HSE 2018). Risk to others is less of a concern. The factors involved in the assessment of risk in people with eating disorders include:

- medical risk
- psychological risk
- psychosocial risk
- Insight/capacity and motivation.

TABLE 1 **Physical Risk in Eating Disorders Index (PREDIX)** Reference: Jones *et al.* (2013 p 202)

System	Test or investigation	Moderate risk	High risk
Nutrition	Body mass index Rate of weight loss	<15 kg/m^2 >0.5 kg/week	<13 kg/m^2 >1 kg/week
Cardiovascular	Blood pressure Postural drop Pulse rate Peripheral cyanosis	<90/60 mmHg >10 mmHg <50 bpm	<80/50 mmHg >20 mmHg <40 bpm Yes
Musculoskeletal	Unable to stand up unaided (stand-up–squat test[a])	Grade 2	Grade 0–1
Temperature		<35°C	<34.5°C
Blood profile	White cell count Neutrophils Haemoglobin Platelets	Concern if outside normal limits	<2.0 x 109/l <1.0 x 109/l <9.0 g/dl <110 x 109/l
Biochemistry	Potassium Sodium Phosphate	Concern if outside normal limits	<2.5 mmol/l <130 mmol/l <0.5 mmol/l
Electrocardiogram	Pulse rate Corrected QT interval (QTc) Arrhythmias	<50 bpm	<40 bpm >450 ms Yes

bpm, beats per minute.
a. The stand-up–squat test gives a clinical indication of muscle power and may be used to monitor progress. The patient either lies flat on the floor and has to sit up or sits in a chair and has to stand up, without, if possible, using their hands. Scoring: Grade 0, completely unable to rise; Grade 1, able to rise only with use of hands; Grade 2, able to rise with noticeable difficulty; Grade 3, able to rise without difficulty.

- Patients near to death often look well
- BMI range: <13 over 18 years of age; under 18 years of age median BMIÐ70%, or rapid weight loss (>1kg per week) high risk
- Physical examination, including muscle power (SUSS test)

- Blood tests: especially electrolytes, glucose, phosphate, Mg, liver function tests, full blood count
- Electrocardiogram, especially QTc interval, also ST and T-wave changes
- Do NOT discharge patients at high risk with- out specialist consultation
- Even mild hypokalaemia in eating disorders probably signifies low total body potassium and more severe hypokalaemia can recur after discharge with fatal results (RCPsych 2021).

Nursing staff should notify the medical team if:

- Pulse is below 40bpm or above 120bpm,
- Temp below 35.5c, and/or;
- Systolic BP below 90mm (adolescent < 80mm), or if;
- Significant postural drop of more than 20mmHg; or postural tachycardia > 20 bpm
- See Appendix 1 and 2 for up to date comprehensive risk assessment guidelines for people with Eating Disorders in Medical emergencies.

The core psychopathology must be well understood by Nurse's working with Eating Disorder patients. If not we tend to get into a control battle using behavioural techniques without understanding the function of the eating behaviours. That is not to say behavioural approaches are not effective in weight restoration, they are, however it is the way these approaches are used and qualitative research has highlighted that for the patient, the most helpful Clinician in terms of ensuring recovery is the one who understands how the Eating Disorder makes sense in the person's life and why it is so important to them at that point in their life. Behavioural interventions are a core component of inpatient treatment of eating disorders. A team approach to treatment is essential. Everyone involved in the inpatient treatment of a person with eating disorders should have knowledge and understanding of the psychopathology of the disease and how it can distort thinking, body image and behaviours of the person with an eating disorder.

Additional assessments include:

Compensatory Mechanisms

- Binging/Purging – frequency, what food do you binge on?
- Signs of purging (enlarged parotid glands, calluses on knuckles, cracked/split lips)
- Laxatives, diuretics, emetics, appetite suppressants (e.g. amphetamines, caffeine)
- Chewing / spitting food
- Fasting
- Eating in front of others
- Exercising (type, frequency, length)
- Need for treating staff to have an awareness of attempting to utilise "normal" activities to burn calories and the effects of same on severely malnourished individuals (excessive tooth brushing, pacing, movement etc.)
- Deliberate exposure to cold (opening windows, wearing less clothing etc.) to generate shivering to attempt to burn calories.

Attitudes to weight and shape

- Feelings on body and weight?
- Family attitudes to weight and food? (Are there family attitudes about weight loss or being overweight? Are restrictive eating patterns considered normal within the family unit? Is there a family history of eating disorders?)
- Motivation to restrict diet?
- Insight into illness and motivation for change
- Distorted body image
- How often do you weigh yourself?
- Fear of loss of control
- Guilt or self – disgust
- Thoughts and feeling about binging (before and after).

Current diet

- What does a typical day's eating look like?
- Meals/snacks etc.
- How do the family regard a current days eating for the person with the eating disorder? Do they think it is disordered/ restrictive? Do they consider it normal?

Menstrual Cycle/Bone Health/Fertility

- Current menstrual cycle (any menstrual disturbances or amenorrhoea)
- Use of contraceptives
- Infertility
- Loss of libido
- Bone fractures/osteoporosis
- Bone density tests.

Delayed puberty is common in prepubescent adolescents with anorexia nervosa. Endocrine effects such as amenorrhoea, menstrual disturbances and/or fertility issues in women could be considered presenting signs and symptoms of an eating disorder. (Bodywhys 2013, Mullins *et al.* 2016).

Bone Health and Eating Disorders Research shows that loss of bone density and bone mineral deficiencies are common in individuals with eating disorders (especially anorexia nervosa), and that damage can occur early in the course of an eating disorder. Puberty is a time of rapid growth in bone density, with peak bone density reached by the age of 25-30. If damage or insufficient growth occurs during adolescence, an individual may not achieve their optimal bone density, increasing risk of osteoporosis. If osteoporosis develops, bones become fragile and are likely to break from the slightest injury or fall. Bone fractures, chronic pain, disability, and loss of stature may occur.

Physical Symptoms/Examination

It is important to identify and treat physical complications and to consider possible differential diagnoses, such as diabetes, hyperthyroidism, diarrhoea and vomiting, and inflammatory bowel diseases. Gastrointestinal (GI) problems are one of the most common consequences of an eating disorder. Individuals with Anorexia Nervosa, Bulimia Nervosa, and other eating disorders experience a number of GI changes which are believed to be caused by starvation, malnutrition, and the underuse of the GI tract. GI problems experienced by people with an eating disorder include:

- Bloating
- Constipation
- Diarrhoea
- Flatulence
- Abdominal pain
- Fullness after eating even very small amounts.

A full physical examination should include at least:

- Height, weight and BMI
- Blood investigations: FBC, U&E, LFT, Bone Profile, Glucose, Magnesium, Phosphate, CRP,
- TFT, Vitamin B12, Folate, Ferritin, Vitamin A, Vitamin D, Zinc, Selenium,
- ECG
- Examination of blood pressure (standing and lying)
- pulse and core temperature
- An electrocardiogram (ECG) if the BMI is less than 16 or if medications are prescribed that prolong the QTc interval.

