MANAGEMENT OF CHILDREN PRESENTING ACUTELY TO ST GEORGES WITH ANOREXIA NERVOSA

Patient presents to Trust with anorexia nervosa
- To outpatients under any consultant
- To Emergency Department with complications or crisis
- Transfer from a Specialist Eating Disorders Unit with medical complications
- Semi-planned admission from the care of CAMHS in the community

Clinical assessment:
- For degree of medical instability (Sec 5.0)
- For risk of refeeding syndrome (Sec 8.0)
- To identify medical or psychiatric co-morbidities
- To identify child safeguarding concerns

Weight & height (Sec 3.2) | History (Sec 4.1) | Examination (Sec 4.2) | Observations (Sec 4.3) | Investigations (Sec 4.4)

RISK ASSESSMENT (Sec 5.0, Table 2)
- Red feature or significant medical or psychiatric co-morbidity
- Amber features with no red features
- All green or blue features

D/W the following to consider need for medical admission:
- CAMHS CEDT / named psychiatrist (or duty CAMHS clinician)
- Named paediatrician (or on-call paediatric consultant) (Sec 6.0)

D/W CAMHS CEDT or psych liaison (Sec 6.2) to plan safe discharge to community care

Decision to admit | Decision to discharge

Inform all MDT (Sec 6.2) | Assess risk refeeding syndrome and specific medical complications (Sec 8.0) | Book bed via 6448 bleep | Arrange RMN

Manage specific medical complications and risks (Sec 7.0 Table 5) | Start meal and monitoring plan as per risk level (Sec 8.0) | Complete Individual ED plan (App 4) and give patient / parent info leaflet (App 5)

Named paediatrician eating disorders: Dr Luci Etheridge (via mobile, 9am-5pm) CAMHS CEDT: 0203 513 6793 (9am-5pm)
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1.0 BACKGROUND AND INTRODUCTION
This guidance describes the standard of care for all children / young people presenting acutely to St. George’s Hospital with anorexia nervosa.

Anorexia nervosa is a serious disorder with life-threatening physical as well as psychological complications. It has an incidence of around 65 per 100,000 adolescents aged 10-19 and tends to run a protracted course, lasting 5-6 years on average, at a crucial time in a young person’s development. However, the incidence is currently rising and there is also a rise in early-onset (<13 years) eating disorders. 90% of sufferers are female but males tend to be under diagnosed and treated.

Evidence shows that good joint working between CAMHS and paediatric services, with carefully planned pathways and guidance, can improve outcomes for young people.

CAMHS services for local young people with eating disorders are currently arranged in the following way:

- Tier 3 dedicated ED team – the CAMHS Community Eating Disorders Team (CAMHS CEDT), based at Springfield Hospital, currently receives referrals for all young people with eating disorders from the Wandsworth, Merton, Sutton, Richmond and Kingston areas. The multidisciplinary team based there co-ordinates and provides the outpatient mental health management of the eating disorder (occasionally with joint care from the locality Tier 3 team), working jointly with the patient’s GP, who retains primary responsibility for patients’ physical health monitoring and management. This is consistent with current commissioning arrangements.

- Tier 3 locality teams – the borough cased CAMHS team may be managing cases of young people with other mental health issues who also have eating difficulties, or unrecognised eating disorders. There are different pathways for childhood feeding disorders and sub-threshold eating issues that come under the locality team. There are referral criteria and a joint care protocol between the CAMHS CEDT and borough-based locality teams.

- Tier 4 – these Specialist Eating Disorders Unit (SEDU) services are funded and arranged centrally via NHS England for the most severe cases. There are two SEDUs in the local area; Wisteria Ward at Springfield and the Priory, Roehampton. Patients who live locally may also be referred to an SEDU located ‘out of area’, usually depending on bed availability. The decision on admission to an SEDU needs to be made by the CAMHS CEDT, or in some cases, the Tier 3 locality CAMHS team.

In line with national best practice guidance, St George’s has a named paediatrician, Dr Lucinda Etheridge, with interest and expertise in eating disorders. She works closely with the CAMHS CEDT.
2.0 PRESENTATION
Young people with anorexia nervosa may present to St George’s in a number of ways:

- To children’s outpatients, under any consultant, with an unrecognised eating disorder
- To children’s outpatients, under any consultant, with an eating disorder as an additional complication of a known long term condition e.g. diabetes
- As an outpatient referral from CAMHS CEDT to Dr Etheridge for paediatric review as part of assessment of a known eating disorder
- To the Emergency Department with symptoms from an unrecognised eating disorder
- To the Emergency Department with physical or psychological complications of a known eating disorder
- As a transfer from an SEDU or another acute hospital with serious physical complications of a known eating disorder
- As a semi-planned medical admission for management of current or anticipated physical complications as part of eating disorder treatment e.g. high risk of refeeding syndrome

Any of these patients may require a period of inpatient admission and management.

2.1 Recognition of anorexia nervosa
Young children and adolescents may present without the ‘typical’ features of eating disorders seen in older people e.g. amenorrhea, significantly low BMI. The behaviours associated with disordered eating are often covert and may be hidden from family.

It is, therefore, important to consider an eating disorder and to ask directly about the possibility in all young people presenting with weight loss, low weight or other features seen in anorexia nervosa.

All young people in whom an eating disorder is suspected must be seen without parents present, with a chaperone if needed, to ask about eating behaviours and body perception.

Behavioural indicators of a possible eating disorder are:
- Reluctant attendance
- Focusing on physical symptoms e.g. bloating, constipation, tiredness
- Covering the body
- Resisting weighing or examination
- Being evasive or angry when asked about eating
- Being restless or even agitated
Diagnostic features of anorexia nervosa are:

- Refusal to maintain body weight or failure to gain weight after a period of growth
- Intense fear of gaining weight
- Altered body perception – however, note that some young people with a long history who are very low weight may have insight into their low weight and recognise how thin they are now, although won’t have done previously. Altered body perception may include a significantly underweight young person being happy with their current body size and weight, perceiving that this is acceptable and desirable.
- Undue influence of body weight or shape on self esteem
- Denial of seriousness of low weight
- Primary amenorrhoea or secondary amenorrhoea/oligomenorrhoea in girls post menarche

2.2 Medical differential diagnosis of anorexia nervosa

In general, if the history and findings are suggestive of anorexia nervosa then time should not be wasted pursuing a medical cause. However, the following differentials should be considered at initial presentation:

**Table 1: medical differential diagnoses of anorexia nervosa**

| Gastrointestinal | Coeliac disease | Combination of history, examination and basic investigations. Note bloating and ‘intolerance’ of food is commonly reported in anorexia nervosa as part of the illness behaviour and GI symptoms can be part of laxative abuse.
|                 | Inflammatory bowel disease |                          |
|                 | Peptic ulcer disease       |                          |
| Endocrine       | Diabetes                   | Combination of history, examination, review of growth patterns and investigations. |
|                 | Hyperthyroidism            |                          |
|                 | Glucocorticoid insufficiency|                          |
| Oncological     | Lymphoma                   | Combination of history, examination and basic investigations. Note weight loss alone is an uncommon presentation of brain tumour; anorexia nervosa is more common. |
|                 | Leukaemia                  |                          |
|                 | Brain tumour               |                          |
| Chronic infection| TB                         | Assessment of risk factors from history and targeted investigations if warranted. |
|                 | HIV                        |                          |
|                 | Chronic viral infection    |                          |
3.0 ANTHROPOMETRIC ASSESSMENT

Accurate height and weight measurement is vital in assessing anorexia nervosa. It is important to recognise that patients with anorexia nervosa may go to some lengths to make themselves appear shorter than they are or to make their weight appear higher than it is. Many young people will prefer not to know their weight, especially during recovery, or will make incorrect interpretations of the numbers, so it is best not to offer it or allow them to see.

3.1 How to take measurements

In an outpatient or ED setting coats, jumpers, shoes and heavy/bulky clothing should be removed for weight and height measurements. Consideration should be given as to whether the patient has hidden heavy items in any pockets or in their waistband and patients asked to empty pockets. Make sure they are standing with legs straight and feet together and back against the wall when measuring height.

In an inpatient setting weigh the young person twice weekly (Monday and Thursday) on the same scales, in the morning before meals. This should be done wearing underwear or light pyjamas and after they have gone to the toilet. Check all pockets for contents before weighing. Patients should not have access to ward scales. Patients may “water-load” in order to mimic weight gain. Access to fluids should therefore be controlled. Patients may try to drink from other patient’s drinks, taps/toilets/showers etc and hence restriction to these may need to be arranged. If there is ongoing concern, measurement of urine specific gravity (normal in the morning >1.010) at the same time as being weighed may be necessary.

3.2 Calculating and interpreting BMI

Body Mass Index gives a measure of weight for height. However, using BMI alone as a measure of malnutrition has limitations, especially in children under 10 years of age, due to normal changes in weight, height and BMI during childhood and puberty. BMI also varies with ethnicity.

