Lothian NHS Board

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Date 31/12/2025
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Dear

FREEDOM OF INFORMATION – EATING DISORDERS

I write in response to your request for information in relation to eating disorders.

Question:

- I would be grateful if you could provide copies of any internal guidelines, protocols, policies or standard operating procedures that relate specifically to mealtime/ dining room support in the treatment of eating disorders within your services. This includes, but is not limited to, documents that cover:
  - expectations and roles of staff during mealtimes
  - levels of supervision and support before, during and after meals or snacks
  - management of meal-related distress, behaviours or incidents
  - use of any structured mealtime programmes or approaches
  - Nasogastric feeding or the use of oral nutrition supplements
- If different guidelines are used in different settings, please provide all relevant documents. For example, where your organisation has separate or adapted guidance for:
  - inpatient wards
  - day-hospital or day-programme services
  - intensive outpatient / intensive community treatment
  - outpatient or community services
- Similarly, I would also be grateful if you could provide all protocol versions, if different protocols apply to different age groups, including:
  - adult eating disorder services
  - CAMHS / children and young people's eating disorder services
  - all-age or transition services, if applicable

Answer:

I have been provided with information to help answer your request by our Dietetics Service.

In-Patient services:

Attached meal support leaflet we give to parents and SOP for Melville Unit (IPU) - Treatment for an Eating Disorders that includes meal support. This is for children and young people.

The V5 documents relate to adult in-patients at the Regional Eating Disorders Unit (REDU) at St Johns Hospital.

NG Feeding protocols are currently being reviewed for both children and young people and adults. As these have not been completed or ratified they are not included here.

Out-patient and Community services:
Provided by CAMHS and by Lothian Eating Disorder Service (LEDS).
Regarding the Lothian Eating Disorder Service (LEDS), Please find the information below:

- **Service Overview:**
  The Lothian Eating Disorder Service is a transdiagnostic service providing support to individuals aged 18 and above. It operates Lothian-wide and is community-based.
- **Meal Support Provision:**
  We are currently developing a formal protocol for meal support provision, including prioritization criteria. This work is ongoing, and we aim to complete it within the next few months.
  At present:
    - We have **five staff members** who can provide meal support.
    - This is **not meal supervision** as in inpatient settings; rather, it is a supportive contact where the professional and patient eat together to help the patient challenge themselves.
    - Provision of meal support is currently discussed in MDT meetings.
    - Common uses for it currently are:
        - **Preventing hospital admission**
        - Supporting patients to increase intake at home
        - On **discharge from hospital** if identified as an area of concern
    - Therapists may also offer meal support within therapy sessions as per care plan/formulation.
    - Staff providing meal support receive supervision from a therapist and dietitian.
- **Nasogastric (NG) Feeding in the Community:**
  For ARFID patients, we have recently introduced NG feeding in the community.
    - The **Scottish Eating Disorder Dietitians Network** has formed a subgroup to create guidance and best practice for NG feeding in ARFID and other eating disorder patients in the community. We anticipate this document will be available by the **end of 2026**.
    - We have attached our LEDS care plan outlining considerations and requirements for feeding a patient in the community.

I hope the information provided helps with your request.

If you are unhappy with our response to your request, you do have the right to request us to review it. Your request should be made within 40 working days of receipt of this letter, and we will reply

within 20 working days of receipt. If our decision is unchanged following a review and you remain dissatisfied with this, you then have the right to make a formal complaint to the Scottish Information Commissioner within 6 months of receipt of our review response. You can do this by using the Scottish Information Commissioner's Office online appeals service at www.itspublicknowledge.info/Appeal. If you remain dissatisfied with the Commissioner's response you then have the option to appeal to the Court of Session on a point of law.

If you require a review of our decision to be carried out, please write to the FOI Reviewer at the email address at the head of this letter. The review will be undertaken by a Reviewer who was not involved in the original decision-making process.

FOI responses (subject to redaction of personal information) may appear on NHS Lothian's Freedom of Information website at: https://org.nhslothian.scot/FOI/Pages/default.aspx

Yours sincerely

ALISON MACDONALD
Executive Director, Nursing
Cc: Chief Executive
Enc.

Cognitive Behavioural Therapy for Eating Disorders (CBT-ED)

Information for patients, parents and carers

CBT-ED (or sometimes referred to as CBT-E; CBT- Enhanced) is an evidence-based treatment for eating disorders including Anorexia Nervosa, Bulimia Nervosa, Other Specified Feeding or Eating Disorders (OSFED) and Binge Eating Disorders. It is often recommended as a second-line treatment for children and young people with Anorexia Nervosa or Bulimia Nervosa. This is because generally the first-line treatment for these presentations is Family Based Treatment (FBT) (SIGN 2021).

Sometimes CBT-ED is also used following a trial of FBT or if you have completed FBT but some eating disorder behaviours or thoughts still remain that require a little more work. For some young people and families FBT may not be appropriate or indicated. In these situations, CBT-E may be considered as a first-line treatment.

What is CBT-ED?

CBT-ED often focuses on the current moment. It is about working on identifying and changing behaviours and thoughts (cognitions) that keep the eating disorder going. CBT-ED has been shown to be able to support young people to recover from the eating disorder, especially if change can be made during and in-between the initial sessions. This can mean changing what and how often you eat and if you need to, put on weight. It will require a lot of effort and practice, and you will be supported by a trained clinician.

The clinician you will work with will support you to identify thoughts, feelings and behaviours that keep the eating disorder going and support you to develop strategies to overcome these difficulties. It is understandable that young people may feel frightened of making some of these changes but you will be supported to do this with your clinician and this is an essential part of recovery from an eating disorder.

What does CBT-ED look like?

Due to the serious nature of eating disorders and the significant impact they can have on your physical, mental, and social life, there are several treatment non-negotiables. This means there are aspects of CBT-ED treatment that must happen for it to have a chance at being successful.
These are:

- **Being weighed**- you will be weighed at the start or middle of sessions, and it will be discussed with you as part of the work you are focussing on in the therapy.
- **Attendance**- it is important you attend the session as planned in order keep momentum.
- **Food diaries**- you will be asked to record what and when you eat and your thoughts/feelings about this so we can help identify patterns and changes.
- **Active change**- you will be actively involved in treatment and be asked to practice tasks agreed with your clinician between sessions and work towards goals in recovery. CBT-ED is not a 'talking-only' therapy- there is lots of 'doing' e.g. changing eating patterns and behaviours.

- **Physical monitoring** – if required, you will need to have your physical health monitored. This can involve having your bloods taken to check your physical health.

- **Change in treatment approach**- if your physical and/or mental health worsens, CBT-ED may be paused or stopped, and a different treatment approach considered. Sometimes, it's not the right time for CBT-ED but that doesn't mean it can't work in the future.

Early stages of treatment

You and your clinician will work on understanding things that keep the eating disorder going and will work on changing your eating disordered behaviours (such as by doing things like eating more regularly, putting foods you used to eat back in your diet and reducing other eating disorder behaviours such as vomiting or over-exercise). You will be weighed, and you will be asked to record what you eat and thoughts/predictions and feelings around this. You may also have 1- 2 dietetic appointment(s) and regular physical monitoring alongside your CBT-ED appointments. Your clinician will work with you to consider if and how your parents/carers can be involved to support you with CBT-ED.

Early review

You and your clinician will have a review as early as session 4 and before session 10 to see how treatment is working. We know that early response to treatment (behavioural changes) is a good predictor that CBT-ED will be helpful for you to achieve and maintain recovery. Treatment will be reviewed regularly to ensure it is helpful and your clinician would work with you to try to overcome any initial barriers to make sure treatment can continue and be successful.

Middle phase of treatment

You will be supported to continue to change your eating behaviours and will be introducing food you enjoy/used to enjoy and may feel worried about. You may be encouraged to eat in social situations/different settings and continue to challenge eating disorder thoughts, beliefs, and rules. You may begin to explore body image and might work with your clinician on other factors such as low self-esteem or perfectionism.

Ending phase of treatment

The last stages of treatment will focus on relapse prevention and maintaining recovery now and in the future. Sessions may be further apart by this stage and, depending on each individual, you may be weighed less often, or weighing may have stopped.

How long does CBT-ED take?

CBT-ED sessions can vary from 10 to up to 40 sessions. Sessions are usually weekly and how many sessions will depend on your current eating disorder difficulties. Attending sessions regularly is an important part of CBT-ED to ensure it has the best chance of working.

Body image

Lots of young people (or their parents) often want to do the body image module of CBT-ED first, as they believe feeling better about your body will resolve all the eating difficulties. However, the research tells us it doesn't quite work like this and establishing regular eating and appropriate body weight are often needed to see cognitive and perceptual change. Body image work usually comes in the middle or towards the end of CBT-ED.

Parental involvement

You will attend the sessions on your own. However, it can be helpful for parents/carers to join for part of the sessions to determine ways to support you with tasks or to improve their understanding of eating disorders. Sometimes parents/carers will also be part of the regular reviews of treatment.

FBT versus CBT-ED

FBT and CBT-ED have similar approaches – focusing on returning to regular and consistent eating patterns, including a variety of foods/food groups, targeting problematic eating disorder behaviours and ensuring physical health restoration.

If needed, CBT-ED can be started following FBT, or occasionally during final stages of FBT if there are still specific thoughts or behaviours that you require support with.

One of the main differences in CBT-ED and FBT is that FBT requires families to be included in all sessions and CBT-ED is typically you on your own. However, parents and carers can be involved in reviews, homework tasks of CBT-ED and receive updates to help support you in your recovery and treatment.

FBT can be more helpful if you are unsure about change or if you know you need support and help with your eating disorder to make change.

CBT-ED is often a good approach if you are an older young person, have more independence, live alone, or are willing and motivated to identify the problems and make changes towards recovery.

For more information, please discuss with the CAMHS team you/your loved one is seen by.

Child and Adolescent Mental Health Services
Standard Operating Procedure

NHS Lothian

East Region
Melville Inpatient Unit (IPU) - Treatment of an Eating Disorder Standard Operating Procedure (SOP)

Approved by: Melville Inpatient Unit Leadership Team CAMHS SMT REAS SMT then Andrew Watson	Date Approved: 9th January 2025 15th January 2025 12th February 2025, 6th May 2025
Authors: Lorraine Small, CAMHS Eating Disorder Senior Clinical Nurse Specialist	Effective from: February 2025
Version: 1.0	Review Date: February 2027

Royal Edinburgh Hospital and Associated Services (REAS)

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1. PURPOSE

The aim of this Standard Operating Procedure (SOP) is to standardise assessment, treatment and care of young people presenting to the Melville Inpatient Unit with an eating disorder (ED) between the ages of 12-18 years. The SOP is underpinned by recommendations made by the National ED Service Review (2021), the Mental Welfare Commission for Scotland (2020) and the draft Care and Treatment of Eating Disorders (ED) National Specification (2023). In parallel to these national reports there have been two further prominent published guidelines that have informed this SOP. The SIGN Guidelines for EDs (2022) provides recommendations based on the evidence for best practice in the management of people with EDs and the Medical Emergencies for EDs (MEED; 2022) provides comprehensive guidance on the recognition, assessment, and management of all EDs that people can present with as a medical emergency. We have also drawn on best practice recommendations made by the Quality Network for Inpatient CAMHS Standards (2021) and the Quality Standards for Inpatient Eating Disorder Units (2021).

Therefore, the purpose of this SOP is to support teams to provide safe, effective, and person-centred care.

2. INTRODUCTION

EDs are serious mental health conditions that involve abnormal eating behaviour and preoccupation with food, accompanied in most instances by prominent body weight or shape concerns (ICD-11, 2022). EDs can have a significant impact on an individual's physical health, psychological wellbeing, and associated functioning. ICD-11 classification (2022) includes several ED categories including Anorexia Nervosa, Bulimia Nervosa, Binge ED and

Other Specific Feeding and EDs. Avoidant Restrictive Food Intake Disorder (ARFID) is not underpinned by a preoccupation with body weight or shape and as a result is classified as a Feeding Disorder in ICD-11. Many ARFID patients may be treated in CAMHS, paediatrics and community child health but **are not** covered by this protocol. However, ARFID is covered by the MEEDs Guidelines and should be referred to in the first instance to manage risk.

International clinical practice guidelines recommend that most individuals with an eating disorder should be treated in outpatient care (Hay et al., 2019). However, when individuals cannot be managed in the community due to physical or psychiatric risk, there is a need for a range of more intensive service structures including inpatient treatment.

3. SCOPE

The SOP aims to set clear expectations around the assessment and treatment of young people with an ED and their families/carers, that require an inpatient admission to Melville Inpatient Unit:

- Clear referral criteria for admission to Melville Inpatient Unit
- Collaborative admission and discharge goals.
- Roles of each member of the MDT in assessment and delivery of treatment
- Supporting family/carers in developing skills for young people to return home.
- Ensuring safe discharge planning

4. DEFINITIONS

Digital Mental Health Risk Assessment (DMHRAx) - this is a risk assessment used across mental health services in Lothian and is located on Trak, Electronic Patient Health Record.

TRAK - patient record & management system used by NHS Lothian. The system stores patient information for anyone who has received care in NHS Lothian. Consultation, investigation & treatment come together to form an Electronic Patient Record (EPR). This covers all specialist care for a young person including CAMHS and Paediatrics.

5. RESPONSIBILITIES

All clinical staff working within Lothian CAMHS assessing and treating young people with an ED have a responsibility for implementing this standard operating procedure as appropriate to their role. Locality clinical and administrative Team Leads are responsible for coordinating the implementation of the standard operating procedure.

All clinical staff should be aware of their own responsibility and accountability when carrying out procedures and must always adhere to professional codes of practice and ensure their clinical competence is maintained.

