**Admission overview sheet for medical staff**

(This provides an overview of considerations during the admission period)

|  |  |
| --- | --- |
| **Re-feeding bloods** | Day 1-5 (inclusive), day 7, day 10, day 14 (e.g. if risk of delayed refeeding e.g. low starting kcals/slower daily meal plan increases)(Na, K, Ur, Cr, Ca, Mg, P04 and Alb)(**Ref:** *Junior MARSIPAN; BDA)* |
| **ECG** | Days 1, 5, 10 |
| **Prescribe Vitamins** | * Multivitamins

Thiamine (see Refeeding guidelines document; may be required in older teens) Please prescribe the following for 10 days:* **Thiamine –** 100mg TDS (with the first dose administered 30 minutes before initiating feeding) either orally or crushed and flushed via feeding tube
* **Vitamin B Compound Strong** 1 tablet TDS **OR**  **Vitamin B Syrup/ Vigranon** **B** 5ml TDS
* **1 Sanatogen A-Z**  tablet OD **OR 1 Forceval Soluble (**dissolved in 50ml water via feeding tube) OD

If enteral route not available, * Administer intravenous **Pabrinex®** (ampoules 1 and 2 = one pair) OD 30 minutes before initiating feeding and then OD for 3 days. If after 3 days it is not possible to revert to oral or enteral route, further supplementation should be discussed with the Nutrition team.

**Refeeding vitamin protocol for under 14 year olds**1 x A-Z tablet OD or 1 x Forceval Junior Soluble (dissolved in 50 ml water via feeding tube) OD. |
| **MARSIPAN criteria** | Ensure Junior MARSIPAN criteria are completed to assess risk. |
| **Weighing** | * Admission weight
* “First morning weight” (to ensure no water loading on admission)
* Regular weights on Monday and Thursday mornings

 ***Note:*** *Weigh before breakfast; ensure young person has been to the toilet beforehand.* *Weigh in light clothing.* * Do NOT share weight with patient

The ideal rate of weight gain, for recovery, is a weekly gain of **800g,** which is considered optimum as a psychiatric inpatient (NICE).  The team will set an expectation for this at admission as weight gain may not initially happen in some patients and so the expectation will instead be agreed for the weight to be maintained and for a regular eating pattern to be established.  There may be variations in the early stages of refeeding. Often once a young person starts building up their intake you may notice an initial weight gain followed by stabilisation or even slight weight loss. This can be due to unmatched nutritional requirement. Fluid retention and oedema can occur in the initial stages of refeeding; this should resolve in 7-10 days. |
| **Observations** **(See care plan)** | Frequency of observations to be documented on daily review sheets. This will vary depending on physical risk and compliance as follows:* Cardiac monitoring: *Continuous* ***or*** *Overnight* ***or*** *Not required*
* Sats, BP, Pulse, Temp, Resp rate: *4 hourly* ***or*** *12 hourly*
* Daily lying & standing BP: *required* ***or*** *not required*
 |
| **Meal Plan** | Refer to dietitian for meal plan. Copy of meal plan to be included in notes. Do NOT deviate from plan. NO additional foodstuffs/fluids to be given by staff or family. |
| **Meal supervision** | All meals to be supervised by staff initially and/or until agreed otherwise (to be decided on a case by case basis) **If supervising, please ensure you have viewed the ‘online learning for staff’ (see below)**Breakfast: 30 minsSnacks : 15 minsLunch: 30 mins (45 mins total if dessert included at meal)Dinner: 30 mins (45 mins total if dessert included at meal)*Ensure you ask the young person how they like to be supported at meal times, i.e. chatting, radio, TV, music, prompts re time limits, whether they would like any feedback re progress etc.*  |
| **Nasogastric feeding tube (NGT)**(see form) | The decision to use nasogastric feeding should be made jointly between paediatrics and CAMHS. It would be unusual for this decision to made over a weekend. If safe to do so, would be preferable to use intravenous fluids for a couple of days pending an MDT discussion about ng, rather than institute ng feeding at a weekend or out of hours.  |
| **Mobile Phone/internet** | The decision for the young person to have access to mobile phone/internet is to be agreed with EDS and Consultant of the Week at point of admission.  |
| **Bed Rest** | Ensure total bedrest in Week One Wheel chair to toilet – 5 mins allowedWheel chair to shower – 15 mins allowedSupervision in toilet/shower will be needed where high risk of covert exercise Challenge any excessive movement witnessed. |
| **Activity** | Ensure young person can engage in activity at bedside for distraction purposes and to alleviate boredom, e.g. Arts/crafts/colouring/films/reading/music/pets.NO school work to be done. |