Calculate BMI in the usual way:

\[ BMI = \frac{\text{weight (kg)}}{\text{height}^2 (m)} \]

BMI should then be plotted on a centile chart (see appendix 1) and the % weight for height (or % median BMI) calculated by looking at the 50th centile BMI on the chart. This is done in the following way:

\[ \% \text{ weight for height} = \left( \frac{\text{actual BMI}}{50^{th} \text{ percentile BMI for age and gender}} \right) \times 100 \]

The % weight for height gives a more useful indicator of risk (see section 5.0) so should be documented for all patients.
4.0 CLINICAL ASSESSMENT OF THE ANOREXIC PATIENT

Initial clinical assessment, in ED, ward or clinic settings, has the following aims:

A. Assess degree of medical instability (see section 5.0)
B. Assess risk of refeeding syndrome (see section 8.0)
C. Identify medical and psychiatric co-morbidities
D. Identify any child safeguarding concerns

4.1 History

Weight and diet
- Any previous weights and timings of these
- Food intake - going through all meals and snacks daily
- Any foods or food groups excluded and why
- Any active restriction taking place eg calorie counting, portion control, exclusions
- Any measures to avoid eating or hide restriction eg hiding food
- Any food refusal

Fluid balance
- Fluid intake daily – amount and type, any fluid restriction or refusal
- Urine output and bowel habit
- Self-induced vomiting, frequency, and the reasons for this

Eating behaviours
- Who prepares food and is around at mealtimes
- What mealtimes are like psychologically and emotionally eg anxiety, arguments, aggressive behaviour
- Engagement and progress with any previously agreed eating plans
- Bingeing and the reasons for this

Activity
- Daily exercise – both overt ie sports, dance, and covert eg running up and down stairs
- Other calorie burning eg going out in cold with no coat, wearing lots of layers in heat
- Why exercise is undertaken eg to burn off food eaten, to look different, to relieve anxiety

Other symptoms
- Energy levels, attention and concentration eg with schoolwork
- Abdominal symptoms – abdominal pain, bloating, heartburn, haematemesis, constipation
- Cardiovascular symptoms – syncope or pre-syncopal symptoms, palpitations, oedema
- Dermatological – dry skin, cold peripheries, poor healing, pruritus, hair growth/loss
- Menstrual cycle in girls – menarche, previous pattern, duration amenorrhoea

Drug history
- Medications, including psychiatric medication eg antidepressants, olanzapine; and over the counter medication eg St John’s Wort, caffeine, herbal supplements, diet pills
- Use of laxatives or diuretics and the reasons for this

Psychosocial
- Mood and anxiety, including any deliberate self-harm or suicidal ideation
- Motivation for the future and thoughts about recovery
- Siblings and other family members and how they are coping with the illness
- School and attainment/difficulties and expectations
- Friendships and coping mechanisms
- HEADSS screen (see adolescent health guidance)

4.2 Examination
- Full systems examination
- Assessment of malnutrition: pallor, oedema, acrocyanosis, lanugo hair, thin hair, muscle wasting, poor skin healing, evidence of specific deficiencies e.g. angular cheilitis
- Assessment of hydration: skin turgor, mucous membranes, capillary refill time
- Evidence of purging: knuckle callus, parotid hypertrophy, dental erosion
- SUSS tests
  - Ask to sit up from lying, without using hands
  - Ask to squat and stand back up, without using hands
  - Score for both from 0-3:
    - 0 = unable to rise, 1 = able to rise only using hands, 2 = able to rise with noticeable difficulty, 3 = able to rise without difficulty

4.3 Observations
All young people must have:
- Pulse rate sitting and standing
- Blood pressure sitting and standing
- Temperature

4.4 Initial investigations
At first presentation, all young people should have the following investigations:
- 12 lead ECG
- FBC and film
- Ferritin, B12, folate, vitamin D
- Coeliac screen
- U&E, LFT, bone profile, magnesium
- TFT
- Glucose – if <2.6 then also full hypoglycaemia screen (as per endocrine guidance)
- Chloride and bicarbonate if history of vomiting
- Amylase and lipase if abdominal pain
- LH, FSH, prolactin, oestradiol, testosterone, AFP and β-HCG in girls with amenorrhea
5.0 RISK ASSESSMENT: HOW ILL IS THE PATIENT?
Assessing risk of physical and/or psychological harm is complex and multifactorial. It combines clinical assessment with physical investigations; assessment of mood, motivation and engagement; and assessment of support for the young person.

The Junior Marsipan guidance framework shown in Table 2 should be followed and completed for every young person who presents for the first time in any setting. The table shows the different elements of risk assessment, the factors gathered from clinical assessment that allow assessment of risk in each area, and a RAG rating for risk stratification. Go through each area in turn and place the child in a red, amber, green or blue category. The most severe category found at each area should be used. The framework does not prescribe definite management but helps in weighing up options and targeting specific areas of management.
### Table 2: Junior Marsipan risk assessment framework

<table>
<thead>
<tr>
<th>RED (high risk)</th>
<th>AMBER (alert to high concern)</th>
<th>GREEN (moderate risk)</th>
<th>BLUE (low risk)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BMI and weight</strong></td>
<td>%BMI &lt;70 Recent wt loss ≥1kg / week for 2 consecutive weeks</td>
<td>%BMI 70-80 Recent wt loss 500-999g / week for 2 consecutive weeks</td>
<td>%BMI 80-85 Recent wt loss up to 500g / week for 2 consecutive weeks</td>
</tr>
<tr>
<td>CVS</td>
<td>Heart rate (awake) &lt;40 bpm Recurrent syncope Postural drop SBP of 20mmHg or to &lt;0.4th centile for age/sex OR postural rise HR &gt;30 bpm Arrhythmia</td>
<td>Heart rate (awake) 40-50 Occasional syncope Sitting BP &lt;0.4&lt;sup&gt;th&lt;/sup&gt; centile OR postural drop SBP 15mmHg OR postural rise HR up to 30 bpm</td>
<td>Heart rate (awake) 50-60 Pre-syncopal symptoms but no postural drop Sitting BP &lt;2&lt;sup&gt;nd&lt;/sup&gt; centile Prolonged peripheral (normal central) CRT</td>
</tr>
<tr>
<td>ECG</td>
<td>QTc &gt;460ms (F) or &gt;400ms (M) PLUS arrhythmia or evidence electrolyte abnormality</td>
<td>QTc &gt;460ms (F) or &gt;400ms (M)</td>
<td>QTc &lt;460ms (F) or &lt;400ms (M) and taking medication known to prolong QTc</td>
</tr>
<tr>
<td>Hydration</td>
<td>Fluid refusal Reduced urine output 7-10% dehydrated Inappropriate normal heart rate +/- low BP in malnourished person</td>
<td>Severe fluid restriction 5-7% dehydrated</td>
<td>Fluid restriction &lt;5% dehydrated</td>
</tr>
<tr>
<td>Temperature</td>
<td>&lt;35.5 degrees C</td>
<td>&lt;36 degrees C</td>
<td></td>
</tr>
<tr>
<td>Biochemistry</td>
<td>Hypo – phosphataemia, -kalaemia, -natraemia, -calcaemia, -glycaemia, -albuminaemia</td>
<td>Hypo – phosphataemia, -kalaemia, -natraemia, -calcaemia</td>
<td></td>
</tr>
<tr>
<td>Eating behaviour</td>
<td>Acute food refusal OR intake 400-600 calories/day</td>
<td>Restriction to &lt;50% required calories, vomiting or laxatives</td>
<td>Moderate restriction Bingeing</td>
</tr>
<tr>
<td>Engagement with plan</td>
<td>Eating history</td>
<td>Violent from child around mealtimes Violent behaviour from parents e.g. force feeding</td>
<td>Poor insight Lacks motivation Resists changes</td>
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<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Activity and exercise</td>
<td>Exercise history</td>
<td>&gt;2h/day uncontrolled exercise in context of malnutrition</td>
<td>1-2h/day uncontrolled exercise in context of malnutrition</td>
</tr>
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<td>Self-harm</td>
<td>Psychiatric history</td>
<td>Self poisoning, suicidal ideas with moderate to high risk completed suicide</td>
<td>Cutting or similar, suicidal ideas with low risk completed suicide</td>
</tr>
<tr>
<td>Other mental health diagnoses</td>
<td>Psychiatric history</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUSS test</td>
<td>SUSS test</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>History, exam, bloods</td>
<td>Confusion/delirium Acute pancreatitis Gastric/oesophageal rupture</td>
<td>Mallory-Weiss tear Reflux or gastritis Pressure sores</td>
</tr>
</tbody>
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6.0 ADMISSION TO A PAEDIATRIC WARD
Admission to a paediatric ward will only be indicated in circumstances when a young person requires medical treatment as a consequence of complications which cannot be safely managed on an outpatient basis or within a mental health setting.

The purpose of the admission is to treat their physical condition so that they can be discharged once their medical state has been stabilised, either home or to the appropriate mental health setting.

In general, the following groups of young people may need admission to a paediatric ward:

A. Management of significant physical complications of severe malnutrition and/or associated behaviours e.g. metabolic disturbance, cardiac arrhythmia, dehydration
B. Management of an acute medical illness unrelated to, but complicated by, anorexia nervosa
C. To begin the process of refeeding for families who are not coping, with the aim of this continuing at home once stabilised
D. Re-feeding for severe malnutrition and anticipated medical instability whilst awaiting a bed in a SEDU
E. Difficulties in placement of nasogastric tube (NGT) in a SEDU
F. Any young person where there are safeguarding concerns that need further investigation and management planning eg self-harm, family breakdown

6.1 Process
In line with all other paediatric admissions, beds should be requested and booked via the paediatric bleep holder on bleep 6448.

All patients aged up to and including 17 years of age will be admitted to a paediatric ward. Wherever possible, this should be Frederick Hewitt ward. The decision about whether the patient needs a bed space in a bay or a cubicle near the nurse’s station is dependent on the level of risk assessment eg medical instability, risk of self-harm. This should be discussed with the admitting consultant and the nurse in charge.

Patients aged 18 years or more should be referred to Dr Penny Nield, consultant gastroenterologist. They will require management by adult teams on an adult ward. This is the responsibility of the ED team or the psychiatry liaison team to arrange and is not the responsibility of paediatric staff.

6.2 Responsible consultant and shared care with CAMHS
All young people with an eating disorder will be admitted jointly under the care of a paediatrician and a CAMHS consultant.

Admission should always be discussed and agreed by both a consultant paediatrician and a relevant CAMHS professional.
In the case of potential emergency admissions, either from ED or clinic, the patient should be discussed with the following people:

### Table 3: contact details for professionals

<table>
<thead>
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<th>Role</th>
<th>Availability</th>
<th>Contact Information</th>
</tr>
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<tbody>
<tr>
<td>Dr Lucinda Etheridge (named consultant for Eating Disorders)</td>
<td>During working hours when not on leave</td>
<td>Mobile phone via switch</td>
</tr>
<tr>
<td>The attending paediatric consultant or on-call paediatric consultant</td>
<td>8.30 – 5.00 - attending Out of hours - on-call</td>
<td>Names available on RotaWatch Contact via switch</td>
</tr>
<tr>
<td>The patient’s named specialty consultant</td>
<td>During working hours If known to another team eg diabetes</td>
<td>Via switch or their secretary</td>
</tr>
<tr>
<td>The CAMHS CEDT – Dr Joel Khor (consultant), Dr Lisa Davies (consultant), or Robert McCandless (team lead therapist)</td>
<td>During working hours If known to the team OR if a local patient (Wandsworth, Merton, Sutton, Kingston, Richmond)</td>
<td>Harewood house, building 1 Springfield University Hospital 0203 513 6793</td>
</tr>
<tr>
<td>Psychiatry liaison nurse</td>
<td>Outside of working hours OR if an out of area patient OR if patient is known to another psychiatrist eg privately, not yet referred to CAMHS CEDT</td>
<td>Via switch</td>
</tr>
</tbody>
</table>

In the case of young people who are admitted for medical instability and not known to the CAMHS CEDT, they should be contacted on the first available working day for advice, liaison with other CAMHS services to agree the lead psychiatrist, and to ensure CAMHS review takes place as soon as possible.

