Appendix 10. Re-feeding in anorexia nervosa: information for ward staff†

What is anorexia nervosa

Anorexia nervosa is a mental disorder where patients try to restrict their food intake to lose weight. It has the highest mortality of all mental disorders, generally due to the risks related to physical health. Patients usually believe that they are fat, despite efforts by others to convince them otherwise. They are terrified of gaining weight, not only fearing becoming fat but also fearing loss of control. This fear can lead to behaviours to avoid food such as vomiting after eating, consuming large amounts of laxatives, hiding food, lying about what has been eaten or excessive exercising. When encouraged to gain weight, patients will usually feel terrified and become distressed. Although psychological problems underlying anorexia nervosa generally require the patient to achieve some level of health before psychological therapy can address these problems directly, psychological work needs to take place at all phases of recovery, even at very low BMI. The nature of the work needs to be adapted to the patient's physical presentation.

When is acute hospital admission needed for anorexia nervosa

Although the main treatment for anorexia nervosa should be undertaken by eating disorders services and generally based in the community, patients with severe anorexia nervosa require admission to an acute hospital when their life is at risk due to metabolic instability from malnutrition, rapid weight loss or frequent vomiting or laxative abuse.

Re-feeding in an acute hospital: risks

Physical risks

- Re-feeding syndrome (rapid drop of phosphate, potassium or magnesium)
- Arrhythmias from abnormal or rapid correction of chronically abnormal electrolytes
- Death soon after discharge (if discharge occurs solely on the basis of electrolytes being corrected without consideration of the overall physical risk profile)
- Constipation
- Increased side-effects of medication.

Mental health risks

- Distress (e.g. tearfulness, withdrawal, anger) is almost inevitable for the patient
- Self-harm or suicide if the patient is unable to manage the distress associated with increased calorie intake (this may even be calories that seem negligible to staff, such as the sugar in 5% dextrose solution)
- Sabotaging food intake due to terror of weight gain (e.g. disconnecting nasogastric feed, tipping nasogastric feed or dietary supplements down the sink, hiding food)

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- Exercising to burn calories (e.g. wriggling legs in bed, walking up and down corridors)
- Misleading weight measurement due to terror of weight gain (e.g. drinking large amounts of water or putting weights in pockets before being weighed)

Problems that may occur for staff

- Staff feeling helpless or cross at apparently irrational behaviour
- Patients telling different staff different things which can cause staff to feel frustrated with each other, with some feeling they are unfairly being labelled as 'bad'
- Staff feeling emotionally drained at displays of significant distress related to treatment
- Mixed messages/different decisions being made by different staff who have not communicated (usually in response to persuasion from the patient)

Guidelines for ward staff managing re-feeding in patients with anorexia nervosa

Communication with the patient

- Be aware that the patient may be very frightened of dying, but equally frightened of gaining weight. They require non-judgemental, supportive but firm management.
- Although there can be few, or no, negotiations about nutrition due to the medical risks, you should try to help the patient feel in control over other aspects of their care if this is safe and possible, for example choosing the time they want to have a wash.
- To reduce the patient's fear and suspicion, try to keep some consistency of a sympathetic member of staff to be her allocated nurse each day. This nurse should be experienced, and not a nursing student, so they have gained skills in remaining supportive but firm.
- Remind the patient that you know they are scared, but that their fears are the anorexia talking and you need to help them overcome this. You recognise that re-feeding is not the only solution to anorexia nervosa but that they need to be physically healthy enough to be able to leave hospital to continue psychological therapy. Also remind them that staff will not let them get overweight, and that the aim of acute hospital treatment is just to become medically safe.
- Only the consultant physician or consultant liaison psychiatrist should talk to the patient about detailed aims of the admission, supervision or plans for discharge. If asked by the patient, other staff should say that these decisions are the responsibility of the consultants but that the admission in general is to be as brief as possible to ensure that the patient is physically safe to leave an acute hospital and return to the support of eating disorders or general mental health services.

Communication with the relatives

Relatives may also be very anxious and so may appear very demanding or critical. If the patient agrees, it is often helpful to arrange a meeting with them regularly to explain the treatment and hear concerns. It may be useful to have one relative who acts as a contact with the ward and informs the rest.

Monitoring nutrition

- Weigh the patient on the same scales on the ward on admission and twice a week during treatment ensuring that the patient does not have weights concealed in their pockets or on their person.
- Try to weigh the patient at the end of the night shift, after they have been to the toilet but before eating/drinking in the morning – always document the time of weighing as well as the weight.
- Try to start the patient on prescribed dietary supplements (unless they say they would prefer nasogastric feeding) but if the patient is unable to achieve sufficient intake after 24 h then use nasogastric feeding. If the patient remains in hospital after stabilisation on dietary supplements or nasogastric feeding they may introduce solid food. The dietician can

advise on calorie-checked matches to the hospital menu.

- The food chart and any fluid chart must be completed by the allocated nurse who has witnessed the intake.
- Be aware that early weight gain is likely to be re-hydration or oedema.
- If weight gain does not occur as expected from prescribed calories then consider whether the patient is hiding food, tipping feed down a sink or into a container, taking laxatives or exercising on or off the ward including in bed.
- If weight is going up but other measures such as appearance and muscle power are not improving, consider that the patient may be falsifying weight (e.g. drinking lots of water before being weighed).
- In general it is not helpful for patients to know their weight more than once a week since they will get unduly distressed by minor fluctuations.
- The only staff to discuss the current or planned weight with the patient should be the dietician and consultant physician. This avoids other staff getting drawn into promises they cannot keep or increasing the patient's anxiety. Other staff should remind the patient which staff are able to discuss their weight concerns, and that their worry about weight is one of the unhelpful anorexic thoughts that you are trying to help them overcome. Then try to distract the patient by switching to another topic such as their previous hobbies or other interests.
- Patients should be strongly encouraged to avoid going to the toilet or into the bathroom for at least 30 min, and ideally for 1 h, after eating (to avoid the risk of vomiting). Patients who are detained under mental health legislation should generally be observed in the bathroom if they insist on going during this time period.

Management decisions and staff communication

- Be observant to indications that the patient, her relatives or friends have brought in things that counteract the treatment, for example laxatives.
- Management decisions about changes to feed, medication or hydration, unless an emergency, should only be made in consultation with the consultant physician.
- Any changes to feed or hydration should be explained to the patient so they know what to expect. Medication changes should be discussed, but unless essential the patient's wishes in this regard should be respected.
- Ideally, a ward nurse would join the daily ward round but if this is not possible the medical team need to liaise with the ward nurses before and after ward round decisions.
- The patient should be kept in an observable bed and if there are concerns about self-harm or sabotaging the re-feeding then a one-to-one mental health trained nurse should be provided to both support the patient's anxiety and maintain safety.

Patients detained under mental health legislation

- If a patient wants to self-discharge they should be given time to discuss their fears and attempts should be made to get them to stay and talk to the liaison psychiatry team and their consultant physician.
- If a patient with life-threatening complications of anorexia nervosa or strong suicidal wishes wants to self-discharge an urgent referral to the mental health service should be made. If the patient wants to leave before this assessment, then they should be detained under Section 5(2) of the Mental Health Act 1983 (or equivalent legislation) to enable a full assessment of their mental disorder and related risks.
- If the patient continues to refuse re-feeding then ask the liaison psychiatry service whether they should be detained under the Mental Health Act for treatment.
- If a patient is placed on Section 5(2) then inform the local approved mental health practitioners who will organise the Mental Health Act assessment.
- The use of the mental health legislation for treatment of anorexia nervosa enables the provision of food, hydration, medication, close observation and nursing or medical care