6.0	SPECIFIC PROCEDURE	

An MDT approach that will work collaboratively in their approach to support eating disorder assessment, care and treatment of young people and their families/carers. See **Appendix 1** to demonstrate a summarised visual representation of this process.

6.1	Referral Process	

Refer to CAMHS East Region Melville Inpatient Unit Referral to Discharge SOP, CAMHS Standard Operating Procedures (SOPs) (scot.nhs.uk)

6.2	Goals of Admission	

The overall aims of inpatient admission may be:

1. Weight restoration: ensuring they are medically stable throughout this process.
2. Establish a regular eating pattern, involving their support network.
3. Support young people and family to cope with the distress that eating & weight restoration may bring.
4. Assessment and Formulation of associated difficulties that are maintaining the eating disorder with recommendations for ongoing treatment.

These goals should be agreed with the young person at their Early Care Planning Meeting (ECPM)

6.3	Initial Admission Process	

Core tasks of initial admission process apply both in and out of hours. Please refer to Risk assessment framework for assessing impending risk to life, MEEDs, page 31 college-report-cr233-medical-emergencies-in-eating-disorders-(meed)-guidance.pdf (rcpsych.ac.uk)

Table 1.1 Initial Medical Management	Additional Information
Patients should be examined and clerked in paying particular attention to:	➢ Cardiovascular system – cold/discoloured extremities, poor capillary refill, stable postural difference (persisting for 3 minutes) in heart rate or blood pressure, abnormal heart rate or rhythm requiring ECG. ➢ Clinical hydration status ➢ SUSS (Sit-Up, Squat and Stand) for proximal muscle weakness – (falling risk, ability to transfer safely). ➢ Menstrual status, where appropriate

	➢ Cognitive slowing ➢ Pressure sores and skin breakdown. ➢ Signs of vomiting – swollen gums and tooth decay, hard skin on the back of the hand (Russell's sign), swollen salivary glands. ➢ Signs to suggest an alternative diagnosis. ➢ Potential presence of important co-occurring conditions such as autism, attachment difficulties, or psychiatric comorbidities. These should be fed back into the formulation to support treatment considerations.
Blood tests	Blood order sets of "CAMHS Eating Disorder Baseline" at admission. *Full blood count* *Iron studies* *B12/folate* *U&Es* *LFTs* *Calcium, phosphate, magnesium, (zinc on admission)* *Amylase* *25-OH-Vitamin D* *Creatinine kinase* *TCO_2* *Glucose* *Thyroid function tests* *Coeliac screen* *Other bloods depend on differential diagnoses considered.* If the patient is at risk of re-feeding syndrome, some of these bloods will need to be repeated frequently until stable. Any abnormalities in the above should be corrected as needed. Changes in electrolytes have a direct bearing on changes in meal plan. There is an NHS Lothian protocol for treatment of vitamin D deficiency and insufficiency) Weekly blood monitoring – blood order set "CAMHS Eating Disorder Monitoring"
ECG	Baseline 12 lead ECG on admission to assess for prolonged cQT interval, T wave abnormalities or dysrhythmia. Most show sinus bradycardia
Vitamin & Mineral Supplementation	Routinely prescribe for first 7-10 days, - Thiamine 100mg TDS daily for **10 days**. - 1Forceval® capsule OD one hour after meal OR 1 Forceval® Soluble tablet dissolved in water OD. Prescribed for 0800 hours with note on Hepma stating given with or after food.

Table 1.2 Nursing Team Tasks	Additional Information
SCN/CN will identify the Nursing Team and Key Worker.	
A member of the Nursing Team on shift will be identified by the Nurse in Charge to support the admission process. The admission pack and checklist will be used.	Admission Pack is found on Shared Drive. Getting To Know Me (GTKM) will be an ongoing piece of work completed by Key Worker.
Initial Nursing Care Plan inputted on Trak (Care Planning Tab)	Ongoing review within Weekly Ward Round Meeting
Update DMHRx within Questionnaires Tab on Trak	Ongoing review around risk and updated as required
Update Patient Board in Nursing Office	
Apply and upload Physical Observations 72-hour Care Plan, 4x daily physical observations at 4 hourly intervals of 0800 hours, 12 noon, 1600 hours and 2000 hours within the first 72 hours of admission	Template found on Shared Drive
Arrange for weight to be taken the following morning and inform the young person.	See section 6.5.2 Re. weighing
Allocation of Meal Support and Post Meal Support (PMS) will be done by the Nurse in Charge of each shift.	A more detailed care plan will be developed and regularly reviewed
Food/Supplement Chart to be placed in kitchen and accurately updated after each meal/snack.	
Inform family/carers of admission with basic information of the Ward Phone number and visiting policy.	
Commence Stage 1 Meal Plan, KITCHEN Copy (Appendix 2) and copy to young person and family (Appendix 3)	A CAMHS Dietician will review within 1 day during the week and on the first working day after the weekend/public holidays. Please note at weekends the meal plan should be increased to Stage 2 after 48 hours once blood results checked for any abnormal electrolytes that may indicate problems of re-feeding. Nursing staff to contact CAMHS Duty Doctor to seek clarification with Higher trainee Psychiatrist that this is safe to do so. This should be clearly documented on Trak. A nominated member of the nursing team will inform the young person and family/carer of the planned change to meal plan.

Trak Notes to be inputted as per current ward policy	

Thereafter, core assessment will continue by the Nursing Team alongside specialist assessment via the MDT where appropriate.

Organisation of an Early Care Planning Meeting (ECPM)

- An ECPM will be organised by CAMHS Tier 4 Admin within **5 days** of admission.
- Key professionals from within the Melville Inpatient Unit that will support the assessment process will be invited to attend.
- Key professionals associated with the young person's care should be identified in the National Inpatient Referral Form and be included in the invite.
- The young person, and their parents/carers if appropriate, will be invited by Tier 4 Admin.
- The ECPM will be chaired and minuted. This will be inputted on Trak on the same day of the meeting. Canned text '\camhsecpm' within the Structured Ward Round Tab on Trak should be used by the identified CAMHS Clinician at the meeting.
- The Psychology Team will carry out a File Review which will be presented in a formulation diagram. Where possible, this will be available to the MDT in advance of the young person's ECPM.
- In communicating with the young person and their caregivers, there should be clear expectations set about the goals of admission. This includes advising them that the Melville Inpatient Unit is an acute psychiatric ward, and that plans may have to change over the course of their admission. There may be circumstances that full admission goals are not reached due to the balance of clinical demand within assessment of risk management. However, the MDT should ensure that area specific Tier 4 or community services are identified and referred to in order to support early discharge considerations.

6.4	**Nutritional Management and minimising risk of Refeeding Syndrome (RFS) In and Out of Hours**	

- A CAMHS Dietician will prescribe a Meal Plan following initial review to re-establish a regular eating pattern and start the process of weight restoration.
- Thereafter meal plans are increased weekly, to achieve a minimum weight gain of 0.5kgs a week.
- **The meal plans should not be negotiated day to day with the patient but serve as a prescription for all staff to support the young person to eat.**
- Daily fluid requirements are calculated using Great Ormond Street Hospital Nutritional Guidelines (2018) Appendix 4.
- The young person will be allowed dislikes that preceded the development of ED according to the parental/ carer history. These will be detailed on their Individual Meal Plan.
- Vegetarian Diets: If the decision to become vegetarian clearly predates the onset of the eating disorder this will be respected and enabled as far as possible. During an inpatient admission, young people will be discouraged from following becoming a vegetarian or following a vegetarian diet, as this would not be a priority within their treatment plan at this time. However, ongoing MDT discussions that are inclusive of a young persons choices remain essential, with clear rationale as to why the Melville Unit would not support this decision.

- Vegan Diets: A young person who presents following a vegan diet will have a detailed diet history with their family to help determine if this has been a longstanding diet followed by the young person or has evolved as the eating disorder developed. A decision to support the young person to continue with a vegan diet will be considered on an individual basis in collaboration with their parents/carers and the Multidisciplinary Team. This will include an assessment of their ability to eat a wide range of vegan foods during the recovery process. However, we need to consider that weight restoration can be difficult on a vegan diet.
- Any concerns with abnormal electrolytes should be escalated to the Melville Inpatient medical team. Out of hours, it would be the CAMHS Duty Doctor via switchboard on '0'

Re-feeding Syndrome The most up to date evidence (MEEDs) suggests that for adolescents, starting at 1400kcals – 2000kcals/day, and increasing by at least 200kcals/day up to 2400kcals/day, is safe for all patients except those at highest risk of refeeding syndrome**, provided that medical parameters are closely monitored** (Appendix 9)Indications of higher risk would be young people with other serious medical comorbidities, e.g., diabetes, sepsis which would increase their risk of re-feeding syndrome. Low white cell count is also associated with an increased risk of refeeding syndrome. This should be discussed with medical team and Dietitian and meal plans amended to take account of any increased risk.

If this young person is identified at high risk of refeeding, then seek medical advice.

Table 8: Factors associated with the risk of refeeding syndrome (page 76, MEEDs)

Clinical feature	High risk level	Management
Extremely low weight	m%BMI <70% BMI <13[173]	Cautious refeeding
Prolonged low intake	Little or no intake for >4 days	Cautious refeeding
Deranged baseline electrolytes	Low potassium, phosphorus, magnesium	Measure levels up to twice per day initially and supplement as needed
Low white blood cell count	<3.8	Monitor
At risk for low thiamine The precise requirement for thiamine is not known.	Low thiamine and other vitamins	Pabrinex, oral thiamine. and multivitamins.
Medical comorbidities and/or complications	Infection, e.g. pneumonia, cardiac disease liver disease, alcohol misuse, other serious disease	Should be discussed with an acute medical unit and HDU/ICU considered if the patient has a serious comorbidity. Refeed cautiously

The risk of refeeding is greatest in the first few days of refeeding; however, it may occur later. Biochemical monitoring should continue until electrolyte parameters are stable and **extend to 2 weeks to detect late developing RFS**.

- The meal plans comply with normal guidelines for protein, fat and carbohydrate but are higher in phosphate. Milk is prescribed on meal plans to increase phosphate intake.
- The young person will be asked to avoid highly refined sources of carbohydrates, fizzy drinks, fruit juices and sweets until the risk of re-feeding syndrome has passed.

- Staged meal plans (Appendix 2 and 3) are used to minimize the risk of complications of refeeding too quickly or undernutrition. These meal plans increase every 1-2 days, by 200kcals until the young person is meeting their nutritional requirements to achieve a weight gain of a minimum of 0.5kgs a week.
- The young person should be encouraged to drink to meet their daily fluid requirements, but not to exceed them. Daily fluid requirements are calculated using Great Ormond Street Hospital Nutritional Guidelines (15) see Appendix 4.
- If phosphate falls below normal range the meal plan should not be increased but remain the same until phosphate stabilises.
- If bloods suggest abnormal biochemistry, supplementation of electrolytes, vitamins or minerals may be necessary. Check the Children's BNF and refer to Pharmacy for further advice.

Recognising Re-feeding Syndrome

Young Person may feel:
• Tired • Weak • Confused
Physical Observations may show:
• Slow respiratory rate (bradypnea) • High blood pressure (hypertensive) • Swelling in legs (oedema)
Blood results may show:
• Abnormal sodium and fluid levels • Low magnesium • Low potassium • Low phosphate.

6.5	CAMHS Melville Inpatient Nursing Team	

The following interventions form part of the nursing role to support treatment interventions, manage risk and track progress.

6.5.1 Meal Support

- The delivery of meal support is a high priority intervention to support young people to develop an intake that supports recovery.
- The nurse in charge of the shift will delegate and plan the shift following handover. Only staff that have completed the Meal Support Training will should be allocated to young people for meal support. Staff break timings should be considered to ensure staff can eat before or after ward mealtimes. Staff are not expected to eat with the

young people during meal support, however, if they do, this should not be classified as their break.

- The purpose of meal support is to provide practical and emotional support before, during and after eating. The aim is to increase success with completion of meals/snacks to challenge ED behaviours like restriction, bingeing, and purging.
- Therapeutic Meal Support Guidance details the support offered before, during and after that should be in place for every young person. (Appendix 5).
- The allocated Staff Nurse (SN) Keyworker role is to collaboratively develop Person Centred Care Plans via Trak, which addresses Meal Support objectives that details the non-negotiable aspects of their care and treatment, alongside what they identify as helpful or less helpful during meal support. The Key Worker should provide the young person and their families/carers a copy of their care plan. The Care Plan should be reviewed regularly, at least once a week. All Care Plans are saved within "Care Planning" tab on Trak.
- The individual care plan for Post Meal Support (PMS) must be agreed by the Early Care Plan meeting. This should reflect the potential impact on the PMS from Neurodevelopment Disorder can be an extremely distressing time for young people and include the location of the support. Staff are encouraged to proactively support young people with distraction and restful activities (board games, crafts etc.) during this time.
- At the start of each shift, the nursing team will allocate a member of the Melville team to facilitate Post Meal Support.
    - **30 minutes** restfulness after a snack has been completed.
    - **1 hour** restfulness after a meal has been completed.
- All meals/snacks must be closely supervised by a health professional (or parent/carer if agreed by the team) as per the individual care plan.
- The young person is expected to eat all the food and drink prescribed by the CAMHS Dietician. This expectation must be made explicit to the young person with clear and consistent boundaries around the timing of meals and snacks: **The young person is expected to attend all mealtimes: 3 meals, 3 snacks as per ward routine.**

Meal/Snack	Time	Supplement Time	Post Meal Support
Breakfast	0830-0900	10 mins	1 hour
Morning Snack	1030-1045	5 mins	30 mins
Lunch	1230-1300 20 mins for main meal, 10 mins for pudding	10 mins	1 hour
Afternoon Snack	1500-1515	5 mins	30 mins
Dinner	1700-1730 20 mins for main meal, 10 mins for pudding	10 mins	1 hour
Supper	1915-1930	5 mins	30 mins

- If a young person is unable to manage in the time prescribed, this should not be viewed as a failure on the part of the professional or young person. It should be explained to the young person that we still need to ensure their nutritional needs are met and a nutritional supplement will be offered as prescribed. The details of the prescribed amounts are included on the Staged meal plans Kitchen Copy (Appendix 2).
- All foods and drinks including supplement must be documented clearly describing in detail the exact amount taken on the ward food record chart – daily.

