EATING DISORDER GUIDELINES FOR EMERGENCY DEPARTMENTS

PRACTICE GUIDELINE ©

DOCUMENT SUMMARY/KEY POINTS

- These guidelines are for children and adolescents who present to the SCH or CHW Emergency Department with a diagnosis or query diagnosis of an eating disorder.
- It is recognised that children and adolescents who present with an eating disorder can be at a high risk of medical instability and/or psychiatric complications including suicidal ideation and deliberate self-harm and therefore require intervention to prevent further life threatening deterioration.

CHANGE SUMMARY

- New joint Emergency Department guideline at SCH and CHW.
- Replaces SCH ED *Eating Disorders* guideline [16.e.07] and SCH *Refeeding Syndrome: Prevention and Management – SCH* [13:7036].

READ ACKNOWLEDGEMENT

- Medical and Nursing staff working in CHW or SCH Emergency Departments should read and acknowledge they understand the contents of this document.

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

Approved by:	SCHN Policy Procedure and Guideline Committee	
Date Effective:	1st January 2016	**Review Period**: 3 years
Team Leader:	Clinical Nurse Consultant	**Area/Dept**: Eating Disorders Unit, CHW

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Introduction

Children and adolescents with an eating disorder are at great risk of medical and psychiatric complications, in particular those presenting with Anorexia Nervosa. It is therefore essential to have efficient and timely medical and psychiatric assessment and treatment commenced.

The cause of medical complications can be due to both the amount of weight loss, the rapidity of the weight loss and the compensatory behaviours that may be being used. Children and adolescents with an eating disorder have high levels of psychiatric comorbidity. Acute psychiatric presentations include major depression, deliberate self-harm, suicidal ideation, anxiety disorders and obsessive compulsive disorder.

Triage

- All children and young people presenting to the Emergency Department will be triaged using the Australian Triage Scale (ATS). Triage category will reflect urgency of care.
- Baseline medical observations (pulse, BP and temperature)
- Where the Admitting Officer is contacted ahead of presentation
    - Medically unstable patients will be directed to their local paediatric hospital including SCH.
    - Medically stable patients will be referred to the Eating Disorder CNC at the CHW (Ph: 9845 2446 in hours).
    - A one page form can be sent to the referring medical practitioner to assess medical stability (See Appendix A).

Monitoring

- Medical instability for the purpose of this document is defined as:
    - Heart Rate < 50 beats/min
    - Temperature < 35.5°C
    - Blood Pressure < 80/40 mm/Hg or postural drop >30 mm/Hg
- All unstable patients should be placed in a monitored bed to allow for continuous monitoring of their heart rate and blood pressure.

If a person presents dehydrated (SG ≥ 1020) then this needs to be taken into consideration with their observations i.e. a person's heart rate will be higher when dehydrated.

Medical Assessment

After the initial medical assessment the treating ED doctor will:

- **In Hours**
  - **CHW:** Advise the eating disorder registrar or eating disorder CNC of the patients arrival and condition who in turn will notify the necessary medical and psychiatric consultants
  - **SCH:** Advise the paediatric registrar on the mental health team of the patient's arrival. The registrar will liaise with the allocated paediatrician for General Medicine.
- **Out of Hours**
  - **CHW: I**f the patient is medically unstable contact the Adolescent Medicine consultant on call **OR** if medically stable contact the mental health CNC or psychiatry registrar on call for a mental health assessment and discuss with the Psychiatrist on call. If the patient is discharged contact the eating disorder team in hours to discuss follow-up.
  - **SCH:** Contact the General Paediatric consultant on call.

Investigations

- ECG
- Bloods for patients who present medically unstable or when assessment indicates: EUC, FBC, LFT, TSH, T3, T4, LH, FSH, oestradiol, amylase, ferritin, CK, CMP and BSL (*eating disorder order set on power chart at CHW*).
- Measurement of vital signs (pulse, postural BP and temperature)
- Urinalysis
- Height and weight

Consent

- In children under the age of 14 years treatment including naso-gastric refeeding can occur with parental consent
- In children between the ages of 14 and 16 years treatment ideally requires adolescent and parental consent.
- In children aged 16 years and older treatment requires the consent of the adolescent.
- In children aged over 14 years who are medically unstable and consent is refused, alternate consent should be sought with consideration given to the use of the mental health act.
- Consent to be documented in patients notes