Questions might include

- Have you had any faints or funny turns? (this might indicate postural hypotension)
- Are you feeling the cold more than previously? (common in severe weight loss)
- Have you had abdominal pain (might be related to binge eating or inflammatory bowel disease)
- Constipation (can occur in fasting)
- Sore throat (resulting from vomiting)
- Bloating (often experienced after eating in the context of prolonged fasting)
- lethargy (related to an eating disorder or differential)
- Hematemesis (in vomiting)?
- When was the last time you had a period?

Physical Signs of an Eating Disorder

- **Dehydration**
- **Hypothermia**
- **Syncope (e.g. low BP, postural drop)**
- **Cardiac arrhythmias (Bradycardia)**
- **Suicide attempts**
- **Overwhelming infection**
- **Renal failure (e.g. elevated creatinine)**
- **Bone marrow suppression**
- **GIT dysfunction**
- **Acute massive gastric dilatation from bingeing**
- **Enlarged Parotid Glands from purging**
- **Electrolyte imbalance (e.g. potassium, sodium)**
- **Dorsal hand calluses from inducing purging**

Guidelines for the Inpatient Management of Adult Eating Disorders in General Medical and Psychiatric Settings in NSW (2014)

Mental Health/Psychiatric Symptoms

Most patients with anorexia nervosa have a lifetime history of at least one comorbid mental disorder such as:

- Major Depressive Disorder
- Anxiety Disorders
- Obsessive Compulsive Disorders
- Self-harm and suicidal ideation.

A nationally representative survey in the United States estimated that 56 per cent of patients with anorexia nervosa had a lifetime history of at least one comorbid mental disorder and that 34 per cent had three or more comorbid disorders (Hudson *et al.* 2007).

Personality disorders and traits — a variety of comorbid personality disorders and traits can occur in anorexia nervosa and more than one disorder or trait can occur in the same patient. Diagnosis of a comorbid personality disorder rests upon the patient's history prior to onset of anorexia nervosa, given that anorexia nervosa can affect the patient's cognitions, emotions, and interpersonal functioning. An awareness of signs and symptoms of mental illnesses and distress and a recovery focused, holistic approach are beneficial when engaging with people who have comorbid diagnoses.

In a review of six studies that used diagnostic interviews, the most common personality disorders in patients with anorexia nervosa were:

- Obsessive-compulsive (15 % of patients with anorexia nervosa)
- Avoidant (14%)
- Dependent (7 %)
- Narcissistic (6 %)
- Paranoid (4 %)
- Borderline (3 %) (Cassin 2005).

Current Medication

Recent systematic reviews of RCTs and meta-analyses of the pharmacological treatment of AN suggest weak evidence for the use of any psychotropic agents with no evidence that selective serotonin re-uptake inhibitors (SSRIs) treat the core feature of AN or prevent relapse. Low doses of antipsychotics such as olanzapine or quetiapine may be helpful when patients are severely anxious and demonstrate obsessive eating-related ruminations, but more trials are needed (Frank and Shott 2016).

- When prescribing medication for people with an eating disorder and comorbid mental or physical health conditions, take into account the impact malnutrition and compensatory behaviours can have on medication effectiveness and the risk of side effects.
- When prescribing for people with an eating disorder and a comorbidity, assess how the eating disorder will affect medication adherence (for example, for medication that can affect body weight).
- When prescribing for people with an eating disorder, take into account the risks of medication that can compromise physical health due to pre-existing medical complications.
- Offer ECG monitoring for people with an eating disorder who are taking medication that could compromise cardiac functioning (including medication that could cause electrolyte imbalance, bradycardia below 40 beats per minute, hypokalaemia, or a prolonged QT interval).

Drug and Alcohol Use

High rates of substance misuse have been found among adults with eating disorders. Substance misuse often involves the use of amphetamines, caffeine and tobacco to control appetite and weight. A broader range of substances, particularly alcohol, may be misused in young people with BN.

In assessment of patients with eating disorders, the aims of the first session is to

- Establish rapport
- Start an assessment to establish the nature and severity of the problem
- Manage any risks – medical and psychological
- Help any 'significant others' with their anxieties.

How do we establish rapport?

- Rapport is something that develops gradually but it is important to get off to a good start. Empathy has been highlighted as being key to developing this rapport.
- Eating Disorder patients are very perceptive to the clinician's genuineness so therefore core clinical skills such as empathy, warmth, genuineness and collaborative working are very important.
- Collaborative approach – patients need to feel in control of their treatment so involve them. Instead of imposing rules about dietary intake, allow the patient to take more ownership but minimise choices. Minimising choice reduces the potential for conflict and/or splitting between the person and treating staff. All staff working with the person need to have an awareness of the treatment plan to attempt to ensure a synchronised approach to care and treatment.
- Credibility: that the Nurse knows what she is talking about. It is very important when working with Eating Disorders that we have a good understanding of nutritional rehabilitation.
- Acknowledge how difficult it is for the patient, as they usually don't request treatment. Most people with Eating Disorders don't see any disadvantages to their Eating Disorder behaviours – making it ego-syntonic in nature. It is very important therefore to acknowledge the perceived advantages short term/long term along with the disadvantages. If the advantages for the patient are not acknowledged, then the patient won't feel understood or validated. Ensure from the beginning that as Nurses we assist the patient make sense of how their Eating Disorder helps them.
- Do not neglect process, much can be learned from the way in which a client presents and interacts in session – it's not what you say, it's how you say it.

Anorexia Nervosa (AN)

AN is a serious mental health issue. It is estimated that after having AN for 10 years, 10% of people will die from the illness. After 30 years, up to 20% of people affected will die - a fifth of these from suicide. Death rates for young women aged between 15 and 24 years with AN are six to twelve times higher than the annual death rate from all other causes. AN has the highest morbidity and mortality of any mental health disorder (Arcelus *et al.* 2011, Jauregui-Garrido & Jauregui-Lobera, 2012). Strother *et al.* (2012) describes eating disorders in males as 'under diagnosed, under treated and misunderstood'. Most disturbingly, disordered eating practices may, for the first time, be increasing at a faster rate in males than in females (Mitchison *et al.* 2014).

According to the DSM-5 criteria, to be diagnosed as having AN, a person must display:

- Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory and physical health)
- Either an intense fear of gaining weight or of becoming fat or persistent behaviour that interferes with weight gain (even though significantly low weight)
- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation or persistent lack of recognition of the seriousness of the current low body weight
- Subtypes: restricting type, binge eating / purging type.

