9: Summary sheet for dietitians

Who is this for?
Dietitians providing input to primary care, acute medical wards and eating disorder services. If you are not specially trained in eating disorders dietetics, consult a dietitian who is so trained.

a. Risk assessment

The patient will usually have been assessed by a doctor, and should have a medical risk assessment as per this guidance. As a dietitian, you are in a good position to provide a nutritionally informed opinion about a number of areas including the degree of likely patient cooperation with treatment, severity of malnutrition, micronutrient deficiencies, physical symptoms due to malnutrition, risk of refeeding syndrome and, where appropriate, parental knowledge and feeding practices, possible food allergies or socially acceptable dietary restrictions e.g. veganism.

See Chapter 2 and Appendix 3

b. Location of care

You may meet the patient in the community, in a medical ward, a paediatric ward or an eating disorders inpatient or day service. In each location, your role is to assess, advise on nutritional risk and implement appropriate plans, in liaison with an eating disorders dietitian as needed.

See Chapter 3

c. Safe refeeding

In this area, your expertise is invaluable. You will be aware of the risks of rapid feeding but also the (probably greater) risks of underfeeding. You will advise on the most appropriate route of refeeding, oral food, oral nutritional supplement or enteral feeding, (nasogastric or nasojejunal), and the nature of the diet or feed. You will advise on rate of refeeding and associated micronutrients provision. You will work closely with doctors, nurses and therapy staff in the multidisciplinary team and liaise with the specialist eating disorders clinicians as needed, if not within a specialist team. Particularly for younger patients in the community but also in hospital, you will liaise with parents and carers and provide advice on nutritional treatment.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

A trusting relationship between patient and dietitian is key to promoting successful recovery. Without it, the patient may feel compelled to oppose nutritional treatment. The dietitian uses communication and counselling skills as well as motivational enhancement.

Sometimes the dietitian may need to challenge the patient and this can affect the relationship. Patients unable to make progress with oral food may need nasogastric feeding which is a specialist dietetic area. Patients with type 1 diabetes and eating disorders present particular challenges for nutritional/physical health restoration, as do those with coeliac disease and multiple confirmed food allergies.

See Chapter 6

e. Families and carers

The dietitian may support treatment at home along with the therapy team, explaining principles of nutrition to the family/carers. In hospital, the dietitian may need to meet with the family/carers to explain changes in the refeeding process, such as beginning nasogastric tube feeding.

See Chapter 7

f. Compulsory admission and treatment

Patients on a compulsory treatment order may require feeding assisted by staff, occasionally with sedation. The dietitian needs to work closely with medical and nursing staff to manage this very challenging process. There are dietetic guidelines, endorsed by the British Dietetic Association, on modifying standard dietetic practice for patients who are detained and require nasogastric tube feeding against their will.

See Chapter 8

g. Diabetes mellitus type 1

Diabetes complicates the management of any eating disorder. To promote weight loss, the patient may avoid insulin or hypoglycaemic drugs, and this can lead to failure of diabetic control. The dietitian with expertise in both eating disorders and diabetes, working together with medical and nursing staff can contribute significantly to the management of this challenging combination.

See Chapter 9 and Annexe 3