Eating Disorders: Assessment, Admission and Initial Management - A Quick Reference Guide

WAEDOCS provides a consultation service for clinicians throughout Western Australia (WA), to build capacity in the identification, assessment and best-practice management of youth (aged ≥16) and adults presenting with an eating disorder.

In the absence of specialist eating disorder beds or day programme in the public sector in WA, WAEDOCS has created this Quick Reference Guide to provide health professionals, especially Emergency Departments, with a guide to assess, admit and initially manage. We recommend having a copy of our full guidelines for reference.

**Background**

Increasingly eating disorders are understood as neurobiological disorders, whose aetiology and treatment sit at the interface of physical and mental health care. Emerging evidence suggests early intervention, including assertive nutritional rehabilitation and structured psychological support with a multidisciplinary plan for relapse prevention, can significantly improve prognosis.

Severe malnutrition and “starvation syndrome” (1) can be experienced in people at any weight, resulting in physical and cognitive effects including poor insight regarding nutritional and medical risk. Severely malnourished individuals are unlikely to be able to reverse starvation on their own.

People with high risk medical complications or recurrent presentations may require inpatient admission to enable nutritional rehabilitation/weight gain to a level sufficient for brain recovery from malnutrition, as otherwise this will continue to drive cognitions and impair engagement with psychological treatments, perpetuating the cycle of weight loss and readmission. “Discharge from hospital should only occur when the person is medically stabilised, has had enough nutrition to reverse any cognitive effects of starvation so that she or he can benefit from outpatient or day patient psychotherapy (often several weeks of nutrition are required to achieve this)” (RANZCP; 2). Access in Perth to public psychological services and the private day program for people with eating disorders requires an individual to safely sustain a BMI >16 kg/m², and BMI ≥17kg/m² is associated with improved ability to benefit from outpatient treatment (3).

**Uses and limitations of WAEDOCS clinical guidelines**

Guidelines are not a substitute for professional knowledge and clinical judgment. Evidence-based guidelines should always be used in conjunction with good clinical judgement.

Guidelines can be limited in their applicability by a number of different factors: the lack of high quality research and the generalisability of research findings, and the uniqueness of individual patients.

The full set of guidelines for the management of eating disorders can be accessed by calling WAEDOCS on: 1300 620 208 or emailing: waedocs@health.wa.gov.au

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**Assessing Risk in a Person with an Eating Disorder**

Ask questions of the patient which may reveal current behaviours and cognitions associated with disordered eating, as well as physical and psychiatric symptoms. People with eating disorders tend to have both an impaired ability to self-assess risk and an intense fear of losing control/gaining weight. Family members may provide vital information. **A comprehensive patient assessment should include:**

- **Weight:** Current BMI: formally measured (not self-reported) height & weight (patient should be weighed in gown); highest and lowest weight since the age of 16 and weight trajectory.
- **Weight loss:** Duration, amount, means (dietary restriction, vomiting, laxative and diuretic abuse, excessive exercise).
- **Recent nutritional intake:** ask in detail for intake over the past two weeks.
- **History of presenting illness:** and precipitants, including previous eating disorder history.
- **Cognitive features:** Fear of weight gain, body image distortion, denial of the seriousness of the condition, rigid rules about food/eating.
- **Hormone functioning:** In females, age at menarche and any amenorrhoea; in males, sexual desire and performance.
- **Co-morbid conditions:** Medical, psychiatric including suicidal ideation or deliberate self-harm.
- **Family functioning:** Support systems (or lack thereof).
- **Physical and health assessment:** see indicators below to determine need for admission.

**Medical Instability: Why BMI should never be the sole determinant**

Many people with severe malnutrition/purging present in a compensated state and may not exhibit the full extent of their medical instability at the point of initial presentation. With increased caloric intake and increase in weight/BMI they may become more unstable in the first days/weeks of an admission.

Some people may present in the “healthy” weight range but be severely medically compromised if they have fasted for a long period and/or lost a large amount of weight within a short time. They may exhibit other cognitive features of eating disorders, including distorted body image and fear of weight gain.

Because of the intense fear of weight regain, patients may modify their weight/height measurement, which can result in an artificially high BMI calculation.

Malnourished people may be fearful about engaging in treatment and may be inaccurate in their self-reporting. Risk assessment and treatment decisions should be informed by medical parameters and not solely on the patient’s account. Family members/carers and the patient’s GP/psychologist can provide a more objective picture of symptoms and behaviours.

The biggest risk is unintentional death due to starvation or purging. The patient can feel fine and have normal bloods just before sudden death due to arrhythmia.
Indicators for Admission – if patient meets any of the following criteria:

Criteria below are adapted from the RANZCP (2014) and NSW (2014) Guidelines (2,4).

Note: RANZCP guidelines specify criteria for settings of care. WAEDOCS has decided to identify these indicators as general criteria for admission, given the potential for inaccuracy of weight at initial admission, risk of clinical deterioration on refeeding and the variability of medical support to mental health settings across WA.

