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# Eating Disorders: A Clinical Update

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MAKING A DIFFERENCE, FOR YOU, WITH YOU.

# Aim to cover…

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- Physical health risk assessment – MEED and aims of admission
- Nutritional care plans for those admitted
- NGT feeding under physical restraint
- Ethical issues
- Q & A

# Medical Emergencies in Eating Disorders

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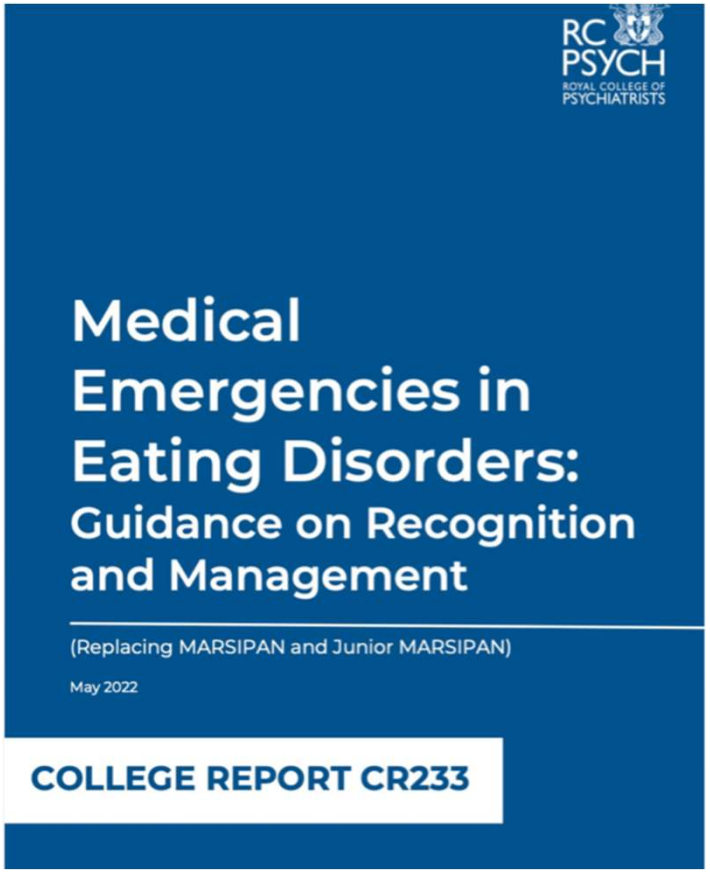


- New guidelines released in 2022
- Document designed to support with management of eating disorders in acute non-specialist settings/in emergencies
- Aims to reduce avoidable deaths due to lack of awareness of risk of ED's
- Replace all previous guidelines (MARSPIAN/JR MARSIPAN) with an all-age document
- Includes traffic light risk assessments (any RED highlights need for clinical evaluation) – a common language around risk assessment
- Includes profession specific summary sheets
- Advice on management of re-feeding syndrome - safe re-feeding is key!

# MEED Guidelines

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**Physical health risks:**

- Anthropometrics
  - Rate of weight loss
  - % median BMI
- Cardiovascular health
  - ECG abnormalities
  - Heart rate (awake)
- Hydration
- Temperature
- Muscular function
- Associated clinical states
- Bloods
  - Biochemical
  - Haematological

**Mental health risks:**

- Disordered eating behaviours
- Engagement with treatment
- Exercise
- Purging
- DSH

# Aims of acute admissions

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- Medical stabilisation
  - Food is the medicine
  - Differential diagnosis (undiagnosed cancers, coeliac, thyroid, IBD etc…)
- Identifying the crisis
  - Food is the medicine
- Empowering families to care for their child or the patient to feed themselvs
  - Food is the medicine
- Preventing readmission
  - Food is the medicine

**Your job is NOT to treat the ED but to facilitate nutritional rehabilitation and medical stabilisation so they can access treatment.**

# The Levels of the Refeeding Hierarchy™


**Level 5: Challenge Foods**

Start to introduce challenge foods only when the first 4 levels are successfully accomplished. These are foods that are hard for the child to eat.

**Level 4: Variety**

Start introducing more variety for meals and snacks day to day. Choose different meals and snacks.

**Level 3: Micronutrients**

Start focusing on the child getting a balance of appropriate vitamins, minerals, fibre and discretionary fluids (ie. coffee, tea, etc.).

**Level 2: Macronutrients**

Focus on getting an appropriate balance of carbohydrates, proteins and fats so the body can function optimally.

**Level 1: Foundation of "Enough"**

Ensuring that the child is eating enough food (energy) and fluids to meet their nutritional needs. We don't focus on how the child is getting the food or what the child is eating. We just want enough.