### 6.3 How shared care works in practice

- **Defining the care team**
  
  Both paediatric and CAMHS teams, including both consultants, nursing staff and dietician, should meet prior to the admission or very shortly after admission to agree a treatment plan. The aim of the admission should be clarified. This plan should address factors described in this guidance and needs to be clearly documented. Where possible parents should be involved in the planning and patient’s voice heard. Whilst it can take some time to develop the detail of the initial treatment plan, this is time well spent.

  In the case of admissions from a SEDU, a consultant to consultant discussion should take place prior to admission between the consultant psychiatrist and a consultant paediatrician. This will be Dr Etheridge when she is not on leave, or the attending paediatric consultant when Dr Etheridge is away. The process and plan for shared care should be agreed and documented at this discussion and communicated to the rest of the team.

- **Involving parents and the patient**
  
  The details and rationale for the plan should be communicated to patient and parents. Detailed documentation is very important to avoid future confusion when the patient
questions the plan. It is good practice for the patient and parents to have a copy of the plan. Information sheets for patients and families are helpful. These are provided in this guidance.

- **Reviewing the plan**
  This plan needs to be reviewed by the whole team regularly (e.g. once to twice weekly) and the patient and parent need to be made aware of when these reviews will take place and how they can have some input into the process e.g. writing letters to the meeting, through discussions with key nurse. All staff, patient and parents should know that no changes will be made to the treatment plan outside of these reviews (unless in an emergency) and without discussion with all parties. It can be helpful to offer patient and parents a regular time to meet a named professional outside of the review meetings to discuss concerns. Any questions can then be directed to the team.

- **Communicating the plan**
  There should be agreement as to how the plan will be communicated to staff at each shift and to any agency staff. The individual eating disorders plan in this guidance provides a starting point for this.

- **Providing information**
  Advice sheets can be useful to staff unfamiliar with dealing with adolescents with anorexia and are provided in this guidance.

### 6.4 Arrangements for RMNs

All young people admitted due to their eating disorder will require 1:1 nursing with a Registered Mental Health Nurse (RMN).

Young people transferred from a SEDU will be transferred with an RMN and the SEDU will continue to provide the RMN on a daily basis throughout the length of the stay.

Young people admitted as an emergency will need to have an RMN sourced and provided through the 6448 bleep holder/nurse in charge of the accepting ward. They should not be transferred from ED until the RMN is available. This will be funded by the Trust.

If young people are assessed by CAMHS to be at high risk of self-harm and suicide then two RMNs may need to be provided. This question should be explicitly addressed by CAMHS at initial assessment, as per Trust policy.

Once the young person has been stabilised and assessed on the ward by CAMHS and the paediatric consultant, the decision may be taken that 1:1 supervision can be provided by a ‘special’ Healthcare Assistant (HCA) rather than an RMN. However, this is a joint consultant decision to be made in conjunction with nursing staff and the family and after a full risk assessment.
6.5 Dietetic involvement
The paediatric dietician for the ward should be contacted within working hours on the first working day of admission, via the office on extension 2036, to arrange an initial assessment. There is no out of hours dietetic cover.

6.6 Roles and responsibilities of staff
Successful and safe management of young people with anorexia nervosa requires a co-ordinated MDT approach. All team members have responsibility for ensuring safe patient care. The table below outlines the main responsibilities of different team members:
Table 4: roles and responsibilities of staff

| Admitting paediatric doctor (consultant or junior) | • Ensure full and complete clinical assessment, as per this guidance  
| • Arrange and review initial investigations and act on results  
| • Undertake initial Junior Marsipan risk assessment  
| • Initiate medical management  
| • Assess refeeding risk and initiate a suitable meal and monitoring plan  
| • Begin contact with relevant professionals to ensure plan for stay is clarified  
| • Inform patient and family of admission process and plan using the information sheets provided |
| Named consultant paediatrician (Dr Etheridge when available, attending consultant when not) | • Review physical and nutritional assessment as soon as possible after admission  
| • Advise on medical management of anticipated and actual complications  
| • Advise on risk of and monitoring of refeeding syndrome  
| • Discuss and agree plan for refeeding with CAMHS  
| • Discuss and agree any deviations from this guidance with CAMHS  
| • Clarify plans with patient and family and ensure they are fully updated on progress at least weekly  
| • Ensure joint review with CAMHS at least weekly  
| • Refer to other specialist paediatric teams as needed eg gastroenterology, endocrine  
| • Ensure liaison between all MDT members takes place  
| • Ensure discharge is planned and safe  
| • Take responsibility for any safeguarding issues |
| Named consultant psychiatrist (CAMHS CEDT in most local cases) | • Advise on risk assessment and supervision level at admission (via a duty clinician if out of hours)  
| • Liaise with the named paediatric consultant within 24 hours of admission and then at least twice weekly  
| • Arrange CAMHS review of the patient on the ward within 48 hours to review risk assessment and agree plans  
| • Discuss and agree plan for refeeding with named paediatric consultant  
| • Advise on behaviour management and agree any deviations from this guidance  
| • Agree and document consent and the legal framework for treatment, and arrange assessment under the Mental Health Act if necessary |
### Management of children presenting acutely to St George’s with Anorexia Nervosa

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
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</table>
| RMN or 1:1 special nurse          | - Ensure 1:1 supervision of the patient at all times, as per their Individual Eating Disorders Plan  
- Work constructively with the ward nurse to care for the patient  
- Document the patient’s progress and any mental state observations at the end of each shift  
- Supervise food choices and meal times, as per this guidance and the patient’s meal plan and Individual Eating Disorders Plan  
- Document all food and drink taken  
- Ensure the patient complies with any bed rest prescribed  
- Supervise the patient in toileting and personal care, as agreed on the Individual Eating Disorders Plan  
- Observe the patient for expected covert behaviours eg water loading, and act on these  
- Recognise the risk of deliberate self harm and supervise the patient to prevent this  
- Undertake any therapeutic work with the patient and family as directed by the consultant psychiatrist  
- Engage the patient in art/craft/reading activities at the bedside and liaise with school and play to provide these  
- Comfort the patient and family as needed in times of distress  
- Use de-escalation techniques in times of high stress  
- Accompany the patient off the ward for any allowed activities eg school, play |
| Attending paediatric consultant and their team | - Review patient’s physical health and management and update patient, family and nursing staff on this daily  
- Liaise with the named paediatric consultant about management planning  
- Carry out any planned investigations and monitoring  
- Ensure management plans are in place as advised  
- Ensure medical arrangements are in place for safe discharge |
| **Monitor the patient’s mental state and advise on psychiatric medication** |  
| **Ensure joint review with paediatrics at least weekly** |  
| **Ensure patient and family are fully updated on progress at least weekly** |  
| **Liaise with other relevant mental health professionals eg local or specialist teams** |  
| **Apply for Tier 4 funding via NHSE for a SEDU bed if needed** |  
| **Arrange referral to a SEDU if needed** |  
| **Organise any community follow-up needed on discharge** |  

**MANAGEMENT OF CHILDREN PRESENTING ACUTELY TO ST GEORGE’S WITH ANOREXIA NERVOSA**

Responsible authors: Lucinda Etheridge, Joel Khor, Carole Bettley, Yasmin Baki  
Sone Spies, Abigail Swancott, Rachel Barratt  
Date published: September 2015  
Review date: September 2018
<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
</table>
| Ward nurse                      | - Work constructively with the RMN/special nurse to care for the patient, including assisting the RMN in documenting patient care  
- Complete care pathways for the patient  
- Undertake all physical observations as agreed with the medical team, monitoring (including fluid balance) and weighing of the patient  
- Escalate physical concerns to the paediatric doctors  
- Assess pain scores  
- Monitor tissue viability  
- Assist the patient with special personal care and hygiene needs  
- Pass an NGT, if needed, and administer NG feeds  
- Administer any prescribed medicines |
| Ward nurse in charge            | - Ensure that the ward nurse and RMN/special nurse are working together to care for the patient  
- Ensure that the patient’s medical needs are handed over to the ward nurse at each shift change  
- Ensure that the RMN/special nurse at each shift change has been given a copy of the patient’s Individual Eating Disorders Plan and meal plan and had a hand over of daily needs |
| Paediatric dietician            | - Review all new patients within 1 working day of admission  
- Agree patient's prior dislikes and any special dietary requirements eg diabetic, Halal, at this assessment  
- Provide suitable meal plans, in liaison with the named paediatric consultant, based on the meal plan frameworks in this guidance and any meal plan in place at admission  
- Oversee new meal plans, based on the meal plan frameworks in this guidance, at planned points in liaison with the paediatric consultant  
- Provide regimes for NG feeding, in liaison with the named paediatric consultant, based on this guidance  
- Provide nutritional supplements for meal replacements  
- Liaise with the CAMHS CEDT or SEDU dietician around discharge |
7.0 MANAGEMENT OF SPECIFIC MEDICAL COMPLICATIONS

Initial medical management should focus on the following:

- Addressing hydration status
- Identifying and correcting glucose and electrolyte abnormalities
- Minimising cardiovascular risks
- Identifying and treating possible complications of low weight and malnutrition

Table 5 below outlines specific measures that may need to be taken.

7.1 Role of HDU/PICU

Some patients may require high dependency care for closer physical monitoring. Any patient where there is concern should be discussed with the consultant for referral to PICU. However, the following groups are more likely to need this:

- Hypokalaemia with serum potassium <2.5 mmol/L
- Hyponatraemia with serum sodium <120 mmol/L
- Cardiac arrhythmia
- Sepsis requiring more than 20 mls/kg fluid resuscitation (due to expected reduced cardiac function and ability to cope with large fluid loads)

7.2 Significant purging

Medical problems in patients who purge (vomit or abuse laxatives) are directly correlated to the mode and frequency of purging. Frequent vomitors – more than 3 times a day on most days – are most at risk of significant metabolic disturbance. Some of these problems may only become apparent after they have stopped purging, so it is important to be aware of them and anticipate them.

