The ALPINE Folder

Resources for Clinical Staff looking after Young people (under 18) with a confirmed or suspected Eating Disorder

The ALPINE project is a collaborative effort between the Sussex Partnership FT Hampshire CAMHS Specialist Eating Disorder (ED) Team and the HHFT paediatric team.

This folder should provide all the necessary information and links for clinical staff to assess and initiate treatment for young people requiring a paediatric review and possible admission to hospital.

This version has been adapted for use by Salisbury District Hospital

Contents

Other key documents and resources

1) Online resources are linked to on this Sway – you can access it using the QR code or URL https://sway.office.com/NlBLYeNxZEXb8HSJ

    a. It links to the National guidelines (**MARSIPAN**)
    b. It also links to regional guidance used by the **Maudsley** and **GOSH**
    c. It links to local CAMHS services, as well as national charities and other resources

2) The Young Person's Folder - information we give to young people on admission.
3) Eating disorder admission spreadsheet (includes growth charts/ risk assessment/ ward round documentation)
4) Bedside folder useful information. Includes:
    a. Admission overview for medical staff
    b. Care plan
    c. Specific physical assessment parameters and actions to take
    d. Online training for staff providing meal support
    e. Guidelines for behavioural management of mealtimes
    f. Guidelines for physical activity
    g. Calculating weight for height
5) Food chart
6) Meal plans

Approach to initial discussions and assessment

It is critical that the team assessing the Young Person can organise themselves to inspire confidence during the inevitable challenges of the admission process. This relies on:

- Expertise – ensuring that the right team members are involved at the right time using the same guidelines and language
- Clear, consistent communication – every handover, conversation and contact is an opportunity to build on this or destroy it.
- Co-ordinated teamwork – It is essential that named professionals are involved in the process regularly to ensure that all team members are aware of where they fit it, and what else is happening
- Flexibility where appropriate, but only within the context of clear structured agreed plans and timelines
- Regular, structured reassessment and planning

Most young people admitted to hospital with an eating disorder will come in because of one or more MARSIPAN red criteria (below, and available as a single sheet in the folder). It is helpful to think of their admission in 3 phases:

Stage One: **Refeeding**

- **Aim:** To re-introduce feeding and build up to a meal plan which would allow for 0.5-1 kg weight gain/week. All meals and snacks supervised by staff. Total bedrest is prescribed with physical monitoring and daily blood tests. Regular ECGs day 1,5,10.

Stage Two: Consolidation

- **Aim:** To consolidate the meal plan and structured routines. Bed rest should continue until cardiovascular parameters stable, and weight gain occurred. After this the young person can gently mobilise for purposeful activity on the ward only. Parents are encouraged to supervise some meals or snacks towards the end of this time period.

Stage Three: Planning for home/discharge

- **Aim:** To support the parents in supervising meals and discuss home management and support. Some meals may be encouraged to happen off the ward, or at home towards the end of this time period. Dietitian will meet with young person and family before discharge to provide home meal plan. Young person can mobilise off the ward (this will be specified for individual patient). Day of discharge will be set by agreement between paediatrician and EDS (Dorset) team. Follow-up will be in the community and will be organised by the EDS (Dorset) team.

Admission,, Risk Assessment and Feedplans

If the young person is to be admitted, the following needs to be done

1) Complete normal medical admission proforma. Using the risk assessment tool which is generated by the spreadsheet, complete a risk assessment of the young person. including any special observations (e.g. lying and standing BP) and investigations (e.g. ECG) that are necessary to ascertain level of risk. Document a clear plan. Print off the ward round proformas and the useful information for bedside folder.
2) Make and agree a feed plan. Start with a meal plan that matches closely to what they have been having .. In some cases, if there is little eaten, it will be better to continue on a lower meal plan until this is established. The expected total fluid intake for the day should be added to the meal plan.
    a. The expectation should be that the young person eats and drinks normally and supplements should be avoided except in exceptional circumstances
    b. A decision needs to be made regarding enforcement and supervision, and possible escalation to NGT. A decision to ng feed needs to be jointly made between Paeds, CAMHS and a dietician
    c. It is expected that meal supervision will be provided by ward staff in the stabilisation stage of the admission. Completion of meals should be documented on the food chart. All fluid intake should also be documented on the meal plan.
    d. A copy of the meal plan goes in the combined medical/ nursing notes.
    e. Although there is no good evidence base to this, we would generally prescribe
        i. Thiamine 100mg tds and Strong B complex, 1 tds for 10-14 days
        ii. A multivitamin such as Berocca once daily to continue
        iii. Consider Vitamin D/ Phosphate/ Mg/K according to blood results
3) Add a copy of the meal plan and the care plan to the young persons folder.

Risk assessment

All young people admitted to the ward need risk assessment, and this needs documenting in the proforma. This is not an exact science, and the assessment will evolve with time. However risks to be considered are as follows:

- <u>Marsipan ED risk assessment (printed off from ED spreadsheet)</u>
    - This give a basic guide to risks both of their situation acutely, as well as the risk of refeeding problems.

- <u>Other Risks to the young person (document on admission proforma)</u>
    - Mental Health – Risks to young person relating to mood, risk of self-harm, previous self harm/suicide, and other known/suspected mental health/ behavioural difficulties
    - Supervision and potential issues relating to imposed treatments/monitoring/ restriction
    - Medical Co-morbidities including risks of skin/thrombotic complications
    - Challenges relating to admission including family support available
    - Drug/ alcohol/ smoking issues
    - Safeguarding risks, including risks of exploitation
    - Sexual Health risks

- <u>Potential Risks to staff/ Other patients/visitors</u>

Guidelines for the Inpatient Management of Young People with Anorexia nervosa and other Restricted Eating Disorders

Contents

1. Introduction

Children and young people with anorexia nervosa, bulimia nervosa or disordered eating that significantly restricts their intake of food/fluid are admitted to the Paediatric Unit when they are seriously ***medically*** unwell. They are admitted to be stabilised until they are safe for discharge for continuing care either in the community or to a Psychiatric Inpatient Unit (Tier 4). Significant psychological intervention at this stage is not desirable or effective. The aims for admission are:

1. Physical and nutritional assessment
2. Attain physiological stability by managing the complications of malnutrition
3. Commence appropriate refeeding whilst managing the complications
4. Initiate nutritional recovery

There is no set length of time for patients with eating disorders to stay on the ward as this will vary greatly from case to case.

