14: Summary sheet for physiotherapists

Who is this for?

Physiotherapists in general adult, child and adolescent and specialist services assessing and managing patients with severe eating disorders.

a. Risk assessment

A severely ill patient with an eating disorder may present with problems within the realm of physiotherapy expertise. Look at the items on the risk assessment tool (Chapter 2) and consider whether they may indicate or interfere with physiotherapy treatment. Risks that may emerge include poor mobility, difficulties transferring and liability to fall, as well as increased activity levels and dysfunctional exercising behaviour.

See Chapter 2 and Appendix 3

b. Location of care

In a medical ward, the patient is likely to be very unwell with weakness and possible electrolyte disturbance. In other services, including paediatric and psychiatric wards, BMI may not be so low, but the patient will still be subject to risks mentioned above. For patients who purge, at any weight, risks of cardiac arrhythmia and low blood pressure can affect mobility.

See Chapter 3

c. Safe refeeding

Refeeding the patient in hospital will mainly be the remit of doctors, nurses and dietitians. However, the physiotherapist may become involved in the general care of the patient, together with nurses, and help maintain functional movement, safety with transfers, improve mobility and help prevent pressure sores and venous thrombosis in a patient, with or without a nasogastric tube or intravenous infusion.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

The behavioural problems that can complicate the patient's treatment include some areas in the remit of the physiotherapist, as well as the nurses. These include working to address dysfunctional exercising behaviours, both covert and overt, including increased standing, 'fetching' items, fixed and held postures, reducing clothing to induce shivering, or leaving the ward to exercise in other areas of the hospital.

See Chapter 6

e. Families and carers

The physiotherapist may well be in contact with family members, especially in younger patients. They may require support to manage the patient's distress in dealing with restrictions on mobility, and with their own understandable anxiety and distress about their relative's serious illness. Educating carers about how to approach excessive exercise can also prove very useful.

See Chapter 7

f. Compulsory admission and treatment

A patient with an eating disorder who is at high risk and refusing treatment may require assessment under the Mental Health Act or equivalent. Compulsory treatment usually does not influence the provision of physiotherapy interventions because they are always provided with consent. If a patient is thought to lack capacity, discuss with senior ward staff about whether that affects physiotherapy treatment.

See Chapter 8

g. Diabetes mellitus type 1

Diabetes complicates the management of any eating disorder. Insulin or hypoglycaemic drugs may be avoided by the patient in order to promote weight loss and this can lead to failure of diabetic control. In the long term, increased severity of diabetic complications can occur. The patient may have neuropathy with numbness of toes or fingers or a tendency to faint when standing and retinopathy with reduced vision and the physiotherapist must be aware of these risks as part of assessment and treatment planning. Consult with senior ward staff about any modifications of approach that may be required.

See Chapter 9 and Annexe 3