1.1 Appendix 1 – Printable Risk Stratification Table

PIER
Paediatric Innovation, Education and Research Network

Paediatric Eating Disorders Risk Assessment Tool

Clinical name and role:

……

……

Date and time: ……..

Patient's Details **(Affix sticker)**
Name:
Date of Birth:
Hospital Number:

MEDICAL ASSESSMENT:

Following clerking and examination, all patients attending the Children's Emergency Department with restricted eating should be discussed with the senior clinician on duty (SSU/CED/General Paeds on call out of hours) to make an informed decision as to the medical management of the young person, using this risk assessment tool to help you.
Before completing this tool, you will need to have performed:

- ☐ Full history and Examination
- ☐ ECG
- ☐ WEIGHT and HEIGHT on EVERY ADMISSION
- ☐ Full set of observations including lying and standing pulse and BP
- ☐ Bloods: FBC, U&Es, LFTs, CK, TTG, TFT, Bone Profile (Calcium), Magnesium, Inorganic Phosphate (note this is may NOT be part of the bone profile at local Hospital and must be requested separately).
- ☐ Muscle function testing – see flowchart or below for explanation.

MEED RISK ASSESSMENT:

Parameter	**High Risk** Impending risk to life **ADMISSION HIGHLY LIKELY TO BE NEEDED**	**Medium Risk** Alert to high concern for impending risk to life **CONSIDER ADMISSION**	**Low Risk** Low impending risk to life **AIM TO DISCHARGE AFTER MEAL IN ED**	**Assessment Outcome** **(To be completed by a medical professional)**
	Weight/ BMI			
Weight loss	Recent weight loss ≥1kg/week for 2 weeks (consecutive) in any patient	Recent weight loss of 500-999g/week for 2 consecutive weeks in an undernourished patient.	Recent weight loss of <500g/week or fluctuating weight.	
% BMI	<70%	70-80%	>80%	

Calculating %BMI: Use MARSIPAN app or, using BMI charts, divide the patient's BMI by the 50th percentile BMI.

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Observations				
Please be aware of signs of infection as this will increase metabolic demand and increase risk.				
HR (awake)	<40	40-50	>50	
Blood pressure	Standing systolic BP <90mmHg associated with recurrent syncope AND postural drop in systolic BP of >15mmHg or increase in HR of over 35bpm		Normal standing systolic BP for age and gender with reference to centile charts. Postural drop in systolic BP of <15mmHg or increase in HR of < 35bpm	
ECG abnormalities	QTc >460ms (females) >450ms (males) OR any other significant ECG abnormalities. Taking medication known to prolong QTc interval (e.g. olanzapine/ SSRI)		QTc <460ms (females) <450ms (males)	
Temperature	<35.5°C tympanic or <35°C axillary OR >38°C	<36°C or > 37.5 °C	>36°C but < 37°C	
Hydration – Dehydration requires urgent rehydration				
Assessment of hydration status	Fluid refusal/severe fluid restriction Severe dehydration (10%) Reduced urine output, dry mouth, postural BP drop, decreased skin turgor, sunken eyes, tachypnoea, tachycardia		Minimal fluid restriction No more than mild dehydration (<5%), may have dry mouth or concerns about risk of dehydration with negative fluid balance. NB. Some YP with eating disorders consume excess fluid to inflate weight	
Clinical signs and symptoms				
Muscular function SUSS Test	Unable to sit up from lying flat, or to get up from squat at all or only by using upper limbs to help	Unable to sit up or stand from squat without noticeable difficulty	Able to sit up from lying flat and stand with no difficulty	

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Blood Results				
Please be aware that normal range bloods are expected even in severe malnutrition and are not reassuring, abnormal bloods are of significant concern.				
White Cell Count	<2.0 x 10^9/L OR > 11.0 x 10^9/L	<4.0 x 10^9/L		
Neutrophils	<1.0 x 10^9/L	<1.5 x10^9/L		
Haemoglobin	<100 g/L	<110 g/L		
Platelets	<130 x 10^9/L	<110 x 10^9/L		
Potassium	<2.5 mmol/L	<3.5 mmol/L		
Phosphate	<0.5 mmol/L	0.5-0.9 mmol/L		
Sodium	<130 mmol/L	<135 mmol/L		
Magnesium	<0.5 mmol/L	0.5-0.7 mmol/L		
Urea	>10 mmol/L	>6.5 mmol/L		
Creatinine	**AKI 1:** >1.5x previous known creatinine OR >1.5x age specific upper limit of reference (ULR)	<1.5x previous known creatinine OR age specific ULR	Age related Upper Limit Reference Creatinine: 12y: 67umol/L (67) 13y: 74umol/L (76) 14y: 75umol/L (83) 15y: 79umol/L (98) 16y: 81umol/L (99) Female (Male)	
Albumin	Hypoalbuminemia			
CK	>200			
Glucose	<3.0 mmol/L			
Please note unless the patient is experiencing a seizure or coma it can be dangerous and inappropriate to treat low BM with dextrose alone, in the context of malnutrition, as it can increase risk of precipitating refeeding syndrome. Only treat low blood sugar if symptomatic, and if emergency treatment needed please treat with FOOD or FEED. Watch for refeeding syndrome and urgently treat electrolyte abnormalities.				
Transaminases	X3 normal range			
Eating Disorder Behaviours				
Disordered Eating Behaviours	Acute food refusal or estimated calorie intake <400kcal/day			
Engagement with Management plan	Physical struggles with parents/carers with nutrition or reduction of exercise. Poor insight or motivation Staff or parents/carers unable to implement meal plan prescribed.		Some insight and motivation to tackle eating problems. May be ambivalent but not actively resisting.	

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Eating Disorder Behaviours				
Activity and exercise	High levels of dysfunctional exercise in the context of malnutrition (>2h/d)		Mild level of or no dysfunctional exercise in the context of malnutrition (<1h/d)	
Purging behaviours	Multiple daily episodes of vomiting and/or laxative abuse	Regular (≥3x per week) vomiting and/or laxative abuse		
Self-harm and suicide	Self harm Self-poisoning, suicidal ideas with moderate to high risk of completed suicide. If in doubt refer for Inreach CAMHS risk assessment.	Cutting or similar behaviours, suicidal ideas with low risk of completed suicide.		

Please remember that 20% of the mortality from severe anorexia is from suicide and this diagnosis (Anorexia Nervosa) carries the highest mortality of any psychiatric diagnosis