GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Eating Difficulties/Eating Disorder In-Patient Care Pathway

Original Created By ABMU Eating Disorder Task & Finish Group (2018)

Approved: February 2019 / June 2021

Next Review Date June 2023

Reasons for Admission to Inpatient Services

Most young people with eating disorders will be managed on an outpatient basis. However, on occasion inpatient facilities may be necessary.
The criteria for this falls into three categories:

1. **Medical Instability**
2. **High risk of refeeding syndrome**
3. **Ongoing weight loss in spite of outpatient support** (this could initially be to Community Intensive Therapy Team (CITT) or a planned referral to Ty Lydiard.

The management of both **Medical Instability** and **High Risk of Refeeding Syndrome** are broadly the same:

Aim of Admission

Gradual and controlled reintroduction of nutrition while achieving medical stability. To empower the family/carer to manage the care for a young person up to the age of 16, with an eating disorder while achieving medical stability.

Refeeding is initially attempted using meal plans obtained from dietetics. If this is refused, nasogastric feeding should be used. Note that a keypart of assessing risk involves calculating the Percentage Median BMI (%mBMI). Additionally, young people who are not very underweight but have dropped from a high starting point quite quickly are also at risk of refeeding syndrome.

Acute Medical In-Patient Management

All admissions should be discussed with the Consultant on call. Refer to Appendix 1 (Referral Criteria). The child and family should be provided with information regarding the treatment plan and issued with the Eating Difficulties information leaflet.

information leaflet Eating difficulties.p

The parents / carer should be advised that they will be expected to remain resident during the admissionand adhere to the treatment plan. If the young person refuses to comply a Psychiatric opinion should be sought at that stage to assess the child's capacity to refuse treatment and if necessary, invoke the Mental Health Act. If the Mental Health Act is required, the on-call duty psychiatrist is to be contacted in all cases.
Any decision to impose treatment requires involvement of all professionals at senior level and the family.

Initial Management

Initial management should address hydration status, refeeding and appropriate correction of electrolyte and glucose abnormalities. In addition you can refer to the **Maudsley Service Manual for Child and Adolescent Eating Disorders, 2016).** This can be accessed via Swansea Bay Paediatrics SharePoint

Original Contributors

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Appenidicies

Appendix 1: Criteria for Referral (Maudsley Service Manual for Child and Adolescent Eating Disorders, 2016)

Appendix 2: Prinicples of Inpatient Mangement (Maudsley Service Manual for Child and Adolescent Eating Disorders, 2016)

Appendix 3: Dietetic Management and Daily Meal Plans

Appendix 4: Appendix 5 Management of meals and snacks

Useful Contact numbers

CAMHS Swansea 01792 582139 Neath 01639 862750
Bridgend 01639862534

Dietician Morriston 01792 703239

Paediatric Consultant Gastroenterologist: Dr Mike Cosgrove 01792 285043 or 01792 530744

Please can all staff using this care pathway verify their signature and initials

Print Name	Signature	Designation	Bleep/contact

NURSING ASSESSMENT ADMISSION DAY 1

DATE: **TIME:**

Paediatric Consultant **CAHMS Consultant**	**Illness/medical conditions on admission (including history of self-harm)**
Named nurse	
GP/ Address	**Child Protection Register Checked:** **On register: Yes No**
Next of Kin	**Out of area:**
Address if different from above	**Allergies**
Telephone numbers: **Landline** **Mobile**	**Medication on admission**
Religion	**Other professionals involved**
Members of Family	**Social Worker**
Home Language	**School**
Smoker : Yes No	

Initial Observations

Temp	Pulse	Resps	O2 sats	CRT	Pain score

Blood Pressure & Pulse	Weight on admission (wearing a theatre gown and underwear, the patient is able to see their weight if they wish)	Height	Percentage Median BMI (%mBMI) Calculated via Instant height for weight APP, (available via free download/installed on ward Ipads)
Standing: **Lying down:**			

ADMISSION DAY 1

Medical Assessment

Date:	Time:	Assessing Doctor:
History of present complaint:		
Past medical history:		
Neonatal history:		**Immunisations:** Up to date? Yes: ☐ No: ☐ If 'no', reason:
		Allergies:

Drug History:		
Drug:	Dose	Frequency

Development:
Family Tree & Social History:

EXAMINATION

Temp	Pulse Standing Lying down	Resp	O2 Sats	BP Standing Lying down	CRT	Glucose

Initial Assessment

%mBMI:____% weight loss: kg/wk over_____weeks

Days < 500kCal/d: days

Phosphate:__mmol/L White Cell Count:_____10^9/L IGF 1 (nmol/L): _____

Muscle wasting: YES/NO Lanugo hair: YES/NO

Are there areas of skin breakdown ?

Last Menstrual Period (LMP)

General Pubertal Assessment

ECG
Performed: YES/NO **Findings**

General Appearance

Does the child look unwell? Yes: ☐ No: ☐

ENT:

Ears: Right: Mouth/Throat:

Left:

Cardiovascular system:

Respiratory system:

Gastrointestinal & Genito-urinary system:

Central & Peripheral Nervous system:

A V P U (circle one)

Initial diagnosis (including differential diagnosis):

Date: **Time:** **Assessing Doctor:**

Plan: (Senior review)

Initial Investigations:
FBC/ film U&E/ LFT/Bone/Mg TFT Coeliac screen Ferritin

Glucose *(if hypoglycaemia <2.6 mmol/L also plasma Betahydroxybutyrate/ Non-esterified fatty acids/ Cortisol/ Insulin/ C-peptide/ Acylcarntines/ Urine organic acids/ ketones (urine dipstick)*

B12/Folate/Vitamin D/Chloride/Bicarbonate/ Potassium (*If history of vomiting)*

Amylase/Lipids *(If history of vomiting/abdominal pain)*

Prolactin. FSH, LH, Estradiol, AFP, BHCG *(if amenorrhoea present)*

12 Lead ECG – *Clear documentation of the QT interval is essential (QT/√RR). Note that a prolonged QT_C can be associated with cardiac arrhythmia. It is sex dependent.*

On-going cardiac monitoring is only necessary if the 12-lead ECG has shown a prolonged QTc or significant concerns about the heart rate (eg bradycardia with heart rate<50 when awake).

Minimal vital signs observation should include - 6-hourly temperature, pulse, respiratory rate, blood pressure , pain assessment , conscious level and oxygen saturations (RCN , 2017)
Blood glucose, strict input/output, bed rest should be considered based on clinical appearance.

It is essential mineral and vitamin supplementation is commenced as soon as possible:

Phosphate Sandoz 5 – 17 years: 16 mmol bd (can be increased if necessary to a maximum of 97 mmol/day in 2 – 4 divided doses). This should be reviewed after day 4 blood sampling

Either

Vitamin B Liquid (Vigranon B) 1 – 12 years: 10 ml TDS, 12 – 18 years: 15 ml TDS

OR

Vitamin B complex strong tablets 12 – 18 years: 2 tablets TDS

(Please review at Day 5)

Multivitamins – (Sanatogen or Forceval 1 tablet/day)

*If strong suspicion of thiamine deficiency use IV Pabrinex instead of Vitamin B Complex Strong
(Please review at Day 5)

Pabrinex Adult: 2 pairs of 5 ml ampoules (1 pair = ampoule 1 + ampoule 2) diluted with 50 ml to 100 ml (0.9% sodium chloride or 5% glucose) given over 30 minutes TDS

Under 6 years: quarter of the adult dose

6 – 10 years: third of the adult dose

10 – 14 years: halft to two thirds of the adult dose

14 years and over: as for the adult dose

References:

1. BNF for Children 2018-2019
2. Pabrinex Intravenous High Potency, Concentrate for Solution for Infusion https://www.medicines.org.uk/emc/product/1427/smpc accessed 21/01/2019, last updated: May 2018

Additional Comments

Doctor's Signature:_____Print Name:_____

Discharged from PAU to:	
Ward ☐	**HDU ☐**
Home ☐	

Nurse: Date: Time:

Nursing Admission Checklist

When a young person is admitted to the ward with an eating disorder whether known or not to CAMHS, CAMHS are to be notified, CRISIS will support if available. CAMHS will assess and offer appt on discharge, or put in a referral to CITT if further support at home will be needed, or they will be transferred directly to Ty Lydiard following CITT assessment

Initial care plan

☐ Confirm medical monitoring requirements – cardiac monitoring is only necessary if the 12-lead ECG has shown a prolonged QTc or significant concerns about the heart rate (eg bradycardia with heart rate<50 when awake).

Minimal vital signs observation should include - 6-hourly temperature, pulse, respiratory rate, blood pressure , pain assessment , conscious level and oxygen saturations (RCN , 2017)
Blood glucose, strict input/output, bed rest should be considered based on clinical appearance.