This guidance is based on Junior MARSIPAN: Management of Really Sick Patients under 18 with Anorexia Nervosa (January 2012, Royal College of Psychiatrists, London)

2. Re-feeding syndrome

There are no evidence based guidelines for the reintroduction of nutrition in children or adults with an eating disorder. There is no evidence to show that higher caloric rates of initiating feed leads to an increase in refeeding syndrome. Current suggested guidelines range from starting at 10-60 kcal/kg. There is in fact evidence to show that lower starting caloric intakes lead to under-feeding syndrome, where the young person can lose weight and become further physically compromised. Junior MARSIPAN recommends that the starting nutritional intake should not be less than the level eaten prior to admission. As long as there is close physical monitoring, a safe increase from baseline is in the region of 200kcal/day for the initial risk period (first 5 days). If phosphate drops, then intake should remain static, not reduce, until it stabilises. Typically blood tests are done daily during the first 5 days. The aim is to reach full nutritional requirements for steady weight restoration to begin after the initial risk period of 5 days. After the first week the meal plans should be altered to ensure a continued weight gain of 0.5-1kg per week (usually a caloric intake of 2200-2500 kcal/day.)
There is evidence that early weight restoration in eating disorders leads to overall better outcomes. Those at highest risk of re-feeding syndrome are individuals with very low weight for height, minimal (<600kcal/d) or no nutritional intake for 3-4 days, weight loss of over 15% in the past 3 months, and those with abnormal electrolytes before feeding.

3. Calculating percentage BMI

The degree of underweight is an important factor in predicting risk from malnutrition. Most papers advise using a percentage weight for height. In the UK the WHO calculation is recommended which uses the median BMI for age and gender (50th centile).

$$\text{Percentage BMI} = \frac{\text{Actual BMI} \times 100}{\text{Median BMI for age and gender}}$$

$$\text{BMI} = \frac{\text{Weight (kg)}}{\text{Height (m)}^2}$$

BMI charts are available on the wards and the median BMI is 50th centile for age and gender on these charts. The CAMHS/EDT teams may use the term 'weight-for-height' which is a percentage that is equivalent to the 'percentage BMI'.

4. Admission criteria (consider in context of the wider picture)

Admission to an acute medical bed should be considered for young people who fulfil **ANY** of the following criteria. These are the 'red' high risk factors in the Junior MARSIPAN guidelines. There may be other factors indicating need for admission that are 'amber' or not on this list.

1. Weight-for-height/Percentage BMI <70% (approx. <0.4th BMI centile)
2. Recent loss of weight of 1kg or more/week for 2 consecutive weeks and/ or >15% in 3 months
3. Cardiovascular compromise:
   - 3.1. Heart rate <40bpm (awake) or >100bpm
   - 3.2. History of syncope
   - 3.3. Marked orthostatic changes (fall in systolic blood pressure of 20mmHg or more, or blood pressure below the 0.4th – 2nd centile for age, or increase in heart rate > 30bpm)
   - 3.4. Irregular heart rate (not including sinus arrhythmia)
4. ECG abnormality:
   - 4.1. Girls QTc>460ms / Boys QTc>400ms, with evidence of bradyarrythmia or tachyarrythmia (excludes sinus bradycardia and sinus arrythmia)
   - 4.2. ECG evidence of biochemical abnormality
5. Significant dehydration, fluid refusal
6. Hypothermia (<35.5^{o}C)
7. Biochemical abnormality: See Sections 6 and 7
   - 7.1. Hypoglycaemia
   - 7.2. Hypophosphataemia
   - 7.3. Hypokalaemia
   - 7.4. Hypomagnesaemia
   - 7.5. Hyponatraemia
   - 7.6. Hypocalcaemia
8. Food refusal:
   - 8.1 Acute food refusal
   - 8.2 Estimated calorie intake ≤600kcal per day
9. Aggression to parents in relation to feeding or attempts to limit behaviours
10. High levels of exercise (>2h/day) in context of malnutrition
11. Self-poisoning and suicidal ideation
12. Medical complications of starvation:
    a. Confusion and delirium
    b. Acute pancreatitis
    c. Gastric or oesophageal rupture
    d. Seizures
13. Significant medical co-morbidity
14. Failure of outpatient treatment

5. Initial assessment

On admission the following features should be assessed and documented using the proforma

1. History:
   - Eating/dieting behaviour:
     - Amount of weight loss (maximum and minimum weight with dates)
     - Rate of weight loss
     - Dietary intake
     - Fluid intake
     - Caffeine intake
     - Purging, vomiting, laxatives, diuretics
     - Exercise
     - Family compensation
   - Co-morbid conditions
   - Medical complications – assess for dyspepsia, acute pancreatitis, central abdominal pain (can be a feature of superior mesenteric artery syndrome)
   - Suicidal ideation

2. Examination:
   - Height and weight – calculate percentage BMI (weight-for-height) and document, plot weight, height and BMI on a centile chart (available on wards)
   - Heart rate – bradycardia, postural tachycardia
   - Lying and standing blood pressure – hypotension (refer to standardised chart), postural drop
   - Temperature - hypothermia – beware of <35^{o}C
   - Hydration – normal or raised heart rate can be sign of dehydration, assess clinically, (take creatinine and urea with caution as there may be a low creatinine from poor muscle mass and a raised urea from catabolism)
   - Features of malnutrition – lanugo hair, dry skin, pressure sores
   - Evidence of purging – enamel erosion, swollen parotid gland, calluses on fingers
   - Peripheral oedema – linked to severity of acute malnutrition