- Pseudo-Barrter’s syndrome: Normotensive hypokalaemic hypochloraemic metabolic alkalosis due to secondary hyperaldosteronism. Occurs 2-3 days after stopping purging, when oedema develops. Important to check U+E and bicarbonate 2-3 days after admission (or vomiting is stopped) and after apparently correcting any initial hypokalaemia. Will need additional potassium supplementation alongside slow IV saline for 24-48 hours to turn off aldosterone production. After this, ensure total body potassium is built back up with oral supplements for a week, aiming for a serum potassium of about 4.5-5.0 mmol/L. Spironolactone can also be helpful for a week.
- Oesophagitis/ Mallory Weiss tear: needs cessation of vomiting and a period of PPI
- Constipation: due to persistent stimulant laxative abuse, may need weaning onto Movicol and then gradual withdrawal
- Sialadenosis: non-painful bilateral parotid swelling, improves with NSAIDs and if suck lemon drops.
| **Cardiovascular** | Bradycardia <50 bpm or postural tachycardia | Bed rest and continuous heart rate monitoring  
Nurse at 30-45° head up if bradycardia worsens on lying flat |
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<tbody>
<tr>
<td></td>
<td>Hypotension &lt;0.4&lt;sup&gt;th&lt;/sup&gt; centile or postural drop &gt;15 mmHg</td>
<td></td>
</tr>
</tbody>
</table>
|                   | Prolonged QTc (in any lead) Arrhythmia associated with malnutrition or electrolyte disturbance | Bed rest and cardiac monitoring  
Discuss with cardiologist – medication unlikely to be helpful but may need to stop some medicines eg olanzapine, which prolong QTc, until better nutritionally Identify and correct specific electrolyte disturbances |
| **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 review  
Fluid bolus 10mls/kg and reassess  
Consider other causes eg sepsis |
| **Metabolic**     | Hypokalaemia <3.0 mmol/L (HDU/PICU if <2.5 mmol/L) | Supervision to prevent vomiting  
Slow 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 monitoring  
Oral/NG supplements |
|                   | Hypoglycaemia | Full hypoglycaemia screen (hypoglycaemia is unusual)  
IV 10% dextrose 2mls/kg followed by infusion if symptomatic  
Otherwise a sugary drink or Hypostop and re-check |
| **Immunity**      | Skin breakdown | Pressure mattress  
Tissue viability advice |
|                   | Neutrophil count <1.0 x10<sup>9</sup> PLUS fever >38°C | Septic screen  
Broad spectrum antibiotics |
| **Neurological**  | Confusion, headache | Review feeding – is this refeeding syndrome encephalopathy?  
Paediatric neurology review ?venous sinus thrombosis  
Septic screen and consider antibiotics and aciclovir |
| **Gastrointestinal** | Gastric dilatation (feeling full PLUS visible distension) | NGT decompression  
Slow rate of feeding |
|                   | Severe abdominal pain | Consider pancreatitis, check amylase and lipase  
AUSS 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 liver  
Monitor as refeed carefully with reduced fat, check clotting and triglycerides |

**Table 5: specific physical assessment parameters and actions to take.**

**MANAGEMENT OF CHILDREN PRESENTING ACUTELY TO ST GEORGE’S WITH ANOREXIA NERVOSA**

Responsible authors: Lucinda Etheridge, Joel Khor, Carole Bettley, Yasmin Baki

Directorate: W&C

Sone Spies, Abigail Swancott, Rachel Barratt

Date published: September 2015

Review date: September 2018
8.0 REFEEDING SYNDROME: ASSESSMENT AND MANAGEMENT
Refeeding syndrome is a clinical syndrome characterised by cardiac arrhythmia, encephalopathy or seizures following reintroduction of nutrition in profoundly malnourished patients.

Biochemically, the main feature is hypophosphataemia, but there are often other electrolyte abnormalities eg hyponatraemia, hypokalaemia, hypocalcaemia and hypomagnesaeemia.

8.1 Pathophysiology
Most studies on refeeding syndrome have been done on malnourished infants in the developing world or in conditions where there are other comorbidities. In starvation, catabolic pathways dominate, mediated by cortisol, glucagon and growth hormone. These promote gluconeogenesis, glycogenolysis, lipolysis and ketogenesis with a degree of insulin resistance. Carbohydrate takes over from protein and fat as the main energy source. Substrate use generally reduces, as cardiac and lean muscle mass reduces and body temperature falls.

When nutrition is reintroduced, especially carbohydrate, there is a switch back to glucose metabolism. Insulin release drives intracellular movement of electrolytes, especially phosphate, and water. Magnesium and thiamine are key co-factors in this. Therefore, rapid refeeding following prolonged starvation, especially with carbohydrate, can lead to an exaggerated insulin surge and hypophosphataemia, which leads to the clinical manifestations.

8.2 Refeeding versus underfeeding
The evidence base for refeeding syndrome in previously healthy young people with anorexia nervosa is less clear. NICE guidance remains conservative in its approach to refeeding, with small starting calorie amounts and small daily increments. However, a number of centres have noted this to be counter-productive and lead to an ‘underfeeding syndrome’, where patients lose weight in hospital and get further complications of low weight. A number of studies have reported safe refeeding at much higher calorie amounts, with very low rates of hypophosphataemia. Nutrition is the key treatment for a number of the medical complications, so further weight loss can be unsafe.

Therefore, Junior Marsipan guidance recommends that an over cautious approach to refeeding is not required for the majority of patients, but that monitoring is essential.

8.3 Assessing risk of refeeding syndrome
All young people should be assessed and assigned a risk of refeeding syndrome within the first 24 hours of admission, as in Table 6. Only one feature is required to dictate risk.

This should be reviewed by the named consultant paediatrician as soon as possible, seeking dietetic input and, if needed, specialist gastroenterology input.
Table 6: assessment of refeeding syndrome risk

<table>
<thead>
<tr>
<th></th>
<th>HIGH RISK</th>
<th>MODERATE RISK</th>
<th>LOW RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>% BMI</td>
<td>&lt;70%</td>
<td>70-79%</td>
<td>&gt;80%</td>
</tr>
<tr>
<td>Weight loss</td>
<td>1kg/week for 4 weeks</td>
<td>500g – 1kg/week for 2 weeks</td>
<td>500g/week for 2 weeks or less</td>
</tr>
<tr>
<td>Caloric restraint</td>
<td>Abstinence &gt;5 days or &lt;1000 calories per day for 10 days</td>
<td>Abstinence 3-5 days or 1000-1500 calories per day for 10 days</td>
<td>&gt;1500 calories per day</td>
</tr>
<tr>
<td>Plasma albumin</td>
<td>&lt;18 g/dL</td>
<td>18-40 g/dL</td>
<td>&gt;40 g/dL</td>
</tr>
<tr>
<td>Plasma phosphate level</td>
<td>&lt;0.8 mmol/L</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ECG findings</td>
<td>Prolonged QTc (&gt;440ms boys or &gt;460ms girls)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8.4 Medications to help prevent refeeding complications
The following medications should be prescribed and started on admission in all patients assessed to be at high risk of refeeding syndrome:

- Multivitamin (Sanatogen) one tablet once daily (or Abidec 1.2 mls daily)
- Thiamine 100mg twice daily
- Phosphate Sandoz 2-3 mmol/kg/day in two divided doses

All patients should be started on a Multivitamin until they are on a calorie amount sufficient for weight maintenance – generally around 1800 calories per day.

8.5 Choosing meal plans and monitoring regimes
On the whole, patients should never be started on a refeeding plan that begins at a lower calorie amount than they have been managing as an outpatient. This will promote underfeeding syndrome. Therefore, the home meal plan should be the starting point on admission if in doubt, until consultant, dietetic and CAMHS input can be sought.

Refeeding syndrome in anorexia nervosa is most likely to occur in the first 2-4 days after refeeding starts, but may occur 7-10 days later. Blood tests and ECG monitoring are used to pick up the development of signs of refeeding syndrome, such as electrolyte disturbance and prolonged QTc or arrhythmia. Neurological observations help detect signs of a developing encephalopathy. High risk patients need closer initial monitoring.

Table 7 shows the basic day by day plan for different groups of patients according to risk. However, this may need adapting for very high risk patients or those who develop complications.
Table 7: Basic feeding and monitoring plan for patients stratified by refeeding risk

<table>
<thead>
<tr>
<th>High refeeding risk patients</th>
<th>Moderate refeeding risk patients</th>
<th>Low refeeding risk patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day 0</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 4 hourly TPR, BP – to continue</td>
<td>• 4 hourly TPR, BP – to continue</td>
<td>• 4 hourly TPR, BP – to continue</td>
</tr>
<tr>
<td>• Cardiac monitor and neuro obs 4 hourly</td>
<td>• Baseline bloods and ECG (sec 4.4)</td>
<td>• Baseline bloods and ECG (sec 4.4)</td>
</tr>
<tr>
<td>• Baseline bloods and ECG (sec 4.4)</td>
<td>• Start multivitamin (sec 8.4)</td>
<td>• Start multivitamin (sec 8.4)</td>
</tr>
<tr>
<td>• Start 1000 cal/day meal plan or NG feed</td>
<td>• Start 1400 cal/day meal plan or NG feed</td>
<td>• Start 1600 cal/day meal plan, or usual home meal plan (whichever is higher)</td>
</tr>
</tbody>
</table>

| **Day 1**                   |                                   |                            |
| • Cardiac monitor and neuro obs 4 hourly | • Bloods: FBC, U+E, LFT, bone profile, Mg | • 1600 cal/day (or home) meal plan |
| • BD bloods: FBC, U+E, bone profile, Mg (LFT once daily) | • 1 hour post-meals CBG | • 1400 cal/day meal plan |
| • 1 hour post-meals CBG | • ECG | • 1400 cal/day meal plan |
| • 1000 cal/day meal plan or NG | • Bloods: FBC, U+E, LFT, bone profile, Mg | • 1600 cal/day meal plan |

| **Day 2**                   |                                   |                            |
| • Cardiac monitor and neuro obs 4 hourly | • Bloods: FBC, U+E, LFT, bone profile, Mg | • 1600 cal/day meal plan |
| • BD bloods: FBC, U+E, bone profile, Mg (LFT once daily) | • 1 hour post-meals CBG | • 1400 cal/day meal plan |
| • 1 hour post-meals CBG | • ECG | • 1400 cal/day meal plan |
| • 1000 cal/day meal plan or NG | • Bloods: FBC, U+E, LFT, bone profile, Mg | • 1600 cal/day meal plan |