Patients who are not as unwell as indicated here may still require admission. If in doubt, consider liaison with WAEDOCS regarding appropriate setting of care.

| Rapid weight loss, low weight | • Loss of >1 kg/week over several weeks OR  
|                              | • Grossly inadequate nutritional intake (<1000kcal daily) for >2 days OR  
|                              | • BMI < 14kg/m² (for ages 16-18: admit if <75%-85% ideal body weight, i.e., approximately BMI 16 kg/m² for a 16 year old) |
| Purging                      | Daily (uncontrolled; sufficient to cause distress and/or medical instability) |
| Blood pressure               | < 90mmHg systolic or postural blood pressure >10 mmHg drop (lying to standing) |
| Heart rate                   | ≤40 bpm (adolescents <50 bpm) or >120 bpm or postural tachycardia >20 bpm (increase in >20 bpm from lying to standing) |
| ECG                          | Any arrhythmia including QTc prolongation, nonspecific ST or T-wave changes including inversion or biphasic waves |
| Blood sugar                  | Below normal range / < 3.5mmol/L |
| Sodium                       | <130mmol/L |
| Potassium                    | Below normal range* |
| Magnesium                    | Below normal range* |
| Phosphate                    | Below normal range* |
| Albumin                      | Below normal range* |
| Liver enzymes                | Mildly elevated |
| Neutrophils                  | <1.5 x 10⁹/L |
| Temperature                  | <35.5°C or cold/blue extremities |
| Psychiatric concerns         | Significant psychiatric risk such as deliberate self-harm or suicidal ideation. Moderate-high agitation and/or distress. |

* Clinicians should refer to their individual organisation’s reference values
Medical monitoring & Multi-Disciplinary Team (MDT) management

The goals of medical management aim for medical stabilisation via:
- Prevention and treatment of re-feeding syndrome
- Safe nutritional and weight restoration
- Reversal of acute cognitive effects of starvation

DAILY OBSERVATIONS
- U+E / Mg$^{2+}$ / PO$_4$
- FBP / Vitamin B12 / Folate / Ca$^{2+}$
- Other investigations as indicated by clinical findings
- QID observations of:
  - Temperature,
  - Respiration Rate,
  - Lying and standing Heart Rate, AND Blood Pressure – lying and standing, if safe to do so
- Daily ECG
- Blood Sugar Levels (BSLs) QID (2 hrs. post prandial irrespective of feeding route) and 0200 (management of hypoglycaemia as per local hospital diabetic management policy)

DAILY SUPPLEMENTATION
- 300mg Thiamine OD
- 1 Complete Multivitamin and Mineral Supplement OD
- 1 B Complex Supplement OD
- 500mg Phosphate Sandoz BD
- Replace abnormal electrolytes as clinically indicated

NOTIFY RMO IF:
- Pulse is below 50bpm,
- Systolic BP below 90mmHg or if:
  - Significant Postural Drop of more than10mmHg or:
  - Postural Tachycardia >20 bpm
  - Temp below 35.5°C
  - QTc interval >450ms
  - BSL<4mmol/L

CONSIDER MHU TRANSFER IF MEDICALLY STABLE FOR 72 HOURS AS PER:
- Systolic BP 90mmHg or above
- (>80mmHg if reviewed and agreed in conjunction with psychiatrist in charge of the mental health ward / unit).
- Heart rate >50 and <100 bpm
- No significant postural tachycardia or hypotension
- Normal ECG
- Normal electrolytes

CONSIDER DISCHARGE TO COMMUNITY IF AS ABOVE, PLUS:
- Consuming regular adequate nutrition on and off the ward
- Returns from 48 hrs leave medically stable and eating adequately
- Cognitive effects of starvation reduced sufficiently to be able to engage in outpatient psychotherapy (BMI >16 kg/m$^2$)
- Clear plan for collaborative MDT community care (including mental health governance)
Initial Nursing Management

- On admission (preferably with patient consent) search belongings for laxatives, diuretics, chewing gum, sweeteners, etc. Repeat on return from any ward leave.
- Create Individualised behavioural management plans (IBMP) outlining activity, level of observation, bathroom access, meal support, leave, etc.
- 1:1 Supervision (provide support and reduce compensatory behaviours).
- Initially no off ward leave due to medical risk.
- QID observations of: Temperature, Respiration Rate, Lying and standing Heart Rate, AND Blood Pressure – lying and standing, if safe to do so.
- Daily ECG.
- Blood Sugar Levels (BSLs) QID (2 hrs. post prandial irrespective of feeding route) and 0200 (management of hypoglycaemia as per local hospital policy).