☐ Fundamentals of care completed

☐ Commence in-patient pathway meal plan – Dieticain can be contacted for queries regarding meal plans /oral nutritional supplements

☐ Inform CAMHS (in all cases)

☐ Clerked and medication prescribed (It is essential mineral and vitamin supplementation is **prescribed and commenced** as soon as possible) Medication should be reviewed at day 5.

☐ Ensure adequate medication in stock and inform ward pharmacist

☐ Ensure nursed in an appropriate area

☐ Inform play team of admission

Nursing Entry

Dietitian Admission Sheet

Refer to Appendix 3

Name: Signature: Date:

Initial Psychological Assessment

Name: Signature: Date:

Play and Activity Plan

Name: Signature: Date:

Day 2 Date_____

Minimal vital signs observation should include - 6-hourly temperature, pulse, respiratory rate, blood pressure , pain assessment , conscious level and oxygen saturations (RCN , 2017) blood glucose, strict input/output, bed rest should be considered based on clinical appearance.cardiac monitoring is necessary if the 12-lead ECG has shown a prolonged QTc or significant concerns about the heart rate (eg bradycardia with heart rate<50 when awake).

Capillary blood glucose should only be monitored if previously low, and monitoring discontinued when 2 successive values are above 4mmol/L in the absence of symptoms.

Electrolytes, especially phosphate, should be carried out on admission and daily following refeeding. For those who have additional risk factors (hypoalbuminaemia)or oedema, electrolytes should be measured up to 8 – 12 hourly.

Nursing Entry (Please comment on parental involvement)

Night (AM) Time

Day (AM)Time:

Day (PM) Time:

Dietitian

Play Team

CAMHS/Psychiatry

DAY 2 Medical Entry_____Date_____Time_____

Symptoms:

On examination:

Temp ^{0}C Pulse Resps BP Sats

Drugs *(it is essential the appropriate vitamins have been prescribed)*

Nutrition: Commence day 2 of feeding plan

Results:

- ☐ Admission blood results reviewed and written in
- ☐ U&E
- ☐ Phosphate
- ☐ Magnesium

Impression & Plan:

Name: Signature: Date:

Day 3 Date_____

Minimal vital signs observation should include - 6-hourly temperature, pulse, respiratory rate, blood pressure , pain assessment , conscious level and oxygen saturations (RCN , 2017) blood glucose, strict input/output, bed rest should be considered based on clinical appearance.

Capillary blood glucose should only be monitored if previously low, and monitoring discontinued when 2 successive values are above 4mmol/L in the absence of symptoms.

Electrolytes, especially phosphate, should be carried out on admission and daily following refeeding. For those who have additional risk factors (hypoalbuminaemia)or oedema, electrolytes should be measured up to 8 – 12 hourly.

Nursing Entry (Please comment on parental involvement)

Night (AM) Time:

Day (AM)Time:

Day (PM) Time:

Dietitian

Play Team

CAMHS/Psychiatry

DAY 3 Medical Entry_____Date____Time_____

Symptoms:

On examination:

Temp ^{0}C Pulse Resps BP Sats

Drugs

Nutrition: Commence day 3 of feeding plan

Results:

☐ U&E Phosphate Magnesium Other

Impression & Plans:

Name: Signature: Date:

Day 4 Date_____

Minimal vital signs observation should include - 6-hourly temperature, pulse, respiratory rate, blood pressure , pain assessment , conscious level and oxygen saturations (RCN , 2017) Blood glucose, strict input/output, bed rest should be considered based on clinical appearance.

The young person should be weighed in a surgical gown and underwear on a scales in a treatment room or bathroom. They are permitted to see their weight but may chose not to.

☐ Weight(pre breakfast)_____kg

Nursing Entry (Please comment on parental involvement)

Night (AM) Time:

Day (AM)Time:

Day (PM) Time:

Dietitian

Play Team

CAMHS/Psychiatry

DAY 4 Medical Entry_____Date_____Time_____

Symptoms:

On examination:

Temp ^{0}C Pulse Resps BP Sats

Drugs

Nutrition: Commence day 4 of feeding plan

Results:

☐ U&E Phosphate Magnesium Other

Impression & Plans:

Name: Signature: Date:

Day 5 Date_____

Minimal vital signs observation should include - 6-hourly temperature, pulse, respiratory rate, blood pressure , pain assessment , conscious level and oxygen saturations (RCN , 2017) Blood glucose, strict input/output, bed rest should be considered based on clinical appearance.

Nursing Entry (Please comment on parental involvement)

Night (AM) Time:

Day (AM)Time:

Day (PM) Time:

Dietitian

Play Team

CAMHS/Psychiatry

DAY 5 Medical Entry_____Date_____Time_____

Symptoms:

On examination:

Temp ^{0}C Pulse Resps BP Sats

Drugs (*Review prescription and consider discontinuing Phosphate, Vitamin B complex and Forceval)*

Nutrition: Commence day 5 of feeding plan

Results:

U&E Phosphate Magnesium Other

Impression & Plans:

Name: Signature: Date:

Day 6 Date_____

Minimal vital signs observation should include - 6-hourly temperature, pulse, respiratory rate, blood pressure , pain assessment , conscious level and oxygen saturations (RCN , 2017) Blood glucose, strict input/output, bed rest should be considered based on clinical appearance.

Nursing Entry (Please comment on parental involvement

Night (AM) Time:

Day (AM)Time:

Day (PM) Time:

Dietitian

Play Team

CAMHS/Psychiatry

DAY 6 Medical Entry_____Date_____Time_____

Symptoms:

On examination:

Temp ^{0}C Pulse Resps BP Sats

Drugs

Nutrition: Commence day 6 of feeding plan

Results:

U&E Phosphate Magnesium Other

Impression & Plans:

Name: Signature: Date:

Day 7 Date_____

Minimal vital signs observation should include - 6-hourly temperature, pulse, respiratory rate, blood pressure , pain assessment , conscious level and oxygen saturations (RCN , 2017) Blood glucose, strict input/output, bed rest should be considered based on clinical appearance.

Nursing Entry (Please comment on parental involvement)

Night (AM) Time:

Day (AM)Time:

Day (PM) Time:

Dietitian

Play Team

CAMHS/Psychiatry

DAY 7 Medical Entry_____Date_____Time

Symptoms:

On examination:

Temp ^{0}C Pulse Resps BP Sats

Drugs

Nutrition: maintain day 6 of the feeding plan

Results:

U&E Phosphate Magnesium Other

Impression & Plans:

Name: Signature: Date:

Day 8 Date_____

Minimal vital signs observation should include - 6-hourly temperature, pulse, respiratory rate, blood pressure , pain assessment , conscious level and oxygen saturations (RCN , 2017) Blood glucose, strict input/output, bed rest should be considered based on clinical appearance.

The young person should be weighed in a surgical gown and underwear on a scales in a treatment room or bathroom. They are permitted to see their weight but may chose not to.

☐ Weight(pre breakfast)_____kg (Contact dietician if lost weight)

Nursing Entry (Please comment on parental involvement)

Night (AM) Time:

Day (AM)Time:

Day (PM) Time:

Dietitian

Play Team

CAMHS/Psychiatry

DAY 8 Medical Entry_____Date_____Time_____

Symptoms:

On examination:

Temp ^{0}C Pulse Resps BP Sats

Drugs

Nutrition: maintain day 6 of the feeding plan

Results:

U&E Phosphate Magnesium Other

Impression & Plans:

Name: Signature: Date:

Day 9 Date_____

Minimal vital signs observation should include - 6-hourly temperature, pulse, respiratory rate, blood pressure , pain assessment , conscious level and oxygen saturations (RCN , 2017) Blood glucose, strict input/output, bed rest should be considered based on clinical appearance.

Nursing Entry (Please comment on parental involvement)

Night (AM) Time:

Day (AM)Time:

Day (PM) Time:

Dietitian

Play Team

CAMHS/Psychiatry

DAY 9 Medical Entry_____Date_____Time_____

Symptoms:

On examination:

Temp ^{0}C Pulse Resps BP Sats

Drugs

Nutrition: maintain day 6 of the feeding plan

Results:

U&E Phosphate Magnesium Other

Impression & Plans:

Name: Signature: Date:

Day 10 Date_____

Minimal vital signs observation should include - 6-hourly temperature, pulse, respiratory rate, blood pressure , pain assessment , conscious level and oxygen saturations (RCN , 2017). Blood glucose, strict input/output, bed rest should be considered based on clinical appearance.