## SPECIFIC PHYSICAL ASSESSMENT PARAMETERS AND ACTIONS TO TAKE

|  |  |  |
| --- | --- | --- |
| **CVS** | Bradycardia <50 bpm or postural tachycardia >30 bpmHypotension <0.4th centile or postural drop >15 mmHg | Bed rest and continuous heart rate monitoring NutritionNurse at 30-45O head up if bradycardia worsens on lying flat |
| Prolonged QTc (in any lead)Arrhythmia associated with malnutrition or electrolyte disturbance | Bed rest and cardiac monitoringNutritionDiscuss with cardiologistMay need to stop some medicines eg sertraline, which prolong QTc, until better (d/w CAMHS)Identify and correct specific electrolyte issues |
| **Fluid balance** | Dehydration >5-7% clinically | ORS oral/ NG over 24-48 hours – beware of large IVIs (cardiac compromise)Monitor U&Es |
| Hypovolaemia – inappropriate normal heart rate/ tachycardia, marked hypotension, prolonged CRT centrally | Senior reviewFluid bolus 10mls/kg and reassessConsider other causes eg sepsis |
| Oedema – with hypokalaemic hypochloraemic metabolic alkalosis due to secondary hyperaldosteronism.  | Occurs 2-3 days after significant vomiting stops.Give slow IV saline + KCL for 48 hours plus additional oral potassium for 1 week to rebuild stores. May need spironolactone. |
| **Metabolic** | Hypokalaemia <3.0 mmol/L (HDU/PICU if <2.5 mmol/L) | Supervision to prevent vomitingSlow IV correction alongside slow 0.9% saline, with cardiac monitoring |
| Hyponatraemia <130 mmol/L | Supervision to prevent water loading |
| Hypo-phosphataemia, - calcaemia or – magnesaemia (with no arrhythmia) | Bed rest and cardiac monitoringCareful refeedingOral/NG supplements |
| Hypoglycaemia  | Consider full hypoglycaemia screen (hypoglycaemia is uncommon)Offer a sugary drink oral or NG first and re-check IV 10% dextrose 2mls/kg followed by infusion only if symptomatic |
| **Immunity** | Skin breakdown | Pressure mattressTissue viability advice |
| Neutrophil count <1.0 x109 PLUS fever >38OC | Septic screenBroad spectrum antibiotics |
| **Neuro** | Confusion, significant headache | Is this refeeding syndrome encephalopathy?Paediatric neurology review ?venous sinus thrombosisSeptic screen and consider antibiotics and acyclovir |
| **GIT** | Gastric dilatation (feeling full PLUS visible distension and large aspirates) | NGT decompressionSlow rate of feeding  |
| Severe abdominal pain | Consider pancreatitis, check lipaseAUSS for duodenal and gastric dilatation in SMA syndrome (loss of SMA fat pad) |
| Deranged LFTS (ALT >3 x normal) | AUSS – starvation induced has normal liver, refeeding induced has fatty liverMonitor as refeed carefully with reduced fat (dietician review), check clotting and triglycerides |
| Oesophagitis/Mallory Weiss tear | Stop vomiting and give PPI |
| Sialadenosis (painless parotid swelling) | NSAID and suck lemon drops |