DSM-5 classifies current severity of anorexia nervosa according to BMI

Mild – BMI 17 to 18.49 kg/m2

Moderate – BMI 16 to 16.99 kg/m2

Severe – BMI 15 to 15.99 kg/m2

Extreme – BMI <15 kg/m2

The secretive nature of eating disorders can be problematic in terms of diagnosis as persons may not see their behaviours as a problem and may present with other complaints not specific to their weight and dietary restriction (Flahavan, 2006). Although early intervention is seen to significantly reduce mortality rates, the degree of secrecy surrounding the eating disorder seriously obstructs many efforts in the search for help and from a medical perspective, diagnosis. Secrecy and denial are key elements in the maintenance of the eating disorder and are used in particular by the AN sufferer, in a desperate attempt to avoid conflict and confrontation, thus remaining 'in control' (Reas *et al.* 2000). Eating disorders in boys and young men may face particular difficulties because of the misconception of eating disorder being a 'female issue' it can be difficult for a male to admit that they are affected by an eating disorder. The prevalence of self-harm in people with eating disorders is thought to be about 25%, for many, self-harm and an eating disorder co-exist, but for others self-harm can develop to replace an eating disorder or vice versa (Self harm UK, 2018).

NICE (2017) guideline for treating all people with Anorexia Nervosa
The NICE (2017) guideline for treating all people with AN advocates:

Psycho-education

- Monitoring of weight, mental and physical health and any risk factors
- An MDT approach that is coordinated between services
- The involvement of the person's family members / carers (as appropriate)
- Awareness that helping people reach a healthy weight / BMI is a key goal
- Awareness that weight gain is key in supporting psychological, physical and quality of life changes necessary for improvement / recovery
- Sharing the results of the person's weight with them and their family members / carers (if appropriate). (There is a need for awareness that this approach may at times be counterproductive. A person with an eating disorder may feel they have met their treatment goal if they achieve a certain weight- there is a risk they may disengage from treatment even if they are physically and/ or mentally not well enough to do so).

The Nurse's Role in the Psychological Care of the Person

An empathic approach is key to enhancing nursing engagement, promoting recovery and instilling hope. Establishing rapport is essential to the development and maintenance of a therapeutic alliance. Zugai *et al.* (2013) states the therapeutic nurse patient alliance enhances adherence to treatment, supports weight gain, whilst also ensuring a positive inpatient experience. According to Zugai (2016) nurses hold a highly influential role in inpatient care, fulfilling important care roles such as supervision, the consistent implementation of care plans and close monitoring of physical progress. Zugai *et al.* (2013) found people have a preference for strong and professional relationships with nurses and that these relationships may possibly have implications for weight gain and the perceived quality of the inpatient experience. In contrast, perceived negative staff attitudes and an over emphasis on weight and weight restoration have been identified as unhelpful or harmful aspects of treatment (Button & Warren, 2001).

Inpatient Nursing Guidelines for Anorexia Nervosa

- Engage with the patient, build a trusting relationship, provide information as often as required (memory/cognition are both affected by starvation). Provide support and encouragement to the patient during the difficult process of early nutritional rehabilitation. Enforce care plan with compassion and be firm without being punitive.
- Distress in eating disorder patients in this stage of treatment is the norm rather than the exception, they have severe weight and food phobia and are being exposed to both multiple times a day in quantities they have avoided for a long time. Skills in tolerating and managing distress will be required by the nursing staff, and need to be taught to the patient.
- The management of the family and carers is very important during this often stressful and distressing time. Families may require detailed information, and frequent updates – establish who in the team who will deliver this. It will be natural for the family to be sympathetic to the appeals from their loved one for an alteration in treatment plan. It can be helpful to involve the family as much as possible in understanding the care plan, the rationale for it, and the clinical milestones needed. Give families a copy of the care plan, or appropriate version of the care plan, wherever possible. It can be helpful to arrange for a family member to attend a portion of ward round each week to reduce splitting.
- In general leave from the ward is not granted due to medical risk, and when appropriate monitor leave carefully as per care plan.

Physical Health Monitoring in Inpatient care

Vital signs should be monitiored 4hrly until stable for a minimum of 72hrs.
Only then should they be changed to QID.

QID lying and standing blood pressure.	**Blood Glucose Level-**
Medical review or rapid response protocol indicated if: Pulse below 60bpm; Temperature below 35.5C; Systolic BP below 90; Significant postural drop of more than 10mmHg	QID 1-2 hrs AFTER meals Rationale: low glycogen stores and an abnormal insulin response may lead to post-meal low BGLs, and low BGLs in the morning/overnight Suggested times: 04.00hrs and 1–2 hrs post each main meal Medical review or rapid response protocol indicated if blood glucose levels of <4.0mmol/l
Daily ECG- Continue same until medical stability has been maintained for at least 72hrs Full bed rest if medically unstable Accurate assessment of persons nutritional status and eating behaviours	**Blood Tests-** as per Medical Emergencies in eating disorders (MEED) Guidance on recognition and management (2022) (Replacing MARSIPAN and JUNIOR MARSIPAN) and clinical indication.

- Full bed rest if medically unstable
- Accurate assessment of persons nutritional status and eating behaviours

Blood Tests Indicators

- Low Sodium: suspect water loading (<130 mmol/L high risk) or occult chest infection with associated SIADH
- Low Potassium: vomiting or laxative abuse (<3.0 mmol/L high risk) (note: low sodium and potassium can occur in malnutrition with or without water loading or purging)
- Raised Transaminases
- Hypoglycaemia: blood glucose <3 mmol/L (if present, suspect occult infection, especially with low albumin or raised C-reactive protein)
- Raised Urea or Creatinine: the presence of any degree of renal impairment vastly increases the risks of electrolyte disturbances during re-feeding and rehydration (although both are difficult to interpret when protein intake is negligible and muscle mass low) (NHS 2018).

Nursing Considerations

WEIGHT	Measure and record, weight, height & urine specific gravity the morning after admission at 6.30am after voiding, and repeat on 2 set days each week.
HEIGHT	Measure in early morning, check person is standing at full height.
BOWEL CHART	Record bowel activity (or lack of) daily as person may have reduced gut motility (they may find this distressing and want to reduce eating and will need encouragement, and support, explaining continued eating is the only way to resolve discomfort).
INTAKE	Record all offered intake as well as all consumed food & fluids.

Nursing Considerations:

Check all meals against the meal plan; patient should not be allowed to choose meal from the meal plan at this stage (see nutritional management plan).
Request family members to assist with the management plan, by NOT bringing in food and medications (e.g. laxatives) from home or allowing patient to exercise.

Monitor and contain eating disorder behaviours:

Visually observe the patient at a minimum frequency of 15 minute intervals.

- It is often more effective particularly on medical wards to provide 1:1 constant supervision
- Shared room (rather than single room)
- Exercise
- Vomiting /chewing/spitting
- Limit physical activity (the patient may require bed rest to reduce energy expenditure).
- Support at meals and post meals e.g. crosswords, puzzles for distraction
- Access to toilets needs to occur prior to meals (encourage patients to use bathroom before meals as access after will be denied for one hour). When risk is high, supervision is required during toileting and shower use to reduce opportunities for purging behaviour(s) and or laxatives/diuretics use. Lock any bathroom ensuites and restrict the patient to using the ward toilet
- Manage constipation with psychoeducation regarding the biological factors that influence this including inadequate food intake, lack of dietary fibre and fluid restriction. Use stool softeners with caution and only when clinically indicated. Do not allow laxatives to be brought from home.

Inappropriate fluid intake:

- Monitor fluid intake for under or over drinking
- Restriction
- If possible provide supervision during and after meals to observe and record intake.