Nursing Entry (Please comment on parental involvement)

Night (AM) Time:

Day (AM)Time:

Day (PM) Time:

Dietitian

Play Team

CAMHS/Psychiatry

DAY 10 Medical Entry_____Date_____Time_____

Symptoms:

On examination:

Temp ^{0}C Pulse Resps BP Sats

Drugs

Nutrition: maintain day 6 of the feeding plan

Results:

U&E Phosphate Magnesium Other

Impression & Plans:

Name: Signature: Date:

Discharge Criteria

When discharging home the outpatient meal plan will need to be given. A follow up appointment with CAMHS or CITT should be arranged depending on who the suitable team is following assessment initially by CAMHS and then CITT if required.
Alternative after CITT assessment if required Ty Lydiard may be asked to assess for in-patient treatment and a transfer to Ty Lydiard in patient unit arranged.

Admit to Ty Lydiard

Doctor's diagnosis			
Observations	Regular obs (tick)		Frequency:
ID bands	(tick)		
If mental health act & Mental capacity act are in use refer to correct procedure			
Doctor review	Tick If required)		
Prescribed medication			
Nutrition	Feeding as per meal plan		
	NG Tube		Size
	Calculated feeds		Per meal plan
Investigations (tick all that apply)	Bloods		
Transferring Nurse	Time of Transfer		

Discharge Home

Date: Time:						
Contact numbers number given	Y		N			
:						
Discharging doctor:						
Outpatient meal plan given	Maudsley restoring a health weight meal plan given [ ] Alternative (Please specify)					
Prescribed take home medication:	Y		N			
Given advice on meal time management	Y		N			
Other Professionals informed: (please tick all that apply)	CAMHS CITT Child Protection Nurse Dietitian Social Worker Paeds Community Nurse					
Discharged against medical advice:	Y		N			
Discharged in to the care of:						
Follow Up Yes / No						

Discharge Planning
(please include details of action to be undertaken if patient is re-admitted)

Appendix 1

Criteria for Referral (Maudsley Service Manual for Child and Adolescent Eating Disorders, 2016)

Initial Assessment

Meal Plan Guidance and Follow Up Schedule

Risk assessment Tool

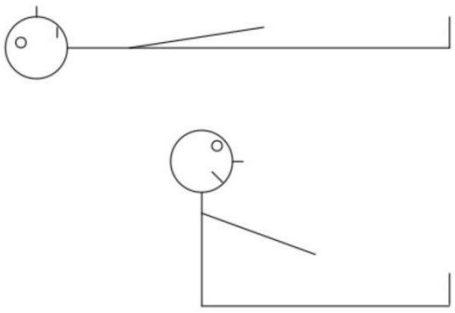
	HIGH RISK 2 CRITERIA REQUIRED	MODERATE RISK	Low Risk
%mBMI	<70%	70-80%	>80%
Weight loss	1kg/wk for 4 weeks		
Period of abstinence (< 500 kCal/d)	>=5 days	3-5 days	<3 days
Plasma Phosphate	<0.8 mmol/L		
White cell count	<3.8 10^9/L		

Blood Tests and Meal Plan Schedule

	Week 1		Week 2		Week 3	
Risk	**Meal plan (kCal)**	**Bloods & Clinical Review (No of Days after Introduction of week 1 meal plan)**	**Meal Plan (kCal)**	**Bloods & Clinical Review (No of Days after Introduction of week 2 meal plan)**	**Meal plan (Kcal)**	
High	**1500**	**1,3,5**	**2500**	**1**	**2500**	**x**
Moderate	**1500**	**1,3**	**2500**	**x**	**2500**	**x**
Low	**2500**	**2**	**2500**	**x**	**2500**	**x**

Sit Up Squat Stand (SUSS) Test: Description and scoring

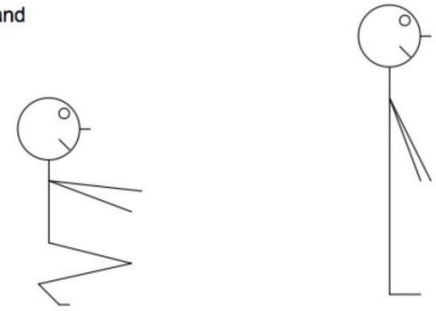
SitUp



Sit Up: Patient lies on the floor and sits up without, if possible, using his/her hands

0: Unable,
1: Able only using hands to help
2: Able with noticeable difficulty
3: Able with no difficulty

SquatStand



Squat Stand: Patient squats down and rises without, if possible, using his/her hands

Subsequent review

Physical Risk Criteria		ALERT Admit	CONCERN Regular review Admit if Non-Adherent to meal plan
Nutrition	% mBMI	<70%	<60%
	Skin	Areas of breakdown	spreading
	Rash (purpuric)	Present	
Circulation	Systolic	<90	<80
	Postural drop (mm Hg)	10mmHg Or presyncope	20 or rise in pulse >30 or syncope
	Heart rate	50	<40
Temperature		<36°C	<34.5°C
Musculo-Skeletal	Squat, Sit up and Stand (SUSS) test	2	0
Gastrointestinal			Abdominal pain involuntary vomiting
Metabolic	Glucose	<4.0mmol/L	<4.0 mmol/L AND drowsiness/non -anxiety related

			jitteriness/pallor
Bone Marrow	WCC		
	Neutrophil count	<1.0	<1.0 and fever/unwell
	Hb		<9g/dl and tachycardia
	Platelets		<100
Salt/ Water balance	Na	130-139	<130 mmol/L
	K		<3 mmol/L
	Mg		< 0.6mmol/L
	Ca		<2mmol/L
	PO4		<0.8mmol/L
ECG	QTc		>440 in boys >460 in girls

Appendix 2

Principles of Inpatient Management (Maudsley Service Manual for Child and Adolescent Eating Disorders, 2016)

The threshold for medical admission is based on the findings of the medical assessment which has four objectives. It must:

1. attribute a risk of physical instability (a measure of frailty)
2. attribute a risk of developing the refeeding syndrome (which dictates how cautious and closely monitored reintroduction of nutrition should be),
3. exclude other medical cause of weight loss
4. serve to reinforce the psychoeducational messages to the young person and the family

Monitoring of medical instability following refeeding

For the first 48 hours the young person should remain on bed rest/limited activity, with cardiac monitor and 4-hourly temperature, pulse, respiratory rate and blood pressure. If parameters are stable by day 3, aspects of this can be relaxed on a caseby case basis. Capillary blood glucose should only be monitored if previously low, and monitoring discontinued when 2 successive values are above 4mmol/L in the absence of symptoms.

Electrolytes, especially phosphate, should be carried out on admission and daily following refeeding. For those who have additional risk factors (hypoalbuminaemia) or oedema, electrolytes should be measured up to 8–12hourly.

Children should be weighed twice weekly

Hypophosphatemia

Studies suggest that 80% of hypophosphatemia occurs in the first 4 days of refeeding. If plasma phosphate falls below reference range, doses of oral phosphate should be increased, or intravenous phosphate be considered (<0.4 mmol/L). In the context of other parameters of physical instability refer to Maudsley Guidelines Appendix 1

Myelosuppression

Children and young people with malnutrition typically have low total white cell and neutrophil counts. The clinical significance of this is uncertain.

Neutropenia can be racial and it is important first to ensure normal haematinics and blood film. **If the neutropenia is < 1 10^9/L AND associated with a fever > 38ºC, young people should receive broad spectrum intravenous antibiotics pending cultures.**

MentalHealth Issues and Supervision

Many children and young people with eating disorders will have comorbidities such as depression or anxiety disorders, obsessive compulsive symptoms or personality disorders. They commonly have marked anxiety around food and meal times, which they convey to those caring for them. This anxiety may cause some to be evasive about their food intake, and even hide food to give the impression it has been eaten. Equally, young people may surreptitiously drink large amounts of water ('water loading') in order to make their weight appear higher than it is. It is essential therefore that a parent or member of staff is able to sit with the young person during mealtimes to offer them support. If there are other psychiatric comorbidities, or suspicion of purging behaviours (tampering with the NG tube,occult exercising/vomiting, hiding food), 1:1 supervision by an appropriately trained person who has built up a rapport with the child or young person will be necessary. Strict boundaries should be given for mealtimes, with clear guidance to the young person of plan should a meal not be completed within the allotted time:

45 minutes for meal-times (30 minutes main meal and 15 mins dessert)

30 mins for breakfast

30 minutes for snacks

No access to the toilet should be allowed for 30 minutes after each meal or snack.

Children and young people should remain on the ward during the admission. They may be allowed negotiated periods away as part of their therapeutic plan, but these must be agreed in advance.

MentalHealth Act

For some children who do not consent to treatment, it may be necessary to use the Mental Health Act. Admission for most children should have been negotiated with them at the outset and on the whole most will consent. For those where consent cannot be obtained, early psychiatric opinion and advice on the use of the Mental Health Act should be sought, in the first instance from the on-call Child and

Adolescent Mental Health team with early inputwhere available from the Eating Disorders Service.