Monitor and contain eating disorder behaviours

- **NUTRITION**: Only food authorised by the dietitian is to be consumed.
- Record all offered food and fluids / NGT feeds.
- Request family members/carers support with adherence to the IBMP by not supplying foods from outside or medications, or allowing patient to exercise.
- NGT Feeding – Lock pump, tube visible and sealed with tape at the join. Observe for potential tampering.
- Monitor fluid intake for ↑ or ↓ consumption and record specific gravity daily (assess for water loading - excessive intake of fluids to falsify weight).
- **MEAL SUPPORT**: through boundary setting and role modelling. Refer to WAEDOCS Guidelines for meal management and NGT feeds.
- Attend to toilet needs prior to meals.
- No vomiting, chewing, spitting – ideally 1:1 supervision during meals (30 mins) and post-meals (60 mins), at snack time (15 mins) and post-snack (30 mins).
- **EXERCISE**: refer to WAEDOCS BMI Guidelines for physical activity.
- **WEIGHT**: Do not discuss weight or weight goals at point of initial admission, given the potential for inaccuracy of weight at admission.

Use of the 2014 Mental Health Act (5)

Criteria for applying the 2014 MHA in Western Australia include:

1. **The person is experiencing a mental illness for which the person is in need of treatment.** All eating disorders are mental illnesses (listed in DSM-5).
2. **Because of the mental illness there is a significant risk to health and safety / or a significant risk of harm to the person.** Anorexia nervosa has a mortality of up to 20%, predominantly as a result of malnutrition and suicide.
3. **The person does not demonstrate that they have the capacity to make treatment decisions.** An eating disorder can impact upon accurate self-perception and judgement regarding medical risk and the need for treatment.
4. **There is no less restrictive way to provide the treatment that the person needs.** Assessment of decision-making with respect to setting and restriction of care should take into account evidence of an individual’s ability or lack thereof, to engage safely with treatment. (Access to public specialist eating disorder psychology requires an individual to be able to sustain their BMI >16 kg/m²).
Initial Nutritional Management

Relevant for medical, nursing and dietetic staff

TO MINIMISE THE RISK OF RE-FEEDING SYNDROME IT IS RECOMMENDED THAT YOUR TEAM COMMENCE THESE INSTRUCTIONS IMMEDIATELY

Monitor patient daily whilst at risk of re-feeding
(Patient at risk of re-feeding >7-10 days post adequate nutritional restoration)

Route of Nutrition Restoration will depend on medical stability and BMI. Consult the facility dietitian

Commence with 6000kJ/day meal plan (see following page)

CONTINUOUS NGT FEEDING
- Medically unstable regardless of BMI
- Unable to tolerate any oral diet
- Medical co-morbidities complicated by an eating disorder (ED)
- BMI <13.5kg/m²

ORAL DIET (OR ORAL AND ENTERAL)
- If medically stable
- Able to tolerate oral diet
- If BMI >13.5kg/m²

Must meet all three criteria to qualify.

24 hour continuous enteral feeding with a suitable enteral feed as below:
- Nutritional complete, 6.3kJ/ml (1.5kcal/ml)
- Low to no fibre containing
- Lower carbohydrate (40 – 50% total CHO)

Increase by 2000kJ every 2 – 3 days until target energy content.

Recommend 3 main meals + 3 snacks
- If patient unable to complete main meal or snack, provide a 6.3kJ/ml (1.5kcal/ml) oral nutritional supplement top up
- Increase by 2000kJ every 2 – 3 days until target energy content achieved

See Pg. 7 For Sample Meal Plan

Observe for symptoms of refeeding syndrome as listed on risk assessment

Note:
- If physical safety does not warrant enteral feeding, the patient should be given 24 hours to demonstrate the ability to consume the required intake with supervision
- If after 24 hours they are unable to comply then it is recommended that an enteral feeding tube be inserted for nutrition restoration

Refer to C/L Psychiatry Service as per local policy
6000 kJ/day Meal Plans

Solid Oral Diet - can be started prior to review by your facility dietitian:

**Breakfast:** 1 Portion Pack Cereal (Cornflakes™ or Rice Bubbles™) + 150ml Hilo Milk + 1 Portion Pack Tinned Fruit in Natural Juice

**Morning Tea:** 200ml UHT Flavoured Milk + 1 Piece Fresh Fruit

**Lunch:** Hot Main Meal (standard portion / serve size). Must include carbohydrate e.g., potato / rice / couscous / pasta

**Afternoon Tea:** 200ml UHT flavoured milk

**Dinner:** Hot Main Meal (standard portion / serve size). Must include carbohydrate e.g., potato / rice / couscous / pasta

**Supper:** 200ml UHT flavoured milk

**Liquid Oral Diet if unable to tolerate solid oral diet:**

**Breakfast / Lunch / Dinner:** 200ml Fortisip (no fibre) OR 200ml Ensure Plus (tetrapack)

**Morning Tea / Afternoon Tea:** 100ml Fortisip (no fibre) OR 100ml Ensure Plus (tetrapack)

**Supper:** 200ml Fortisip (no fibre) OR 200ml Ensure Plus (tetrapack)

- If after 24 hours they are unable to comply then it is recommended that an enteral feeding tube be inserted for nutrition restoration.
References


(4) NSW Ministry of Health (2014) Guidelines for the Inpatient Management of Adult Eating Disorders in general Medical and Psychiatric Settings in NSW


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