Nutritional Management of Anorexia Nervosa

The ideal feeding method is oral, however many persons at this level of severity require NG feeding for optimal treatment. Some persons may opt for NG feeding when this unwell as it reduces demands and guilt, for others oral feeding will fail. This needs to be reviewed daily and at this severity of illness the individual must be moved to NG feeding sooner rather than later. The Mental Health Act (2001) may be required. (Please see Appendix 3 for further information).

NG feeding is often the safest way of reintroducing nutrition; by the time the person reaches a medical bed they are usually critically ill. If the person is hypoglycaemic or bradycardic, delivering a constant and controlled supply of carbohydrate is less likely to cause reactive hypoglycaemia, and feeding persons overnight can help keep their low heart rate and blood sugar level at a safer level. Feeding rates provided are a guide only, a personalised plan with regular monitoring and adjustment is always preferable. For persons not at high or extreme risk of refeeding syndrome, orally delivered nutrition of approximately 1800 calories per day is an appropriate starting point for a period then gradual increases titrated to the persons weight gain and level of physical activity (e.g. 200 calorie increases twice per week once clinical and biochemical markers are stable). For most adult persons a final level of 2400-2600 calories per day is sufficient to induce weight gain (with the occasional person requiring more). Ensure the current meal plan, with feeding method is clearly written and copies available for staff and the person. It is essential that only food on the meal plan is consumed i.e. no food to be brought in from outside, and no diet foods / lollies / chewing gum are allowed as these can be used to diminish appetite and / or may have a laxative effect. If a person is struggling to adhere to the feeding regime it is likely a 1:1 nursing special will be initially required. Ideally this will be a registered psychiatric nurse. If possible all staff working with the person should have some level of training about working with people experiencing eating disorders.

Discharge Planning and Transition

Discharge needs to be carefully planned with the patient, family and carers, preferably from the outset of admission. The Royal College Psychiatry 2017 (CR208) recommends the following when managing transitions when the patient has an eating disorder;

- Awareness
- Early identification and notification
- Involve family and carers
- Flexible timing
- Close links between services
- Transition coordinator
- Provide good information
- Clear protocols and pathways
- Patient-centred transition plan
- Multidisciplinary discharge planning meeting
- Overlap period of joint working
- Respect for attachments and therapeutic alliances.

The report focuses on aspects of transitions that need particular recognition (i.e. transition from CAMHS to AEDS/ general adult to mental health services) suggest helpful practices and warn against those which are perceived as unhelpful.

Bulimia Nervosa (BN)

According to the DSM-5 criteria, to be diagnosed as having BN a person must display:

- Recurrent episodes of binge eating; an episode of binge eating is characterised by both of the following: eating in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances and a sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating)
- Recurrent inappropriate compensatory behaviour to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics or other medications, fasting, excessive exercise
- The binge eating and inappropriate compensatory behaviours both occur on average at least once a week for three months
- Self-evaluation is unduly influenced by body shape and weight
- The disturbance does not occur exclusively during episodes of AN.

Assessment of people with Bulimia Nervosa

Medical assessment of people with BN is an essential part of treatment as the effects of binging and purging are not obvious. Assessment should include measurement of weight, height, pulse rate, blood pressure and calculation of BMI. Patients with BN who are vomiting frequently or taking large quantities of laxatives (and especially if they are also underweight) should have their fluid and electrolyte balance assessed to check for hypocalcaemia and dehydration. Other assessments such as random glucose, cardiovascular examination and ECG should be done as medically indicated. Assessment should include inquiry into characteristic eating disorder behaviours and cognitions. Behaviours namely binge eating, weight control behaviours, self-induced vomiting, laxative and / or diuretic misuse, dietary restriction and / or fasting, compulsive or driven exercise and others such as insulin misuses in diabetic persons or the use of diet pills or illicit stimulant drugs. Cognitions namely of weight and shape overvaluation, body image and eating preoccupations. People should be assessed for a past history of other eating disorders, especially AN, as this may be associated with increased likelihood of relapse and poor outcomes (Hughes *et al.* 2013). Common psychiatric co-morbidities are anxiety and mood disorders, impulse control and substance use disorder. Evidence points towards early intervention positively affecting outcome therefore, as clinicians we need to engage the sufferer in treatment at the earliest possible opportunity.

Treatment of Bulimia Nervosa

The treatment of persons with BN requires vigilance and a collaborative effort. Where primary psychological treatment is provided by a therapist without medical training, a GP will need to assist with medical assessment and / or ongoing care. It is important to remember recovery can only begin when a person is ready for change. Most people with BN can be treated as outpatients unless concerns exist regarding the management of severe self-harm and / or suicide risk.

Psychiatric admission (if required) for people with BN should normally be undertaken in a setting where staff, have experience of managing this disorder. When electrolyte disturbance is detected, it is usually sufficient to focus on eliminating the behaviour responsible. However, in some cases supplementation is required to restore the patient's electrolyte balance with dietary advice being sought. Oral rather than IV administration is recommended, unless there are problems with gastro intestinal absorption. If a person is severely dehydrated or depleted of essential nutrients, hospitalisation may be required. Careful attention should be paid to dental hygiene. Depression, anxiety and periods of emotional overwhelm often accompany BN. Addressing these and other psychological aspects of the disorder is crucial to recovery. Selective Serotonin Reuptake Inhibitors (SSRIs) may have a useful role in symptom reduction for BN. However, they should not be the primary treatment and should be used in conjunction with therapy or self-help. Health care professionals should be aware that people with BN who have poor impulse control, notably substance misuse, may be less likely to respond to a standard programme of treatment. As a consequence treatment should be adapted to address the problems presented. Keeping the first phase of treatment focused on stopping eating disorder behaviors and putting other problems aside until the last phase of treatment, appears to be more effective than doing the reverse. Many people are surprised to learn that their psychological problems, such as depression or anxiety, often improve or even disappear once their eating patterns have normalized. However, for some, other disorders persist even after their BN has been resolved. In these cases, teens often feel better equipped to deal with their other issues once they are physically healthy and eating normally.

Risks associated with Bulimia Nervosa

There is evidence of an increased risk of medical co-morbidities including, but not exclusive to, those associated with obesity, notably Type II diabetes mellitus and hypertension.

Physical Complications of Bulimia Nervosa

Secondary to vomiting	Dental erosion; parotid gland enlargement; Russell's sign; oedema; oesophagitis; Mallory-Weiss tears on the oesophagus; oesophageal rupture; pancreatitis; conjunctival haemorrhages secondary to raised intracranial pressure.
Secondary to purgative abuse	Constipation/diarrhoea, rectal prolapse.
Related to binges	Dilation of the stomach- this poses a risk of gastric rupture and death.
Biochemical abnormalities	Decreased- potassium, manganese, sodium, chloride. Increased- amylase, bicarbonate. Metabolic alkalosis.