| **Day 3**                   |                                   |                            |
| • Cardiac monitor and neuro obs 4 hourly | • Start 1600 cal/day meal plan | • Start 1800 cal/day meal plan |
| • BD bloods: FBC, U+E, bone profile, Mg (LFT once daily) | • 1 hour post-meals CBG | • Start 1800 cal/day meal plan |
| • 1 hour post-meals CBG | • ECG | • 1800 cal/day meal plan to continue |
| • 1000 cal/day meal plan or NG | • Bloods: FBC, U+E, LFT, bone profile, Mg | • 1800 cal/day meal plan to continue |

| **Day 4**                   |                                   |                            |
| • Continuous HR monitor | • Bloods: FBC, U+E, LFT, bone profile, Mg | • 1800 cal/day meal plan to continue |
| • Bloods: FBC, U+E, LFT, bone profile, Mg | • Start 1400 cal/day meal plan | • 1800 cal/day meal plan to continue |
| • Start 1400 cal/day meal plan or NG | • Bloods: FBC, U+E, LFT, bone profile, Mg | • 1800 cal/day meal plan to continue |

| **Day 5**                   |                                   |                            |
| • Continuous HR monitor | • Bloods: FBC, U+E, LFT, bone profile, Mg | • 1800 cal/day meal plan to continue |
| • Bloods: FBC, U+E, LFT, bone profile, Mg | • ECG | • 1800 cal/day meal plan to continue |
| • ECG | • Start 1600 cal/day meal plan or NG | • 1800 cal/day meal plan to continue |
| Day 6 | Continuous HR monitor  
| Bloods: FBC, U+E, LFT, bone profile, Mg  
| **Start 1800 cal/day meal plan or NG**  |
| Day 7 | Continuous HR monitor  
| Bloods: FBC, U+E, LFT, bone profile, Mg  
| ECG  
| **1800 cal/day meal plan or NG to continue**  |
| Day 8 | Routine obs if stable  
| Stop phosphate and thiamine if bloods stable  |
| Day 9 | Routine obs if stable  
| Bloods: FBC, U+E, LFT, bone profile, Mg  |
| Day 10 | Routine obs if stable  
| Stop multivitamin  |

**Notes**
- Increase frequency of obs as needed, as per observation policy.
- Increase frequency bloods/ECGs if metabolic disturbance, cardiac or refeeding signs/symptoms.
- STOP calorie increase if phosphate drops, until stabilised.
- Ensure daily fluid requirement is also met.

**Special circumstances:**
- Young children (<13 years) and/or those with a weight <30kg, or %BMI <65%, may require lower starting amounts of 10-20 cals/kg/day. Their starting feeding regime should be discussed between the consultant paediatrician and dietician.
9.0 MEAL PLANNING AND MANAGING MEALTIMES
The management of mealtimes in a paediatric ward is a crucial part of the young person’s medical treatment and it is important that staff are able to recognise this and see it as similar in importance to any other prescribed treatment. Often it is the only intervention which is likely to lead to an improvement in the young person’s medical state and speed recovery and discharge.

9.1 Process for mealtimes
Food will be chosen based on the meal plan provided. The RMN/special nurse should assist the patient in making their choices from the meal plan but the patient should not be allowed to change/alter food or go to the food trolley. ALL meals, including snacks, must be closely supervised by the RMN/special nurse.

Generally, parents are advised not to be present for mealtimes, at least initially. However, as discharge is planned this may change, especially if discharge home is planned where parents will be supervising mealtimes. A decision should be made with the whole team as to whether the parents do or do not have any involvement with the feeding regime and this should be discussed with patients and parents. If parents are going to be present, a timetable should be drawn up of when this will happen to manage expectations. The RMN/special nurse should also support the parents in how to manage mealtimes using the same guidance given to staff in the staff information leaflet (Appendix 3).

The following time limits should be adhered to:
- 30 mins breakfast
- 20 mins snacks
- 30 mins main meal
- 15 mins dessert

At the end of these times the plate should be removed. The young person should not be allowed to the toilet for 30 minutes after a meal to prevent vomiting.

The young person should be made aware that if the meal is not completed they are expected to drink a prescribed supplement drink (Fortisip). This will be on the meal plan.

ALL food and fluids must be documented clearly by the RMN/special nurse, describing in detail the exact amounts taken.

9.2 Meal plans
See Appendix 2 for basic meal plans, which will also be kept in a ward folder. These may be adapted by the dietician as needed. Copies of the meal plan in use should be given to the following people:
- RMN/ special nurse for bedside plan
- Parents
- Patient
- Medical notes
10.0 NASOGASTRIC (NG) FEEDING

The preferred option for refeeding is oral food and fluids. However, some patients may require NG feeding, either on admission or at some point during admission. Some young people prefer NG feeding as it relieves them of the stress of eating, but this has to be balanced with longer term recovery and, occasionally, the opportunity to self-harm.

The decision to undertake NG feeding should generally be a joint decision between the paediatric consultant, CAMHS consultant and dietician, unless there is a medical emergency. The young person and family should understand on admission that an NG will be placed if they do not manage sufficient oral intake and that this is to ensure their safety due to the medical risk of not eating. If the young person is not meeting the prescribed oral intake (as food or oral supplements) within 24 hours of being on the ward and receiving the meal plan an NG should be passed as soon as possible.

NG feeding is less likely to be perceived negatively if:

- The procedure has been fully explained, demystified and medicalised on admission
- It is treated as part of standard management, and not a punishment or indication of failure

Patients, parents and staff can be very upset by this and worried about the long term implications. Although there are not many studies in this area, there is evidence that NG feeding does not, in itself, have an adverse impact on long term psychological wellbeing or therapeutic relationships. Indeed some studies report positive reflection on the process and that nasogastric feeding had little effect on overall satisfaction of treatment.

Additional recommendations:

- Insertion of an NGT should be by trained medical staff following Trust protocol. Symptomatic relief should be offered, including fluids.
- Supported meals should continue to be offered and psychological support given to help the patient. At each meal the young person should be offered food first, then the appropriate volume of supplement orally and finally the supplement should be given via NG.
- Scare tactics should be avoided.
- It is useful to give a bolus feed as soon as the tube has been safely passed and confirmed in place. This serves three functions.
  - Firstly, it avoids anticipatory anxiety.
  - Secondly, it shows that the clinical team passed the tube because nutrition was needed urgently.
  - Lastly, in the unlikely event that the patient was later to remove the tube, or to refuse consent, at least some nutrition will have been achieved.
11.0 MANAGING BEHAVIOUR
The overall approach to managing expected behaviours while in hospital should be a firm but kind one. Consistency is very important so clear handovers between staff are crucial. Some of the areas that need specific attention are:

- Managing mealtimes
- Managing bed rest and physical activity
- Managing unhelpful relationships with staff
- Managing parental expectations

This is the responsibility of all staff caring for a patient but will be largely managed day to day by the RMN or special HCA. Appendix 3 has an information sheet for staff which should be given to the RMN to read at the start of every shift, along with the patient’s Individual Eating Disorders Plan found in Appendix 4.

12.0 LEGAL FRAMEWORKS FOR TREATMENT
Consideration of the use of legal frameworks, as with all situations of care for young people with anorexia nervosa, should always consider:
1. Providing clinical care which is comprehensive and compassionate.

These two points matter, singly and jointly, and most especially if the admission is the first stage of the young person’s treatment for their eating disorder. If all of this is not done to a good clinical standard, the patient may become more unwell. If it is not done compassionately, there is a risk that the patient may feel brutalized, and this may set them up badly for the subsequent and potentially lengthy psychological treatment.

It is far better to be knowledgeable about risk and to plan in advance, than to be faced with using legal frameworks for non-consent late on a Friday afternoon. If a nasogastric tube might be needed, it is better to be trying it and talking about it early on, rather than opening up the subject at a stage when the patient, their family and the clinical staff are starting to feel desperate, and the stakes are very high.

12.1 Capacity, consent and the Mental Health Act (MHA)
The first consideration must always be to act in the child or young person’s best interests, and applies to all children and young people up to their 18th birthday. Remember these young people are sick and are unlikely to be competent to make a decision for themselves around this complex issue. If the situation is life threatening you MUST intervene to safeguard the young person’s health.

Those with parental responsibility should always be consulted and consent sought and documented. Due consideration should be given to involving them in earlier discussion if it is considered that the young person may abscond or refuse feeding. The practitioner must remember that the young person may refuse care and, before more formal measures are
taken, a firm, clear and authoritative approach may resolve any refusal. For example, a young person may be told that a nasogastric tube will be passed in order to supplement their nutrition and keep them safe. Do they wish to be held gently and firmly whilst this is done, or remain still throughout the procedure? They are then only being given the choice of how the procedure is done, rather than whether it is done and giving them the option to refuse. However, if the child does refuse and, for example, actively prevents a procedure, then further consideration must be given on how to take the issue forward.

The underlying principles of using Mental Health Legislation in the management of this patient group are broadly applicable i.e. anorexia nervosa is a serious mental disorder, inpatient re-feeding is at times an essential and a direct treatment for this, and, in rare situations where there is life-threatening physical risk and an unwillingness or inability to agree to treatment, compulsory treatment can and should be instituted. Under the MHA feeding is recognised as treatment for anorexia and can be done against the will of the patient as a life-saving measure. Although a last resort, the decision to apply the MHA should be considered from the outset, for example, in a patient refusing treatment in ED.

“The refusal of a competent 16 or 17 year old to be medically treated can be overridden by their parents or other person who has parental responsibility for that 16 or 17 year old, or by the Court. Consideration should be given to whether the use of the Act, if applicable, would be appropriate. Emergency treatment - In an emergency situation a doctor may undertake treatment if delay would be dangerous (see para 15.25). It is good practice in that situation to attempt to obtain the consent of the parents or other person with parental responsibility”.

Young people under 16 can be treated against their will if at least one parent consents to treatment on their behalf. However, if the child actively fights his/her parents’ decision regarding the necessity of the treatment, treatment under the MHA needs to be considered. This applies to decisions within the zone of parental control i.e. ones which parents would normally make on behalf of children, and in the best interests of the child.

16 – 18 year olds can be admitted under the MHA and treated against their will, although this should rarely be required. It is essential, however, that it is done when it is necessary. If both the child and the parent refuse treatment, local safeguarding procedures should be followed and use of the Children Act might be necessary to prevent significant harm.