3. Investigations:
   - ECG – rule out other causes of bradycardia, arrhythmia, QTc (using Bazetts formula QTc= QT/√RR)
   - Blood sugar – hypoglycaemia is common
   - Full blood count - do not forget the possibility of other diagnosis (eg leukaemia, lymphoma, infection)
   - Urea and electrolytes, creatinine, calcium, phosphate, magnesium, liver function tests – particularly looking for hypokalaemia, hyponatraemia, hypocalcaemia, hypomagnesaemia and hypophosphataemia.
   - Hormones - thyroid function tests, LH, FSH, oestrogen, testosterone if male. Hypothalamic down-regulation is almost universal
   - Vitamin D
   - Venous blood gas – a metabolic acidosis would be expected with purging
   - Urinalysis – pH, specific gravity (may be low if water loaded) and ketones

6. Initial medical management

Refeeding syndrome is complex and life-threatening. Simply put, it occurs when the starving body gets a carbohydrate load that stimulates insulin production. This can very quickly drain the body's supplies of electrolyte and co-factors, requiring senior consideration and intervention

1. Before increasing food intake await the initial blood results :
   - If very low plasma electrolyte concentrations (i.e. phosphate <0.4mmol/l, potassium <2.5mmol/l, magnesium <0.5mmol/l) the increase in food intake may result in further drops. They should, therefore, be corrected before increasing food intake
   - If electrolytes are low (generally, phosphate <1mmol/l, potassium <4mmol/l, magnesium <0.7mmol/l or adjusted calcium <2.0mmol/l) supplementation should be considered at the same time as feeding

2. Medication:
   - Oral thiamine (50mg tds) with vitamin B co strong (one tablet tds) and Sanatogen A-Z multivitamins (one tablet od). Seek advice from pharmacy/ dietitians for patients under 12 years of age.

7. Management of complications

1. Hypoglycaemia:
   - Hypoglycaemia may be present on presentation or postprandial. If the patient is asymptomatic give the next feed early. If IV glucose is needed at admission, give thiamine first.
2. Dehydration:
   - For severe shock and dehydration Critical Care review should be considered. IV fluids should be given to treat shock. However, boluses should be given with caution due to the risk of precipitating heart failure.
   - If the patient is not shocked oral or NG rehydration is more appropriate
3. Electrolytes:
   - Consequences of electrolyte abnormalities:
     - Hypophosphataemia– Altered myocardial function, arrhythmias, congestive heart failure, acute ventricular failure, liver dysfunction, lethargy, weakness, seizures, confusion, coma, paralysis, rhabdomyolyisis, haematological disturbances
     - Hypokalaemia – Arrhythmias, cardiac arrest, respiratory depression, decreased ability to concentrate urine, constipation, ileus, weakness, rhabdomyolysis
     - Hypomagnesaemia – Arrhythmias, tachycardia, respiratory depression, abdominal pain, constipation, ataxia, confusion, muscle tremors, weakness, tetany
   - What to do if abnormal:
     - T**he majority of electrolyte problems, will occur in the first 4 days, when daily monitoring is mandatory. Review the patient clinically, get an ECG and make a plan.** If electrolytes are abnormal or showing a downward trend feeding should generally not be stopped. The abnormality should be treated and the level of feeding continued at the current level until the electrolytes are normalised.
     - The SORT guidelines are at the end of these guidelines, and give advice on IV replacement for low Calcium, Phosphate, Potassium and Magnesium. There is advice on oral replacement for all except Phosphate. For a phosphate below 1, start oral Phosphate as per the BNFC, and if it is below 0.65 consider IV replacement over 12 hours and repeating the tests. The PIER network oncology guidelines have excellent flow sheets for an approach to electrolyte replacement.

4. Sepsis – Malnutrition increases the risk of sepsis and may not manifest symptoms. Clinicians need to be aware of this when reviewing unwell patients with Eating Disorders.

8. Monitoring

1. Vital signs:
   - Heart rate, blood pressure, respiratory rate and level of consciousness should be monitored every 6 hours for the first 72 hours then twice daily
   - Lying and standing blood pressure daily
   - Daily temperature
   - Bedside blood glucose twice daily

2. Blood tests:
   - Daily electrolytes for the first 72 hours as a minimum, unless unstable then there may need to be more frequent, then 7 days later (due to the risk of late re-feeding syndrome)
   - Weekly full blood counts – neutropenia is common and takes several weeks to improve
   - Weekly blood gas especially if concerns about purging
   - Prior to discharge TFTs and hormones should be checked again

3. Weighing:
   - The young person should be weighed twice a week at the same time, on the same scales, in their underwear, before breakfast and after going to the toilet. There is no benefit to measuring more than twice a week. Weight trends are more important than individual measurements.
   - Warn the patient and family that weight may drop in the first couple of days and this is to be expected as the body adjusts to different food and fluid intake, and initial weight gain may be slow if small portions are needed to avoid refeeding syndrome.

9. Psychosocial management

1. A core team for the young person during this admission is created. This consists of the Consultant Paediatrician, Consultant Psychiatrist (or their delegated clinician) and the Dietician.
2. Contact the Dietician for a joint assessment of the risk of re-feeding syndrome and agree the frequency of investigations and portion sizes of meals bearing in mind what the young person was eating prior to admission.
3. Place on complete bed rest, including using a commode. Bed rest can be very distressing for a young person with anorexia so it should be accompanied by appropriate distracting activity which may include some school work.
4. If required provide 1:1, 24 hour specialing by as few different nurses as possible to prevent splitting (playing one off against another). See guidelines for Admit patient to a bay or a single room – the latter might be preferable early in the admission for dignity and confidentiality during bedside discussions but towards discharge moving to a bay will make observation simpler. Parents and families are viewed as partners in enabling a young person's recovery. Parents will usually be allowed to stay overnight but at times this may not be in the best interests of the young person. Taking into consideration the potential length of stay with anorexia, balancing the needs of siblings and that of the parent(s) to regroup and recharge, going home may be preferable. This should be discussed with the parents by the core team.
5. Discussions about changes to the treatment plan should include the young person and their family. Decisions regarding the care plan can be made by a member of the core team usually after consultation. Medical responsibility remains with the paediatrician.