Discharge

Most admissions will be for 5-7 days as calorie intake is gradually increased with appropriate monitoring. When discharging home the out patient meal plan will need to be given and a follow up appt with CAMHS or CITT arranged depending on who the suitable team is following assessment initially by CAMHS and then CITT if required.

Alternatively after CITT assessment if required Ty Lydiard may be asked to assess for inpt treatment and a transfer to Ty Lydiard inpt unit arranged.

It is essential that alldocumentation including meal plans, drug charts, blood results and ECGs be transferred with the young person.

Appendix 3

Dietetic Management and Daily Meal Plans

Dietetic Management of Inpatients Admissions for Eating Disorders

Nutritional management of eating disorder patients should be agreed as part of an MDT Nutrition Ward round or in direct consultation with the managing Consultant Paediatrician. Children and young people will be referred to throughout this document as 'children'

The dietetic aim during the child's inpatient stay is to provide a restorative eating plan, supporting the medical management of the child during their inpatient stay. The clinical goal will be a gradual and controlled reintroduction of nutrition.

Estimated Energy Requirements are not routinely calculated for patients as these do not provide an accurate assessment of individual needs. A food first approach should be implemented with **all** patients. Restorative eating should be seen as a treatment of urgency and meal plans should be introduced at the earliest opportunity.Early reintroduction of nutrition should align with the guidance of the South London and Maudsley NHS Foundation Trust (Maudsley Service Manual for Child and Adolescent Eating Disorders, 2016)

Day 1 – 1200 kcal/24 hours
Day 2 – 1500 kcal/ 24hours
Day 3 – 1750 kcal/ 24 hours
Day 4 – 2000 kcal/ 24 hours
Day 5 – 2250 kcal/ 24 hours
Day 6 – 2500 kcal/ 24 hours
Day 7 onwards – to continue Day 6 meal time structure throughout the hospital admission.
Discharge - Maudsley Restoring a Healthy Weight Meal Plan to be provided (unless otherwise directed by the CAMHS Service).

If the child refuses to eat the meals/ snacks provided then nutritionally equivalent volumes of supplement drinks should be given. If oral foods and supplements are both refused the need for Naso gastric feeding should be discussed with the paediatrician and psychiatrist. Supplements or nasogastric feed choices should be a low carbohydrate high calorie formula.
The weight appropriate choices are:-

< 30kg – Paediasure Compact
>30kg - Ensure Compact

Acute decompensation may occur quickly and is more likely to present in those most malnourished (lowest % BMI) or those with rapid weight loss prior to admission.If biochemical markers indicate nutritional concerns these should be corrected medically, no changes should be made to the progression of the meal plan.Excluding gains for correction of rehydration, a gain in weight of between 0.5 and 1 kg per week would be expected when the 2500 kcal/ day meal plan is achieved. It is notable that this may not be achieved during short term admission and the purpose of an acute episode of admission with be to achieve medical stability to facilitate ongoing clinical care in a community setting.

At point of discharge families should be provided with the Maudsley Restoring a Healthy Weight Meal Plan *(regardless of whether they have reached the 2500 kcal during the hospital admission),* unless otherwise directed by the CAMHS Service. The Paediatric Dietitian should seek guidance and support from Specialist Eating Disorders Dietitian if queries arise during a patient's hospital admission.

Key considerations:-

Parent/ Carers should be supported to take full responsibility of the food choices and meal-time supervision. The dietitian should agree a weekly meal plan in consultation with parent/ carer and then explain this to the patient. Discussions with parent/ carers should include consideration of the opportunity to start challenging any food restrictions. In the event that the child is admitted over a weekend period **when the dietitian is not available, the Day 1/ Day 2 regimen should be instigated by the medical team.**

Food preferences that pre-exist eating disorders may be supported, if reasonable and practical. However caution should be taken to ensure that such adaptations do not exclude significant nutrient groups. A maximum of three food dislikes can be agreed with parent/ carers, but these should not be from within the same food group.

Requests for vegetarian and vegan meal provisions should be discussed with parent/ carers. It may be appropriate to start to challenge these choices if they are part of an overall restrictive eating pattern. Whilst the clinical need may be to have a broader nutritional range at this time, children can still be supported to align themselves with these principles in other ways i.e. choice of clothing, footwear, toiletries.

The family should be provided with a copy of the weekly meal plan (family copy to exclude calorie information). Further copies should be available for nursing staff and medical records.

No other members of the MDT should discuss or agree any changes/ substitutions to the meal plan. The attached All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients these can be used by the dietitian to discuss alternative food choices if the family wish to bring these in from home.

ALL WALES
NUTRITION AND CAT

http://www.wales.nhs.uk/sitesplus/documents/862/FOI-077e-15.pdf

Naso gastric feeding

Naso gastric feeding should **only** be introduced if oral diet or oral nutritional supplements are refused.

Naso gastric feeds should be delivered as a bolus feed and care should be taken to monitor adequacy of fluid intake. Naso gastric feeding should be delivered in line with the original meal plan therefore the choice of supplement, timings and equivalent supplement volume should be as per the oral feeding plan.

Meal Plan Day One (1200kcal)

Breakfast	30 mins	Standard bowl of cereal and 200ml semi skimmed milk **and** Small cup of fruit juice (100ml)	200 kcal	Ensure Compact – 85 ml (204 kcal and 8.5g protein).
Morning Snack	30 mins	Three digestive biscuits **Or** 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	150 kcal	Ensure Compact 65ml (156 kcal and 6.5g protein)
Lunch	45 mins	Half a jacket potato with tuna or baked beans or cheese **Or** Any sandwich with a protein filling (ham/ tuna/ cheese/ chicken) **AND** A milk based pudding – yoghurt/ ice-cream/ custard or rice pudding	300 kcal	Ensure Compact 125ml (300 kcal and 13 g protein) **** if main meal is eaten but dessert needs to be replaced with supplement please give just 30 ml of Ensure Compact.***
Afternoon Snack	30 mins	Three digestive biscuits or 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	150 kcal	Ensure Compact 65ml (156 kcal and 6.5g protein)
Supper	45mins	Half portion of main hospital meal To include:- Protein food – meat/ fish/egg Starchy carbohydrate – potatoes/ rice/ pasta Vegetables/ salad or baked beans **AND** A small glass of fruit juice (100ml)	300 kcal	Ensure Compact 125ml (300 kcal and 13 g protein)
Evening Snack	30 mins	150ml of semi skimmed milk **Or** hot chocolate	100 kcal	Ensure Compact 45 ml (108 kcal and 4.5 g protein)

Target fluids – 1500-2000ml per 24 hours.

Agreed Dislikes:-
1 2 3

***children under 30kg should be provided with Paediasure Compact**

Menu provisions will only be safe to undertake if these are used in combination with the recommended vitamin supplementation and biochemical monitoring.

Meal Plan Day Two (1500kcal)

Meal	**Time**	**Options**	**Calorie Content**	Equivalent Supplement* (full volume to be given If any part of the meal is not consumed).
Breakfast	30 mins	Standard bowl of cereal and 200ml semi skimmed milk and 1 slice of toast with butter and jam Small cup of fruit juice (100ml)	300 kcal	Ensure Compact 125ml (300 kcal and 13 g protein)
Morning Snack	30 mins	Three digestive biscuits **Or** 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	150 kcal	Ensure Compact 65ml (156 kcal and 6.5g protein)
Lunch	45 mins	Half a jacket potato with tuna or baked beans or cheese **Or** Any sandwich with a protein filling (ham/ tuna/ cheese/ chicken) **AND** A milk based pudding – yoghurt/ ice-cream/ custard or rice pudding	300kcal	Ensure Compact 125ml (300 kcal and 13 g protein) **** if main meal is eaten but dessert needs to be replaced with supplement please give just 30 ml of Ensure Compact.***
Afternoon Snack	30 mins	Three digestive biscuits **Or** 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk with a piece of fruit	150 kcal	Ensure Compact 65ml (156 kcal and 6.5g protein)
Supper	45 mins	Half portion of main hospital meal To include:- Protein food – meat/ fish/egg Starchy carbohydrate – potatoes/ rice/ pasta Vegetables/ salad or baked beans **AND** A small glass of fruit juice (100ml)	300 kcal	Ensure Compact 125ml (300 kcal and 13 g protein)
Evening Snack	30 mins	200ml of semi skimmed milk **Or** hot chocolate and a digestive biscuit.	250kcal	Ensure Compact 110 ml (264 kcal and 11 g protein)

Target fluids – 1500-2000ml per 24 hours.

Agreed Dislikes:-
1 2 3

*children under 30kg should be provided with Paediasure Compact

Menu provisions will only be safe to undertake if these are used in combination with the recommended vitamin supplementation and biochemical monitoring.