Note that a consultant paediatrician cannot be the responsible clinician for a patient detained under the MHA. Under the amended Act the responsible clinician must be an Approved Clinician, in this situation usually a psychiatrist. If paediatric staff suspect that formal measures are necessary then the patient’s psychiatrist should be contacted as soon as possible to discuss how to proceed.
13.0 SAFEGUARDING YOUNG PEOPLE WITH ANOREXIA NERVOSA

Young people with eating disorders have the same needs to be safeguarded as any other patient. The named paediatric consultant is responsible for completing and signing the Safeguarding Issues Form (purple form) on admission and discharge.

Consideration should be given to a Child in Need referral to Children’s Services for any young person admitted with an eating disorder. This will generally be with parental consent. However, some specific issues that may require discussion with Children's Services are:

- Deliberate self-harm or suicidal ideation
- Parental anger / force feeding / aggression towards the young person
- Parental collusion, neglect, inadequate provision, or obstruction of access to appropriate medical intervention for the eating disorder to the extent that it is preventing treatment
- Family psychiatric illness, alcohol/substance abuse or domestic violence
- Harmful effect of the eating disorder on other siblings
- Significant effect of the eating disorder on family financial circumstances / housing

14.0 DISCHARGE AND TRANSFER

The optimal length of a paediatric admission is no more than 7-10 days. This will generally allow enough time to stabilise unwell patients, monitor for refeeding syndrome, and prevent psychological deterioration due to the instability of being on an acute medical ward. Discharge planning should begin at admission, led by the CAMHS consultant.

14.1 To community outpatient care

Young people who comply with an eating plan and are felt to be stable may be discharged to home. Before this happens, a clear plan for CCEDT follow-up should be made by the CCEDT and communicated to ward staff, and the family should have copies of the meal plan to continue at home. A copy of the discharge summary should be sent to the named psychiatrist.

14.2 To an intensive treatment daycase programme (ITP)

The Maudsley (near King’s Hospital) have an ITP that patients may be suitable for. Referral to this should be made by the CCEDT and co-ordinated through them. The ITP will generally arrange an assessment at the Maudsley prior to accepting referrals. To be considered suitable, patients must be eating 2500 calories per day and be medically stable. A copy of the discharge summary should be sent to the team, along with copies of all blood tests and ECGs.

14.3 To a SEDU

Some young people, either orally or NG feeding, may require a period of inpatient admission if they are not making progress in the community or are felt to be high risk of relapse in the community. Again, this referral is arranged and co-ordinated through the CCEDT. The patient needs to be medically stable to be transferred.
Although a SEDU can manage NG feeding and basic blood and ECG monitoring, transfer between facilities is a high risk time for patients so optimum transfer time needs to be discussed. Transfer will depend on bed availability so there may be delays. In this case, a clear plan needs to be made between the named paediatrician and the CCEDT about where the patient will be managed pending the SEDU bed.

A copy of the discharge summary should be sent to the team, along with copies of all blood tests and ECGs.

14.4 Medical follow-up
Generally, medical follow-up will not be needed unless there are specific medical complications or other medical co-morbidities that require monitoring. Current commissioning arrangements are that the patient’s GP shares care with CAMHS for patients in the community. The CAMHS CEDT have a number of template letters to outline to GPs what monitoring is expected and will take responsibility for liaising with the GP about this. However, if in doubt, discuss follow up with the named paediatric consultant.

15.0 REFERENCES


Pippa Hugo and Ruth Meadows. St George’s Hospital protocol for the management of nutrition critical patients with anorexia nervosa.


Berlowitz M and Hugo P Book chapter (full title to be added)

Appendix 1 BMI AND BP CENTILE CHARTS

BMI centile charts for girls and boys:
Systolic blood pressure centiles: adapted from Jackson et al, ADC 2007, 92, 298-303.
Meal Plan – 1000kcal  - From Mite Paediatric Ward menu

Offer food first and then Fortisip Compact orally if refused.
If the meal plan is not followed within 24 hours of admission to ward an NG tube should be passed for feeding (Fortisip Compact boluses)

<table>
<thead>
<tr>
<th>Meal</th>
<th>Fortisip Compact</th>
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</thead>
<tbody>
<tr>
<td>Breakfast (250kcal)</td>
<td></td>
</tr>
<tr>
<td>Small bowl cereal (30g flakes or 2 Weetabix) with 150ml semi skimmed milk</td>
<td>If full meal not eaten: 105ml ¼ meal eaten: 80ml ½ meal eaten: 50ml ¾ meal eaten: 25ml</td>
</tr>
<tr>
<td>Mid Morning (150kcal)</td>
<td></td>
</tr>
<tr>
<td>1 slice toast and 1 portion of margarine</td>
<td>If full snack not eaten: 60ml ¼ snack eaten: 45ml ½ snack eaten: 30ml ¾ snack eaten: 15ml</td>
</tr>
<tr>
<td>Lunch (250kcal)</td>
<td></td>
</tr>
<tr>
<td>½ standard portion of main meal ½ standard portion of potatoes Standard portion of vegetables</td>
<td>If full meal not eaten: 100ml ¼ meal eaten: 75ml ½ meal eaten: 50ml ¾ meal eaten: 25ml</td>
</tr>
<tr>
<td>Mid Afternoon (100kcal)</td>
<td></td>
</tr>
<tr>
<td>200ml semi skimmed milk OR 2 biscuits OR Chocolate mousse or yoghurt</td>
<td>If full snack not eaten: 40ml ¼ snack eaten: 30ml ½ snack eaten: 20ml ¾ snack eaten: 10ml</td>
</tr>
<tr>
<td>Evening Meal (250kcal)</td>
<td></td>
</tr>
<tr>
<td>½ standard portion of main meal ½ standard portion of potatoes Standard portion of vegetables</td>
<td>If full meal not eaten: 100ml ¼ meal eaten: 75ml ½ meal eaten: 50ml ¾ meal eaten: 25ml</td>
</tr>
</tbody>
</table>
Meal Plan – 1200kcal - From Mite Paediatric Ward menu

Offer food first and then Fortisip Compact orally if refused. If the meal plan is not followed within 24 hours of admission to ward an NG tube should be passed for feeding (Fortisip Compact boluses)

<table>
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<td>Small bowl cereal (30g flakes or 2 Weetabix) with 200ml semi skimmed milk</td>
<td>If full meal not eaten: 105ml&lt;br&gt;¼ meal eaten: 80ml&lt;br&gt;½ meal eaten: 50ml&lt;br&gt;¾ meal eaten: 25ml</td>
</tr>
<tr>
<td><strong>Mid Morning (150kcal)</strong></td>
<td></td>
</tr>
<tr>
<td>1 slice toast and margarine</td>
<td>If full snack not eaten: 60ml&lt;br&gt;¼ snack eaten: 45ml&lt;br&gt;½ snack eaten: 30ml&lt;br&gt;¾ snack eaten: 15ml</td>
</tr>
<tr>
<td><strong>Lunch (375kcal)</strong></td>
<td>If full meal not eaten: 155ml&lt;br&gt;¼ meal eaten: 120ml&lt;br&gt;½ meal eaten: 80ml&lt;br&gt;¾ meal eaten: 40ml</td>
</tr>
<tr>
<td>Standard portion of main meal</td>
<td></td>
</tr>
<tr>
<td>½ standard portion of potatoes</td>
<td></td>
</tr>
<tr>
<td>Standard portion of vegetables</td>
<td></td>
</tr>
<tr>
<td><strong>Mid Afternoon (100kcal)</strong></td>
<td>If full snack not eaten: 40ml&lt;br&gt;¼ snack eaten: 30ml&lt;br&gt;½ snack eaten: 20ml&lt;br&gt;¾ snack eaten: 10ml</td>
</tr>
<tr>
<td>200ml semi skimmed milk OR 2 biscuits OR Chocolate mousse or yoghurt</td>
<td></td>
</tr>
<tr>
<td><strong>Evening Meal (325kcal)</strong></td>
<td>If full meal not eaten: 130ml&lt;br&gt;¼ meal eaten: 105ml&lt;br&gt;½ meal eaten: 70ml&lt;br&gt;¾ meal eaten: 35ml</td>
</tr>
<tr>
<td>½ standard portion of main meal</td>
<td></td>
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<tr>
<td>Standard portion of potatoes</td>
<td></td>
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<tr>
<td>Standard portion of vegetables</td>
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</table>
Meal Plan – 1400kcal - From Mite Paediatric Ward menu

Offer food first and then Fortisip Compact orally if refused. If the meal plan is not followed within 24 hours of admission to ward an NG tube should be passed for feeding (Fortisip Compact boluses)

<table>
<thead>
<tr>
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<tr>
<td><strong>Breakfast (250kcal)</strong></td>
<td></td>
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<tr>
<td>Small bowl cereal (30g flakes or 2 Weetabix) with 200ml semi skimmed milk</td>
<td>If full meal not eaten: 105ml</td>
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<td></td>
<td>¼ meal eaten: 75ml</td>
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<td></td>
<td>½ meal eaten: 50ml</td>
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<td></td>
<td>¾ meal eaten: 25ml</td>
</tr>
<tr>
<td><strong>Mid Morning (150kcal)</strong></td>
<td></td>
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<tr>
<td>1 slice toast and a portion of margarine</td>
<td>If full snack not eaten: 60ml</td>
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<tr>
<td></td>
<td>¼ snack eaten: 45ml</td>
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<tr>
<td></td>
<td>½ snack eaten: 30ml</td>
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<tr>
<td></td>
<td>¾ snack eaten: 15ml</td>
</tr>
<tr>
<td><strong>Lunch (450kcal)</strong></td>
<td></td>
</tr>
<tr>
<td>Standard portion of main meal</td>
<td>If full meal not eaten: 190ml</td>
</tr>
<tr>
<td>Standard portion of potatoes</td>
<td></td>
</tr>
<tr>
<td>Standard portion of vegetables</td>
<td></td>
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<tr>
<td></td>
<td>¼ snack eaten: 145ml</td>
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<tr>
<td></td>
<td>½ snack eaten: 95ml</td>
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<tr>
<td></td>
<td>¾ snack eaten: 45ml</td>
</tr>
<tr>
<td><strong>Mid Afternoon (100kcal)</strong></td>
<td></td>
</tr>
<tr>
<td>200ml semi skimmed milk OR 2 biscuits OR Chocolate mousse or yoghurt</td>
<td>If full snack not eaten: 40ml</td>
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<td></td>
<td>¼ snack eaten: 30ml</td>
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<tr>
<td></td>
<td>½ snack eaten: 20ml</td>
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<td></td>
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<tr>
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<td>Standard portion of potatoes</td>
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<td>Standard portion of vegetables</td>
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<td></td>
<td>¼ snack eaten: 145ml</td>
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<tr>
<td></td>
<td>½ snack eaten: 95ml</td>
</tr>
<tr>
<td></td>
<td>¾ snack eaten: 45ml</td>
</tr>
</tbody>
</table>
Meal Plan – 1600kcal - From Mite Paediatric Ward menu