10. Meals

1. Meal plan:
    - It is important to consult parents when drawing up a meal plan so that the family's usual diet can be accommodated if possible
    - Patients are allowed 3 food dislikes but not from the same food group, these should be foods they did not eat before developing an eating disorder
    - 3 meals per day which include at least one hot pudding and 3 snacks per day
    - All food and fluid intake must be recorded by nursing staff
    - A copy of the meal plan should be held by staff and the young person
    - Any action to be taken if the meal is not completed (eg volume bolus via NG tube) should be agreed and documented in advance

The young person is allowed to follow the hospital's vegetarian diet. They may be admitted following a vegan diet supported by the Eating Disorder Team but in general it is not possible to maintain the necessary calories for the eating plan whilst following the hospital vegan diet and will need additional and enriched other food items to be sufficient.

    - A staged approach through portion size is advised starting at the level that best correlates with what the young person is currently managing to eat. If they are not eating or eating very limited amounts, start with 1200kcals per day.
    - Insert local meal plans here
    -

2. Mealtimes:
    - Set out by nursing staff
    - Parents are to be present at meal times AFTER the stabilisation phase – They are the main providers of support for the young person. Initially the parents are supported to achieve this by the ward team who will do all of the meal supervision while the young person is being stabilised. Parents may find it helpful to eat their meal along with the young person too.
    - Allow some ventilation of feeling while encouraging young person to eat
    - Meal times and snacks supervised by parents. Allow patient to ventilate feelings as necessary, supporting them to eat for about 30 minutes. If the young person has not eaten their meal in 15 minutes, then allow another 15 minutes with minimal interaction with nursing staff. Snacks should take no longer than 15 minutes and meals no longer than 30 minutes.
    - At the end of this time, remove any uneaten food and avoid negative comments.
    - Ask the young person what interaction they would like over the meal time. In general, avoid praise if the patient has finished their meal as many young people with anorexia nervosa experience this negatively. Saying "thank you for eating your meal" may be more acceptable.
    - Parents can bring in snacks for the young person provided these are agreed with the dietician.

11. NG feeding

Any decision about ng feeding should be jointly made by Paediatricians, CAMHS and a dietician.

1. Depends on:
   - Medical emergency
   - Weight loss or lack of weight gain
   - Decision by Consultant Paediatrician in liaison with the local eating disorder team and the dietician

2. Indications:
   - Severe acute complications
   - Failure to halt weight loss or restore any weight within the usual management guidelines placing the young person's health at risk
   - Must be undertaken in conjunction with the Dietitian

3. Methods:
   - NG feeding should be seen as a short term measure until medically safe to remove the tube
   - Ideally the feeds should be boluses around the time of normal meal times to mimic physiological demand and so the choice can be offered on each occasion (Are you going to eat, drink or be fed this time?)
   - The nasogastric tube to be passed and then left in situ.
   - The ng feeding meal plan should be one meal plan higher than that expected to be eaten orally
   - Bolus feed would be the recommended method unless otherwise indicated.
   - Staff should continue to offer food as per meal plan and communicate a high expectation that the food will be eaten. If food is refused or no attempt is made to eat or complete the meal in the time limits set, then a bolus feed is to be given via the nasogastric tube (this will equate to more calories than they would have eaten).
   - If the young person does eat then they need to comply fully with the daily meal plan until the next joint Paeds, CAMHS and dietician review, when a decision will be made as to whether the tube can be removed.

4. NG tube feeding depends on the competence or capacity of the patient to consent. Refusal requires the appropriate legal framework, usually the Mental Health Act. Discussion concerning these issues with the young person and their family will be documented in the notes.

12. On-going management

1. Any changes in care plan must be in writing and everyone particularly the young person and parents informed
2. Parents to be involved in feeding to build up their confidence in supporting their young person prior to discharge
3. It may be necessary to check the locker and waste bins for hoarded food and laxatives
4. Contact the ward education team for their input during the young person's stay.
5. Depending on weight gain and physiological status, the patient will be given gradually increasing independence. Decisions will be made by the core team. In general weight gain or compliance with the eating plan will allow independence as a direct consequence. Young people should be able to identify a gain in independence for compliance with the eating plan.
6. Increased independence usually but not inevitably increases in the following way:
    - Using the commode unsupervised.
    - Using a toilet unsupervised.
    - Having an assisted shower.
    - Having unsupervised shower.
    - Sitting out of bed.
    - Stopping overnight supervision.
    - Gentle mobilisation around the bay.
    - Going off the ward with parent/carer
    - Going off the ward for trial snacks/meals with parent/carer
7. Supervision requires the young person to be within the eyesight of the nurse but with consideration to the young person's dignity. This will be explained and documented and maintained with consistency