- The young person should remain with the member of staff allocated for support for their meal/snack. If they have finished early in the allocated timeframe, and if staff are ***available to accompany the young person back to the unit, they may be allowed to leave the table;*** **but should remain at the table until a member of staff is able to do this.**
- Post Meal Support will usually be provided by the nursing team in the main area of the ward. Young people are encouraged to sit with staff to utilise distraction for the agreed post meal support time as stated above.
- Toilet observations are part of treatment plan for those who are finding it difficult not to purge, exercise or falsify their weight. Toilet observations will only be put in place if there is reason to suspect one of these is happening. This would mean that the bathroom door is always locked. Toilet observations will be carried out by female staff if the patient is female and this means that they will be in sight of the person using the bathroom, whether that be to use to toilet, to do hair or to have a shower. If the shower observations are required, then the curtain will be closed enough for privacy but open enough for staff to see the patient. For more detail regarding Continuous Intervention and supporting risk assessment and care planning, please access http://intranet.lothian.scot.nhs.uk/Directory/pireas/policiesandprocedures/Documents/Continuous%20Intervention%20SOP.pdf s
- Melville Inpatient Unit staff will also be supported with regular (monthly) line management meetings in compliance with the Keyworker SOP (Policies, Procedures and Ward Documentation (scot.nhs.uk).

6.5.2 Obtaining a weight.

Each time a young person is weighed, it should be consistent with the routine to ensure accuracy.

- The young person will be informed of the ward routine around expectations of obtaining regular weights.
- Baseline weight on admission to the ward should be taken on the first morning following admission. Thereafter the young person will be weighed each Monday morning before breakfast which will be before meals/feeds. This will help minimise fluctuations in weight from non- nutritional variables.
- The Nurse in Charge will identify a Nursing Team member at the start of the shift to support taking the weight. Gender of staff should be appropriately considered for this task.
- A member of the Nursing Team will support the young person through this process, being mindful of the distress that this may cause. Allowing sufficient time to prompt, facilitate and support the young person. Staff should ensure they are prepared in advance to input or write the weight at the time of the measurement.
- Staff must be alert to increased distress, anxiety and possible weight falsifying behaviours like water loading on the evening before the day the young person is to be weighed.
- Staff should be alert to the possibility of water loading. Prescribed meal plans will indicate if further fluid can be given out with of set eating times. If extras are give, then this should accurately be recorded on their individualised food and fluid balance sheets. Other indicators of water loading could include accessing empty bottles, prolonged showering or running of taps within their ensuite. If there is ongoing concern around water loading, measurement of urine specific gravity prior to being weighed may be necessary.

- Young people will be weighed in their underwear (no shoes or slippers) after they have gone to the toilet to empty their bladder.
- Staff should be alert to indicators of weight falsification (e.g. young people secreting small weights, coins, etc. on their person).
- Direct the young person to stand on the scales, with both feet flat on the platform and stand still, with arms relaxed by their side. Record the number that is displayed.
- Young people will be informed of their weight at this time.
- Weight should be entered on "Observations/Measurements – Body Measurements" on Trak alongside a calculated weight for height percentage.
- The young person must not have independent access to scales on the ward or should not at home whilst on pass.
- Target weights are not considered to be helpful so will not be given.
- Spot (the young person is not aware of the day) weights may be required when there is concern around weight falsification. This will be discussed by the MDT and a decision on when this should take place agreed. Nursing staff to carry out the weight process as above but on a day other than the routine Monday.

6.5.3 Physical Monitoring

- All Nursing Staff have eObs for PEWS and NEWS2 as an assigned skill.
- Frequency of physical observations will be done as part of the admission process and are included in the Physical Health Care Plan. 4x daily physical observations at 4 hourly intervals of 0800 hours, 12 noon, 1600 hours, and 2000 hours for the first 72 hours of admission. This forms the baseline measurements. Following this, a decision will be made, depending on risk, on frequency of physical observations.
- Physical observations will be carried out by appropriately trained staff. The 0800-hour observations should be carried out in the young person's bedroom. All other physical observations are to take place in the Treatment room on the ward.
- Physical observations include a
    - core temperature (Tympanic Thermometer to be used),
    - heart rate (HR), lying to standing Blood Pressure (BP) after 1 minute and 3 minutes (See Appendix 7 and 8),
    - Oxygen Saturations
-
- Standardised Clinical Escalation for the Physically Deteriorating Child or Young Person – General PEWS Electronic TRAK Early Warning Scores details the procedure of inputting observations and escalation.
- PEWS (0-16 years) is accessed via Trak and a Quick Reference Guide can be accessed here http://intranet.lothian.scot.nhs.uk/Directory/eHealth/programmesandprojects/TRAK/PEWS%20on%20Trak/Documents/THP_SM_PO_TRG_TMAT_PEWS_Quick_User_Guide_V1.0.pdf
- For young people 17 years and over, then NEWS2 SOP and Reference Guides can be accessed here: http://intranet.lothian.scot.nhs.uk/Directory/spsp/SPSP/DeterioratingPatient/Pages/e-Obs.aspx
- Food/Fluid chart should be accurately completed after every meal and snack on a paper copy that is stored in the ward kitchen. These are then collated and stored within the patient buff folder and reviewed weekly by the CAMHS Dietician.
- Patients may have trouble controlling their temperature due to their physiological state. Staff should be particularly vigilant of a low temperature (<36°C) and escalate. Escalation plans are documented within the young persons Physical Health Care

Plans. Nursing staff to follow the process within trak to escalate concerns. Staff should be aware that patients may attempt to dress inappropriately to lose heat. Patients should be reminded to dress warmly and to have covering on their feet.

- Pl*ease pay particular attention to p*ressure area care on admission and during their stay -observe for signs of skin breakdown daily. Utilise the appropriate risk assessment and nurse on pressure mattress if indicated.

6.5.4 Activity

- Staff should be aware that young people with eating disorders may be driven to excessively exercise or engage in micro exercising e.g., standing, leg movement and tensing muscles.
- The young person may require prompting and redirection when these behaviours are identified. Enforced bed rest is not likely to be helpful. Therefore, restful activities and support to help distract them and manage their distress should be collaboratively Care Planned. This should be inputted on Trak under Care Planning Tab.
- Arrangements for toileting and washing will need to be considered to prevent excessive exercise. There should be provisions for privacy put in place when considering implementing supervision for showering/bathing or unlocking toilet doors.
- Excessive exercise (for example pacing, standing, leg jiggling) should be challenged by the nursing team. Redirection with suggestions of alternative restful activities and encouraging parents/carers to support this too is important.

6.5.5 Maintaining a safe environment.

- Standard ward specific procedures (e.g. regular checks, floor check every 15 minutes in the hour and documented by the floor nurse.)
- Staff must be aware of any treatment orders or Mental Health Act orders – indicators on Trak (symbols) and papers uploaded to Sci Store.
- Staff should be alert to self-harm and respond as per ward procedure.

6.6	Core Initial Assessments	

- The Occupational Therapist will engage the young person in a period of initial assessment. This assessment takes place within 3 working days of admission. Initial assessments explore routine, occupational functioning, meaningful activity, and barriers to participation in occupation. Occupational Self-Assessment and Interest Checklist are also used where clinically indicated.
- A member of the Psychology Team will meet with each young person to fill out a series of standard self-report intake measures with the addition of:
    - EDE-Q (The Eating Disorder Examination).
    - AQ10 (The Autism Spectrum Quotient) is an autism screening tool. This is not used diagnostically but to highlight possible need for adaptations to care and treatment in those scoring highly, or further assessment e.g. of sensory processing differences.
    - Each young person is provided with a report summarising their responses to the questionnaires and they can discuss this further if they wish to. Repeat measures will be carried out at 6 to 8 weekly intervals to capture progress over time and comparison discharge measures.
- The psychiatrist will meet the young person to take a history and perform a physical and mental state examination. Comorbid neurodevelopmental conditions and

psychiatric disorders will be considered as appropriate, and further assessments recommended as necessary.

- Psychoeducational material: The BEAT pack 'Helping a loved one recover from an eating disorder: A Guide for Families' can be given to the family on admission. Please check in ECPM whether they have received one of these. Copies are available on the shared drive.
- 1:1 Psychology assessment will be offered to each young person and the information gathered will be used to inform the MDT formulation that is developed. .
- The family therapist will meet with parents /carers to gather information from a systemic perspective, to contribute to the MDT formulation. This will include discussion about their previous experience of their CAMHS journey and treatment up to the time of admission. A need for family therapy may be identified at this stage.
- Upon admission all young people on the ward will be invited to ward-based open groups. These groups are optional but encouraged as part of the Melville Inpatient Unit group programme. Open groups optimise access to arts psychotherapies in a way that is unthreatening and supportive of a young person's engagement with their care.
- Young people will also be invited to participate in an OT session early in admission to create a personalised motivational placemat. These placemats serve a dual purpose of supporting motivation at mealtimes and contain information regarding meal support preferences to support staff in providing tailored meal support to each young person. These are regularly reviewed and updated and saved onto SCI Store.
- All young people on the ward will be invited to participate in the weekly group activity sessions run by OT.
- The Social Worker can offer a range of assessment, support and information to children and families. Practical advice and help regarding financial issues are also available and families can be helped to find resources and speak with partner agencies for further support.

6.7	**Multi-Disciplinary Team (MDT) Core Tasks supporting admission**	

6.7.1 Weekly Ward Round Meetings (WRM) are held weekly for each young person. These are chaired and minuted. This will be inputted on Trak on the **same day** of meeting. Canned text \CAMHSWRM1 within the Structured Ward Round Tab on Trak should be used by the identified CAMHS Clinician at the meeting.

Specific ED Core tasks of Weekly Ward Round Meetings (WRM)

- Review of Goals of Admission (set in ECPM)
- Updates from all professionals and outcomes of Assessments
- Psychiatric review of mental state, medication, assessment, Mental Health Act considerations.
- Review and update Physical Observations monitoring frequency.
- Review Meal Support Care Plan:
    - Nursing Staff to support the planning of parents/carers attending meals/snacks on the ward. Initially to observe meal support, followed by opportunities to be involved in the delivery of meal support.
    - OT and Dietician to offer parents/carers 'Mealtimes at Home Session 2'. Admin can support the confirmation of this appointment via a phone call or letter.

- Nursing Assessment and Care Planning, inclusive of GTKM.
- Updates to DMHRx
- Planning around Therapeutic Passes (See Appendix 7)
- Consideration of ED consultation with Eating Disorder Development Team.
- Discharge planning, and identifying pathways to community care, including any additional supports required outside of CAMHS e.g. school liaison/YPPM or social work support.

Ongoing care and treatment should consider input from across the MDT that is indicated following discussions within WRMs. These include:

6.7.2 Occupational Therapy

- A collaborative programme of intervention with associated occupational goals will be agreed and implemented. This may include exploring restful meaningful occupations which can be used on the ward or engagement in the 'In the Zone' programme to explore emotional regulation skills.
- Visual timetabling and visual communication tools are widely used and shared with the wider team to support use for the young person.
- Mealtimes at Home Sessions will be offered to all parents/carers at the young person's ECPM. These structured sessions focus on shopping, food choices, portion sizes, routines pre and post mealtimes and specific eating disorder behaviours and are facilitated by an OT and Dietitian. These are offered in 2 separate sessions, lasting up to 90 minutes per session.

6.7.3 Clinical Psychology

- The Psychology team will offer to facilitate and chair MDT formulations for the young person. These will happen around 5 to 6 weeks from admission and be based on information gathered from the young person, their family, observations on the ward and past CAMHS intervention. The Clinical Psychologist will collaboratively share and adapt the formulation with the young person and parents/carers, with the young person's consent.
- Learning to Cope with Distress: for someone with an Eating Disorder, eating can cause extreme distress. Part of the inpatient task is to work with young people to help them to develop ways of coping with or managing this distress. Distraction and self-soothing skills are the most commonly used techniques for coping with anticipatory anxiety before meals, coping at the table and coping with feelings of guilt and disgust which often follow eating. These skills can be covered and supported by various members of the Multidisciplinary Team, and techniques shared with their families/carers. When required, this can be supplemented by 1:1 therapeutic work.
- Individual psychology work will be offered to each young person. This will focus on developing a formulation which will identify interventions and therapy goals. Often the young person can present with comorbid mental disorders so psychological work can cover a range of presentations and interventions.

6.7.4 Systemic Family Therapy

- Suitability for systemic family therapy is identified following MDT formulation, or may be considered at a later stage, depending on severity of illness, ability to engage, age and family circumstances. Therapy may focus on relationships between family members and how they are impacted by the eating disorder, building on strengths, experiences, and resources to create positive change to aid recovery.

- Family therapy may include all family members but may also involve different parts of the family at different times e.g. sessions with siblings to provide a safe space to ask questions about their sibling's eating disorder to help them to better understand it.
- If FBT is likely to be the treatment offered on discharge and they have not had FBT already, the family therapist would liaise with the appropriate Tier 3 Outpatient Team and identified FBT clinicians. If FBT has been paused due to admission, then ongoing liaison and linking with the Tier 3 Outpatient FBT clinicians is essential.