Offer food first and then Fortisip Compact orally if refused. If the meal plan is not followed within 24 hours of admission to ward an NG tube should be passed for feeding (Fortisip Compact boluses)

<table>
<thead>
<tr>
<th>Meal</th>
<th>Fortisip Compact</th>
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</thead>
<tbody>
<tr>
<td>Breakfast (250kcal)</td>
<td>If full meal not eaten: 105ml ¼ meal eaten: 75ml ½ meal eaten: 50ml ¾ meal eaten: 25ml</td>
</tr>
</tbody>
</table>
Small bowl cereal (30g flakes or 2 Weetabix) with 200ml semi skimmed milk |
| Mid Morning (150kcal) | If full snack not eaten: 60ml ¼ snack eaten: 45ml ½ snack eaten: 30ml ¾ snack eaten: 15ml |
1 slice toast and a portion of margarine |
| Lunch (650kcal) | If full meal not eaten: 270ml ¼ meal eaten: 205ml ½ meal eaten: 135ml ¾ meal eaten: 65ml |
Standard portion of main meal  Standard portion of potatoes  Standard portion of vegetables |
| Mid Afternoon (100kcal) | If full snack not eaten: 40ml ¼ snack eaten: 30ml ½ snack eaten: 20ml ¾ snack eaten: 10ml |
200ml semi skimmed milk OR 2 biscuits OR Chocolate mousse or yoghurt |
| Evening Meal (450kcal) | If full meal not eaten: 190ml ¼ snack eaten: 145ml ½ snack eaten: 95ml ¾ snack eaten: 45ml |
Standard portion of main meal  Standard portion of potatoes  Standard portion of vegetables |
Meal Plan – 1800kcal - From Mite Paediatric Ward menu

Offer food first and then Fortisip Compact orally if refused. If the meal plan is not followed within 24 hours of admission to ward an NG tube should be passed for feeding (Fortisip Compact boluses)

<table>
<thead>
<tr>
<th>Meal</th>
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<tbody>
<tr>
<td>Breakfast (375kcal)</td>
<td></td>
</tr>
<tr>
<td>Small bowl cereal (60g flakes) with 200ml semi skimmed milk</td>
<td>If full meal not eaten: 155ml ¼ snack eaten: 120ml ½ snack eaten: 80ml ¾ snack eaten: 40ml</td>
</tr>
<tr>
<td>Mid Morning (150kcal)</td>
<td></td>
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<tr>
<td>1 slice toast and a portion of margarine</td>
<td>If full snack not eaten: 60ml ¼ snack eaten: 45ml ½ snack eaten: 30ml ¾ snack eaten: 15ml</td>
</tr>
<tr>
<td>Lunch (650kcal)</td>
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<tr>
<td>Standard portion of main meal</td>
<td>If full meal not eaten: 270ml ¼ meal eaten: 205ml ½ meal eaten: 135ml ¾ meal eaten: 65ml</td>
</tr>
<tr>
<td>Standard portion of potatoes</td>
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<tr>
<td>Standard portion of vegetables</td>
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<tr>
<td>Standard portion of pudding</td>
<td></td>
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<tr>
<td>Mid Afternoon (100kcal)</td>
<td></td>
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<tr>
<td>200ml semi skimmed milk OR 2 biscuits OR Chocolate mousse or yoghurt</td>
<td>If full snack not eaten: 40ml ¼ snack eaten: 30ml ½ snack eaten: 20ml ¾ snack eaten: 10ml</td>
</tr>
<tr>
<td>Evening Meal (450kcal)</td>
<td></td>
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<tr>
<td>Standard portion of main meal</td>
<td>If full meal not eaten: 190ml ¼ snack eaten: 145ml ½ snack eaten: 95ml ¾ snack eaten: 45ml</td>
</tr>
<tr>
<td>Standard portion of potatoes</td>
<td></td>
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<tr>
<td>Standard portion of vegetables</td>
<td></td>
</tr>
<tr>
<td>Supper (100kcal)</td>
<td></td>
</tr>
<tr>
<td>200ml semi skimmed milk OR 2 biscuits OR Chocolate mousse or yoghurt</td>
<td>If full snack not eaten: 40ml ¼ snack eaten: 30ml ½ snack eaten: 20ml ¾ snack eaten: 10ml</td>
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Appendix 3
INFORMATION FOR STAFF CARING FOR YOUNG PEOPLE WITH ANOREXIA NERVOSA

This guidance should be read by all staff starting a shift looking after a young person admitted with anorexia. It should be read in conjunction with the patient’s Individual Eating Disorders Plan, which will be kept by the patient’s bedside, along with their meal plans.

When a young person with anorexia is admitted to a ward for treatment they, and their family, can be very anxious. Emotions can run high and the young person is often in a severely malnourished state. This will have an impact on their ability to take in information.

All patients and carers are given an information sheet on admission outlining the approach to treatment and the ‘rules’ for their stay. However, they may need reminding of these.

### Duties of the RMN

The RMN, or 1:1 nurse, is responsible for the following every shift:

- Ensuring 1:1 supervision of the patient at all times, as per their Individual Eating Disorders Plan
- Working constructively with the ward nurse to care for the patient
- Documenting the patient’s progress and mental state observations at the end of each shift
- Supervising food choices and meal times, as per the patient’s meal plan and Individual Eating Disorders Plan
- Documenting all food and drink taken every shift
- Ensuring the patient complies with any bed rest prescribed
- Supervising the patient in toileting and personal care, as agreed on the Individual Eating Disorders Plan
- Observing the patient for expected covert behaviours eg water loading, and acting on these
- Recognising the risk of deliberate self harm and supervising the patient to prevent this
- Undertaking any therapeutic work with the patient and family as directed by the consultant psychiatrist
- Engaging the patient in art/craft/reading activities at the bedside and liaising with school and play to provide these
- Comforting the patient and family as needed in times of distress
- Using de-escalation techniques in times of high stress
- Accompanying the patient off the ward for any allowed activities eg school, play
Patients and parents are given the following rules about the treatment programme at admission:

1. There will only be two food choices or dislikes allowed during the admission and these will be agreed at the start. Staff will not enter into any discussion or negotiation regarding this. The only exception to this is when there is an identified medical reason for a food not to be given.

2. The young person will be expected to follow a meal plan, which has been drawn up in advance by a dietician and is nutritionally and medically appropriate. The patient can make whole choices from this plan, with the support of the RMN, but cannot change it in any other way.

3. Meals will be taken from the trolley or kitchen by the RMN. It is important that the meal is presented as plated, with no alterations, and patients are not allowed to come to the trolley or kitchen. The food presented should be seen as the patient's prescribed medicine.

4. At meals and snacks the following time-limits should be adhered to:
   - 30 minutes per main meal
   - 15 minutes per dessert
   - 30 minutes for breakfast,
   - 20 minutes for Snacks

   At the end of these times any leftover food should be removed and if the meal has not been eaten a supplement drink given, as outlined in the meal plan.

5. The young person will be given 24 hours to comply with the meal plan and, if they are unable to eat, then the expectation is that an NG tube will be placed.

6. The young person should go to the toilet prior to their meal or snack. This ensures that they have no reason to go to the toilet after a meal and reduces the risk of them purging after food has been consumed. The young person should be made aware that they should not go to the toilet / bathroom for 30 minutes after each meal or snack.

7. The young person is expected to be on bed rest. If allowed to mobilise to the toilet, then they will be supervised by the RMN, who should listen at the toilet door for prohibited behaviours, such as purging, water loading or exercise, and challenge these.

8. They will be weighed on Mondays and Thursdays, before breakfast in nightwear (without a dressing gown or slippers). They can discuss with the team whether they want to know their weight.
How to manage mealtimes

Mealtimes will be very difficult and distressing for patients and they may require a great deal of reassurance. It can also be a very difficult and emotionally exhausting experience for staff. The young person with anorexia may exhibit high levels of distress and animosity towards staff. It can be difficult to know how to respond to the young person’s resistance at mealtimes and staff, and parents, can often feel powerless in being able to get them to eat.

The patient’s anorexia will drive them to attempt to engage staff in negotiations regarding food, use tactics to avoid or delay food e.g. TV/music at mealtimes, and also distract staff in order to dispose of food e.g. place food in sleeves, pockets, hair and into the bed or drop food. They need to again be firmly told that staff are aware they are trying to avoid eating and that they need to start. Any dropped, thrown or wasted food will be replaced. Staff need to be extra vigilant during meals, but also calm and firm in their refusal to engage in discussions regarding food.

It is helpful for staff to provide a consistent message about what is expected. There should be a high expectation communicated to the young person that they need to complete all meals and snacks, plus drinks. Staff should remind patients that the meal plan and rules set out at admission are not open to discussion. Although this will meet with initial resistance and protestations, continuing to give this message can be very helpful in breaking down anorexic resistance.

Occasionally, young people will become very agitated during meals and shout or throw food. Again, maintaining a firm consistent approach is vital while explaining that you understand their distress. However, it does not change the fact that they are expected to eat. If the level of distress is overwhelming for staff, or they feel at risk, then they will need to seek support and the on-call CAMHS team contacted for urgent advice.

The following responses can be helpful at mealtimes. Although the phrases sound very mechanical, repeating them in as neutral a tone as possible gives the young person a clear message that you are in charge and will not become engaged in arguing about the meal.

- If reluctant to start eating - “you need to pick up your knife and fork / spoon and begin to eat”
- If delaying or trying to distract from eating - “you need to eat your food as it is part of your prescribed treatment here.”
- If upset, distressed or angry - “I know you do not want to eat it but you have no choice as I (the doctors/ team) am saying that you have to eat it.”
- If trying to negotiate - “I cannot get into discussion with you about how much you are to eat – you are expected to eat all of the food.”
- If trying to negotiate - “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.”
### Managing the need for bed rest

All admitted patients should be on bed rest for at least the first 48 hours, until further assessment can take place.