13. Discharge:

1. No target weight gain will be given but on average weight gain should be about 0.5-1kg per week, and to be at least sufficient to allow discharge without a risk of early re-admission
2. The parents will have been joining the young person at meals so they will have learned appropriate portion sizes and food types that are recommended
3. Parents should feel confident and able to continue feeding their young person at discharge
4. The Dietitian/CAMHS/EDT will provide the family with an eating plan to follow after discharge
5. CAMHS/EDT will arrange outpatient follow-up with their team
6. The young person should be walking short distances without supervision before discharge
7. An appropriate professional in the community from CAMHS/EDT will be monitoring the patient's weight, initially weekly
8. The date of discharge will be agreed between the core team and the family. The aim is to discharge the patient home. However if they are not making sufficient progress for discharge, CAMHS/EDT may arrange transfer to an age appropriate psychiatric inpatient unit with experience in treating anorexia nervosa
9. Factors to consider when planning discharge are
    - The original rationale for admission, i.e. physical compromise
    - The current physical health and any continuing medical requirements
    - Nutritional status, method of feeding and monitoring
    - Family and individual's needs, circumstances and preference
- Success of periods of leave home (if there are concerns about discharge , consider trial of leave)

14. Management flow chart

Stage One: **Refeeding**

- **Aim:** To re-introduce feeding and build up to a meal plan which would allow for 0.5-1 kg weight gain/week. All meals and snacks supervised by staff. Total bedrest is prescribed with physical monitoring and daily blood tests. Regular ECGs day 1,5,10.

- Decision made to admit to medical ward
- Admission clerking, ECG, height and weight, percentage BMI, lying and standing blood pressure, lying and standing heart rate, temperature, blood sugar completed
- Initial electrolytes, full blood count and venous blood gas checked, documented and treated if abnormal
- Contact ward Dietician and CAMHS/EDT
- Determine appropriate level of exertion for young person (e.g normal mobility, certain number of walks to bathroom, wheelchair, total bed rest)
- Determine if 1 to 1 nursing required
- Formulation of a management plan
- Medical:
    - Daily electrolytes including phosphate and magnesium, once daily for 5 days unless abnormal
- Nursing:
    - Twice daily blood sugars
    - 6 hourly heart rate, blood pressure, respiratory rate and level of consciousness
    - Daily temperature, lying and standing blood pressure
    - Weighing twice per week in gown or similar light clothing
- Nutrition:
    - As per Dietician's plan
    - Guide of 30 minutes for meals and 15 minutes for snacks
    - If not progressing consider meal replacement drinks then NG feeds

Stage Two: Consolidation

- **Aim:** To consolidate the meal plan and structured routines. Bed rest should continue until cardiovascular parameters stable, and weight gain occurred. After this the young person can gently mobilise for purposeful activity on the ward only. Parents are encouraged to supervise some meals or snacks towards the end of this time period.

- Medical:
    - Electrolytes including phosphate and magnesium one week after last set
    - Repeat full blood count one week after last set
    - Repeat hormone tests before discharge
- Nursing:
    - Daily blood sugars
    - 12 hourly heart rate, blood pressure, respiratory rate and level of consciousness
    - Daily temperature, lying and standing blood pressure
    - Weighing twice per week in gown or similar light clothing
    - Increasing confidence of parents and, if appropriate, independence of the young person
- Nutrition:
    - Continued parental involvement
    - Family provided with nutrition plan for at home

Stage Three: Planning for home/discharge

- **Aim:** To support the parents in supervising meals and discuss home management and support. Some meals may be encouraged to happen off the ward, or at home towards the end of this time period. Dietitian will meet with young person and family before discharge to provide home meal plan. Young person can mobilise off the ward (this will be specified for individual patient). Day of discharge will be

set by agreement between paediatrician and CAMHS. Follow-up will be in the community and will be organised by the TEDS team.

Appendix 1- Guidance for Nurses/Support Workers caring for a Young Person with an Eating Disorder on Paediatric Settings

If you are reading this information you have been tasked with supporting a young person and their family, where the young person has been diagnosed or is suspected of having an eating disorder, such as anorexia nervosa. The aim of the guidance is to support you in delivering quality care to the young person and family, by ensuring you understand the condition they are managing and how treatment can be started in the correct and most helpful way from the outset.

Young people with eating disorders will be admitted to a Paediatric ward when there is evidence of physical compromise, or in some cases risk of rapid physical deterioration due to the young person being unable to follow a community care plan and increase their dietary intake in the community. In some circumstances, a period of medical stabilisation is needed and allows for the Paediatric team and the Eating Disorders team to work together so that the young person can be safely discharged home and community treatment continued or for the young person to be kept safe whilst a specialist bed is found.

In some situations whilst on the ward the teams will agree that an agency nurse or support worker is required to support the family and young person.

The current first line treatment for child and adolescent eating disorders is a family based intervention (NICE 2017). In view of this, when a young person is admitted to a Paediatric setting we encourage parents to fully participate in their care and treatment, unless contraindicated. This is an opportunity for the parent/carer to develop an understanding of the disorder and their role in their child's recovery. It allows parents/carers to practice supporting their child to eat in a safe environment where the medical risks are being well manged.

Families do not cause eating disorders and unless otherwise indicated should always be part of the treatment plan. It is important to recognise the impact of eating disorders on families and how unknowingly they can gradually accommodate the illness. It is important to be sensitive to this and aid the parents/carers in recognising this and taking a different stance.

So what is your role?

- To support the whole family in this process, to encourage and model to the parents/carers how their child can be supported. It is important not to take over completely, but to be able to recognise when a parent/carer may need some additional support or a break! The ultimate goal will be for the parent/carer to be taking responsibility for all of the meals and snacks ready for discharge home.
- To observe the process, note how parents/carers are managing and how the young person is responding to their support. Feedback in a supportive manner anything you note they did that helped or hindered the young person. Think how you can do this to ensure parental confidence is increased, which is likely to be low at this time.
- Be alert to the tricks of the eating disorder; because of the level of distress and anxiety the illness causes, young people may try to avoid eating so be alert to food mysteriously disappearing, signs of vomiting or secretive exercising. If this happens enquire gently with the young person and ask them what may help them to resist the illness' request. **Please ensure if observed these behaviours are handed over to the Nurse in Charge and the Eating Disorders Team. It may be that a care plan is or will be in place to manage this – please ensure you check at the beginning of each shift.**
- Monitor the young person's mental state and any potential mental health risk factors such as increase in suicidal thoughts, self-harm or urges to want to run away. These concerns

should always be well documented and handed over to the Nurse in Charge and the Eating Disorders Team.