**Care Plan**

|  |  |  |
| --- | --- | --- |
| **Date** |  | **Signature** |
|  | Problem:You, \_ \_ \_ \_ \_ \_ \_ \_ have an eating disorder, and have not been able to eat enough to maintain good health and growth |  |
|  | Goal/objective of admission:* To restore physical health
* To establish regular and sufficient nutritional and fluid intake
* To support you with any difficulties in following the care plan
 |  |
|  | **Weigh Days:*** Weigh days: you will not be able to drink any fluids from midnight
* You will not be able to have a shower allowed before weighing
* You need to use the toilet before weighing
* You will be weighed in light clothing
 |  |
|  | **Safety and Support:*** You will be admitted to a bed in view of the nurse’s station and separate from other ED patients
* All curtains +/- door will need to remain fully open at all times, one curtain is to remain open at night and when you are eating your meals
* You will be allowed time to talk through any concerns you may have.
 |  |
|  | **Food and Drinks:*** You will need to choose meals and snacks based on the dietetic meal plan

Your total daily fluid requirement will be documented on your meal plan. Your intake will be documented on your food/fluid chart* Nursing staff/auxiliaries/students/ED staff will supervise all meals and the rest period after meal
 |  |
|  | **Daily Activities*** You will initially be on strict bed rest and will need to use a wheelchair for mobilisation – this may be reviewed to include purposeful’ walking on ward (i.e. to toilet or shower) according to progress
* You may sit out in chair during meals.
* You must use the call bell for toilet/drinks (if longer than 5 minutes for toilet to use toilet in shower room (with nurse supervising from outside of the shower room)
* You may have 10 minutes supervised seated showers (once daily) (nurse supervision from outside of the shower room)
* You may only have access to any device which can access internet as per ward guidance. You can use ward phone (at appropriate times of day)
* Your bedding, belongings, cupboard and nearest bins will be checked each day with you present (look for hidden food, cups, vomit, drinks, mobile phone)
* No school work to be undertaken
* Hospital school or play leaders may provide craft activities
 |  |
|  | **Family*** Your family can visit outside of meal times
* Your friends can visit as per your wishes
* No food or drinks should be brought in from home
* Your family/friends should not to discuss food/ weight/ calories with you
* Your parents will be encouraged to be involved with mealtimes as you near time for discharge home from the ward
 |  |

**IMPORTANT to look at before doing meal support**

|  |
| --- |
| **MOST USEFUL…..**START WITH THIS ONE : AIMED AT PARENTS… but this is what we are aiming to model for themAnxiety management – 5 mins<https://youtu.be/2O9nZAWCkLc>H:\Downloads\qrcode_www.youtube.com.pngMeal support training (suggested by tier 4 PC) start at 04:40 ..whole thing is 35 mins<https://youtu.be/pPSLdUUlTWE>H:\Downloads\qrcode_www.youtube.com (2).pngThis is an overview of how things are done in Taunton (our guidelines will be close to theirs…but they do fortisips if meals not eaten and ng in for one meal at a time…we are not planning to do that at the moment)<https://youtu.be/fzduH6x0yuQ>H:\Downloads\qrcode_www.youtube.com (3).png |

**If more time and interested**

This is what parents are being asked to do at home

General meal support advice – 20 mins – what to do if they are stuck

<https://youtu.be/BVhKXh0gLGc>



Top tips for during a meal – watch from 7 mins to 14 mins

<https://youtu.be/0dS55cDLlDQ>



**Loads of useful resources about managing eating disorders**

[ALPINE Resources - Assessment and Liaison for Paediatric In-Patients with Eating Disorders (office.com)](https://sway.office.com/NlBLYeNxZEXb8HSJ?ref=Link&loc=play)



**Helpful coping strategies for young people**

[A to Z of coping strategies - YouTube](https://www.youtube.com/watch?v=5EXpkVw3fh0)



**A glimpse of hope – created by young people with eating disorders sharing their experiences of getting better**

[ICE Project - Eating Disorders Group ‘A Glimpse of Hope’ on Vimeo](https://vimeo.com/306136147)



# GUIDELINES FOR BEHAVIOURAL MANAGEMENT OF MEALTIMES

Managing mealtimes is often a very difficult and emotionally exhausting experience for ward staff. The young person with anorexia may show high levels of distress and animosity towards staff. Their anorexic thinking will drive them to attempt to engage staff in negotiations about the food and to try to distract staff so they can dispose of food (some young people are very skilled at this). Staff will therefore need to be highly vigilant during meals. Staff should adopt a calm, but firm approach in their refusal to engage in negotiations around food.