Medical Treatment

- It is essential to commence treatment as soon as possible once it is determined that a patient is medically unstable.
- It is recommended that a long-term silastic naso-gastric tube (size 8) is inserted and feeding commenced as below (to be documented in patients notes):
  - If phosphate < 1.0 mmol/L, feeds to be 0.5 kcal/mL at 100mL/hour
  - If dehydrated (urine SG ≥1020), feeds to be 0.5 kcal/mL at 100mL/hour
  - If BMI < 14 the feeds to be 0.5 kcal/mL at 100mL/hour
  - Otherwise commence feeds at 1 kcal/mL at 100mL/hr
  - Appropriate feeds include Ensure 1kcal/mL **(not Ensure Plus)** or Jevity
- Prior to the commencement of feeds 500mg Sandoz Phosphate to be given either orally or via NGT
- Continue Sandoz Phosphate at 500mg BD
- Continuous cardiac monitoring
- Bed rest
- No regular meals at this time
- Commence overhead heating if:
  - HR <50 beats/min
  - Temperature ≤ 35.5°C
- Alter calling criteria (in consultation with a consultant)
  - Yellow zone = HR < 40 beats/min
  - Red zone = HR <35 beats/min

For patients that present to emergency directly from either the outpatient clinic or the day program, it is the responsibility of the treating team to complete the necessary assessments and document a clear treatment plan including the feeding regime.

Mental Health Assessment

Mental health assessment should occur in all medically stable patients prior to discharge or transfer from the emergency department. Psychiatric assessment should occur in medically unstable patients once acute medical treatment, including naso-gastric refeeding, has commenced. Mental health assessment should involve either a Mental Health CNC or Psychiatry Registrar in consultation with the Psychiatrist on call.

- History of presenting illness including
  - Onset and duration of illness
  - Maximum and minimum weights
  - Duration and speed of weight loss
  - Methods of weight-loss (dietary restriction, exercise, purging)
  - Fear of weight gain
  - Abnormal body image
  - Denial of illness severity
  - Previous eating disorder admissions
- Presence of comorbid psychiatric illnesses
  - Mood Disorders (Major Depressive Disorder, Bipolar Disorder)
  - Anxiety Disorders (Generalised Anxiety Disorder, Social Anxiety Disorder, PTSD, Panic Disorder, Separation Anxiety Disorder)
  - Obsessive Compulsive Disorder
  - Psychotic Disorders
  - Drug and Alcohol use
- Safety assessment
  - Suicidal ideation
  - Deliberate self-harm
  - Past suicidal behaviour and deliberate self-harm
  - Risk to others
  - Sexual history
- Family and Social History
  - Family composition
  - Family stressors
  - Family history of eating disorders or psychiatric disorders
- Past Medical and Psychiatric History
- Current Medications

Psychiatric Treatment

Treatment should be decided following assessment in conjunction with the psychiatrist on call.

- In hours, call the Eating Disorder Team (**CHW)** or Mental Health CNC or Psychiatry Registrar **(SCH)**
- Out of hours call the psychiatry registrar on call
- In the case of significant patient distress consideration should be given to the use of regular or PRN antipsychotic medication (Olanzapine 2.5 – 5.0mg, Quetiapine 25 – 100mg, Risperidone 0.5 – 2.0mg)

Appendix A

MEDICAL ASSESSMENT FORM FOR EATING DISORDER PATIENTS

NAME: ……

DATE: ……

	Findings	Increased Vigilance	Criteria for Admission
Pulse		50-60 beats/min	<50 beats/min
Temperature		35.5-36.0°C	<35.5°C
Blood Pressure		Dizziness present	80/40 or greater than a 20mm/hg drop
Hydration		Clinical evidence of dehydration (cap refill/ urinalysis etc)	
Urinalysis		Persistent low Specific gravity (persisting low 1000-1005 suggesting possible water loading/falsification of weights) Ph>8 Ketonuria	
Oedema		Any peripheral oedema	
Stigmata of purging Hand Palate Salivary Glands		Bloods: elevated Amylase, mild hypokalaemia, increased Bicarb	
Stigmata of exercising		Eg erythema over spinous processes from sit ups. New onset or increased in frequency or intensity	
Stigmata of self-harm			Unable to guarantee safety
Electrolytes - abnormal			Potassium < 3.5 mmol/L
ECG Qtc			>450m s