Meal Plan Day Three (1750kcal)

Meal	Time	Options	Calorie Content	Equivalent Supplement* (full volume to be given If any part of the meal is not consumed).
Breakfast	30 mins	Standard bowl of cereal and 200ml semi skimmed milk and 2 slice of toast with butter and jam Small cup of fruit juice (100ml)	400 kcal	Ensure Compact – 170 ml (408 kcal and 7g protein).
Morning Snack	30mins	Three digestive biscuits **Or** 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	150 kcal	Ensure Compact 65ml (156 kcal and 6.5g protein)
Lunch	45 mins	A jacket potato with tuna or baked beans or cheese **Or** Any sandwich with a protein filling (ham/ tuna/ cheese/ chicken) **AND** A milk based pudding – yoghurt/ ice-cream/ custard or rice pudding	600 kcal	Ensure Compact 250ml (600 kcal and 26 g protein) **** if main meal is eaten but dessert needs to be replaced with supplement please give just 30 ml of Ensure Compact***
Afternoon Snack	30 mins	Three digestive biscuits or 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	150 kcal	Ensure Compact 65ml (156 kcal and 6.5g protein)
Supper	45 mins	Half portion of main hospital meal To include:- Protein food Starchy carbohydrate Vegetables **AND** A small glass of fruit juice	300 kcal	Ensure Compact 125ml (300 kcal and 13 g protein)
Evening Snack	30 mins	150ml of semi skimmed milk **Or** hot chocolate	100 kcal	Ensure Compact 45 ml (108 kcal and 4.5 g protein)

Target fluids – 1500-2000ml per 24 hours.

Agreed Dislikes:-
1
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3

*children under 30kg should be provided with Paediasure Compact

Menu provisions will only be safe to undertake if these are used in combination with the recommended vitamin supplementation and biochemical monitoring

Meal Plan Day Four (2000kcal)

Meal	Time	Options	Calorie Content	Equivalent Supplement* (full volume to be given If any part of the meal is not consumed).
Breakfast	30 mins	Standard bowl of cereal and 200ml semi skimmed milk and 2slice of toast with butter and jam Small cup of fruit juice (100ml)	400 kcal	Ensure Compact – 170 ml (408 kcal and 7g protein).
Morning Snack	30 mins	Three digestive biscuits **Or** 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	150 kcal	Ensure Compact 65ml (156 kcal and 6.5g protein)
Lunch	45 mins	A jacket potato with tuna or baked beans or cheese **Or** Any sandwich with a protein filling (ham/ tuna/ cheese/ chicken) **AND** A milk based pudding – yoghurt/ ice-cream/ custard or rice pudding	600 kcal	Ensure Compact 250ml (600 kcal and 26 g protein) **** if main meal is eaten but dessert needs to be replaced with supplement please give just 30 ml of Ensure Compact***
Afternoon Snack	30 mins	Three digestive biscuits or 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	150 kcal	Ensure Compact 65ml (156 kcal and 6.5g protein)
Supper	45 mins	A portion of main hospital meal To include:- Protein food – meat/ fish/egg Starchy carbohydrate – potatoes/ rice/ pasta Vegetables/ salad or baked beans **AND** A small glass of fruit juice (100ml)	600 kcal	Ensure Compact 250ml (600 kcal and 26 g protein)
Evening Snack	30 mins	150ml of semi skimmed milk **Or** hot chocolate	100 kcal	Ensure Compact 45 ml (108 kcal and 4.5 g protein)

Target fluids – 1500-2000ml per 24 hours.

Agreed Dislikes:-
1
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3

*children under 30kg should be provided with Paediasure Compact

Menu provisions will only be safe to undertake if these are used in combination with the recommended vitamin supplementation and biochemical monitoring.

Meal Plan Day Five (2250kcal)

Meal	Time	Options	Calorie Content	Equivalent Supplement* (full volume to be given If any part of the meal is not consumed).
Breakfast	30 mins	Standard bowl of cereal and 200ml semi skimmed milk and 2slice of toast with butter and jam Small cup of fruit juice (100ml)	400 kcal	Ensure Compact – 170 ml (408 kcal and 7g protein).
Morning Snack	30 mins	Three digestive biscuits **Or** 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	150 kcal	Ensure Compact 65ml (156 kcal and 6.5g protein)
Lunch	45 mins	A jacket potato filled with tuna/ baked beans /cheese and side salad **Or** A sandwich with a protein filling (ham/ tuna/ cheese/ chicken), with a packet of crisps **AND** A milk based pudding – yoghurt/ ice-cream or rice pudding	700 kcal	Ensure Compact 300ml (720 kcal and 12 g protein) **** if main meal is eaten but dessert needs to be replaced with supplement please give just 30 ml of Ensure Compact***
Afternoon Snack	30 mins	Three digestive biscuits or 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	150 kcal	Ensure Compact 65ml (156 kcal and 6.5g protein)
Supper	45 mins	Full portion of main hospital meal To include:- Protein food Starchy carbohydrate Vegetables **AND** A small glass of fruit juice **AND** A portion of dessert i.e. crumble and custard	750 kcal	Ensure Compact 315ml (756 kcal and 33g protein) **** if main meal is eaten but dessert needs to be replaced with supplement please give just 100 ml of Ensure Compact***
Evening Snack	30 mins	150ml of semi skimmed milk **Or** hot chocolate	100 kcal	Ensure Compact 45 ml (108 kcal and 4.5 g protein)

Target fluids – 1500-2000ml per 24 hours.

Agreed Dislikes:-
1
2
3

*children under 30kg should be provided with Paediasure Compact

Menu provisions will only be safe to undertake if these are used in combination with the recommended vitamin supplementation and biochemical monitoring.

Meal Plan - Day Six (2500kcal)

Meal	Time	Options	Calorie Content	Equivalent Supplement* (full volume to be given If any part of the meal is not consumed).
Breakfast	30 mins	Standard bowl of cereal with 200ml semi skimmed milk **AND** two slices of toast with margarine/ butter and jam **AND** A small glass of fruit juice	400 kcal	Ensure Compact – 170 ml (408 kcal and 7g protein).
Morning Snack	30 mins	Two digestive biscuits **AND** 200ml of semi skimmed milk **Or** Cheese and crackers	250 kcal	Ensure Compact 110 ml (264 kcal and 11 g protein)
Lunch	45 mins	A jacket potato filled with tuna/ baked beans /cheese and side salad **Or** A sandwich with a protein filling (ham/ tuna/ cheese/ chicken), with a packet of crisps **AND** A milk based pudding – yoghurt/ ice-cream or rice pudding	700 kcal	Ensure Compact 300ml (720 kcal and 12 g protein) **** if main meal is eaten but dessert needs to be replaced with supplement please give just 30 ml of Ensure Compact***
Afternoon Snack	30 mins	Three digestive biscuits or 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	150 kcal	Ensure Compact 65ml (156 kcal and 6.5g protein)
Supper	45 mins	Full portion of main hospital meal To include:- Protein food Starchy carbohydrate Vegetables A**ND** A small glass of fruit juice **AND** A portion of dessert i.e crumble and custard	750 kcal	Ensure Compact 315ml (756 kcal and 33g protein) **** if main meal is eaten but dessert needs to be replaced with supplement please give just 100 ml of Ensure Compact***
Evening Snack	30 mins	200ml of semi skimmed milk/ hot chocolate with one digestive biscuit **Or** Cheese and crackers	250 kcal	Ensure Compact 110 ml (264 kcal and 11 g protein)

Target fluids – 1500-2000ml per 24 hours.

Agreed Dislikes:-

1
2
3

*children under 30kg should be provided with Paediasure Compact

Menu provisions will only be safe to undertake if these are used in combination with the recommended vitamin supplementation and biochemical monitoring. Please refer to the ' *ABMU LHB Eating Disorder In-Patient Care Pathway'*.

Family Copy -Meal Plan Day One

Meal	Time	Options	Equivalent Supplement* (full volume to be given If any part of the meal is not consumed).
Breakfast	30 mins	Standard bowl of cereal and 200ml semi skimmed milk **and** Small cup of fruit juice (100ml)	Ensure Compact – 85 ml
Morning Snack	30 mins	Three digestive biscuits **Or** 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	Ensure Compact 65ml
Lunch	45 mins	Half a jacket potato with tuna or baked beans or cheese **Or** Any sandwich with a protein filling (ham/ tuna/ cheese/ chicken) **AND** A milk based pudding – yoghurt/ ice-cream/ custard or rice pudding	Ensure Compact 125ml **** if main meal is eaten but dessert needs to be replaced with supplement please give just 30 ml of Ensure Compact.***
Afternoon Snack	30 mins	Three digestive biscuits or 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	Ensure Compact 65ml
Supper	45mins	Half portion of main hospital meal To include:- Protein food – meat/ fish/egg Starchy carbohydrate – potatoes/ rice/ pasta Vegetables/ salad or baked beans **AND** A small glass of fruit juice (100ml)	Ensure Compact 125ml
Evening Snack	30 mins	150ml of semi skimmed milk **Or** hot chocolate	Ensure Compact 45 ml

Target fluids – 1500-2000ml per 24 hours.