(Mullins *et al.* 2016 p 323)

Binge Eating Disorder (BED)

BED is less common but much more severe than overeating. Binge eating is almost as common among men as it is among women and is thought to be more common that other eating disorders such as AN and BN. BED is a serious mental health condition. According to the DSM-5 criteria, to be diagnosed as having BED a person must display:

- Recurrent episodes of binge eating
- The binge eating episodes are associated with three or more of the following: eating much more rapidly than normal, eating until feeling uncomfortably full, eating large amounts of food when not feeling physically hungry, eating alone because of feeling embarrassed by how much one is eating and feeling disgusted with oneself, feeling depressed or very guilty afterward
- Marked distress regarding binge eating is present
- Binge eating occurs on average at least once a week for three months
- Binge eating is not associated with the recurrent use of inappropriate compensatory behaviours as in BN and does not occur exclusively during the course of BN or AN methods to compensate for overeating such as self-induced vomiting.

Assessment of Binge Eating Disorder

A person with BED may put off seeking help and support because they are frightened of the reaction they might get if they disclose what they are doing. Shame and fear of rejection become powerful barriers to change. Consultation with a GP is an important first step towards self-care. The GP will look at the physical effects of binge eating and if necessary, can make a referral to a dietician or to a psychologist or therapist.

Treatment of Binge Eating Disorder

People often try to control BED on their own and if they fail they may feel demoralised and depressed. This may lead to further episodes, and consequent feelings of social isolation, missing work and school. More often than not people who experience BED will need the help and support of a health care professional. As with any eating disorder there are many complicated and influencing factors involved. For change to occur and to be lasting, a recovery approach which tackles both the physical and psychological aspect of the disorder will be required. Recovery is typically an ongoing lifelong process with most people experiencing some periods of relapse. Learning to recognise relapse as part of the recovery process and not as a failure can increase the chances of long term recovery. Most physical symptoms can be reversed with weight loss and normalisation of a balanced diet and eating habits. Support groups (such as those offered by Bodywhys) can be very useful in reducing feelings of isolation and providing encouragement through some of the more difficult parts of recovery.

Risks associated with Binge Eating Disorder

Individuals who are overweight and have BED are at risk for a number of life-threatening complications such as high blood pressure, type II diabetes mellitus, heart disease, osteoarthritis, gallbladder disease, high levels of serum cholesterol and particular types of cancer. Other possible medical complications include mobility issues, sciatica, varicose veins, hiatus hernia, trouble sleeping and shortness of breath. Due to the severity of such complications, BED should not go untreated.

Avoidant Restrictive Food Intake Disorder (AFRID)

ARFID is one of the new categories of eating disorders introduced in the updated version of DSM-5. A person with ARFID has an eating disorder that does not fit into the more traditional eating disorder categories. People with ARFID are sometimes called picky eaters. ARFID affects mostly people in childhood or infancy, but it can also affect adults. According to the DSM-5 criteria, to be diagnosed as having AFRID a person must display an eating or feeding disturbance as manifested by persistent failure to meet appropriate nutritional and / or energy needs associated with one, or more of the following:

- Significant loss of weight or failure to achieve expected weight gain or faltering growth in children
- Significant nutritional deficiency
- Dependence on enthral feeding or oral nutritional supplements
- Marked interference with psychosocial functioning
- The behaviour is not better explained by lack of available food or by an associated culturally sanctioned practice
- The behaviour does not occur exclusively during the course of AN or BN, and there is no evidence of a disturbance in the way one's body weight or shape is experienced
- The eating disturbance is not attributed to a medical condition, or better explained by another mental health disorder
- When it does occur in the presence of another condition / disorder, the behaviour exceeds what is usually associated, and warrants additional clinical attention.

Warning Signs of Avoidant Restrictive Food Intake Disorder

A person with AFRID will experience all / some of the following;

- Have trouble digesting specific types of food
- Only like to eat very small portions
- Might be a very slow eater
- Strictly avoids particular types of texture or colors of food
- Has no appetite
- Is afraid to eat (maybe as a result of a frightening choking or vomiting incident)
- Weight loss (might not lose weight but will not gain the weight they should)
- Have issues at school or work because low levels of nutrition make it hard for them to concentrate and work properly.

Treatment of Avoidant Restrictive Food Intake Disorder

A return to nutrition is important for the person's mental and physical health. It is important that a person with ARFID gains weight and nutritional supplements are given if certain foods are still being avoided.

Other Specified Feeding or Eating Disorder (OSFED)

According to the DSM-5 criteria, to be diagnosed as having OSFED a person must present with a feeding or eating behaviours that cause clinically significant distress and impairment in areas of functioning, but do not meet the full criteria for any of the other feeding and eating disorders. A diagnosis might then be allocated that specifies a specific reason why the presentation does not meet the specifics of another disorder. OSFED is a serious mental illness and the most common eating disorder diagnosed in adults and adolescents, affecting both males and females. Around 30% of people who seek treatment for an eating disorder have OSFED. The reasons for developing OSFED will differ from person to person; known causes include genetic predisposition and a combination of environmental, social and cultural factors. People with OSFED commonly present with extremely disturbed eating habits, and / or a distorted body image and / or overvaluation of shape and weight and / or an intense fear of gaining weight (if underweight). The behaviour which causes significant distress and impairment is not better explained by environmental influences, social norms or by another mental health disorder.

Examples of Other Specified Food and Eating Disorders

- Atypical AN: all criteria are met, except despite significant weight loss the individual's weight is within or above the normal range
- BED of low frequency and / or limited duration: all criteria for BED are met, except at a lower frequency and / or for less than three months
- BN of low frequency and / or limited duration: all criteria for BN are met, except that the binge eating and inappropriate compensatory behaviour occurs at a lower frequency and / or for less than three months
- Purging Disorder: recurrent purging behaviour to influence weight or shape in the absence of binge eating
- Night Eating Syndrome: recurrent episodes of night eating, eating after awakening from sleep or excessive food consumption after the evening meal.

Treatment of Other Specified Food and Eating Disorders

As a result of the atypical nature of OSFED, it is most effective to follow the treatments recommended for the eating disorder that most closely resembles the individual person's eating problem. For example, if a person presents with many but not all of the symptoms of BN, it is recommended for that person to seek the same treatment approaches recommended for people with BN.

Risks Associated with Other Specified Food and Eating Disorders

The risks associated with OSFED are severe with people experiencing risks similar to those of the eating disorder their behaviours most closely resemble for example: inflammation and rupture of the oesophagus and stomach (frequent vomiting), chronic constipation or diarrhoea, kidney failure, osteoporosis, irregular or slow heart beat (increased risk of heart failure), loss of or disturbance of menstrual periods in females, increased risk of infertility in males and females.

Outcome measures in Eating Disorders

When deciding on an approach to routinely measuring progress and outcomes in people with an eating disorder, several factors should be considered in relation to the methodology and the tools and measures to be used:

- **psychometric properties:** tools should be valid and provide a reliable measure of change over time
- **clinical utility:** measures should have clinical value and be central to the delivery of care, with progress and outcomes discussed with the patient as part of their treatment
- **staff competence:** staff should be trained and competent in using and supervising the use of outcome measures, including knowledge of when (and when not) to use them, their strengths and limitations, and how to integrate outcomes to guide clinical decisions and interventions
- **time frame:** progress and outcomes should be measured on a session-by- session basis throughout treatment, based on discussion and agreement with the person.