6.7.5 Arts Psychotherapies

- The arts psychotherapies service in the Melville Inpatient Unit comprises Art and Music psychotherapies. Arts psychotherapies are available to anyone on the Melville Inpatient Unit at any stage of their journey i.e., from admission to discharge and through transitions of care where appropriate and 1-1 work can be recommended to all young people, regardless of diagnosis, during their admission.
- Art and music psychotherapies can be helpful when working with complexity due to their accessibility: the non-directive use of the art form provides an opportunity for young people who may struggle or not yet wish to engage with exclusively talking therapies.
- Personalised therapeutic objectives are jointly constructed using the arts and/or words. This can add an alternative perspective to how illness is held by the young person or formulated within the MDT. The therapy and objectives are regularly reviewed and revised to reflect changes in the young person's needs and updated as appropriate via TRAK.

6.7.6 Social Work

- The City of Edinburgh Community and Families Social Work Team based at the RHCYP provides a service to families whose children are coming to hospital, have been admitted to a ward or who have ongoing contact with the RHCYP.
- There is one Social Worker who works alongside the MDT for the Melville Inpatient Unit and CAMHS Day Services, planning support for those families that need it.
- The social worker will aim to meet young people and their families to discuss their needs. They will contribute to the ECPM when available. Young people and their families can arrange to speak with the social worker by asking a member of their young person's nursing team or another member of the Melville MDT. Alternatively, they can request this through Melville Reception.
- The Social Worker can be involved in Weekly Reviews and in Discharge Planning Meetings to support the transition, including referrals to community based social supports.
- For children and young people admitted to the Melville Inpatient Unit from areas outside of Edinburgh, the Social Worker can liaise with other locality Social Work teams when indicated.
- Staff from the Melville Inpatient Unit and throughout Tier 4 Services can request consultation and advice from the Social Worker.
- In discussion with the Social Work Team Leaders, the Social Worker may become the allocated Social Worker in cases where child protection, statutory requirements or other child welfare concerns and needs in CAMHS cases are identified.
- A duty Social Work service is also available daily at RHCYP, Monday to Friday.

6.7.7 Psychiatry

- The psychiatrist acts to lead and coordinate care across the MDT, to assess the physical, psychological, and social needs of the young person, and provide or

arrange for specific treatments. This includes working with the young person's community teams, particularly in preparation for discharge from hospital.

- The psychiatrist will regularly review and assess the young person's mental state, to both confirm their specific eating disorder diagnosis, identify any co-occurring conditions, and monitor treatment response.
- The medical team will lead the reviews of their physical health, with a view to identifying and/or excluding organic causes for their nutritional/dietary or body weight difficulties
- The psychiatrist will assess the risks the young person faces, to their physical and mental health (including cognitive function), by virtue of their illness, and as a potential consequence of refeeding. These risks will inform plans regarding their nutritional plans, intervention levels and pass plans.
- If a young person does not engage with their treatment plan, an Approved Medical Practitioner (AMP) will assess the young person to see if they meet criteria to be detained under the Mental Health Act (MHA). If so, the necessary treatment can be provided without their consent. If any of the criteria are not met, the young person's consent continues to be required. For young people detained using the MHA, a psychiatrist will be their Responsible Medical Officer (RMO), and they will coordinate reviews with the young person's Mental Health Officer, and where appropriate, the Designated Medical Practitioner (DMP) in applying for appropriate orders and authorisations.
- The psychiatrist will, where indicated, prescribe appropriate vitamin supplements and medications in the management of their eating disorder, its associated distress, and any comorbidities.

6.7.8 Therapeutic passes and preparing for eating at home.

Passes support the gradual process of managing time off the ward when it is deemed safe enough and appropriate to do so. This graded approach supports the ongoing assessment of progress and risk, alongside building the confidence of the young people and parents/carers in their work towards discharge. All pass plans should be documented in the pass plan section of the TRAK EPR.

To make therapeutic passes as successful as possible, it is essential that these are planned in advance. In exceptional circumstances, planning of passes may not be possible due to this being a immediate response due to certain scenarios. For example. family emergencies like bereavement or sudden illness or when engagement with the service and/or treatment requires a timelier response. In these circumstances, a discussion between the senior psychiatrist and senior nurse must take place as soon as reasonably possible to assess and manage risk on an individual basis. OOH, the nursing staff should seek further guidance from the CAMHS Duty Dr and CCN.

Early planning of therapeutic passes occurs in the young person's WRM and will be clearly documented on Trak. Clear expectations around passes are set at the meeting and a recognition that passes can change due to changes in risk. The nursing team will support the planning and feedback of the pass outside the meeting. Ongoing risk assessment around passes will include risks related to self-harm, suicidality, over exercising, covert exercise, and purging/compensatory behaviours. The feedback should be documented in Clinical Notes on Trak and will help to inform future passes. Consideration around plans for therapeutic passes will be made for out of area young people who have further to travel. It may be helpful to consider time out with of the WRM to specifically discuss and problem solve with young people, families/carers on practical issues to support passes. There may

also be a consideration from Social Work or OT for particular aspects of planning and supporting passes.

Initially passes will happen outside eating times (0830, 1030, 1230, 1500, 1700 and 1930) as establishing regular meal and snack times are core elements of eating disorder care and treatment on the ward.

Nursing Staff Tasks:

- Arrangements are made to support parents/carers to be present for a meal or snack time with their young person and member of nursing staff as identified in WRM.

Nursing staff will support a more detailed plan for pass following agreement of Pass allocation within the young person's WRM. The identified Nursing Team member will liaise with the young person and their support network to identify:

- Who is supporting the pass.
- The start and return time.
- The rules of the pass
- The contact details for the young person and parent/carer
- That the individual supporting the pass and the young person have the ward phone numbers.
- Any risks and that the appropriate Care Plan is in place and updated on Trak.
- That Care Plan copies given to young person and family/carer.

Timings of return to the ward

These will be agreed in advance of the pass and will **not** interfere with the direct workings of the ward. It is essential that these times are protected:

- Meal and Snack times: 830am, 1030am, 1230pm, 3pm, 5pm and 730pm
- Medication round: 8am, 1pm, 6pm, 10pm
- Handover: 0730-745am, 1230-1pm, and 815-830pm
- Bedtime
- Young Person's Weekly meeting time.

Discretion over timings will be made for those young people that have further to travel.

Please see Appendix 7 "Therapeutic Passes and Preparing to eat at home".

6.7.9 Support and Advocacy

We know that EDs impact the entire family and can cause significant anguish. Parents/Carers may experience caregiver burden, high levels of emotion and difficulties coping. This can impact the recovery process.

Melville Inpatient Unit Parent/Carer Support Group

There is a parent and carer support group open to all families of young people admitted to the Melville Inpatient Unit (unless there are contra-indicators to their participation). The group meets weekly on Tuesdays between 4.30pm and 6.00pm in the Family Support Hub at RHCYP and is facilitated by 2 staff from the Melville Inpatient Unit MDT.
Parents and carers are contacted by phone or in person by the group facilitators to share information about the group and invite them to attend. Young people are also informed about the group by the facilitators.

The aims of the group are to offer a private, safe, and relaxed space for parents to talk, support each other and consider their own or wider family needs. It is also an opportunity for parents and carers to ask questions or share any concerns about their experience of the Melville Inpatient Unit. If these can't be addressed in the group, parents will be supported to discuss or explore these in other appropriate settings.
The facilitators regularly discuss with attendees how the meetings can best meet their needs, and from that may plan sessions based on specific themes or invite other agencies or members of the MDT to attend. These sessions could include input on eating disorders, care for carers, how to manage challenges in family relationships or input from agencies such as Vocal or Beat.
Parents and carers will also be provided with practical information, such as advice on the Young Patient Family Fund, how to access benefits advice or referrals to other agencies that can offer help to families.

Parents and carers are offered 3 post discharge sessions to support them during this period of transition.

When needed, parents or carers can be offered follow up individual meetings with the group facilitators or other staff if matters arise that can't be fully attended to during group meetings.

Parent attendance is recorded on Trak.

Other options for parent/carers support include Beat Resources including online peer support groups and individual support: Support someone else - Beat(beateatingdisorders.org.uk).

For more local resources including parent advocacy and local support groups, please see the CAMHS Eating Disorder Teams space).

The following Good Practice Guide Carers & Confidentiality is helpful to navigate supporting parents and carers while upholding a young person's rights to confidentiality
2018_update_carers___confidentiality_final_draft_16_oct_2018.pdf (mwcscot.org.uk)

6.8	**Discharge**	

ED specific information to consider in addition to the Discharge considerations in the East Region Admission and Discharge SOP:

Outpatient weight obtained (weighed in single layer of clothing following breakfast) and inputted on Trak, specifying this is an Outpatient weight.

Physical observations inputted on Trak under "Observations/Measurements".

Discharge summary that includes admission weight, discharge weight, and physical observations at discharge. It may also be helpful to include particular reflections on successful aspects of admission and recommendations for thresholds for future admissions should they be needed.

It may be necessary to consider referral to CAMHS Tier 4 services. In Lothian, this comprises the CAMHS Assertive Outreach Team (CAOT) and Over 12s Day Programme.

Please see the Appendix 8 for Tier 4 Referral form.

7.0	References	

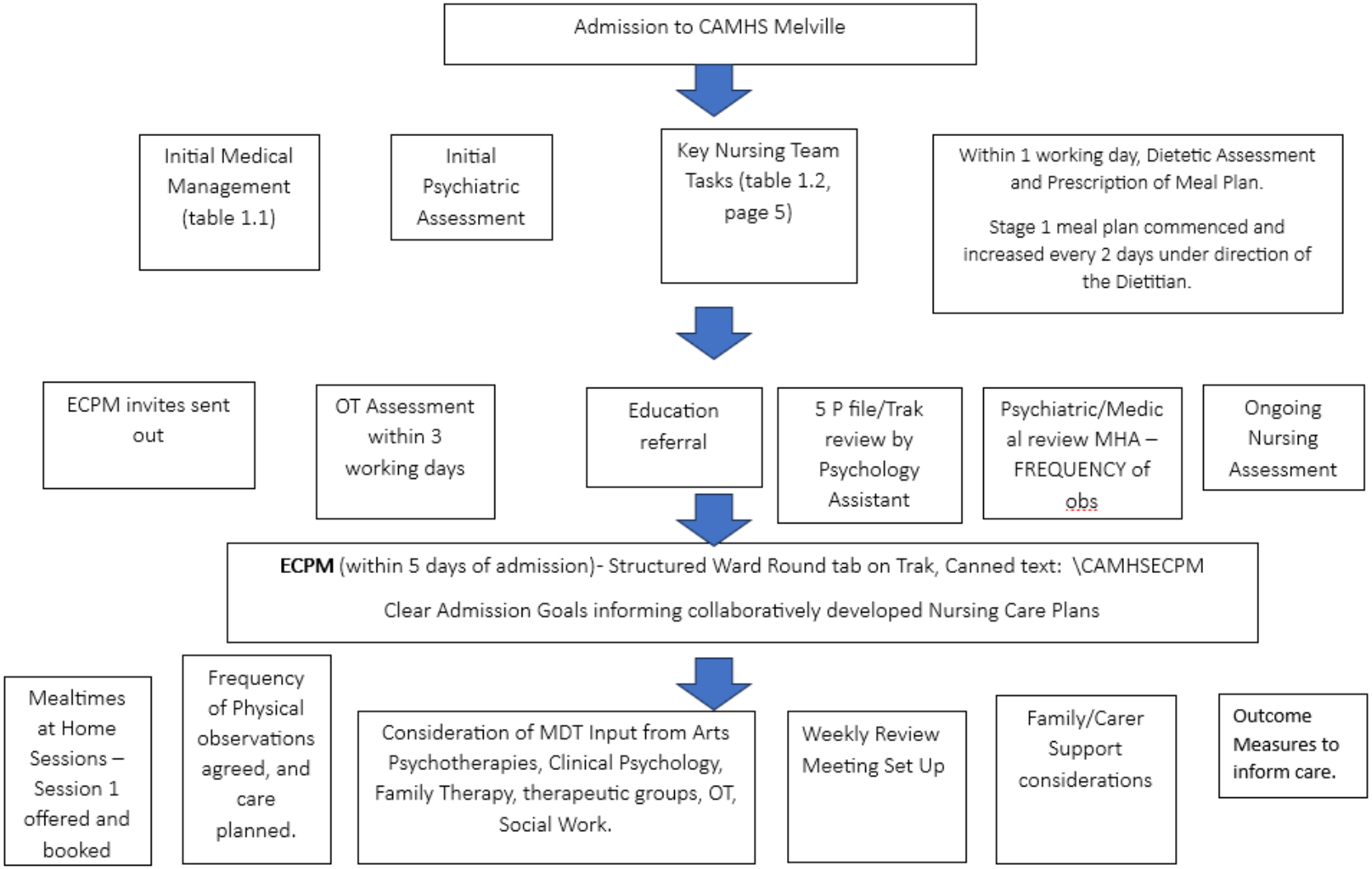
Eating Disorders. A National Clinical Guidlines. https://www.sign.ac.uk/our-guidelines/eating-disorders/