Agreed Dislikes:-
1
2

3

***children under 30kg should be provided with Paediasure Compact**
Menu provisions will only be safe to undertake if these are used in combination with the recommended vitamin supplementation and biochemical monitoring.

Family Copy - Meal Plan Day Two

Meal	**Time**	**Options**	Equivalent Supplement* (full volume to be given If any part of the meal is not consumed).
Breakfast	30 mins	Standard bowl of cereal and 200ml semi skimmed milk and 1 slice of toast with butter and jam Small cup of fruit juice (100ml)	Ensure Compact 125ml
Morning Snack	30 mins	Three digestive biscuits **Or** 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	Ensure Compact 65ml
Lunch	45 mins	Half a jacket potato with tuna or baked beans or cheese **Or** Any sandwich with a protein filling (ham/ tuna/ cheese/ chicken) **AND** A milk based pudding – yoghurt/ ice-cream/ custard or rice pudding	Ensure Compact 125ml **** if main meal is eaten but dessert needs to be replaced with supplement please give just 30 ml of Ensure Compact***
Afternoon Snack	30 mins	Three digestive biscuits **Or** 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk with a piece of fruit	Ensure Compact 65ml
Supper	45 mins	Half portion of main hospital meal To include:- Protein food – meat/ fish/egg Starchy carbohydrate – potatoes/ rice/ pasta Vegetables/ salad or baked beans **AND** A small glass of fruit juice (100ml)	Ensure Compact 125ml
Evening Snack	30 mins	200ml of semi skimmed milk **Or** hot chocolate and a digestive biscuit.	Ensure Compact 110 ml

Target fluids – 1500-2000ml per 24 hours.

Agreed Dislikes:-
1
2
3

*children under 30kg should be provided with Paediasure Compact

Menu provisions will only be safe to undertake if these are used in combination with the recommended vitamin supplementation and biochemical monitoring.

Family Copy -Meal Plan Day Three

Meal	Time	Options	Equivalent Supplement* (full volume to be given If any part of the meal is not consumed).
Breakfast	30 mins	Standard bowl of cereal and 200ml semi skimmed milk and 2 slice of toast with butter and jam Small cup of fruit juice (100ml)	Ensure Compact – 170 ml
Morning Snack	30 mins	Three digestive biscuits **Or** 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	Ensure Compact 65ml
Lunch	45 mins	A jacket potato with tuna or baked beans or cheese **Or** Any sandwich with a protein filling (ham/ tuna/ cheese/ chicken) **AND** A milk based pudding – yoghurt/ ice-cream/ custard or rice pudding	Ensure Compact 250ml **** if main meal is eaten but dessert needs to be replaced with supplement please give just 30 ml of Ensure Compact***
Afternoon Snack	30 mins	Three digestive biscuits or 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	Ensure Compact 65ml
Supper	45 mins	Half portion of main hospital meal To include:- Protein food Starchy carbohydrate Vegetables **AND** A small glass of fruit juice	Ensure Compact 125ml
Evening Snack	30 mins	150ml of semi skimmed milk **Or** hot chocolate	Ensure Compact 45 ml

Target fluids – 1500-2000ml per 24 hours.

Agreed Dislikes:-
1
2

3

*children under 30kg should be provided with Paediasure Compact

Menu provisions will only be safe to undertake if these are used in combination with the recommended vitamin supplementation and biochemical monitoring.

Family Copy - Meal Plan Day Four

Meal	Time	Options	Equivalent Supplement* (full volume to be given If any part of the meal is not consumed).
Breakfast	30 mins	Standard bowl of cereal and 200ml semi skimmed milk and 2slice of toast with butter and jam Small cup of fruit juice (100ml)	Ensure Compact – 170 ml
Morning Snack	30 mins	Three digestive biscuits **Or** 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	Ensure Compact 65ml
Lunch	45 mins	A jacket potato with tuna or baked beans or cheese **Or** Any sandwich with a protein filling (ham/ tuna/ cheese/ chicken) **AND** A milk based pudding – yoghurt/ ice-cream/ custard or rice pudding	Ensure Compact 250ml **** if main meal is eaten but dessert needs to be replaced with supplement please give just 30 ml of Ensure Compact***
Afternoon Snack	30 mins	Three digestive biscuits or 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	Ensure Compact 65ml
Supper	45 mins	A portion of main hospital meal To include:- Protein food – meat/ fish/egg Starchy carbohydrate – potatoes/ rice/ pasta Vegetables/ salad or baked beans **AND** A small glass of fruit juice (100ml)	Ensure Compact 250ml
Evening Snack	30 mins	150ml of semi skimmed milk **Or** hot chocolate	Ensure Compact 45 ml

Target fluids – 1500-2000ml per 24 hours.

Agreed Dislikes:-
1
2
3

*children under 30kg should be provided with Paediasure Compact

Menu provisions will only be safe to undertake if these are used in combination with the recommended vitamin supplementation and biochemical monitoring.

Family Copy - Meal Plan Day Five

Meal	Time	Options	Equivalent Supplement* (full volume to be given If any part of the meal is not consumed).
Breakfast	30 mins	Standard bowl of cereal and 200ml semi skimmed milk and 2slice of toast with butter and jam Small cup of fruit juice (100ml)	Ensure Compact – 170 ml
Morning Snack	30 mins	Three digestive biscuits **Or** 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	Ensure Compact 65ml
Lunch	45 mins	A jacket potato filled with tuna/ baked beans /cheese and side salad **Or** A sandwich with a protein filling (ham/ tuna/ cheese/ chicken), with a packet of crisps **AND** A milk based pudding – yoghurt/ ice-cream or rice pudding	Ensure Compact 300ml **** if main meal is eaten but dessert needs to be replaced with supplement please give just 30 ml of Ensure Compact***
Afternoon Snack	30 mins	Three digestive biscuits or 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	Ensure Compact 65ml
Supper	45 mins	Full portion of main hospital meal To include:- Protein food Starchy carbohydrate Vegetables **AND** A small glass of fruit juice **AND** A portion of dessert i.e. crumble and custard	Ensure Compact 315ml **** if main meal is eaten but dessert needs to be replaced with supplement please give just 100 ml of Ensure Compact***
Evening Snack	30 mins	150ml of semi skimmed milk **Or** hot chocolate	Ensure Compact 45 ml

Target fluids – 1500-2000ml per 24 hours.

Agreed Dislikes:-
1
2
3

*children under 30kg should be provided with Paediasure Compact

Menu provisions will only be safe to undertake if these are used in combination with the recommended vitamin supplementation and biochemical monitoring.

Family Copy - Meal Plan Day Six

Meal	Time	Options	Equivalent Supplement* (full volume to be given If any part of the meal is not consumed).
Breakfast	30 mins	Standard bowl of cereal with 200ml semi skimmed milk **AND** two slices of toast with margarine/ butter and jam **AND** A small glass of fruit juice	Ensure Compact – 170 ml
Morning Snack	30 mins	Two digestive biscuits **AND** 200ml of semi skimmed milk **Or** Cheese and crackers	Ensure Compact 110 ml
Lunch	45 mins	A jacket potato filled with tuna/ baked beans /cheese and side salad **Or** A sandwich with a protein filling (ham/ tuna/ cheese/ chicken), with a packet of crisps **AND** A milk based pudding – yoghurt/ ice-cream or rice pudding	Ensure Compact 300ml **** if main meal is eaten but dessert needs to be replaced with supplement please give just 30 ml of Ensure Compact***
Afternoon Snack	30 mins	Three digestive biscuits or 125ml pot of full fat yoghurt **Or** 200ml semi skimmed milk	Ensure Compact 65ml
Supper	45 mins	Full portion of main hospital meal To include:- Protein food Starchy carbohydrate Vegetables **AND** A small glass of fruit juice **AND** A portion of dessert i.e crumble and custard	Ensure Compact 315ml **** if main meal is eaten but dessert needs to be replaced with supplement please give just 100 ml of Ensure Compact***
Evening Snack	30 mins	200ml of semi skimmed milk/ hot chocolate with one digestive biscuit **Or** Cheese and crackers	Ensure Compact 110 ml

Target fluids – 1500-2000ml per 24 hours.