# Meal planning

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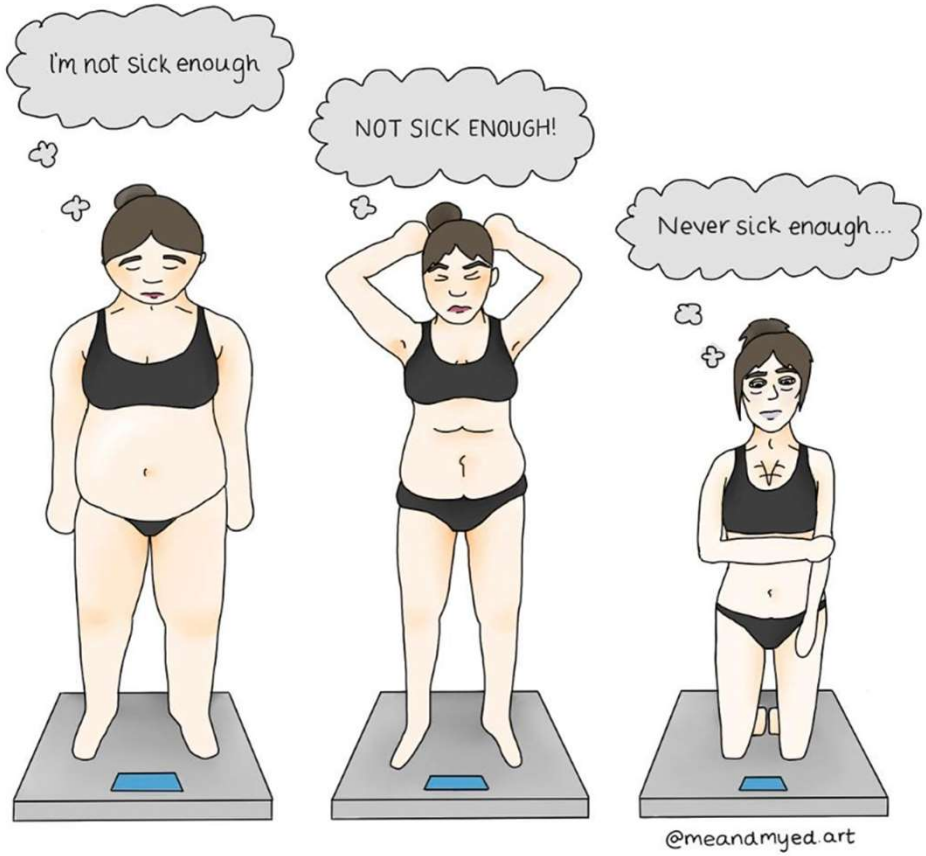
- Emergency 5-day refeeding plan (out of hours)
- Oral first – ALWAYS as this is the least restrictive option
- Consider bespoke meal plan if generic not working
- Supplements only there if sufficient oral intake can not be achieved / maintained
- Supportive NGT – do not rush into this (unless life saving)

# What does it feel like to have an ED?




# Monitoring admissions

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**Do:**

- Talk about trajectory of physical health objectively – is it improving or deteriorating
- Put into context of 'big picture' – e.g. improvement does not mean they are better/fine, they will still need support
- Liaise with CEDS during ward rounds (F2F or over the phone) for joint decision making

**Do not:**

- Make comments re weight or calories
- Praise
- Invalidate their struggle
  - Why are you here?
  - There are sick kids who need this bed.

**The 6 C's of communication**

- **C**alm
- **C**onfident
- **C**onsistent
- **C**oaching / supportive
- **C**ollaborating – with parents and CEDS
- Not **c**olluding with the illness

Keeping conversations simple – don't get into conversations about logic or numbers

# Difficult Conversations

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- Validation:
  - Reflect that you understand it is hard and you can see they are struggling
- Align yourself with them, against the eating disorder:
  - Let them know you are there to support them, not their ED
- Use ‘and’ not ‘but’ to link struggle with action:
  - it’s hard *and* we need to do it.
- Use positive reflections, not consequence talk:
  - What will they gain – short term and big picture thinking – help them zoom out!

