

**Individualised Eating Disorder Care Plan**

***(To be used at admission alongside current eating disorders protocol.***

***Ongoing care plans to be completed in daily notes after each MDT review.)***

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **DOB:** |  |
| **NHS No:** |  | **Date of review:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Professionals/Family involved** | **Name** | **Present at review** | **Invited to next review** |
| Paediatrician |  |  |  |
| Ward nursing staff |  |  |  |
| Dietitian |  |  |  |
| CAMHS clinician |  |  |  |
| Family members |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Weight:** |  | **Date:** |  | **Weight shared with young person:** | **Yes / No** |

*(to be weighed twice weekly as per ED protocol - including on admission, Mon & Thurs)*

**Supervision: Meal / Snack times** **(Meal - 45min/ snack - 30min)**

**Requires supervision following meal:** **Yes/No** (delete as applicable)

|  |
| --- |
| **Meals and Snacks supervised by:** |
|  |

**Bathroom/shower time:** Parents/carers 🞏 Nursing staff 🞏 **Bed rest/wheelchair to mobilise: Yes / No**

|  |  |
| --- | --- |
| **Dislike 1:** *(specific food, not food groups)* |  |
| **Dislike 2:** *(specific food, not food groups)* |  |

**Meal plan:** **Yes / No**

**Meal plan no: NG Plan**

**Mental Health Act:** Informal (not detained) / Section 2 / Section 3 /

Section 5.2 / CTO: Community Treatment Order Date detained:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medication Plan** *(as per prescription chart)* | | | | | | |
| Medication as stated on drug chart: | | | | | | |
| **Re-feeding risk/ bloods required and frequency:** | | | | | | |
|  | | | | | | |
| **Nasogastric feeding** *(ensure NG feeding protocol is followed, consider under parents’ consent)* | | | | | **Yes / No** | |
| **NG Management Plan:**  Support Plan around NG Feeds as discussed with…..  **Prior to feed:**  **During Feeds:**  **What is helpful/may help:**  **What is not helpful:**  **After Feeds:** | | | | | | |
| **Agreed visiting times:** *(Parents not to be present at mealtimes etc.)* | | | | | | |
|  | | | | | | |
| **Ward timetable:** *(Attends school / play therapy etc.)* | | | | | | |
|  | | | | | | |
| **Risk/ Safeguarding concerns:** | | | | | **Yes / No** | |
|  | | | | | | |
| **Allowed to leave the ward supervised by family/carers:** | | | | |  | |
| **Plan Summary:** | | | | | | |
| **Aims of Admission to ……. Ward For Example**   * Maintain physical health * Weight Gain * Re-establish eating pattern needed for ongoing community CAMHS support to be effective   **Management Plan**   * ….. * ……. * ……..   **Tier 4 Bed Search**  It is the responsibility of the CAMHS Team to update care plans and the Form 1 and to submit/re-submit referrals to tier 4 units. Ward staff are not expected to do this. If there are questions from parents or the ……. regarding bed searches, please re-direct these to the CAMHS care team.  This Care plan will be stored in ward notes and a copy made available to ………and parents.  **CAMHS Appointments For Example**   * ……. * ……. * ………. * ……… | | | | | | |
| **Date of next review**: |  | | **Care plan shared with the young person:** | | | **Yes/ No** |
| **Signature of young person:** | |  | | **Date:** | |  |