- High levels of anxiety are very common in young people with eating disorders. This is partially related to the fear that anorexia instils but also to the impact of starvation. Supporting the young person in managing this anxiety is really important. Please see appendix for some anxiety management techniques that maybe helpful.
- The ongoing monitoring of a young person's physical observations is also very important. If the ward team ask you to do this, please ensure that you do a sitting and standing blood pressure, pulse and temperature. (Junior MARSIPAN reference guide in the appendix)
- Provide clear documentation in the medical records regarding any behaviours observed, how the young person and family are coping with the refeeding process and any observations related to the young person's mental state.
- Whilst taking into account the safe management of risk, please consider how to balance that with giving the young person and family some space to be together privately. This will also allow you time to take a comfort break. In rare circumstances where there are safeguarding concerns this may not be possible, in these situations this should be addressed in an agreed plan with the treating team.

Care planning

When a young person is admitted they will need to be reviewed regularly by CAMHS who will work in collaboration with the Paediatric team, the young person and their family to establish a care plan for their time on the ward. This care plan will be guided by medical risk management, what we know about treating eating disorders and the family's knowledge of the young person. The care plan will include-

1. Stage of refeeding- including what stage menu plan the young person is on and guidance around supplements or tube feeding as appropriate
2. Guidance around activity levels; bed rest, wheelchair use, limited walking etc
3. Bathroom use; unless there is evidence of vomiting we would always attempt to ensure bathroom privacy
4. Management of mental health symptoms and any mental health risk if identified

All of the areas related to the care plan should be referred to in any progress notes, so the reviewing teams can evaluate effectiveness.

Therapeutic methods of supporting young people at meal times

- Remain calm and kind
- Being firm and consistent with clear limits and boundaries
- Encourage the young person- acknowledge the challenge and how hard this is and that you are there to support them to recover; remind them that food is their medicine
- Demonstrate empathy recognising and reflecting on how the young person may be feeling
- Do not be punitive - remember that the young person is tormented by the fear that the eating disorder will be projecting; this may be displayed in anger, hostility or distressed behaviour
- Encourage the young person to fight the illness, help them by distinguishing between them and the disorder. Capitalise on the young person's healthier motivated thoughts; join with these healthier thoughts to increase the young person's tolerance so that they can eat
- Encourage generalised conversation about neutral topics, such as things the young person is interested in. Try not to get drawn into conversation around food, weight or shape

Please ensure that any conversation remains professional and age appropriate and does not involve any inappropriate self-disclosure.

Post meal support

This is a time when the disorder will quite often leave a young person with overwhelming feelings of guilt and anxiety. They may ruminate and become distressed because of their fear that what they have eaten will impact significantly on their weight and shape. At these times young people may need support to be distracted away from their thoughts. You and/or the parents/carers can help with this by-

1. Engaging in a sedentary activity such as watching a film, reading, playing cards or a board game, mindful colouring
2. Taking a trip off the ward in a wheelchair if this is an agreed part of the care plan
3. Using some of the relaxation and anxiety management techniques
4. Using sensory objects such as play doh
5. Having a visitor

At the end of your shift with young person and family, please obtain feedback from them as to how they have found the support you have provided. There are some questionnaires enclosed to facilitate this discussion. This is a really important part of the process and will ensure that the needs of the family and young person are being considered throughout their time on the ward.
Should you have any queries or concerns regarding your role during this time, please speak to the Nurse in Charge on the Paediatric ward and/or contact the Hampshire Eating Disorders Team on 0300 304 0062

Appendix 1.1

These relaxation exercises can be used when you require a quick result to a stressful situation. Try each technique individually, so you can decide which one is the most effective. Initially try the exercise for a minute or so, then finding one you like, gradually increasing the time and the situations you use them in. **You will need to practice techniques.**

It is important with each exercise that you focus on the OUT breath and as you breathe out let go of the tension.

Deep Breathing Control

Take three slow, deep breaths. Make sure you are drawing your breath down as far as your lower chest/upper abdomen. As you breathe out feel the tension draining away. You should notice that you feel more in control, steadier and calmer. Continue breathing naturally, but still deeply and slowly. Check your body for physical tension, and let it go.

Mini Relaxation

Make sure both your feet are flat on the floor whether you are sitting or standing. Take one deep breath for a slow count of three, whilst stretching out your hands and arms slightly away from your sides. Let out your breath for another slow count of three, and pull your shoulders down. Do this as many times as required, until you feel calmer and relaxed.

Counted Breathing

Focus on the out breath. Breathe out and count ONE, on the next breath out count TWO, the next one THREE and finally FOUR. Then go back to ONE again and start over. Aim for a calm, steady rhythm. If you lose count start at ONE again and continue.

Breathing with a Word

Think about a word that you feel comfortable with. Try different words, but it should be one that you like the sound of and which induces a feeling of relaxation. Don't actively change your breathing; allow it to be easy and comfortable. Repeat the word you have chosen in your head (or out loud if you wish), every time you breathe out. Try to make the word last as long as your breath out and try to allow it to relax you as much as possible. Words that other people have used include relax, calm, peace, sunshine.