Staff can use mealtimes to build rapport with the young person by engaging them in conversation. Staff must be careful that conversation is not used to avoid eating. The young person should be consistently reminded that conversation can continue as long as they are eating their food.

Staff should communicate a high expectation to the young person that they need to complete all meals and snacks plus drinks. This may be met with resistance and fierce protestations; continuing to give this message is very helpful in breaking down anorexic resistance.

## HOW TO ENGAGE A YOUNG PERSON WITH ANOREXIA

A young person with anorexia can evoke very powerful responses within staff ranging from extreme anger to a sense of wanting to befriend them and make them better. Anorexia can be powerful in ‘sucking’ staff in to unhelpful alliances with the young person. Although at the time this feels like it is helping the young person, it is quite destructive to their management as it becomes harder to set firm boundaries and enforce the food prescription. The following behaviours may indicate this is happening:

### The young person begins to request specific staff to look after them

* Do not make staff changes in response to this
* Make the young person aware that they cannot request this and that all staff are able to look after them

### Drawing staff into discussions about other staff and their likeability (splitting behaviour)

* Make the young person aware this is not an appropriate discussion and you cannot discuss other staff with them
* Encourage them to discuss their concerns with the staff member directly or with their keyworker

### Bringing gifts in for certain staff

* Adhere to trust policy re: the receiving of gifts

### Indicating only certain staff understand them

* Reinforce to the young person that all staff are there to support and understand them

## DEALING WITH SPECIFIC BEHAVIOURS

### Attempts to draw staff into negotiations / arguments regarding food choices and dislikes

* Calmly and consistently remind the young person of the rules set out at admission: this is not open to discussion
* Attempt to direct the conversation away from the argument

### Using conversations / TV / music / games / phone to avoid eating at mealtimes

* Explain that you are concerned the conversation /TV etc are being used to avoid eating and that they will not be available during mealtimes

### Parents engage in negotiations with staff re: food choices and are on the ward prior to mealtimes

* Staff to remind parents of the agreement at admission and support parents to disengage from the young person before and during mealtimes. Parents to be advised they can return to the ward once mealtimes are finished.

### Reluctance to begin the meal

* The young person is to be firmly told that they need to pick up their cutlery and start eating. This may need to be firmly and calmly repeated. *(The resistance is driven by extreme anxiety and the longer the young person sits in fron*
* *t of the meal without eating, the more likely the anxiety will be reinforced).*

### Wearing of baggy clothes and long sleeves, constantly wiping hands on bedcovers and clothes during meals, dropping food on the floor, crumbling up food, letting food drop off the side of the plate.

* Staff to supervise all meals and sit with the young person for the duration of the meal / snack.
* The young person is to be firmly told that if they dispose of food it will be replaced by staff
* Young person’s sleeves to be rolled up if food is being hidden in them
* All crumbs on plate to be gathered together and eaten at the end of the meal

*(The young person may not be aware they are doing these behaviours but may be very skilled at disposing of food. Staff need to be extra vigilant during mealtimes).*

### Screaming / shouting / throwing food or objects

* Be firm and persistent, calmly telling the young person that you understand their distress, but they need to eat their food
* Any thrown food is to be replaced either by food, or by an ONS as per dietetic feeding plan
* Seek support of colleagues if the level of distress is overwhelming and difficult to manage

*(A young person’s level of distress at mealtimes can be very high and the above behaviour is often driven by the sheer terror of having to eat. Staff can be left feeling powerless and distressed themselves).*

### Helpful things to say at mealtimes

* “You need to pick up your knife / fork / spoon and begin to eat”
* “you need to eat as it is part of your prescribed treatment here”
* “I know you don’t want to eat it but you have no choice as I am saying you have to eat it”
* “I am not prepared to get into any discussion with you about the food – I am telling you to eat it”
* “I cannot get into a discussion with you about how much of the meal you are to eat – you are expected to eat all the food”
* “I am reminding you that you have …..minutes left to eat your food. You need to put the food in your mouth and eat it”

Do not enter into discussions about number of calories taken of the total calories of the meal plan.