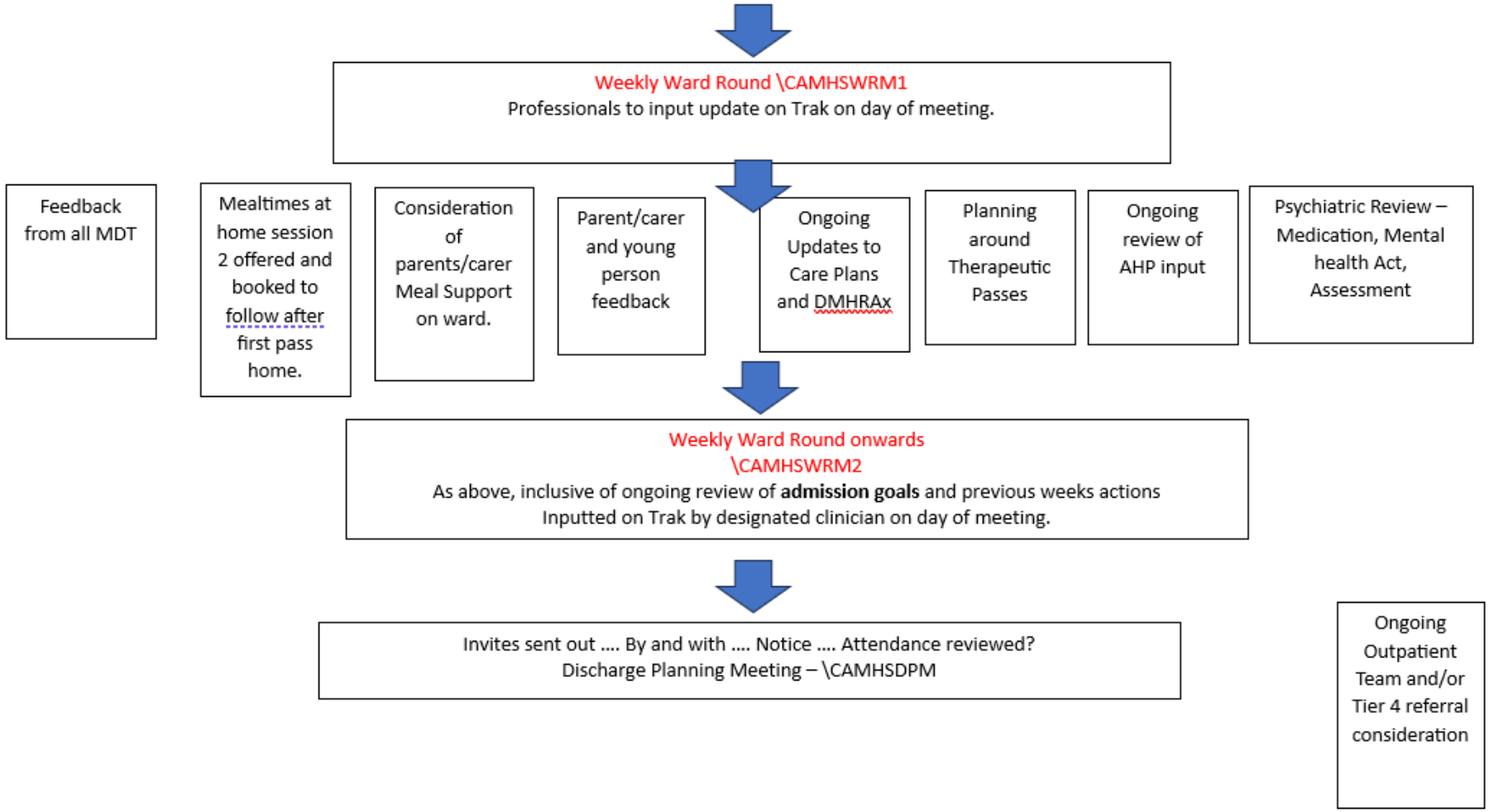
Mental Welfare Commission for Scotland (2020). Living with an eating disorder - new report on peoples experiences in Scotland. https://www.mwcscot.org.uk/news/living-eating-disorder-new-report-peoples-experience-scotland

Royal College Psychiatrists CR233 (2022). Medical emergencies in eating disorders (MEED). Guidance on recognition and management. https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2022-college-reports/cr233

Scottish Government (2021). National Review of Eating Disorder Services: report and recomendations. https://www.gov.scot/publications/national-review-eating-disorder-service
SIGN 164 (2022).

Appendix 1: Initial Admission Process




Weekly Ward Round \CAMHSWRM1
Professionals to input update on Trak on day of meeting.
Feedback from all MDT
Mealtimes at home session 2 offered and booked to follow after first pass home.
Consideration of parents/carer Meal Support on ward.
Parent/carer and young person feedback
Ongoing Updates to Care Plans and DMHRAx
Planning around Therapeutic Passes
Ongoing review of AHP input
Psychiatric Review – Medication, Mental health Act, Assessment
Weekly Ward Round onwards \CAMHSWRM2
As above, inclusive of ongoing review of admission goals and previous weeks actions
Inputted on Trak by designated clinician on day of meeting.
Invites sent out .... By and with .... Notice .... Attendance reviewed?
Discharge Planning Meeting – \CAMHSDPM
Ongoing Outpatient Team and/or Tier 4 referral consideration

Appendix 2: Staged Meal Plans KITCHEN COPY Name: CHI:

Notes for Catering Staff Vegetarian Non-vegetarian	• Must manage both cereal + milk. • Give full supp if either missed	LIKES: DISLIKES:					Small = 200mls Medium = 250mls Large = 400mls
	Breakfast	**am snack**	**Lunch**	**Pm snack**	**Evening Meal**	**Supper**	**9pm on ward**
Stage 1 **1500kcal** **Date:**	Medium fruit juice + Cereal + small milk for cereal (remainder to drink)	Medium milk	Medium water Full Sandwich*	Medium water + yogurt/custard pot	Medium water ½ portion main meal*	Medium milk 1 slice toast with butter/marg and jam/marmalade	Mug of Tea or medium cup water.
FORTISIP	250mls	100mls	200mls	100mls	150mls	200mls	T = 1000mls
Stage 2 **1800kcal** **Date:**	Medium fruit juice + Cereal + small milk for cereal (remainder to drink)	Medium milk + cereal bar	Medium water + Full Sandwich*	Medium water + yogurt/ custard pot	Medium water + Full portion main meal*	Medium milk 1 slice toast with butter/marg and jam/marmalade	Mug of Tea or medium cup of water.
FORTISIP	250mls	200mls	200mls	100mls	300mls	200mls	T= 1250mls
Stage 3 **2100kcal** **Date:**	Medium fruit juice + Cereal + small milk for cereal (remainder to drink)	Medium milk + cereal bar	Medium cup water + Full Sandwich* + Dessert pot	Medium water + Snack item	Medium water + Full portion main meal* + piece of fruit	Medium cup milk 1 slice toast with butter/marg + Jam/marmalade	Mug of Tea or medium cup water.
FORTISIP	250mls	200mls	300mls*	150mls	350mls*	200mls	T = 1450
Stage 4 **2400kcal** **Date:**	Medium fruit juice + Cereal + small milk for cereal (remainder to drink)	Medium milk + cereal bar or packet crisps	Medium fruit juice + Full Sandwich* + Dessert pot	Medium milk + Snack item	Medium water + Full portion main meal* + fruit	Medium milk + 1 slice toast with butter/marg and jam/marmalade	Mug of Tea or medium cup water.
FORTISIP	250mls	200mls	400mls*	250mls	350mls*	200mls	T = 1650

Dietitian Signature: _____ Date _____

*Timing of main meal and sandwich option may vary depending on menu option chosen
Please use ready reckoner for supplement volume

Appendix 2: Staged Meal Plans KITCHEN COPY Name: CHI:

Notes for Catering Staff **Vegetarian** **Non-vegetarian**	• Must manage both cereal + milk. • Give full supp if either missed	LIKES: DISLIKES:					Small = 200mls Medium = 250mls Large = 400mls
	Breakfast	am snack	Lunch	pm snack	Evening Meal	Supper	9pm
Stage 5 **2600kcal** **Date:**	Medium fruit juice + Cereal + small milk for cereal (remainder to drink) + 1 slice toast + butter/marg or jam/ marmalade	Medium milk + cereal bar or packet crisps	Medium water + Full Sandwich* + Hot pudding	Medium milk + Snack item	Medium water + Full portion main meal* + Fruit + dessert pot	Medium milk + 1 slice toast with butter/marg and jam/marmalade	Mug of Tea or Medium cup of water
FORTISIP	350mls	200mls	400mls*	250mls	450mls*	200mls	T = 1850
Stage 6 **2800kcal** **Date:**	Medium fruit juice + Cereal + small milk for cereal (remainder to drink) + 1 slice toast with butter/marg or jam/ marmalade	Medium milk + cereal bar or packet crisps	Medium water + Full Sandwich* + Hot pudding	Medium milk + Snack item	Medium water Full portion main meal* + Fruit + dessert pot	Medium milk + 2 slice toast with butter/marg and jam/marmalade	Mug of Tea or Medium cup of water
FORTISIP	350mls	200mls	400mls *	250mls	450mls*	300mls	T = 1950

PM Snack Item list:

Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
4 Crackers + 2 laughing cow portions	3 Biscuit selection	2 pancakes + butter OR jam	4 Crackers + 2 laughing cow portions	3 Biscuit selection	Chocolate bar	2 x Pancakes (with butter OR jam) x2
FORTISIP :150mls for all pm snacks						

Dietitian Signature: _____ Date _____

*Timing of main meal and sandwich option may vary depending on menu option chosen
Please use ready reckoner for supplement volume

Replacement supplement volumes for foods and drinks

Food Item	FORTISIP (1.5kcal/ml)
1 slice of toast + spread + preserve	100ml
Cereal Bar or Packet of crisps	100ml
Fruit	50ml
Full Sandwich	200ml
Main Meal	300ml
Main Pudding	200ml
Yoghurt/Custard/Ice Cream	100ml
PM Snack Item	150ml

Drinks/ Fluid	FORTISIP + water	Extra notes
Medium cup (250mls) Fruit Juice or Milk	100mls Ensure Plus + 150mls water	
Breakfast Cereal + milk	150mls Ensure Plus + 100mls water.	Must manage both together. i.e Young person must not separate milk and cereal. Give supplement for any part missed.
Extra for smearing/crumbs and small amounts of food left	50mls	Please record any missing volume of food and discuss with the Dietitian

If a young person cannot complete their meal, a nutritional supplement is given. This ensures that they receive the necessary nutrients and fluid as part of a staged recovery plan even when they are unable to consume their entire prescribed meal plan.
The tables below detail the amounts to be given to replace meals, snacks and drinks.

Dietitian Signature: _____ Date _____

*Timing of main meal and sandwich option may vary depending on menu option chosen
Please use ready reckoner for supplement volume

Name: CHI: Dietitian: **CAMHS Patient Copy**

Notes for Catering Staff **Vegetarian** **Non-vegetarian**	• Must manage both cereal + milk. • Give full supp if either missed	LIKES: DISLIKES:					Small = 200mls Medium = 250mls Large = 400mls
	Breakfast	**am snack**	**Lunch**	**Pm snack**	**Evening Meal**	**Supper**	**9pm on ward**
Stage 1 **Date:**	Medium fruit juice + Cereal + small milk for cereal (remainder to drink)	Medium milk	Medium water Full Sandwich*	Medium water + yogurt/custard pot	Medium water ½ portion main meal*	Medium milk 1 slice toast with butter/marg and jam/marmalade	Mug of Tea or medium cup water.
Stage 2 **Date:**	Medium fruit juice + Cereal + small milk for cereal (remainder to drink)	Medium milk + cereal bar	Medium water + Full Sandwich*	Medium water + yogurt/ custard pot	Medium water + Full portion main meal*	Medium milk 1 slice toast with butter/marg and jam/marmalade	Mug of Tea or medium cup of water.
Stage 3 **Date:**	Medium fruit juice + Cereal + small milk for cereal (remainder to drink)	Medium milk + cereal bar	Medium cup water + Full Sandwich* + Dessert pot	Medium water + Snack item	Medium water + Full portion main meal* + piece of fruit	Medium cup milk 1 slice toast with butter/marg + Jam/marmalade	Mug of Tea or medium cup water.
Stage 4 **Date:**	Medium fruit juice + Cereal + small milk for cereal (remainder to drink)	Medium milk + cereal bar or packet crisps	Medium fruit juice + Full Sandwich* + Dessert pot	Medium milk + Snack item	Medium water + Full portion main meal* + fruit	Medium milk + 1 slice toast with butter/marg and jam/marmalade	Mug of Tea or medium cup water.

Dietitian Signature: _____ Date _____

Name: CHI: Dietitian: **CAMHS Patient Copy**

Notes for Catering Staff **Vegetarian** **Non-vegetarian**	• Must manage both cereal + milk. • Give full supp if either missed	LIKES: DISLIKES:					Small = 200mls Medium = 250mls Large = 400mls
	Breakfast	am snack	Lunch	pm snack	Evening Meal	Supper	9pm
Stage 5 **Date:**	Medium fruit juice + Cereal + small milk for cereal (remainder to drink) + 1 slice toast + butter/marg or jam/ marmalade	Medium milk + cereal bar or packet crisps	Medium water + Full Sandwich* + Hot pudding	Medium milk + Snack item	Medium water + Full portion main meal* + Fruit + dessert pot	Medium milk + 1 slice toast with butter/marg and jam/marmalade	Mug of Tea or Medium cup of water
Stage 6 **Date:**	Medium fruit juice + Cereal + small milk for cereal (remainder to drink) + 1 slice toast with butter/marg or jam/ marmalade	Medium milk + cereal bar or packet crisps	Medium water + Full Sandwich* + Hot pudding	Medium milk + Snack item	Medium water Full portion main meal* + Fruit + dessert pot	Medium milk + 2 slice toast with butter/marg and jam/marmalade	Mug of Tea or Medium cup of water

PM Snack Item list:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
4 Crackers + 2 laughing cow portions	3 Biscuit selection	2 pancakes + butter OR jam	4 Crackers + 2 laughing cow portions	3 Biscuit selection	Chocolate bar	2 x Pancakes (with butter OR jam) x2

Dietitian Signature: _____ Date _____

Appendix 4: Calculating Fluid Requirements

Fluid Requirements for children over 10kg.