# Language

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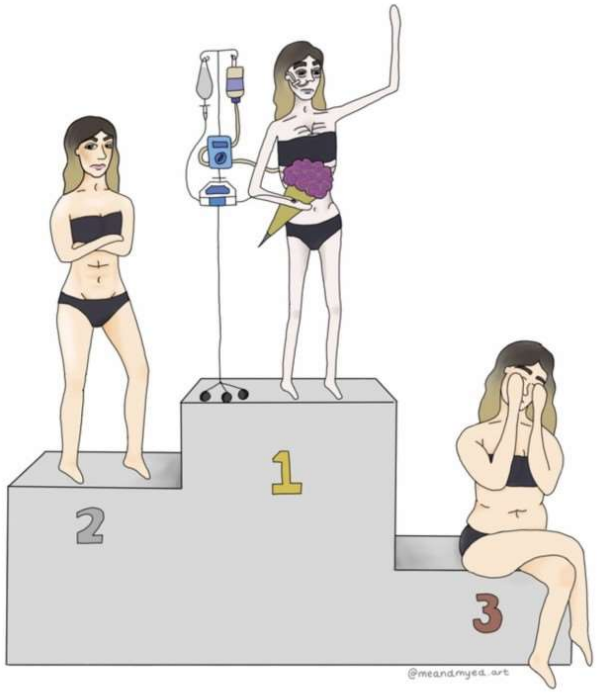
- You are not there to TREAT the ED
- You ARE there to support malnutrition – where you are the expert
- Opportunity to work together
- Using the 6C's of communication will help – but remember, people are human and are usually really scared by acute admissions
  - 'I can see this is really difficult for you, but we do need to achieve X nutrition today, what support do you need?'
  - 'Please correct me if I get something wrong'

# Understanding NGT feeding in ED's




- AN is an egosyntonic disorder
  - Wants to be sicker, they say they feel fine
  - NGT can be a 'badge of honour' or success
  - Passing an NGT may lead to someone giving up the fight and stopping eating totally

# Understanding NGT feeding in ED's

- Supportive NGT feeding can be achieved
  - Understanding the young person's motivations
  - Can be motivational for some – those who do not want to be in hospital and keen to get home
  - Supportive conversations around maintaining oral intake and 'topping up'
  - NEVER USE NGT AS A THREAT
  - NOTICE, NAME, VALIDATE - THEN ACTION
    - 'I can see how hard this is for you, its really common for people in your situation to feel like this, can we try this for 2 or 3 days and see if it helps, if not we will stop it'

# NGT feeding under restraint – guidance available

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Don’t back people into a corner (me v’s them)

BUT can save someone’s life

MHA principles of ‘least restrictive practice’ and ‘proportionate to risk’

- Modify nursing and dietetic practice
  - 2 bolus feeds a day
  - Push syringe bolus
  - Start at 500ml per bolus and is safe to go up to 1,000ml/bolus
  - Higher Fr NGT will aid the passing of enteral feed
  - Use ‘compact’ sip feeds, and products as calogen or 5cal to minimise volume of feed
  - Can thin this mix slightly with water
  - 1,000ml can safely be delivered in ~10mins
  - Always have an exit strategy

# NGT feeding under restraint

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- Lifesaving intervention, but is sensible to intervene if the trajectory indicates lifesaving measures will be required (best interests)
  - Not for 50kcal nor for suboptimal intakes
- Conversation point after first feed:
  - ‘we were serious when we said we would not let you die’,
  - ‘I am sorry that had to happen, how can we prevent it from happening again’
- Exit strategy:
  - MDT discussion with ED team essential
  - Continuing past the point of medical stabilisation is often unhelpful as the patient can give up and behaviour/resistance can become habitual

# Ethical considerations

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- We must act to protect life
  - Ombudsman regulation 28 reports on when this opportunity has been missed
  - However, no clear parameters on when this action is indicated
    - MEED identifies who should be in hospital for management NOT if this intervention is required
  - However, patients report having PTSD post NGT feeding under restraint

- Research suggests that patients with co-morbid presentations may have more repeated and prolonged experiences of NGT feeding under restraint than those with a single diagnosis of AN
  - Should we be more cautious with these patients?
  - Neurodivergence, emotional dysregulation, trauma, RISH (restricted intake self-harm)

# Decision making – The Goldilocks Zone

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- Not rushing into this but not delaying the decision so long that patients don't believe it will ever happen and they deteriorate further
- Full MDT discussion focusing on supporting the patients' needs
- Having discussion prior to any crisis or conflict (advanced care planning)
  - I knew this could happen as it was part of my care plan
- Involving the patient in the decision and hearing their views / wishes on how to support them before, during and after the intervention
  - Collaboration = engagement
  - Environment – lights, music, location on ward
  - Distractions – VR headsets, activities etc…
  - Avoiding '*them v's me*' and the loss of hope and agency leading to isolation and the illness thriving
- Continue to offer least restrictive options i.e. food & drinking supplements
- Meal support is key!
- Holding clinical risk within the MDT, is this really needed <u>today</u>?

# Recovery is possible

''Somewhere between then and now
The salad turned into pizza
The sweetener became flavoured syrup
The ice cream was made from real dairy
The 'I'm not hungry' became 'lets do desert'
The leggings turned into jeans
The food stopped tasting of numbers
The routines turned into spontaneity
The black coffees became milky lattes
The regrets turned into memories
The colour splashed back into my cheeks
The fear turned into faith
And the body I spent years destroying finally felt like home''

Hayley – shared with consent

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# NGT feeding under restraint, references

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