Agreed Dislikes:-
1
2
3

*children under 30kg should be provided with Paediasure Compact

Menu provisions will only be safe to undertake if these are used in combination with the recommended vitamin supplementation and biochemical monitoring.

Daily Meal Plan ***Restoring a Healthy Weight*** **(Maudsley Guidelines)**

Name:	**Date:**

BREAKFAST

- 40g serving of muesli *or* cereal with 150mls full fat milk and 100g fruit e.g. berries
- With 1 x slice of toast with 2tsp of peanut butter *or* chocolate-hazelnut spread *or* butter and jam
- With 200mls fruit juice

MID-MORNING

- 1 x large piece of fruit e.g. banana/apple *or* 2 x medium eg kiwis/plums/satsumas.

With **ONE** of the following:

- 2 x digestive biscuits/ 3 Jaffa cakes/ 1 x regular sized bag of crisps/ 10 dried apricots/ 1 x slice of bread withthickly spread peanut butter or cream cheese/ 1 regular sized pot of full fat yoghurt

LUNCH

Choose **ONE** of the following:

- 1 x bagel/2 slices of bread/1 x pitta/1 x wrap or 1 x roll
- 1 x palm sized jacket potato
- 180g cooked pasta/couscous/rice or similar grain To have with either:
- 1 x egg *or* 3 slices of meat *or* 1 heaped tbsp hummus/nut butter.

Include a small side salad/vegetables and 2tsp of butter *or* mayonnaise *or* salad cream

Followed by 1 regular sized pot of full fat yoghurt and either a snack size chocolate bar/ small bag of popcorn/ yoghurt covered raisins *or* packet of crisps.

- With a 200ml glass of smoothie *or* fruit juice

TEA

Choose **ONE** of the following:

- Breakfast bar, regular packet of crisps, 2 digestive biscuits, 30g of nuts, 40g dried fruit or 35g popcorn.

DINNER

Choose **ONE** of the following:

- 180g of cooked pasta/ rice/bulgur wheat or similar grain
- 1 large jacket potato (approximately palm sized) To have with either:
- a 150g fillet of meat/fish *or* 2 large eggs *or* 100g of cooked minced meat /lentils/ Quorn *or* beans **OR**

choose:

- 350g lasagne/spaghetti bolognaise / shepherd's pie/ cottage pie / risotto *or* ½ a 12 inch pizza Include

salad or vegetables with the meal and 2tsp (used in either cooking or as a condiment) of salad dressing/mayonnaise/butter or oil.

Dessert:

- Choose **ONE** of the following:
  125g full fat yoghurt, custard *or* rice pudding *or* 2 scoops of ice cream. With ½ a tin of tinned fruit/ 25g dried fruit/ 2 tablespoons of fruit compote.

SUPPER

- 200ml mug of milk *or* hot chocolate made with full fat milk. With **ONE** of the following:
- 2 x digestive biscuits *or* cereal bar *or* 30g of nuts *or* 1 x slice of toast with 2tsp of peanut butter *or* chocolatehazelnut spread.

DRINKS

Aim for 1500-2000mls of fluid per day i.e. 6-8 glasses.

Meal Support Information for Staff, Parents and Carers (*not to be shared with the person with the eating disorder)*

About this resource.

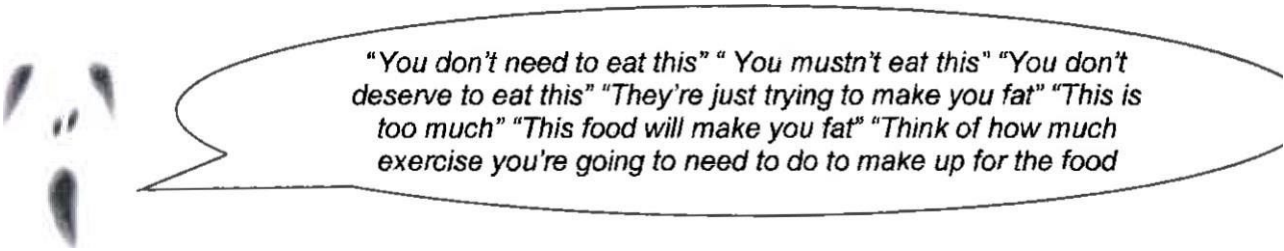
This guide is designed to help you and your family support your child with an eating disorder at mealtimes. It is not an exhaustive guide, and it will not ensure success all the time. It will, however, help to establish an environment in which your child is more likely to be able to eat what they need to eat. It will take time to work out what approach and strategies are most helpful for your child and your family.

A vital part of treatment for an eating disorder involves nutritional rehabilitation and resumption of 'normal' eating. This, however, is not as easy as asking your child to "just eat".

Why is eating so hard?

Eating disorders are fear-based disorders. This means the person has an intense fear about facing food, eating, becoming fat, and have extreme concerns about their body shape and weight. As with anything that causes such intense fear it is a natural human response that the young person with the eating disorder does whatever they possibly can to avoid facing this fear. When someone has an eating disorder their behaviours at meal times are predominantly guided by their emotions, and not by logic. Thus, trying to help your child eat, when the eating disorder is sending them a loud and clear message to do anything but eat, and cause a deep and terrifying fear, is not an easy task.

For a young person with an eating disorder food and mealtimes become a source of fear, distress and anxiety
fuelled by the thoughts and beliefs their eating disorder instills in them. Examples of some of the eating disorder thoughts young people may experience at meal times are:



Why is she/he eating like this?

Eating disorder behaviours can provide short term and relatively quick relief from this distress. Starvation causes the brain to become detail focused and inflexible, often making behaviours more pronounced. Supporting someone to eat and to relinquish eating disorder behaviours may therefore be a challenging task. The person may feel angry about the help you are offering, and will likely feel highly anxious about changing the way they eat.
There are many eating behaviours which are typical of eating disorders and which you may notice during meal support. Some of these include (but are not limited to):

* Stalling; trying to finish last
* Eating easiest food first and saving the most difficult foods for last
* Cutting or breaking food into small pieces
* Hiding food (in napkins/smearing food under the table/hiding food in pockets/dropping food on the floor) * Eating very quickly, very small mouthfuls, very large mouthfuls
* Eating foods without utensils or with utensils which are inappropriate for the meal
* Going to the bathroom during or immediately after a meal to purge or to discard hidden food. * Purging or exercising after a meal

These behaviours can be challenging to observe in your child. It is important to recognise that these behaviours are associated with the eating disorder and are not signs of defiance or disobedience. We do encourage you to establish some boundaries around these behaviours, but remember they are partly caused by starvation, which will resolve with weight gain.

Eating a meal that is adequate for weight gain is generally the most important goal at the beginning of treatment, and completely challenging behaviours may not be the best option at that time.

Meal Support — How do we do this?

The goals of meal support are: Helping your child to eat in the presence of an eating disorder
Creating a warm and supportive environment conducive to eating

The 4C's of Meal Support:

- Stay Calm. Children will pick up on your anxiety, which will probably make them more anxious.
- Be Confident.The more confident you appear the more reassured they will feel.
- Be Consistent. Stick with what you've decided and don't negotiate.
- Be Compassionate. Understand that they are doing something that is very difficult for them.

Things to consider when preparing yourself for supporting your child with eating: * What is to be eaten

- Who will prepare and serve the meal
- When it is to be eaten
- Where it will be eaten
- With whom it will be eaten

What is to be eaten:

Planning is an essential component of meal support and is key to helping reduce anxiety and distress around food related decisions at meal times for your child as well as yourself. When someone has an eating disorder distress is especially heightened at meal times. This makes it difficult for them to make healthy adequate/ appropriate choices that are driven by logic at these times. Their choices at meal times are likely to be fear based and result in eating disorder driven choices. It is helpful to offer your child only minimal choices around their meal. For example it is not a choice whether to have a carbohydrate food or not, but instead would they like rice or pasta. Consider if the choices you give fit with what the family are eating. It is not recommended to make different meals for your child with an eating disorder and the rest of the family. More distinct choices could be given around snacks if your child is able to make these. For example would they like a muesli bar or a tub of yoghurt?

People with an eating disorder often report that if they know what they are having for meals in advance, it reduces anxiety in the lead up and at meal times as they can prepare themselves mentally. Some families choose to plan a week's worth of meals in advance and have this displayed somewhere so there are no surprises come meal time. Once a meal/snack has been planned it is important that there is no re-negotiation at meal times or whilst eating. Make sure that all foods that you will need for meals are available. This helps lessen worry at mealtime. Sometimes if a food item is not available at the designated eating time, it can lead to panic and restricted food intake in someone with an eating disorder.

Who will prepare and serve the meal:

Many families find it very helpful if the child with the eating disorder does not have access to the kitchen during meal preparation. The meal can then be plated and put on the table for eating. This can reduce anxiety in the lead up to the meal.