Normal fluid requirements can be calculated using an adaptation of the Holliday-Segar formula	
11 – 20kg	**100ml/kg for the first 10 kg** **+ 50ml/kg for the next 10 kg**
> 20kg	**100ml/kg for the first 10 kg** **+ 50ml/kg for the next 10 kg** **+ 25ml/kg thereafter to maximum of 2500ml/day**
Example - A Child who weighs 22kg 100ml/kg for the first 10 kgs = 1000 ml 50ml/kg for the next 10 kgs = 500 ml 25ml/kg for the remaining 2kg = 50 ml TOTAL = 1550ml per day (70ml/kg)	

Calculation caveats
Underweight child – Calculate fluid requirements for the child's actual weight. Overweight child – Require less fluid than the calculated volume per kg as their body weight is higher than normal.

From Great Ormond Street Hospital for Children: Nutritional Requirements for children in Health & Disease. 6th Edition August 2015.

Appendix 5: Therapeutic Meal Support

Therapeutic Meal Support Guidance developed by the Melville IPU Nurses Meal Support Champions and the Eating Disorders Development Team

Meal Support

Therapeutic boundaries are important in providing a consistent approach across all meals and snacks for all young people receiving treatment for an eating disorder. Consistency is important to contain anxiety, of which we know is at its highest before, during and after eating. Clear consistent therapeutic boundaries support staff in their task of challenging the eating disorder at the table. If there are adaptions to these therapeutic boundaries, these should be care planned in detail beforehand with a clear rationale behind the changes and a clear pathway/goal setting to support progress within the dining room.

The Melville Inpatient Unit Meal Support Champions (MSC's) have identified these as key therapeutic boundaries that should consistently be followed on the Ward:

Preparing the young people for eating times:

Waking no later than 8 am to allow enough time for young people to get up and organised prior to breakfast. There is also other rationale behind this, for instance, establishing a sleep pattern and basic time management skills that will be essential on returning home.

Giving the young person a 5-minute warning before they are expected through to the dining area. This prompt would include a reminder to use the bathroom and to prepare the items they will need for post meal support. Ideally the young person should know who will be supporting them at that meal or snack. Other reminders that would be helpful include ensuring that they are dressed appropriately to ensure the rules at the table are adhered too.

Young people, family and staff should be made aware of the meal and snack times on the ward. These are protected times (unless agreed **in advance** that family/parent/carer will attend for meal support):

- Breakfast: 0830 – 0850 hours
- Morning Snack: 1030-1045 hours
- Lunch: 1230-1300 hours (20 mins for main meal and 10 mins for pudding)
- Afternoon snack: 1500 – 1515 hours
- Dinner: 1700-1730 hours (20 mins for main meal and 10 mins for pudding)
- Supper: 1915-1930 hours

Allocation of supplement time are:

- 10 mins after a meal and
- 5 minutes after a snack.

At the Table

Young person should have a designated seat with their prompt mat. Staff will decide in advance where the young person is best placed to sit.

Date Endorsed: August 2023
Review Date: January 2025

The staff member allocated to meal support for that young person should be familiar with their care plan and meal plan prior to starting meal support.

Young people and staff are expected to attend the dining room on time and remain consistent with the time limits allocated to each meal/snack. The timing of the meals/snacks will not be altered to allow for late arrival, unless pre agreed).

No phones will be allowed at the table for staff, young people, or family.

Hair should be tied back, out of their face.

Short sleeves are encouraged, or long sleeves rolled up.

Young people to be fully dressed (e.g., no pjs) at the table. No other items like blankets, soft toys, etc should be brought to the table.

No swaps will be negotiated at the table, these will be redirected to a time out with of eating. Staff to be consistent in providing a firm and supportive approach.

Use of condiments – 1 sachet of each will be the maximum allowed to be used.

Staff will direct young people to eat their full amount, including the crumbs left on the plate.

Staff will provide a firm and supportive approach whilst challenging ED behaviours whilst eating, some examples include smearing, taking tiny mouthfuls, crumbing food, leg jiggling.

Staff should support the expectation of the young person to eat until the end time of that meal/snack. There should be no "skipping to supplement."

Use of straws on the unit are not to be used unless care planned for in advance.

At the end of an eating time

Staff should end the meal/snack at the agreed time as stated above. Staff should accompany young people directly back to the ward.

Staff to complete the food/fluid sheet once there is an opportunity to return to the dining area.

Young people to be seated for the allocated time of meal support.

Post meal support should be within the main area of the ward. Young people are encouraged to sit with staff to utilise distraction for the agreed post meal support time. These times are standard, unless agreed to be increased due to risk of purging behaviour:

- 30 minutes restfulness after a snack has been completed.
- 1 hour restfulness after a main meal has been completed (breakfast, lunch, and dinner)

Toilet use is not permitted during post meal support time.

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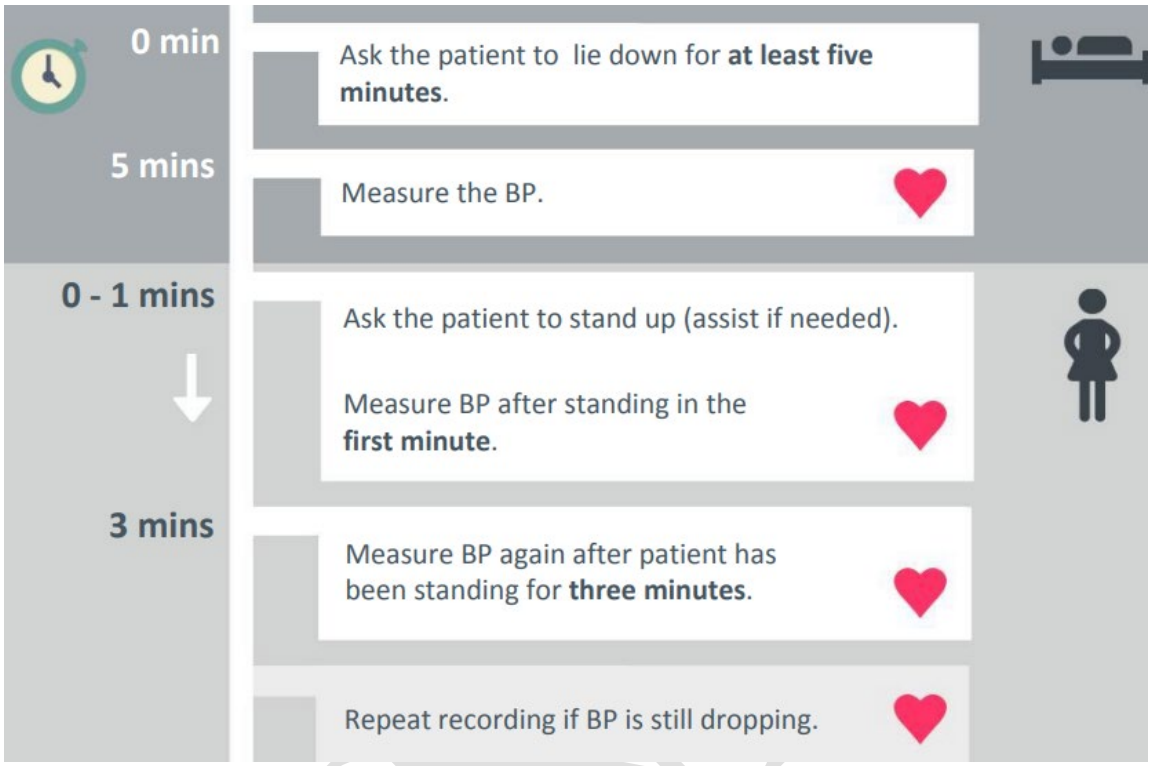
Young people's passes should be arranged to avoid post meal support when possible, to reduce the expenditure of energy at a time they are expected to be restful. We also need to reduce possibility of ED behaviour seeking to compensate after eating. Post meal support is time that ED thoughts may be at their strongest and urges to compensate. Staff need to provide consistent boundaries around post meal support times.

Date Endorsed: August 2023
Review Date: January 2025

Appendix 6: Taking a lying to standing Blood Pressure (BP) and Heart Rate (HR) and BP Centiles

- Always explain the procedure to the patient
- Use a manual sphygmomanometer or the automatic machine, ensuring a selection of appropriate cuff size
- Please take and record both the BP and HR at each identified point:



Extracted from Royal College of Physicians, Falls and Fragility Fracture Audit Programme*:

- Notice and document symptoms of dizziness, light headedness, vagueness, pallor, visual disturbance, feelings of weakness and palpitations.
- Input results on Trak and escalate as appropriate (amber/red flag results).

Risk Assessment Framework for assessing impending risk to life*:

Red: High impending risk to life

Amber: Alert to high concern for impending risk to life

Green: Low impending risk to life

Medical history and examination			
HR (awake)	<40	40–50	>50
Cardio-vascular health[37 38]	Standing systolic BP below 0.4th centile for age or less than 90 if 18+, associated with recurrent syncope and postural drop in systolic BP of >20mmHg or increase in HR of over 30bpm (35bpm in <16 years)	Standing systolic BP <0.4th centile or <90 if 18+ associated with occasional syncope; postural drop in systolic BP of >15mmHg or increase in HR of up to 30bpm (35bpm in <16 years)	• Normal standing systolic BP for age and gender with reference to centile charts • Normal orthostatic cardiovascular changes • Normal heart rhythm

Appendix 7: Therapeutic passes for young people admitted to the Melville Inpatient Unit for the treatment of an eating disorder.

Oral intake should be the priority in seeking medical stabilisation. If an NGT is required then this should be for the shortest amount of time possible, and a clear exit plan made at the start of this intervention. For young people requiring NGT, a decision around if the NGT remains in place during passes should be agreed in advance of the pass. A formulation informed care plan should identify plans for passes and be reviewed weekly.

Stage 1

Car or wheelchair Pass X1 per day – Car or wheelchair passes support a short time off the ward that is of minimal physical exertion. *This is **not inclusive** of a drive to go for a walk or to go shopping.* Request that the car is parked in a car park close to the ward, for example 1A (this can be booked in advance). Car or wheelchair passes should initially be out with of Meal Support Times.

Indicators that Therapeutic pass is safe to offer:

- Stable observations – PEWS over 3 days and in line with MEEDs Risk Assessment Framework
- Stable Bloods
- Settled in mood

Stage 2

Short, escorted walks with staff or family/carer: The aim is to encourage the young person back to normal activity and to avoid 'institutional' routines. The young person will be encouraged to be appropriately dressed for the weather.

Weight bearing activity should not last more than 2x 15 mins or 30 minutes and could include:

- Going for a gentle walk – ideally with a specific purpose, or in a pleasant place, length and terrain should be appropriate.
- Physiotherapy session

Indicators that Therapeutic pass is safe to offer:

- Successful completion of Stage 1 passes
- Successful car or wheelchair pass and continuing to meet those requirements PLUS
- Gaining satisfactory weight of at least 0.5kg a week
- meal plan is meeting the safe minimum requirements for weight gain.

Stage 3

Day Passes – The aim is to support a longer period of time off the ward and may be inclusive of expectation to eat whilst out. The nursing Team will support the family/carer to identify:

- *If NGT in situ*, a plan in place for its removal prior to a day pass
- the day and timing of the Day Pass.
- What plans are for the pass

- ensuring the family/carer have suitable food to follow the prescribed meal plan and have a clear plan in place on how eating will be supervised and supported.
- Guidance around activity should also be given to ensure this is appropriate and safe.
- Managing risk whilst out with the ward should also be discussed as per individual case.
- A return time no later than 8pm.
- The usual pathway for practicing eating at home starts with the young person eating a snack on pass, progressing onto trying a snack and a meal.

Indicators that Therapeutic pass is safe to offer:

- Successful completion of Stage 2 pass plan
- Successful car or wheelchair/walk passes and- continue to meet those requirements PLUS
- Parents/Carers offered and attended at least 1x meal support with young person which has been supported by Nursing Staff on the ward.
- Parents/Carers offered and attended the 1st 'Mealtimes at Home' Session

Stage 4

Overnight Passes – The aim is to support an even longer period of time off the ward and include expectation to eat whilst out on pass. The nursing Team will support the family/carer to identify:

- the day and timing of the Overnight Pass.
- What plans are for the pass
- ensuring the family/carer have suitable food to follow the prescribed meal plan and have a clear plan in place on how eating will be supervised and supported.
- Guidance around activity should also be given to ensure this is appropriate and safe.
- Managing risk accounting for the evening and overnight aspect of this pass

Requirements:

- Successful completion of Stage 3 pass plan
- Successful car/walk/day passes and continue to meet those requirements PLUS
- Attended 2nd 'Mealtimes at Home' Session
- Demonstrated ability to manage a snack and meal off the unit.
- Risk of harmful behaviours overnight assessed and found to be manageable.
- *Optional: Community Team is linked in with either supporting passes home or are establishing regular contact with the family.*

Appendix 8: How to send an internal referral to CAMHS Assertive Outreach

OUTCOME A PATIENT TO AN INTERNAL WAITING LIST

1. Navigate to **Caseload** >> **CP Diary**
2. Within the **CP Diary** screen, at the **Patient's clinic entry**, click **Outcome** 
3. Within the **Outcomes** screen, at **Pathway Decision**, click to choose a relevant outcome i.e., CAMH10 - Treatment Started or Ongoing
4. At **Additional Decisions**, click to choose CAMHX63 - Add to CAOT internal Waiting List
5. Click Update
6. Click Update & Close

Note – Pathway Decision is mandatory. If an Additional Decision is required, Pathway Decision must be chosen first, then make a choice from Additional Decisions

