13: Summary sheet for emergency department staff, on-call medical and paediatric staff

Who is this for?

Doctors in the emergency department, on-call medical and paediatric registrars.

Introduction

Patients with eating disorders will be very anxious and frightened about being in the emergency department. They may feel that they do not deserve treatment, so ensure that you do not trivialise their illness by suggesting that they are not sick enough, that they do not have a low enough BMI or that they appear too well for treatment.

a. Risk assessment

Patients with eating disorders can appear well, even when they are close to death. Consult the risk assessment tool (Chapter 2) and checklist (Appendix 3) and use measures most relevant to the patient that you are assessing.

Anyone with one or more Red rating or several Amber ratings should probably be considered high risk, with a low threshold for admission. Red ratings include:

- BMI <13/<70% mBMI
- Recent weight loss >1 kg/week for 2 weeks in an underweight patient
- HR (awake) <40
- Recurrent syncope with standing BP <90 systolic (<0.4th percentile for age) and postural drop >20 mmHg (or increase HR >30 [>35 if <16])
- Fluid refusal or signs of dehydration
- Temperature <35.5°C tympanic/35°C axillary
- Long Qt or other ECG abnormalities
- Low glucose/sodium/potassium/calcium/phosphate/albumin
- Low WCC, Hb <10
- Acute food refusal/very low calorie intake per day
- Physical struggles with carers over nutrition
- High levels of uncontrolled exercise (>2 hours/day)
- Daily purging behaviours
- Self-harm
- Moderate–high risk suicidal ideas.

Once the risk assessment framework has been completed, the other parts of the checklist provided should also be completed.

See Chapter 2 and Appendix 3

b. Location of care

Patients considered at high risk after completion of the risk assessment should be admitted to an acute medical/paediatric bed for medical stabilisation and safe refeeding, pending assessment by a psychiatrist or eating disorder specialist, and location of a specialist eating disorders bed if necessary. If the patient is admitted to an acute bed, it is advised to consult an eating disorders specialist in person or online urgently for support and advice.

For patients considered able to go home, the emergency medicine doctor, or medical or paediatric registrar should ensure that a referral has been made to the local eating disorder service prior to discharge. This can usually be done online. Do not assume that the next person in the chain (such as the GP) will do this. Consider talking to the eating disorders service prior to discharge if within hours, or a psychiatrist if out of hours.

See Chapter 3

c. Safe refeeding

For most underweight patients with eating disorders, feeding can start at 1,400–2,000 kcal per day, rising by at least 200 kcal per day until weight gain is achieved, e.g. 2,400 kcal per day. Advice on managing nasogastric feeding is provided in Chapter 4. The possibility of refeeding syndrome (e.g. falling phosphate) should be borne in mind and for some patients with coexisting medical illness, lower rates of refeeding may be appropriate, in which case underfeeding syndrome with nutritional deterioration must be avoided.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

Challenging weight-losing behaviours (such as exercising, hiding food or falsifying weight) is difficult in a busy emergency department. A staff member may need to stay with the patient constantly to detect and manage these issues. Write a management plan to share among emergency department staff.

See Chapter 6

e. Families and carers

Consider the concerns of the parent/carer, who may have a considerable amount of knowledge about their loved one's eating disorder, and include them in decision-making about location of care. For those in whom this is a new presentation, provide them with information/resources such as Beat, Anorexia & Bulimia Care or FEAST.

See Chapter 7

f. Compulsory admission and treatment

Preventing a patient from leaving hospital and imposing treatment are closely controlled activities. Certain types of nurse (See Chapter 8) may prevent a patient leaving hospital for a limited time while a medical opinion is obtained. The doctor in charge can prevent a patient leaving the ward for up to 72 hours while longer detention under the Mental Health Act is considered. Before this situation occurs, check what you are allowed to do and, if it seems likely to happen, contact the psychiatrist as soon as possible. If you do something to the patient without consent (such as pass a nasogastric tube,) outside of Mental Health Act guidelines, the patient may take you to court for alleged assault. In the emergency department, the only way to prevent a patient leaving is using the Mental Capacity Act, and this would be extremely rare.

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. In the long term, increased severity of diabetic complications can occur. Reintroduction of insulin can cause electrolyte shifts (especially potassium) and insulin should only be administered under supervision. The diabetes team should guide management, working closely with psychiatrists.

See Chapter 9 and Annexe 3