Potential Requirements to Deliver Services

The HSE (2018) Model of Care aims to support the child / adult experiencing the eating disorder from early intervention through treatment into stabilisation and recovery. The model advocates collaboration among specialists to facilitate access and smooth transitions of care between healthcare settings. Eating disorder services require MDT input and resourcing to meet the needs and manage the risks associated with this complex population. Internationally, there are recommendations that have been implemented (Joint Commissioning Panel for Mental Health 2013, NICE 2017, RANZCP 2014, Royal College of Psychiatrists 2012).

Education and Training for Staff

Education and training for Nurses working with persons with eating disorders should be a tiered approach.

- **Level 1** – a general awareness of warning behaviours of eating disorders for all healthcare professionals. Professional development workshops are suitable for anyone who needs to learn more about eating disorders.

- **Level 2** – encouraging motivation to change is a difficult process. Motivational Interviewing (MI) skills is an evidenced based treatment approach. Readiness to change can be a symptom of the eating disorder. MI skills, psychosocial skills and distress tolerance skills should be provided for nurses working directly with people with eating disorders.

- **Level 3** - specialist skills e.g.
  - Clinical Nurse Specialist (CNSp)
  - Advanced Nurse Practitioner (ANP) roles should include Cognitive Behavioural Therapy-Enhanced (CBT-E) and Family-Based Therapy (FBT) training.

The National Clinical Care programme to date have trained clinicians in accredited CBTe and FBT programmes. Ongoing case supervision is provided to support Continuing Professional Development (CPD) of these programmes.

Eating disorder theory and practice should be delivered at undergraduate BSc level, not only on mental health programmes but paediatric and general nursing programmes as well.
More information on training and education please refer to the NCPED. The NCPED will continue to focus its training strategy on prioritising internationally evidence based specialist training in EDs for clinicians so that the model of care can be delivered.

Clinical Supervision

Clinicians working in the HSE ED teams will have access to supervision through the following:

- Professional supervision provision through existing arrangements with their local line management professional structure
- Case supervision via the clinical leadership of the consultant psychiatrist on the ED team to whom they can go for consultation, advice or support
- The working group also recommends that clinicians on the ED teams have access to regular peer clinical supervision groups through their ED team/network
- Any formal supervisory component required for their training in a particular therapy – the existing FBT and CBT-E clinical supervision groups may be examples of such programmes.

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Zugai, J. S. (2016). Understanding the therapeutic alliance between nurses and consumers with anorexia nervosa in the context of the inpatient setting: a mixed methods study. PHD Thesis, Open Publications of UTS Scholars.

Online Resources

The HSE National Clinical Programme for Eating Disorders www.hse.ie/eng/about/who/cspd/ncps/mental-health/eating-disorders/

Bodywhy's Eating Disorders Association of Ireland www.bodywhys.ie

PiLaR programme for parents, carers and friends of someone with an eating disorder pilar@bodywhys.ie

Adapt: Anorexia and Bulimia www.adapteatingdistress.com

Eating Disorders Association (U.K.) www.b-eat.co.uk / www.eduauk.com

Medical Emergencies in Eating Disorders: Guidance on Recognition and Management (2022) https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr233-medical-emergencies-in-eating-disorders-(meed)-guidance.pdf?sfvrsn=2d327483_50

Gurze (Specialists in eating disorders publications) www.bulimia.com

HSE Eating Disorder Self Care App Read more about the HSE Eating Disorder Self Help App https://www.hse.ie/eng/about/who/cspd/ncps/mental-health/eating-disorders/news/

National Eating Disorders Organisation (U.K.) www.nationaleatingdisorders.org

Mirror-Mirror www.mirror-mirror.org

Something Fishy www.somethingfishy.org

Overeaters Anonymous Ireland www.aoireland.com

Body Positive www.bodypositive.com

Beyond Hunger www.beyondhunger.org

Irish College of General Practitioners offers a "Find a GP" service www.icgp.ie

Irish Health offers a "Find a Professional" service and information on many health topics

www.irishhealth.com

www.carersireland.com

www.nice.org.uk

www.eatingproblems.org.uk

www.spunout.ie

www.headspace.com

www.marzipan.org.uk

Appendix 1: Eating Disorder Risk Checklist for Emergencies

Assessing

Does the patient have an eating disorder?

Yes AN BN Other

Not sure: request psychiatric review

Is the risk high?

- ☐ BMI less than 13 (adults) mMBI<70% (under 18)?
- ☐ Recent loss of >1 kg for two consecutive weeks?
- ☐ Acute food or fluid refusal/intake <400 kcal per day?
- ☐ Pulse <40?
- ☐ BP low, BP postural drop >20 mm, dizziness?
- ☐ Core temperature <35.5°C?
- ☐ Na <130 mmol/L?
- ☐ K <3.0 mmol/L?
- ☐ Raised transaminase?
- ☐ Glucose <3 mmol/L?
- ☐ Raised urea or creatinine?
- ☐ Abnormal ECG?
- ☐ Suicidal thoughts, behaviours?

Is the patient consenting to treatment?

Yes
No: Mental Health assessment requested

Refeeding

High risk for refeeding syndrome?

- ☐ Low initial electrolytes
- ☐ BMI <13 or mBMI <70%
- ☐ Little or no intake for >4 days
- ☐ Low WBC
- ☐ Serious medical comorbidities

Lower risk? Management

- **Start at 1,400–2,000 kcal per day and build by 200 kcal/day to 2,400 kcal/day.**
- **aim for weight increase of 0.5–1 kg/week**
- **Avoid underfeeding**

Higher risk? Management

- **<20 kcal per kg per day**
- **Monitor electrolytes twice daily**
- **build up calories swiftly**
- **avoid underfeeding**

Monitoring
Electrolytes (especially P, K)
ECG
Vital signs
BMI

Managing

Are medical and psychiatric staff collaborating in care?

Yes
No: psych. consultation awaited

Are nurses trained in managing medical and psychiatric problems?

Yes
No and appropriately skilled staff requested/training in place

Are there behaviours increasing risk?