Unless there are cardiac risks on initial assessment, patients can be allowed to mobilise with the RMN to the toilet. However, this should not be more than once every 1-2 hours and if it is felt that young people are trying to exploit this to engage in activity, then a commode should be used. If supervising toileting, the RMN should listen at the toilet door for activity and be prepared to challenge the patient if they suspect vomiting or other harmful behaviour.

Patients on strict bed rest and cardiac monitoring will need to use a commode at the bedside. Patients on bed rest will need help with washing and self-care, with care taken to protect dignity and privacy.

### Managing attempts at excessive activity

Staff should be aware that young people with anorexia will be driven to exercise at any opportunity and this can often be done through subtle behaviours eg constantly standing up, arm or leg movement, muscle tensing, appearing eager to help out around the ward.

Patients will find bed rest distressing so need activities and support to help distract them and manage their distress. The play team and school should be involved in this. They may need repeated reminders that there is concern about their physical health and they need to rest.

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

Supervised trips off the ward in a wheelchair, for fresh air or a change of scene, may be allowed. This should only be with the agreement of the medical and psychiatric teams and done in a planned way. The RMN may be asked to accompany the young person. If the young person goes with parents or carers a clear instruction should be given to everyone that the young person is not to walk anywhere.
Managing relationships with staff

A young person with anorexia nervosa can evoke quite powerful responses in staff. Anorexia is quite powerful at sucking in staff to unhelpful alliances with the patient, which become destructive and make it harder to set boundaries.

If young people request specific staff look after them, or indicate only certain staff understand them, then they need to be made aware that any staff member may care for them and this cannot be changed. All staff members are there to support them and have been given information on how to best care for them.

Staff should not discuss other staff members with patients and should remind patients that this is inappropriate. They should be encouraged to address concerns to the CAMHS team.

Managing parental expectations

In the same way that anorexia can ‘suck in’ staff, parents can also be drawn into the illness and collude with the patient, often in an attempt to try and make some progress. This is why, generally, parents are encouraged not to be around for mealtimes, at least at the start of an admission. This is explained to parents at admission, but they may challenge it and need reminding of it.

If the parents are supervising mealtimes, then the RMN should support them in maintaining the same boundaries. A clear timetable should be drawn up of which meals parents will supervise, so parental and patient expectations are managed. Parents need to be aware of the expected behaviours and helped to manage it. Patients often request parental supervision as they know parents are easier to manipulate. Parents should have the opportunity to discuss this with one of the team beforehand, preferably at a planned meeting with CAMHS. The RMN will, however, need to reinforce this at each mealtime.

Parents may also be drawn into negotiating with staff, for instance around the use of particular staff members, or about extra privileges. However, staff may need to gently remind parents that negotiation is expected but unhelpful and encouraged to address this issue with the CAMHS team.

If the RMN is finding parental expectations hard to manage, then this should be discussed with the ward nurse in charge in the first instance.
Appendix 4 INDIVIDUAL EATING DISORDERS PLAN

The following plan should be completed for every patient on admission and handed over between RMNs/ special HCAs from shift to shift. It can be reviewed and updated as needed.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Preferred name:</th>
<th>Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother’s name:</th>
<th>Father’s name:</th>
<th>Sibling’s names and ages:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEAL PLANS**

…………………………. is being orally / NG fed *(delete as needed).*

Details of the food choices to be taken at each meal, or the supplements to be taken if eating fails, are on the green meal plan in the bedside folder.

**HOW TO MANAGE MEALTIMES**

It is very important to provide a firm but consistent approach to mealtimes, anticipating the distress they may cause but not allowing negotiation or delaying tactics.

**ALL** food and fluid eaten must be documented every day by the RMN.

…………………………….. has been given the following rules for mealtimes:

- Parents can / cannot be present *(delete as needed).*
- *(S)he cannot prepare food or watch food being chosen, but can make whole choices from the meal plan.*
- There will be no negotiation about the content of the meal plan.
- Meals should be eaten within the following times:
  - 30 mins breakfast
  - 20 mins snacks
  - 30 mins main meal
  - 15 mins dessert
- After a meal or snack *(s)he will not be allowed to go to the toilet for 30 minutes.*

Look out for ………………………….. hiding food eg in the bed, in pockets, on the floor.

**TOILETING AND SELF CARE**

…………………………….. is / is not allowed to use the ward toilet *(delete as needed).*

If using the ward toilet, ………………………….. is allowed to go in the toilet alone but the RMN/ special HCA should remain outside the door, listening for prohibited behaviours, eg vomiting, exercising, water loading. If these are heard they should be challenged at the time.

…………………………….. is / is not allowed to take a supervised bath *(delete as appropriate).*
BED REST PLAN

…………………………………… is on the following bed rest plan (*tick the appropriate option*):

<table>
<thead>
<tr>
<th>Strict bed rest</th>
<th>Not to stand up next to bed or move around bed space, except to use commode and facilitate dressing and self-care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mainly bed rest</td>
<td>To stay in bed or chair, except to use ward bathroom (no more than once every 1-2 hours). Not to stand up next to bed or move around bed space except to transfer to chair and facilitate dressing and self-care</td>
</tr>
<tr>
<td>Limited mobility</td>
<td>To spend time in bed or chair, except to use ward bathroom (no more than once every 1-2 hours). Can move to school or playroom in a wheelchair. May be allowed short times off the ward with either parents or RMN, as directed by the medical team. This should be in the wheelchair at all times.</td>
</tr>
</tbody>
</table>

OTHER EXPECTED BEHAVIOURS

………………………………….. should be observed for the following behaviours which may be found in anorexic patients (*tick as appropriate*).

<table>
<thead>
<tr>
<th>Water loading</th>
<th>Do not leave drinks unattended or allow unsupervised access to taps or other patient’s drinks. Do offer and document regular drinks.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessive activity or desire to exercise</td>
<td>Do not allow to get on and off bed repeatedly or go to toilet frequently. Be aware of leg twitching, limb tapping etc. Challenge on this if it is observed and remind of the need for rest. Ensure enough distraction is available, using the ward play team and school eg play activities, books, art.</td>
</tr>
<tr>
<td>Negotiation or manipulation</td>
<td>Do not discuss specific staff members or the behaviour of other team members and remind parents not to be drawn into this.</td>
</tr>
<tr>
<td>Self-harm</td>
<td>Maintain supervision at all times and do not allow access to risky objects or substances eg scissors</td>
</tr>
<tr>
<td>Other (fill in as appropriate)</td>
<td></td>
</tr>
</tbody>
</table>

EMOTIONAL AND EDUCATIONAL NEEDS

………………………………….. is encouraged to do the following (*fill in as appropriate*):
Appendix 5 INFORMATION FOR YOUNG PEOPLE AND THEIR CARERS

You have been admitted to the paediatric ward for treatment due to medical concerns about your anorexia. This treatment is aimed at stabilising your medical condition and an important aspect of this will involve ensuring that you have adequate daily amounts of food and drink.

We know that this can be a very distressing time, both for yourself and your family. We believe that it is most helpful if you are fully informed of your treatment plan on admission as the nature of your illness will mean that you may feel a strong urge to resist treatment. Although the following plan may appear strict and rigid, the aim is to reduce any confusion and to ensure that everyone knows what will happen during your admission.

Your Care Plan

1. You will only be allowed two specific food dislikes that you had prior to your illness. You will only be allowed a vegetarian diet if you were vegetarian before your eating disorder started. Staff will not enter into any discussion or negotiation regarding this. We understand that eating can be a very distressing experience. We have found that the most effective approach to this is to be supportive but very firm in our expectation that you will eat all of the food given to you.

2. All meal plans will be decided by the team and are devised to ensure adequate nutrition. Staff will not engage in any negotiation regarding choices as they are aware that, because of your anorexia, you will wish to reduce food intake whenever possible.

3. It is helpful to think about the eating regime you are being expected to follow as your prescribed medicine or treatment. The reason that staff need to stick rigidly to this eating regime is because your low weight is having a serious impact on your physical health.

4. All meals will be supervised by staff and the following time limits will be followed:
   - 30 minutes per main meal
   - 20 minutes per dessert
   - 30 minutes for breakfast
   - 20 minutes for snacks

   At the end of these times, any leftover food will be removed and if the meal has not been completely eaten you will be given a supplement meal replacement drink (Fortisip).

5. If you are not managing to eat food, then the team will have to consider using a tube to feed you directly. This is sometimes needed to ensure you get the treatment you need. You will be given 24 hours to try and follow the meal plan before this is done. It will be explained to you and your parents fully before it is done.

6. It is likely that in the weeks leading up to your admission your parents have been extremely worried about you. You may also have shown high levels of distress and anger at mealtimes and parents will have often found themselves backing down for fear of making
you worse. Consequently, whilst you are being treated on the ward, parents and carers are asked to visit between or after the main mealtimes of the day. If they are visiting at a meal or snack time then they will be asked to leave the ward until the meal/snack is completed.

7. You will be on bed rest and will not be allowed to move around the ward. This is non-negotiable. This may mean going to the toilet in a commode at your bed side, or you may be allowed to use the ward toilet with a nurse listening at the door. This will be discussed with you. If you are allowed to go to the toilet you will not be allowed to go more than once every 2 hours, and you will not be allowed to go until 30 minutes after food. You will wash at your bedside and, at the beginning, will have one shower/bath per week. This is to ensure you are safe and supported in resisting the urge to exercise or purge following food.

8. You will be weighed twice a week, before breakfast in your nightwear (without a dressing gown or slippers). You can discuss with the team whether you want to know your weight.

Other treatments

Because you are malnourished you may also need medicines, blood tests and ECG tests. These will all be explained to you. These are important to make sure you do not get any serious complications from your illness.

The team

You will have a 1:1 nurse for your stay, to make sure that you are able to follow the plan given. They will supervise your eating, drinking, care and activity. This will not be the same person every day. They will be given written information to help them care for you.

You will meet a dietician once shortly after your admission to establish a meal plan for you to follow. They will not review you regularly or make significant changes to your meal plan.

The ward medical team will see you daily to check your physical progress and do any tests that are needed. They will be supervised by a named paediatrician, whose name will be above your bed, and a psychiatrist. Decisions about progress will be made by the whole team at a twice weekly review meeting. The team will meet with you and your parents to discuss these decisions. However, they will not be changed unless there is an urgent medical need to do so.

A copy of this leaflet has also been given to your parents/ carers so that they are fully aware of your treatment.

If you have any questions or concerns about your treatment you should speak to the nurse in charge of the ward, who will share them with your medical team.