ADD A REFERRAL LETTER

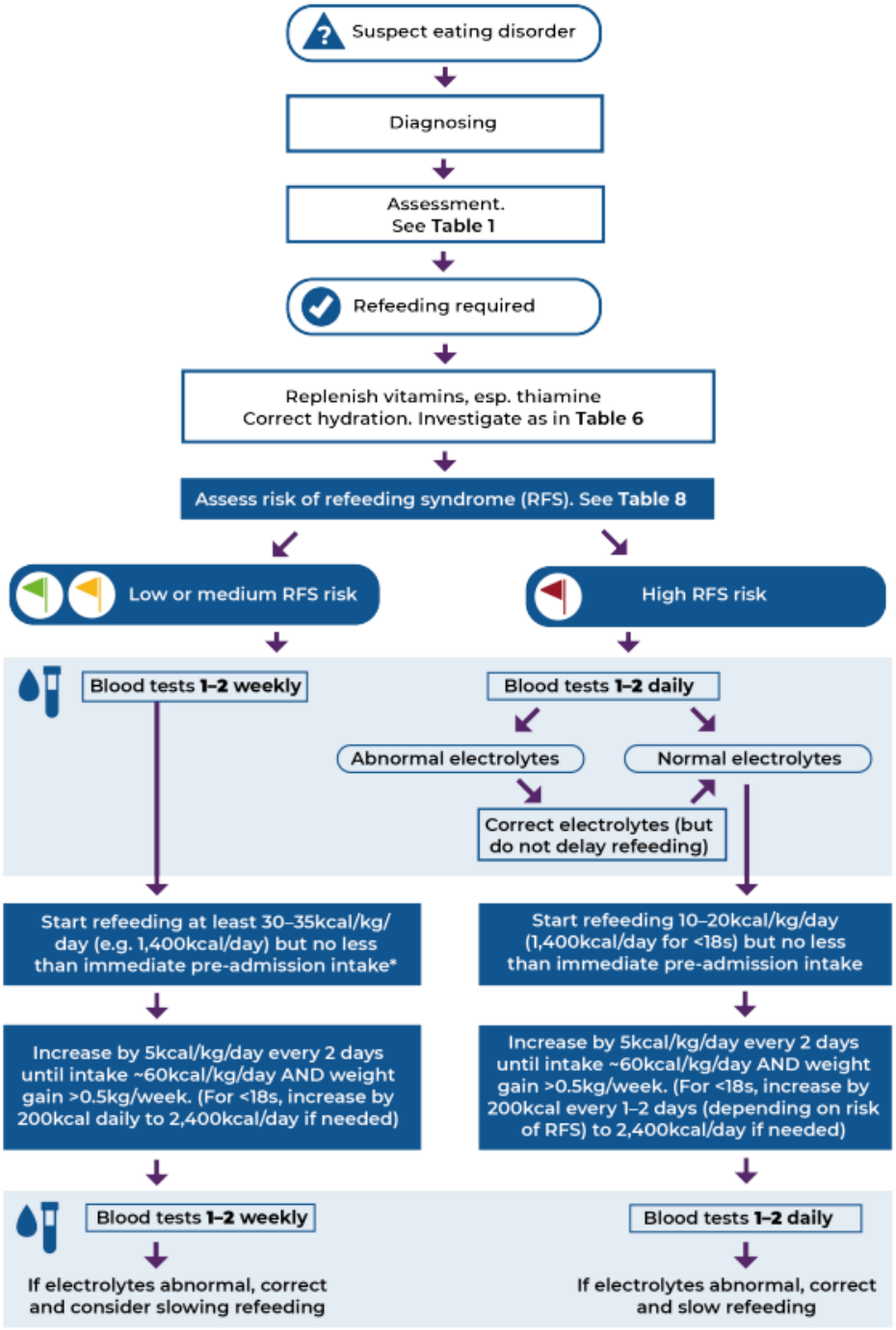
1. Click to select the **Patient's clinic entry**
2. Navigate to **Mental Health** >> **CAMHS**
3. Within the **MH EPR** on the right-hand side of the screen, click the **Correspondence** tab >> **New**
4. At the **Clinical Notes** screen, complete the following fields:
    a. **Note Type:** click the **Spyglass** and choose **Outpatient Clinic Letter**
    b. **Care Provider:** defaults to the Appointment Care Provider
    c. **Select Appointment:** click the **spyglass** and choose the relevant appointment date and time
5. In the free text box, type in **\CAMHST4REF** >> press **spacebar**
6. Complete the referral, as appropriate
7. Enter **Password** and click Update
8. Click **X** in the top right-hand corner to close the screen

EDIT REFERRAL LETTER

1. Navigate to **Caseload** >> **Caseload**
2. Within the **HCP Caseload** section, at **Patient Surname**, key in the Patient's surname
3. Click Find
4. Click to select the Patient's caseload entry
5. Navigate to **Mental Health** >> **CAMHS**
6. Within the **MH EPR** on the right-hand side of the screen, click **Correspondence** >> **Edit**
7. Make the required changes, enter Update **Password** and click

APPENDIX 9: Refeeding Tree (Page 72) MEEDs (2022)

4. Safe refeeding of malnourished patients with restrictive eating disorders



* In adolescents, an initial rate of 1,400–2,000 kcal per day is safe for most patients.

Figure 4: Refeeding decision tree

CHANGE HISTORY

Revision	Date	Changes	Edited By
Version 1	08/11/2024		
Version 1	31/12/2024	Formatting	Lisa Canale, CSM

Meal Support

Regional Eating Disorder Unit

NHS Lothian

Introduction

Welcome to NHS Lothian Eating Disorder Unit's Meal Support Manual. Meal support is both an emotional and practical means of supporting a person with an Eating Disorder while eating. As a highly emotive and sensitive time, patients are prone to using disordered eating behaviours during mealtimes to counteract their anxiety. It is therefore highly important that staff delivering meal support are fully trained in managing this anxiety in a supportive yet constructive manner.

This document has been developed to go alongside our online training clips on NHS Lothian's YouTube account, as well as a PowerPoint file containing the training slides we use. We hope that this package will be used to support other teams introduce a rolling training timetable for staff delivering meal support training.

Acknowledgments:
We would like to thank BEAT, the national eating disorder charity for their consultation throughout the filming process, and for the provision of BEAT Young Ambassadors to support clinicians in gaining an understanding of the experience of a young person receiving meal support. We would also like to acknowledge that two of the slides have been reproduced from the Collaborative Carers training approach developed by Janet Treasure and with permission form BEAT.

Overview

Introduction
This is a Meal Support guide which has been developed by NHS Lothian in conjunction with BEAT, the national eating disorder charity.

Expectations
What you want from training today. Note down suggestions. Please note if there are elements not being met as part of this training, feedback is welcome so the resource can be adapted.

"What is your understanding of meal support?"

Slide 6: Importance of Meal Support
Having a clear understanding of why we do meal support is essential in delivering this treatment. During meal support you are facing the eating disorder head on. It can sometimes be difficult to think clearly in these moments and as a result you can find yourself slipping into unhelpful practice, therefore it is important to have a clear rationale before you enter meal support.
Before, during and after meals are especially difficult for patients with an eating disorder. We cannot underestimate the importance of individualised support around these times.

Poor Practice

Here are some of the behaviours to look for:

- No warning of meal, too casual in his approach with young person
- Left her standing, didn't direct her to sit.
- Too relaxed in his manner
- Up and down from the table allowing eating disorder to be opportunistic
- Changed to "small spoon".
- Reading magazine, distracted from supporting young person.
- Was able to hide food when left
- Crumbling food – why is this important to be aware of and discourage?
- Shaking legs/feet not flat on the floor
- Talking about diets during meal support.
- Spoiling food – using excessive salt
- Interruption from another staff member
- Talking about weight
- Commented on portion size
- Negotiated meal plan – "eat ½ of that and drink your milk". Why is it important not to do this?
- Didn't check that she had finished the milk.

- Negotiated on post meal support – even though they both knew the reasons why this would be discouraged.

Slide 8: Treatment Non-Negotiables

"We have now seen poor practice; lets now think about ways to improve care. As you are all aware, Anorexia is anxiety provoking. Both as individual practitioners and a service, we need to have clear expectations and boundaries around treatment. We need to be upfront and direct about what is non-negotiable in order to provide appropriate and safe treatment. When explaining non-negotiables we need to have clear rationale and we need to explain these in advance (no surprises!). We need to be consistent with these non-negotiables but also encourage autonomy in aspects of their care plan when we can. The explanation of each non-negotiable aspect of treatment needs to be understood by all staff. Can you think what non-negotiables would be?"

As attendees respond, note their answers on the flipchart.

Slide 9: Treatment Non-Negotiables II

Reflect on the answers from the audience on what they believe to be non-negotiable aspects of care.

"Explaining clearly to a young person that they are expected to eat but will be supported to do so is important during the first few hours of admission. Not having nutrition is not negotiable. Be upfront with them that yes, they are expected to gain weight in order to restore health. Explain post meal support and rules around this, for example no going to the bathroom during meal or obs etc".

Why are these rules non-negotiable?

Why do we weight young people weekly?

Why do we expect young people to attend meal and snack times?

Why do we ask young people to be supported after meals/snacks for a period of time?

Why do we put limits around activity?

Discuss the consequences – what are the natural consequences of not eating? Low energy, poor health which may result in…?

Slide 10: Implementing Non-Negotiables

"It can be hard to work collaboratively on non-negotiables, but clearly stating at the start of an admission these terms and then asking how best you can support the young person to follow them or their own personal goals is a good way to create an alliance. "You need to follow these expectations in order to reach your goals.""

"Stating "if you don't eat you'll get tubed" is not good. Although can't guarantee this won't happen in the longer term, it is not an immediate consequence to not eating nor is it motivating. So, if it doesn't happen then the young person may lose trust in you."

Slide 11: Care Planning I

"We all know care planning is part of the NMC requirements, that they need reviewed regularly and must be audited – but is it actually important? YES! But why?"

Slide 12: Care Planning II

"The meaning of collaboration is to work with others to do a task and to reach joint goals. Ultimately you both want the same thing. You can set the boundaries of the treatment and ask them what you can do together to help them manage these. Give young people a choice where you can.

It is helpful to externalise the illness within the care plan to (not all young people will agree with this, but even finding this out is very important).
Having a specific meal time and post meal support plan – discuss what the young person finds helpful!
These are changeable as the young person moves forward in recovery and should be adapted. They would also be slightly different whilst on pass and it may be necessary to have a collaborative care plan with parents for passes when they get to that stage."

Slide 13: DVD Clips of Beat Ambassadors
"The following clips give an insight into what an eating disorder feels to them. These are actresses relaying the words of BEAT Young Ambassadors.". Chose the "insight" clips.

Slide 14: Externalising
"Separating the illness from the young person might be difficult for the young person to hear as they may feel aligned with Anorexia or are Anorexic. It is important that nurses help them separate the young person from the illness. This also helps the staff to recognise how powerful the illness is to make them behave in certain ways. It can support staff in thinking about challenging the eating disorder, while being supportive and caring to the young person."

Slide 15: Distraction
"Distraction is about identifying what that individual finds helpful to divert from their thoughts/distress. Care plan distraction and be specific, it is always helpful to ask the young person their thoughts on this. It may be that they don't know what is helpful but can usually tell you what isn't helpful. It's a good starting place to help the process of finding out what does help. This allows others to know what to avoid and what to encourage. It also ensures consistency."

Slide 16: Post Meal Support
"Post meal support is about supporting, not just observing. You are helping the young person through a highly distressing time. Don't underestimate the need to plan and be aware that this time is challenging. Be around to offer encouragement and to find distracting activities or join in with them on an activity.". Make this section specific to the unit rules that you work in e.g. time, location etc.

Slide 17: On Our Unit
Prepare the flipchart and ask the group what can be done to support the young people after mealtimes on the unit on which they work. Give suggestions if needed, such as meditation, card games, board games, arts and crafts, reading, phoning a friend…

Slide 18:Expectations and Limit Setting
"We need to be aware of our role within the non-negotiable aspects of care. The young person needs to feel contained with consistent care."

Slide 19: Behaviours at the Table I
Discuss as a group. Reflect how powerful the illness is to make young people behave in such ways. Please refer trainees to the Hints and Tips handout attached to this document.

Slide 20: Behaviours at the Table II

Review responses to the discussion as well as those on the slide. Ask the group, “Why do you think young people are doing this?”
Encourage a brief discussion regarding each item and why a young person is doing them; reinforce that the ED thoughts drive the behaviours.
Ask the group, “What can we do to reduce these behaviours?” Encourage group discussion. Give suggestions such as keep calm, encourage consistency, cutting sandwiches in four, asking for hair to be kept away from face, keep hands on the table, reinforce clear time limits, time management, replacing soiled food with new food…

Slide 21: Summary
Never negotiate with staff in front of the young people; this makes the young people feel unsafe.

Slide 22: DVD Clip of Challenging Practice
Ask the group to observe the following clip of a challenging situation. Ask them to reflect on what the nurse done well.
After the clip encourage discussion of what he done well. Remind them that when you are at the table you are the consistent voice aligned with the young person to support them in challenging anorexia.

- Clear direction throughout the meal
- Focused solely on young person
- Acknowledged distress but refocused to task
- Replaced spoiled or spilt food/drink
- Didn’t leave the table
- Stayed calm
- Supportively challenged eating disordered behaviour – scraping sauce from pasta, cutting up into small pieces, smearing in hair
- Directed to behaviour that was encouraged “use your knife and fork”, “sit with your feet flat on the floor”, “tuck your hair behind your ears”.
- Encouraged deep breaths
- Encouraging statements “keep going”, “food is your medicine”, “its okay”
- Affirmed process “good effort” rather than praise
- Maintained expectation of time despite not finishing.
- Activity planned for post meal support

Slide 23: Praise Vs Affirmations
Encourage a group discussion on what might be helpful statements to make and what might also be unhelpful.

Slide 24: DVD Clip of B-eat Ambassadors
Group discussion

Slide 25: Managing Negative Thinking
Try not to get into Eating Disordered talk or provide “therapy” at the table, ie. Arguing that a young person doesn’t look fat or supporting them to see this from a different perspective. Instead try to have empathy for the young person and see the world through their eyes, “I can see this is difficult for you.” while remaining focused on the task of eating. Highlight their previous strengths, “You can do this, you came to the table!” Dance with resistance – prepare for the young person to shut down conversations. Try to motivate by talking about future goals.