**If behaviours persist discuss with the CAMHS MDT. Consideration may be given for use of anxiolytic medication e.g. olanzapine. This would be recommended by a CAMHS psychiatrist but would need to be prescribed by ward staff.**

# GUIDELINES FOR MANAGING PHYSICAL ACTIVITY

It is important to remember that any energy that the young person takes in through eating is reserved for restoring tissue in order to stabilise their medical health. Therefore, a young person being treated for anorexia on a paediatric ward should engage in minimal physical activity.

Young people with anorexia will be driven to exercise at every opportunity in order to reduce their weight. This can be done via quite subtle behaviours:

1. **Constantly standing up**

Remind the young person that they are currently on bed rest due to the level of concern about their physical state

1. **Constant arm and leg movement / walking up and down the ward / offering to help staff give out meals / delivering post / checking on other patients / finding odd jobs to do**

Remind the young person of the severity of their illness and firmly insist that they return to sitting down on their bed or a chair

1. **Going to canteen / coffee shop with visitors / walking outside in the cold / wanting to sit outside in the cold / wanting to sit in the heat with large jumpers on (these are ways of expending energy)**

If the young person wishes to have fresh air, they must be taken out in a wheelchair with a clear instruction to whoever takes them out that they are not to walk anywhere. Trips out should be agreed at the MDT care plan review meetings, should be time-limited and only granted if the young person is co-operating with their treatment.

1. **An eagerness to be very helpful around the ward**

Acknowledge the young person’s wish to be helpful but remind them that because of their physical health they are not able to help in a physical way. They could be offered opportunities to engage in alternative activities such as making a card, playing a game (sitting down), reading, listening to music, watching TV.

**Instructions for calculating %median BMI *or WFH (weight for height)***

%median BMI = Actual BMI **divided by** 50th centile BMI for age and gender **multiplied by** 100

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Age (years)*** | ***50th centile BMI for age*** |  | ***Age (years)*** | ***50th centile BMI for age*** |
| ***Male*** | ***Female*** |  | ***Male*** | ***Female*** |
| 9 | 16.037 | 16.399 |  | 14.75 | 19.158 | 19.822 |
| 9.25 | 16.125 | 16.515 |  | 15 | 19.317 | 19.955 |
| 9.5 | 16.219 | 16.637 |  | 15.25 | 19.475 | 20.083 |
| 9.75 | 16.318 | 16.765 |  | 15.5 | 19.632 | 20.206 |
| 10 | 16.423 | 16.898 |  | 15.75 | 19.786 | 20.324 |
| 10.25 | 16.533 | 17.036 |  | 16 | 19.938 | 20.438 |
| 10.5 | 16.648 | 17.179 |  | 16.25 | 20.087 | 20.547 |
| 10.75 | 16.768 | 17.327 |  | 16.5 | 20.234 | 20.652 |
| 11 | 16.892 | 17.478 |  | 16.75 | 20.378 | 20.751 |
| 11.25 | 17.02 | 17.634 |  | 17 | 20.519 | 20.847 |
| 11.5 | 17.154 | 17.793 |  | 17.25 | 20.656 | 20.938 |
| 11.75 | 17.291 | 17.954 |  | 17.5 | 20.791 | 21.026 |
| 12 | 17.433 | 18.117 |  | 17.75 | 20.923 | 21.11 |
| 12.25 | 17.579 | 18.281 |  | 18 | 21.052 | 21.19 |
| 12.5 | 17.729 | 18.446 |  | 18.25 | 21.178 | 21.267 |
| 12.75 | 17.881 | 18.61 |  | 18.5 | 21.301 | 21.342 |
| 13 | 18.037 | 18.772 |  | 18.75 | 21.422 | 21.413 |
| 13.25 | 18.194 | 18.932 |  | 19 | 21.54 | 21.482 |
| 13.5 | 18.354 | 19.09 |  | 19.25 | 21.655 | 21.548 |
| 13.75 | 18.514 | 19.244 |  | 19.5 | 21.768 | 21.612 |
| 14 | 18.675 | 19.395 |  | 19.75 | 21.878 | 21.674 |
| 14.25 | 18.836 | 19.542 |  | 20 | 21.986 | 21.735 |
| 14.5 | 18.997 | 19.684 |  |  |  |  |