- ☐ Falsifying weight
- ☐ Disposing of feed
- ☐ Exercising
- ☐ Self-harm, suicidality
- ☐ Family to stress/anxiety
- ☐ Safeguarding concerns

Mobilise psychiatric team to advise on management

(RCPsych 2021 p156)

Appendix 2 Risk assessment: evaluating the impending risk to life due to the patient's illness

	High Risk	Alert to High Concern	Low Risk
BMI and Weight	Under 18 years: median BMI Ð70% Over 18: years BMI <13	Under 18 years: median BMI 70-80% Over 18: BMI 13-14.9	Under 18: median BMI Ð80% Over 18: BMI Ð15
Weight Loss	Recent loss of weight of 1 kg or more/week for 2 consecutive weeks in an undernourished patient	Recent loss of weight of 500– 999 g/week for 2 consecutive weeks in an undernourished patient	Recent weight loss of < 500 g/week or fluctuating weight
HR (Awake)	Ð40	40-50	Ð50
Cardiovascular Health	Standing BP below 0.4th centile for age or less than 90 if 18+, associated with recurrent syncope and postural drop in BP of >20 mm Hg or increase in HR of over 30 bpm (35 bpm in Ð16 years)	Standing BP Ð0.4th centile or Ð90 if 18+ associated with occasional syncope; postural drop in BP of Ð15 mm Hg or increase in HR of up to 30 bpm (35 bpm in 16 years)	Normal standing BP for age and gender with reference to centile charts. Normal orthostatic cardiovascular changes. Normal heart rhythm

	High Risk	Alert to High Concern	Low Risk
Assessment of Hydration Status	Fluid refusal. Severe dehydration (10%): reduced urine output, dry mouth, postural BP drop (see above), decreased skin turgor, sunken eyes, tachypnoea, tachycardia	Severe fluid restriction. Moderate dehydration (5–10%): reduced urine output, dry mouth, postural BP drop (see above), normal skin turgor, some tachypnoea, some tachycardia, peripheral oedema	Minimal fluid restriction. No more than mild dehydration (Ð5%): may have dry mouth or concerns about risk of dehydration with negative fluid balance
Temperature	Ð35.5 C tympanic or 35.0 C axillary	Ð36.0 C	Ð36.0 C
Muscular weakness – SUSS Test, Part 1: Sit up from lying flat	Unable to sit up at all from lying flat or Unable to sit up without using upper limbs (score 0 or 1)	Unable to sit up without noticeable difficulty (score 2)	Sits up from lying flat without any difficulty (score 3)
Muscular weakness – SUSS Test, Part 2: Stand up from squat	Unable to get up at all from squatting or Unable to get up without using upper limbs (score 0 or 1)	Unable to get up without noticeable difficulty (score 2)	Stands up from squat without any difficulty (score 3)
Other Clinical State	Life-threatening medical condition, e.g. acute confusion, diabetic ketoacidosis	Non-life-threatening physical compromise, e.g. haematemesis, pressure sores	Evidence of physical compromise, e.g. poor cognitive flexibility, poor concentration

	High Risk	Alert to High Concern	Low Risk
ECG Abnormalities	Ð18: QTc Ð460 ms (girls), 400 ms (boys). 18+: QTc >450 ms (females), 430 ms (males). Any other significant ECG abnormality	Ð18: QTc Ð460 ms (girls) or 400 ms (boys). 18+: QTc Ð450 ms (females), Ð430 ms (males). No other ECG anomaly. Taking medication known to prolong QTc interval.	Ð18: QTc Ð460 ms (girls) or 400 ms (boys). 18+ QTc Ð450 ms (females), Ð430 ms (males)
Biochemical Abnormalities	Hypophosphatamia; Hypokalaemia (Ð2.5mmol/L); Hypoalbuminaemia; Hypoglycaemia (Ð3mmol/L); Hyponatraemia; Hypocalcaemia; Transaminases (3x normal range); In patients with diabetes mellitus: HbA1C >10% (86 mmol/mol)		
Haematology	Low white cell count; Haemoglobin Ð10g/L		

	High Risk	Alert to High Concern	Low Risk
Disordered Eating Behaviours	Acute food refusal or estimated calorie intake Ð500 kcal per day for 2 or more days		
Engagement with Management Plan	Adults: Physical struggles with staff or parents/carers over nutrition or reduction of exercise. Harm to self	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. May be ambivalent but not actively resisting
Activity and Exercise	High levels of uncontrolled exercise in the context of malnutrition (>2 h/day)	Moderate levels of uncontrolled exercise in the context of malnutrition (>1 h/day)	Mild levels or no uncontrolled exercise in the context of malnutrition (Ð1h/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	(RCPsych 2022)

Appendix 3: Essential Components of the Therapeutic Relationship

Essential components of a therapeutic relationship include:

- **Empathy**
- **Respect**
- **Acceptance**
- **Compassion**
- **Trust**
- **Hope**
- **Building rapport**
- **Non-judgmental attitude.**

Appendix 4: The National Framework for Recovery in Mental Health Principles (2017)

Principle 1: The importance of the service user's experience of living with mental health problems.

Principle 2: The service will work with people and groups involved to try to provide the best possible service to service users.

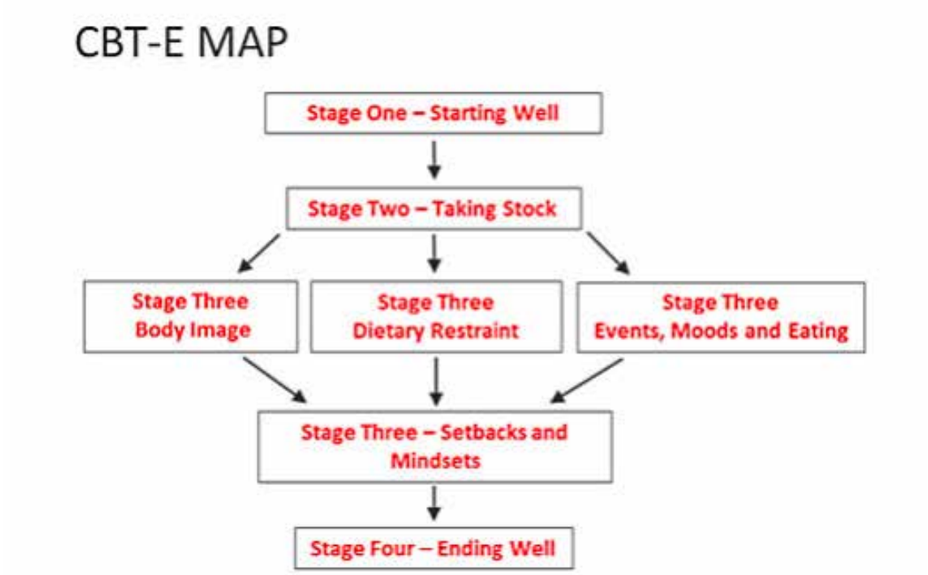
Principle 3: The HSE mental health services must make the recovery of people using its service their most important work.

Principle 4: The mental health service will make sure that everybody is given a chance to learn and understand about recovery and what it means for them, and how it works in practice.

(HSE 2017)

Appendix 5

CBT-E- Enhanced Cognitive Behaviour Therapy: An individualised, 4 staged treatment for eating disorders. Suitable for people diagnosed with anorexia nervosa, bulimia nervosa binge eating disorder and other similar eating disorders (CBT-E 2022).



(CBT-E 2022)

IPT- Interpersonal Psychotherapy: "A time limited, focused, evidenced based approach" The goal of therapy is to improve the person's social and interpersonal relationships in an attempt to reduce distress (Psychology Today 2022).

SSCM- Specialist Supportive Clinical Management for Anorexia: A psychotherapeutic approach with two components- clinical management of anorexia nervosa to attempt to re-establish weight gain and eating and psychotherapy to address any issues identified by the person (McIntosh 2015).