Appendix 1.2 - please note not all of these will be appropriate on the ward

DISTRACTION ACTIVITIES

Distraction helps to take your mind off your negative thoughts
Distraction helps you to control your thoughts by thinking about something else
Distraction can be achieved in many different ways. Here are some ideas……

FUN ACTIVITIES

Idea	**Tick if it is an activity you might try**
1. Watching your favourite TV show or box set	
2. Going to see a film, watching a DVD	
3. Listen to music, download new music	
4. Colouring in	
5. Finger painting	
6. Using make up or face paints	
7. Playing with play dough or modelling clay	
8. Pop balloons	
9. Jumping in puddles	
10. Hunting for things on eBay	
11. Write down your name then make as many words out of it as possible	
12. Counting anything, patterns on wallpaper, tiles, bricks	
13. Playing computer games	
14. Playing with Lego	
15. Playing with fidgets	
16. Doing crosswords, word searches, suduko etc	
17. Going shopping to treat yourself	
18. Playing with your pet	

COMFORTING ACTIVITIES

Idea	**Tick if it is an activity you might try**
1. Cuddling a soft toy or pillow	
2. Take a short nap	
3. Take a shower or bath	
4. Stroke a pet	
5. Have a warm drink	
6. Have a massage or massage your own hands or feet	
7. Wrap yourself in your favourite blanket or throw	
8. Sit in rocking chair or on a swing	
9. Do relaxation or mindfulness exercises	
10. Look at the clouds or the stars	
11. Watch birds or fish	

CONSTRUCTIVE ACTIVITIES

Idea	**Tick if it is an activity you might try**
1. Doing school work or home work	
2. Writing a To Do list	
3. Untangling necklaces, string or wool	
4. Organising your room, clothes or photographs	

5. Cleaning	
6. Organising CD's, DVD's, books in genres, alphabetical and/or chronological order	
7. Reading a book	
8. Cooking a meal or baking a cake	
9. Calling a helpline, Samaritans, Childline etc	
10. Polishing furniture or jewellery	
11. Write a list of positive goals for the future	
12. Shredding	
13. Painting your nails or putting on false nails	
14. Putting on fake tan	
15. Counting backwards from 123 in 9's	
16. Spelling the names of your family and friends backwards	
17. Describe in detail what you can see e.g. colour, size, texture	

CREATIVE ACTIVITIES

Idea	**Tick if it is an activity you might try**
1. Drawing or painting	
2. Make a card for friend or family	
3. Writing poetry, letters, stories	
4. Write a diary	
5. Doodle	
6. Singing	
7. Playing a musical instrument	
8. Knitting or crocheting	
9. Sewing	
10. Origami	
11. Memorising song lyrics	
12. Make a play list of your favourite songs	

SOCIAL ACTIVITIES

Idea	**Tick if it is an activity you might try**
1. Be around other people – family or friends	
2. Phone or message a friend	
3. Helping someone else	
4. Being in a public place	
5. Have a warm drink	
6. Write a card or letter to someone	
7. Invite a friend around or visit a friend	
8. Talk to someone you trust about how you feel	
9. Have a hug with someone close	

PHYSICAL

Idea	**Tick if it is an activity you might try**
1. Take a short walk	
2. Playing with a stress ball	
3. Playing catch with a ball	
4. Dancing	
5. Popping bubble wrap	
6. Ripping up paper into small pieces	

7. Use the Wii	
8. Gardening	
9. Hoovering or sweeping	
10. Do yoga or gentle stretches	

Appendix 1.3 –Session Measure

How was the care you received today?

How would rate the care you have received today?

1……..10

(Poor) *(very good)*

How listened to did you feel?

How well supported by the member of staff did you feel?

How well understood did you feel the member of staff?

How could your care be improved?

Appendix 2 – Section 5(2) Checklist for Dr and Ward Staff

FORM H1 (SECTION 5(2) MENTAL HEALTH ACT 1983 – DOCTOR'S HOLDING POWER) COMPLETION CHECKLIST		
FORM H1 PART 1 – DOCTOR COMPLETES	**What to write on the form**	√
To the managers of [name and address of hospital] **EVEN THOUGH NOT ASKED FOR, THE FULL TRUST NAME MUST BE INCLUDED**	Name of Trust Full name and postal address of hospital/unit including postcode	
I am [PRINT full name]	First name and surname of doctor completing the form If patient is detained at general hospital, doctor must be employed by that NHS Trust (not Sussex Partnership)	
and I am **3 OF THE 4 OPTIONS MUST BE DELETED**	The doctor in charge of the patient's treatment should complete (a)(i) or (a)(ii) if they are an Approved Clinician A junior doctor ("the nominated deputy" under the Act) should normally complete (b)(i)	
In charge of the treatment of [PRINT full name of patient]	The patient's full name, including middle names if applicable	
It appears to me that an application ought to be made under Part 2 of the Act for this patient's admission to hospital for the following reasons--	Brief, clear written evidence to justify your clinical view that the patient: (a) appears to you to be suffering from a mental disorder (symptoms or behaviour associated with mental disorder, rather than a diagnosis would be sufficient) (b) is refusing to remain as a voluntary patient and (c) would be a risk to themselves or others if they were allowed to leave the hospital All 3 points must be addressed. Continue on a separate sheet if required.	
I am furnishing this report by: <Delete the phrase which does not apply>	The form should in all circumstances be handed directly to the nurse in charge of the ward. The form should never be placed in the internal mail. If very exceptionally the form must be sent to the MHA Office, the form must be copied before it is sent.	
Signed and dated	The doctor must sign and date the form. Doctors must wait while the nurse in charge checks the form.	
FORM H1 PART 2 – NURSE IN CHARGE COMPLETES	**What to write on the form**	√
To be completed on behalf of the hospital managers	The nurse in charge of the ward MUST complete this.	
This report was <Delete the phrase which does not apply>	Delete "Furnished to the hospital managers through their internal mail system". Check PART 1 has been correctly completed, signed and dated by the doctor. If not correctly completed , the information MUST be rewritten on a new form. The form cannot be amended in any way.	
Signed on behalf of the hospital managers, PRINT NAME, dated	The nurse in charge must sign and date the form. Inform the MHA Office, keep a copy and send the original FORM H1 to the Mental Health Act Office immediately.	