When is it to be eaten:

Ensure that meals and snacks occur consistently, and at predictable times throughout the day. Having meals at approximately set times and sticking to this helps meal times become a routine and reduces anxiety for the person with an eating disorder. It also helps to re-establish hunger cues and regular eating patterns.

Where it will be eaten, and with whom it will be eaten:

Eating in a relaxed and comfortable environment can help reduce some stress. Meal times can be challenging, not only for the person with an eating disorder but for their family, friends and support people. It is not unusual for the person with an eating disorder to have been eating separately from family and friends for some time. Beginning to eat with others may be new and stressful. Some families find that eating together as a family is the best strategy to help 'normalise' meal times.

Others find that initially this is too stressful and confronting both for the child with an eating disorder as well as for siblings. These families may decide to begin by having one parent/adult caregiver provide meal support and eat with

the child who has an eating disorder, whilst the rest of the family eat together in another room or at another time. There is no wrong or right way to approach this. Think what would be most supportive and fits best with your family situation, and give it a try. If meals are eaten separately, then later when your child is progressing with their recovery rejoining the family meal time would be a goal to work towards.

What else can be helpful?

Role Modelling

Rote modelling also involves demonstrating that you can safely eat a balanced meal from all the food groups without excessive weight gain. Demonstrating a relaxed and comfortable approach to eating and meal times, as well as modelling the social aspects of eating such as engaging in light conversation during the meal is helpful. It is particularly unhelpful to consume diet foods, talk about 'good' and 'bad' foods or to be actively dieting when providing meat support to someone with an eating disorder

Distraction during the meal

The use of distraction during meal times can be very helpful to reduce the anxiety of eating. Using conversation cards to prompt interaction at the table, watching TV shows with non-confrontational content, or doing puzzles etc. can be useful strategies for distraction.

Communication

Try to demonstrate a warm and supportive attitude both through your verbal and non-verbal communication. Try to listen to your child's feelings at meat times, as they are expressed both verbally and through nonverbal cues. If you can see that your child is struggling, try to empathise with their emotional experience (For example if they are having trouble starting their meal and appear distressed you might reflect, "I can see that this is very difficult and distressing for you. Just start with one mouthful").

Enjoy each other's company. Discuss neutral topics rather than focusing on food, calories, or weight during meal conversations. Try to talk about something fun, like your favourite sports teams, hobbies or music, and stay away from potentially confrontational topics such as school. As difficult as it may be, try to keep mealtimes feeling natural, as similar as possible to before the eating disorder began.

It is important to not criticise or respond punitively if your child is struggling with their meal. Be aware that praise may be misinterpreted by the eating disorder as a negative. It may be helpful to plan ahead with your child what comments they find helpful, and what they don't find helpful at meal times.

Prompting and Coaching

Prompting is using clear and simple direction delivered in a calm manner such as "pick up your spoon" "take another bite"...

Coaching is another important element of meal support. Coaching involves gently reminding your child of prediscussed strategies they can use to manage their anxiety (e.g. just focus on one mouthful at a time; breathe). Coaching can also involve gently reminding your child of their goals to help motivate them to keep going with their meal (for example "remember that eating this meal will bring you closer to your goal of returning to school").

Boundary Setting

Another important element of meat support is boundary setting. Boundary setting involves establishing, communicating and implementing clear and consistent boundaries around meal times and eating disorders behaviours. Boundaries create a sense of predictability and safety for the young person.

Some examples of meal support boundaries are:

- Pre-arranged food choices will not be re-negotiated at meal times.
- All of the meal needs to be eaten.
- There is allocated timing for meals (aiming at between 15 and 30 minutes) and snacks (15 minutes).
- Time updates and prompts are provided to help with eating at an appropriate pace.
- Remain sitting appropriately throughout the meal.
- Toilet stops are to be taken prior to the meal or snack.
- Eating disorder behaviour will be challenged supportively.

Post-meal support

The time immediately following meals is often associated with heightened anxiety and physical discomfort. The person might have increased worrying/rumination, seek assurance ("do I look fat?"), try to exercise, purge, pace, self-harm or in other ways try to compensate for eating and to appease the eating disorder's demands. It is important that you validate and empathise with your child's feelings and avoid rationalising. It can be helpful to acknowledge the struggle between the eating disorder thoughts and the non-eating disorder thoughts.

Immediately post-meals it is helpful to spend 30-60 minutes with your child to help them manage their distress and try to ensure they do not engage in unhelpful compensatory behaviours. This is a good time to use distraction and other distress tolerance I anxiety management skills. For example playing a board game together or watching a favourite TV show. This is another good thing to discuss with your child during planning so you can have ideas of things they might find helpful to do post-meals.

Helplines

Beat eating disorders - https://www.beateatingdisorders.org.uk/

F.E.A.S.T. - is an organisation that is international 24/7 online live chat or phone offering peer support to parents facing an ed. No age limit . Email info@feast-ed.org

Phone 013308280031

www.aroundthedinnertable.org (peer support for parents struggling with feeding YP international so available 24/7)

Books:-

Survive FBT. by Maria Ganci isbn 978-0-9944746-0-5; Skills-based Learning for Caring for a Loved One with an Eating Disorder. By Janet Treasure isbn 978-0-415-43158-3;Anorexia Nervosa a survival guide for families and friends and suffers. By Janet Treasure isbn 0-86377-760-0

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GOSH NHS Foundation Trust February 2014. Great Ormond Street Hospital for Children NHS Foundation Trust: Information for Families. Managing mealtimesawhen your child has an eating disorder

Ketty Mental Health Resource Centre. Eating Disorders Meal Support: Helpful approaches for families. http://keltyeatingdisorders.ca!sites/defauffiles/1246-KeW-FactSheet-FINAL.pdf

The Victorian Centre of Excellence in Eating Disorders. Meal Supervision and Support in an Eating Disorders Inpatient Program http://ceed.orq.au/wp-content/uploads/2012/05/mealsupportinpatientdetaÎls2.pdf

Appendix 4 Management of meals and snacks

Meals and snacks must have clear time boundaries and the patient should be reminded of these at the start of each meal/snack and if necessary at intervals though the meal.

Breakfast 30 minutes
Snacks 30 minutes
Lunch and dinner 45minutes (30mins main course, 15 mins dessert)

Offer the young person the opportunity to use the toilet prior to meals and snacks. The toilet should not be used during the post-meal supervision period (1 hour after main meals, 30 minutes after snacks). If it becomes imperative for the young person to use the toilet they must be under eyesight observation as these are very high risk periods for over-exercising or vomiting.

What is served is what is to be eaten – no swaps, negotiations or substitutions to be made. Anorexia may cause the young person to seek to engage a meal

supervisor in negotiations about portion size, the fairness or otherwise of the meal plan etc. Avoid any discussion or negotiation, simply advise the patient that the food is provided according to the plan specified by the dietitian and that they are required to eat what is provided. Swapping food, reducing portions or trying to be helpful or 'kind' in other ways will not aid the young person's recovery and will make future meal supervision harder.

Young people with anorexia who have eaten poorly for a period of time often experience unpleasant gastro-intestinal symptoms once they start to eat again. They may feel bloated and nauseous and may suffer constipation. These sensations can be distressing, particularly as they may be interpreted as evidence of over-eating by the anorexic patient. It is important to reassure the young person that although it can be uncomfortable and distressing that these symptoms are normal and to be expected. The best method of alleviating the symptoms is to continue building up their oral intake as this will enable their gut to adapt. The symptoms will diminish over time. Reducing oral intake simply perpetuates the problem.

Be supportive and firm at mealtimes. Acknowledge how hard it is for the young person but remain calm and firm in encouraging them to complete the meal or snack. Be cautious about offering praise – some young people with anorexia perceive eating as failure and praise can exacerbate their sense of shame and guilt at their perceived failure. If unsure, ask the young person what they would find helpful. In some cases distraction may be helpful – e.g. chatting about neutral (i.e. non-food/weight/shape related) topics, but in other cases the young person may prefer to eat quietly focusing on the task at hand.

Challenge eating disordered behaviours such as cutting food into tiny pieces, pushing food around the plate, eating one pea or raisin at a time, or smearing food. Prevent excessive use of salt/vinegar/ketchup by limiting access to condiments. Be alert for possible attempts to dispose of or hide food. Napkins or serviettes should only be given once a meal is complete as they may be used to hide food if provided during a meal. Sometimes a young person may smear food in their hair or under the table, hide food in clothes, or drop it on the floor. Point out that you have observed this and explain the lost or spoiled food will be replaced. Where possible replace the lost food. If this is not possible add the equivalent amount to the NG feed.

Keep an accurate food and fluid chart so that oral intake and NG feeds can be correctly calculated to meet nutritional and fluid requirements.