MANTRA- Maudsley Model of Anorexia Nervosa Treatment for Adults: An integrative therapy that has been specifically developed to aid in the management of anorexia nervosa. "MANTRA aims to address the cognitive, emotional, relational and biological factors which tend to maintain AN by working out what keeps people stuck in their anorexia, and gradually helping them to find alternative and more adaptive ways of coping" **(The London Centre for Eating Disorders and Body Image 2022).**

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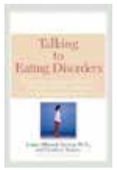
Reading List for Families and Friends

The reading list below is recommended to assist family and friends who are helping their loved one recover from an eating disorder. The list is by no means exhaustive. Please note that these books are not recommended for people still struggling with an eating disorder.

Skills based learning for caring for a loved one with an eating disorder
Author: Janet Treasure

Equips carers with the skills and knowledge needed to support and encourage those suffering from an eating disorder and to help them to break free from the traps that prevent recovery.

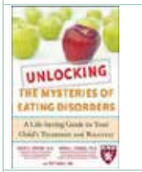


Talking to eating disorders: simple ways to support someone who has anorexia, bulimia, or other eating disorders
Authors: Jeanne Heaton & Claudia Strauss

What to say-and what not to say-when a friend or family member has an eating disorder.

Anorexia nervosa: a recovery guide for sufferers, families and friends
Authors: Janet Treasure & June Alexander

Includes sections for parents and other carers alongside a section for the person with anorexia.



Unlocking the mysteries of eating disorders
Authors: Herzog, Franko & Cable

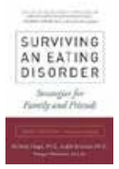
Shatters the myths, mysteries, and misconceptions surrounding eating disorders.

Anatomy of anorexia
Author: Steven Levenkron

Discusses origins, stages and treatment of anorexia and the role family can play in recovery.

Biting the hand that starves you
Authors: Maisel, Epston & Borden

This book illustrates the need to separate the illness from the person and to understand the thinking processes of someone with anorexia or bulimia.

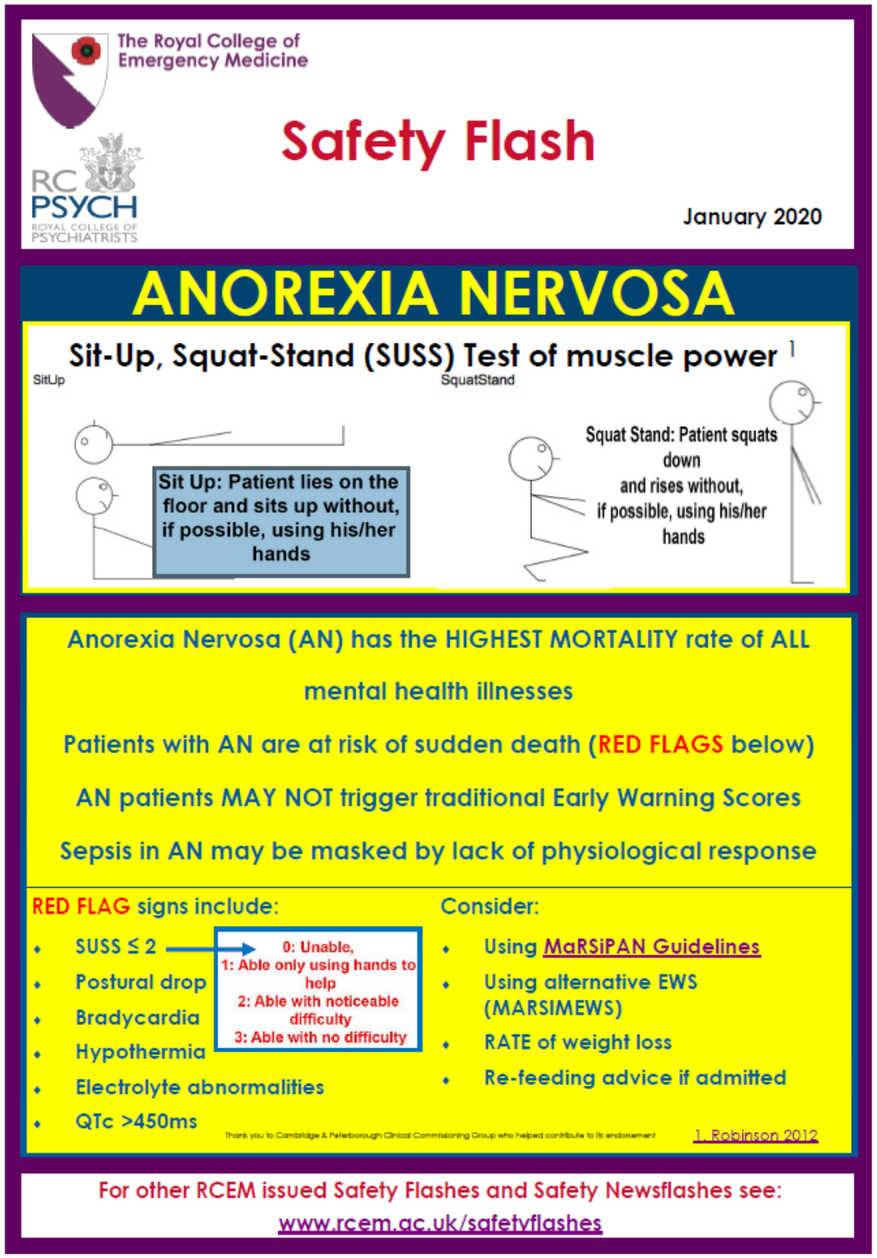


Surviving an eating disorder: strategies for family and friends
Author: Michelle Siegel

Revised edition of a classic book, containing information on what methods and practices work best for families, helping readers take new actions that will encourage the recovery process.

Notes

Notes


The Royal College of Emergency Medicine
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS
Safety Flash
January 2020
ANOREXIA NERVOSA
Sit-Up, Squat-Stand (SUSS) Test of muscle power 1
SitUp
SquatStand
Sit Up: Patient lies on the floor and sits up without, if possible, using his/her hands
Squat Stand: Patient squats down and rises without, if possible, using his/her hands
Anorexia Nervosa (AN) has the HIGHEST MORTALITY rate of ALL mental health illnesses
Patients with AN are at risk of sudden death (RED FLAGS below)
AN patients MAY NOT trigger traditional Early Warning Scores
Sepsis in AN may be masked by lack of physiological response
RED FLAG signs include:
SUSS ≤ 2
Postural drop
Bradycardia
Hypothermia
Electrolyte abnormalities
QTc >450ms
0: Unable,
1: Able only using hands to help
2: Able with noticeable difficulty
3: Able with no difficulty
Consider:
Using MaRSiPAN Guidelines
Using alternative EWS (MARSIMEWS)
RATE of weight loss
Re-feeding advice if admitted
Thank you to Cambridge & Peterborough Clinical Commissioning Group who helped contribute to its endorsement
1. Robinson 2012
For other RCEM issued Safety Flashes and Safety Newsflashes see:
www.rcem.ac.uk/safetyflashes

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