Overview of information and strategies to be considered relating to capacity, consent, confidentiality and the law

Who to call to discuss management:

During normal working hours (Monday-Friday 9am-5pm) the EDT team can be contacted for advice on **0300 3040062**. There is usually a clinician on duty, however they may be in an appointment when you call. We do not usually have the capacity to offer same day urgent assessments but can provide advice on aspects related to managing their eating disorder.

If the young person has newly presented to hospital and is unknown to CAMHS, or requires more immediate CAMHS input (such as due to self-harm or suicidal ideation) the i2i Team should be contacted on **07010020424**. They will liaise with EDT if ongoing support is needed.

The i2i team can also be contacted for advice on weekday evenings until 8pm and 10am-6pm at weekends/bank holidays, when EDT will not be available. EDT works closely with i2i and their staff are experienced and skilled in working with eating disorders.

Outside of these hours the on-call Consultant Child Psychiatrist can be contacted on **08445852208** for telephone advice.

Capacity, Consent and the Law

This is a complex area. Concise RCEM guidelines can be found at https://www.rcem.ac.uk/docs/College%20Guidelines/5z4.%20Consent,%20Capacity%20and%20Restraint%20of%20Adults,%20Adolescents%20and%20Children%20in%20Emergency%20Departments%20(July%202013).pdf and GMC guidance is available at https://www.gmc-uk.org/-/media/documents/0_18_years_english_0418pdf_48903188.pdf

This section is intended to give basic and practical guidance to help manage patients with eating disorders on the paediatric ward.

Under 16s

Children under 16 are not covered by the Mental Capacity Act. Instead a child needs to be assessed whether they have enough understanding and maturity to make up their own mind about the benefits and risks of treatment – this is termed 'Gillick competence'.

If a child is Gillick competent, they can provide consent to the proposed treatment. If a competent child refuses consent, it is unwise to rely on parental consent alone and advice from senior clinicians or legal advice should be sought.

If a child lacks Gillick competence, someone with parental consent may consent to treatment on their behalf. However, if the proposed intervention crosses beyond the scope of parental responsibility and/or involves a deprivation of liberty (such as use of restraint, NG feeding, compulsory use of medication, etc) the Mental Health Act should be considered (see below).

Over 16s

Those aged 16-18 are covered by the Mental Capacity Act and thus assumed to have capacity unless assessment determines otherwise.

If a young person has capacity, they can consent to treatment. If they refuse treatment, this cannot be overridden by parental consent. Treatment may still be given in an emergency situation, otherwise a court order or use of Mental Health Act is required.

If a young person lacks capacity, they may be treated without their consent in their best interests under the MCA, as long as the treatment does not involve a deprivation of liberty. Treatment can also proceed with the consent of someone with parental responsibility as long as the treatment falls within the scope of parental responsibility.

Mental Health Act

Use of the Mental Health Act should be considered for the assessment and treatment of mental disorders in situations where the child or young person refuses consent, or lacks capacity/competence to consent, and the treatment will amount to a deprivation of liberty (i.e. being under constant supervision or control and not being free to leave). Examples suggestive of this include if the person is requiring supervision to prevent excessive exercise or vomiting, one-to-one staffing, is being actively prevented from leaving the ward, needs psychiatric admission, or needs highly invasive interventions such as NG feeding or compulsory use of medications or restraint.

General criteria for using the MHA are - evidence of a mental disorder (any disorder or disability of the mind), with risks to self and/or others and/or of deterioration in health that requires hospital admission.

Section 5(2) – this is a holding power which can be applied by any doctor (F2 or above) to any hospital inpatient. It must be the clinical team directly caring for the patient i.e. the paediatric consultant or their juniors. It allows the patient to be legally held on the ward for a maximum of 72 hours, during which time a full MHA assessment will take place. The duty manager will have the relevant paperwork. NB – this does NOT allow for compulsory treatment under the MHA, and any treatments must be given in accordance with consent/capacity as above. It only applies to hospital inpatients and does not apply to patients in outpatient departments or A&E.

A full MHA assessment is arranged by an AMHP (Approved Mental Health Professional) – who are contactable on 01962 832406 in hours and 03005551373 out of hours.

It may be that patients are detained under the MHA to the paediatric ward if they require paediatric admission due to physical health needs. The relevant sections you should be aware of are **Section 2** – which lasts for up to 28 days for the assessment and treatment of mental disorder, and **Section 3** – which lasts for up to 6 months for treatment of mental disorder. Patients under these sections can be transferred from one hospital (eg paediatric ward) to another (eg psychiatric ward).

If you need advice about aspects relating to consent and treatment you can contact the teams as above (in the who to call section).

De-escalation and Medication Guidelines

The following flowcharts are taken from the PIER Network guidelines, available in full at https://www.piernetwork.org/guidelines.html

In summary, in an escalating situation ensure you consider your own safety first and contact security if needed. Try de-escalation techniques first – speak in a calm, quiet voice using simple language. Where possible, find a safe and quiet space for the young person to calm. Talk to them about what is frustrating them and see if anything can be done to make this easier (being clear if this is not the case). Don't be afraid to allow silence and give them space to talk (it takes longer to process things when very emotional). Try to be empathic and tell them you can see how upset/angry/frustrated they are so that they feel acknowledged.

If the above is not possible or not successful and the patient is very agitated or distressed, consider offering oral medication as per the guidelines. If two doses of oral medication fail, or the patient is at imminent and serious risk of harm, consider rapid tranquilisation with IM medication as per the guidelines. Note that administering medication requires patient consent (see below) or could be given if it is in their best interests and they lack capacity or Gillick competence.

A document of suggested distraction techniques is included in the resource folder. Not all of these will be available or possible on an inpatient paediatric ward but you could consider helping the young person and their family identify a selection of techniques they might find useful to try.

If the young person absconds from the ward and there are immediate concerns about their safety (whether due to physical or psychiatric risks) you should follow the relevant missing child policies and contact security and/or the police for assistance.