Slide 26: Managing YOUR Negative Thinking

The next 13 slides are from a book by Janet Treasure; a lead in Eating Disorder research. She came up with “animal analogies” for parents to think about their caring styles as a way of thinking about expressed emotion (which we know can delay recovery from eating disorders). However they are extremely useful for staff to think about how they approach meal support and anorexia in general.

Slide 27: Janet Treasure: Animal Analogies 1 *(reproduced with permission from BEAT)*
The following animal analogies describe what kind of carer you are. You can be the kangaroo; giving too much sympathy and micromanagement. The rhino, giving too much criticism and hostility. Or you can be a dolphin, giving just enough direction and support. Think of the dolphin, at times the one to nudge the young person forward, sometimes swimming alongside the young person and sometimes leading from the front.
In terms of your emotional response, you may either be a jellyfish, giving too much emotion, being unable to cope and feeling “sad and mad!” You might be the ostrich who will have too little emotion and tries to avoid thinking or talking about their problems. Or you can be the St. Bernard dog, who has just enough calmness, is compassionate and delivers consistency.

Slide 28: Janet Treasure: Animal Analogies II
When someone is so obviously ill or in distress, it can be an instinctual to want to try to protect them by creating a ‘pouch’ of care and protecting them until they are better. However, rather than helping, these efforts may actually deliver the idea that the illness is rewarding them with attention and special treatment. By accommodating the eating disordered behaviours, it can begin to dictate and influence on their care plan. This will be the nurse who will swap the sandwich for “something easier”.

Slide 29: Janet Treasure: Animal Analogies III
Description of cycle.

Slide 30: Janet Treasure: Animal Analogies IV
This response involves trying to present a logical argument towards the Eating Disorder as to why they should change. They may shout, try to take control or try to ‘win’ arguments at meal times. They are loving, they just want the young person to ‘see sense’. However, this gives the young person opportunity to articulate arguments for not changing. The eating disorder is persistent and does not respond to logic. The young person might also feel rejected and unloved when someone close to them has tried to dictate forcefully how and why they should change.

Slide 31: Janet Treasure: Animal Analogies V
Description of cycle.

Slide 32: Janet Treasure: Animal Analogies VI
The dolphin gives just enough balance and direction. This is the staff member who may calmly give clear instructions at the table and remains calm and collected when the young person tries to challenge them or the food. They are gentle and empathetic but firm.

Slide 33: Janet Treasure: Animal Analogies VII
The dolphin here knows that they tried their best at meal support. The person didn’t finish everything but that’s ok, you tried your hardest.

Slide 34: Janet Treasure: Animal Analogies VIII
The Ostrich is the nurse who sees the person smearing mayo over the plate but thinks “well, at least they’re trying” and doesn’t challenge them, “someone else will”.

They know that talking about food and other problems might cause upset and so avoid it. This then runs the risk of their behaviour colluding with the eating disorder.

Slide 35: Janet Treasure: Animal Analogies IX
Description of the cycle.

Slide 36: Janet Treasure: Animal Analogies X
The jellyfish describes the person who will get highly emotional when they see a young person in distress. It describes a raw emotional state where all feelings come up to the surface. This can, rather than being positive, be difficult for young person by giving a message that others can't cope/tolerate this it can reduce self-esteem and creates a sense of guilt and hopelessness or secretiveness.

Slide 37: Janet Treasure: Animal Analogies XI
Description of the cycle.

Slide 38: Janet Treasure: Animal Analogies XII
When a young persons distress is high, try to listen and tune into the situation, do not shout or join in. Do not get paralysed by despair. Provide warmth and nurture. Be reliable, steady and dependable. This is the nurse who will remain calm and call for support if needed.

Slide 39: Janet Treasure: Animal Analogies XIV
Summarise the analogies.

Slide 40: Who Are You?
Encourage group discussion on which animal each attendee is. If they are not already a St. Bernard dog or a dolphin, ask for suggestions as to how they can begin to change to being one.

Slide 41: Personal Support
Ask the group if there are other ways they think would be helpful to support colleagues facilitating meal supports? What can you do personally to support this? Encourage group discussion and reflection, particularly on supervision.

e.g. when your emotions are overwhelming, use your colleagues to support you in temporarily trying to take a step back from the situation. Use self talk e.g. I have half an hour to dedicate completely to this and then I will seek out a break". Remember this is about being effective, not just present.

Slide 42: DVD Clip – Hints and Tips
We're about to finish up with some hints and tips provided by B-eat ambassadors on how we can best support a young person with an eating disorder.
After the clip ask if anyone has any further questions…..

….Slide 43: Questions
Answer any questions attendees may have and thank them for coming.

Meal Support: Hints and Tips

Meal support is a way of practically and emotionally supporting an individual with an eating disorder before, during and after a meal and/or snack. This may be offered in a number of different settings, including inpatient care, at home, or in the community. Below are some useful tips on how to support someone during a meal support.

Pre-meal

- ✓ *Know what the young person finds helpful:* It is helpful to know specific comments the individual finds helpful or unhelpful. This may involve talking to the young person before the meal to find this out. For example, sometimes comments we may think are motivating them may actually be more detrimental in their effect.
- ✓ *Communicate expectations:* If we can discuss with the young person what we expect of them during the meal beforehand, this may save us from entering stressful conversation topics during the mealtime.
- ✓ *Set the scene:* Simply preparing the room and setting the table before the young person comes along to eat can reduce stress and opportunity for the eating disorder to negotiate. Make sure you have a quiet room with minimal distractions and all cutlery/drinks/prepped meals ready to go.
- ✓ *Have conversation topics ready:* Using some general, lighthearted conversation topics that do not relate to weight, diets, body shape or food can lighten the atmosphere and ease anxiety.
- ✓ *Prepare distraction techniques:* Having some (restful) techniques at hand for using after the meal can be helpful in distracting the young person from feeling uncomfortable with the meal they have just eaten. For example, some people enjoy playing cards, watching tv or reading a book.
- ✓ *Plan ahead for all possible outcomes:* There may be times when a young person spoils their meal/snack to avoid completing it. In this instance, it is appropriate to have a spare portion on hand should this happen.

During the Meal

- ✓ *Externalisation:* Separating the identity of the young person to the eating disorder can be a powerful strategy in helping them (and you!) understand

that they are not the problem – that you are there to help support them in overcoming the eating disorder.

- ✓ *Distraction:* This is something which is personal to the individual and documented in their care plan as things which are helpful in reducing stress during and after a meal. This can include having the radio or tv on in the background, or having a variety of topics at hand which the young person is interested in (e.g. school, the weekend, friends, tv shows or seasonal events).
- ✓ *Limit Setting:* Try to highlight how long the young person has to complete the meal, and give prompts if necessary during the meal to support them to complete within a time limit. Acknowledging and setting limits on behaviour is helpful, e.g. 'I can see you….That is not helpful.'
- ✓ *Positive affirmations:* Some commonly used affirmations that can be supportive to the young person include, 'This seems really difficult for you,' 'I can see you're trying really hard,' or 'It takes a lot of courage to do this.'
- ✓ *Listening skills:* Use your body language to convey a sense of support and understanding, e.g. nodding and leaning forward, or saying 'Uh-huh,' or 'I see.'

<u>After the Meal</u>

- ✓ *Support:* After a meal is time to be restful and support/distract the young person in sitting with their thoughts about the meal they have just eaten. Young people are discouraged from using the bathroom for the hour post-meal to prevent eating disorder behaviour such as vomiting. Instead, offering company during restful activities such as puzzles, chat, playing cards or TV can reduce distress.

Meal Support YouTube Clips

As a part of this Meal Support Manual, we have included the URL to NHS Lothian CAMHS's video clips on YouTube. These clips are useful in showing alongside the Powerpoint training package, and the script included within this package will give you prompts as to when to use them.

https://www.youtube.com/playlist?list=PLmii-IHSw9OpYemPsCLsy5FRXGI67qqwL

This link will guide you to a series of videos which include the following;

1. Poor Practice example: This short video depicts a scene in which a young woman is being supported by a member of staff at lunchtime. This example highlights some of the examples of what a meal supporter should not do.
2. Good Practice example: This video shows the same staff member supporting the young woman in an understanding and attentive manner. He now prepares the young person for the meal, supports them with encouraging and positive affirmations when they are finding the meal difficult, and sticks to the rules around toilet breaks and portion sizing.
3. Challenging Behaviour example: In this video, we see that the young person struggling with the meal and attempts a number of different challenging eating disordered behaviours which are managed and supported by the staff member.

There are then a series of videos containing two Beat Ambassadors discussing their own experience of meal supports, what they found helpful and unhelpful, and give some hints and tips on how best to support someone with an eating disorder, from personal experience.

If you require further information on this resource, please contact Fiona.duffy@nhslothian.scot.nhs.uk or lorraine.small@nhslothian.scot.nhs.uk

MEAL TIME MANAGEMENT

WHAT IS MEAL SUPPORT

- An intervention to re-establish "normalised" eating
- Emotional support for an individual with an eating disorder BEFORE, DURING AND AFTER meals and snacks in order to enable them to successfully complete the food and to minimise any compensatory behaviours
- In a family setting, hospital setting or with friends
- Difficult thing to do and a difficult thing to receive

REASONS WE WOULD USE MEAL SUPPORT

- Nature of the illness means accepting nutrition is difficult
- Prevent further deterioration in nutritional state
- Loss or lack of recognition of hunger cues
- To break the binge purge cycle
- To reduce unhelpful behaviours
- To model normalised eating

WHAT ARE WE TRYING TO ACHIEVE?

- Facilitate meal completion to an agreed goal: weight gain, stabilisation,
- To support an increase in food consumption
  - Despite physical discomfort
- Normalise eating behaviours
  - May be breaking longstanding rules
- Re-introduce eating as a pleasant sociable experience
- Increase confidence around food

ARFID

- Adapted approach required
- May be out with the dining room on 1:1 with staff
- Graded exposure to food
- Distractions may be required
- Adapted meal plans
- May experience “fears” not associated with weight
- Longer process which will continue following discharge

WHO CAN PROVIDE SUPPORT?

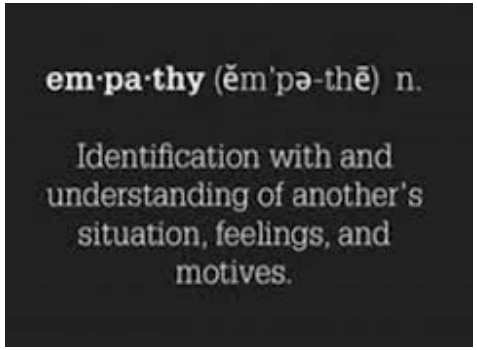
- All members of the team or family / friends
  - Gain valuable insight during meal times
- It helps if:
  - You feel confident and comfortable around food
  - You can remain calm and non-judgemental
  - You have good communication skills
  - You can demonstrate genuine empathy
  - You can be a healthy role model

PRACTICALITIES

- Set meal times
  - Breakfast, morning snack, lunch, afternoon snack, evening meal and supper
- Individualised meal plans agreed by dietitian
- Portion sizes agreed
- Agree times for meal completion
  - Half hour for main meals and fifteen minutes for snack meals
- Set expectations: completion in food form, discussions about meal plan outwith the dining room
- Environment: protected meal times, table layout, relaxed atmosphere
- What if someone is unable to complete their meal?

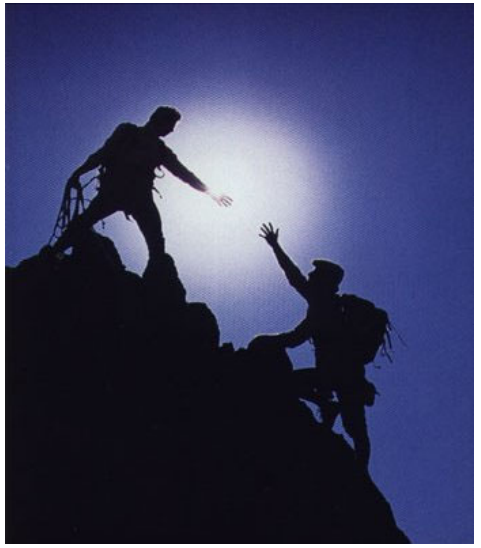
PROVIDING SUPPORT

- Expect resistance
- Reminders about their individual goals
- Empathise about how difficult it is
- Validate their feelings: fear, confusion, frustration
- Demonstrate your faith in their ability
- Keep their mind active and away from negative feelings
  - Don't argue about anorexic thoughts
- Observe recurring behaviours and comment appropriately



PROVIDING POSITIVE SUPPORT

- Very individual approach
  - Success and praise – only if sincere
  - Reminding of timings
  - Prompt cards / place mats / goals set
- Be true to your thoughts and feelings but be careful!
  - "It's the right thing to do"
  - "I understand how difficult this must be….."
  - "You're doing a great job"
  - "I'm really impressed by your hard work"
  - "I know this is not easy but I can see you're trying"



ANOREXIC THOUGHTS

- Pride in the ability to restrict
- Uniqueness
- Feelings of shame
- A feeling of control which you are trying to take from them
- Why are you trying to make me fat?
- If I start to eat, I'll loose control

WHAT WILL NOT HELP

- Becoming irritated
- Using guilt or shame
- Lecturing about the dangers of anorexia nervosa
- Bribing and bargaining
- Force feeding or food games

GUIDELINES

- Clear expectations very important, no surprises
- Unpredictability or inconsistency causes increased anxiety
- Consider guidelines and be clear about the rationale
- Do staff eat with the patients?
  - Can they leave parts of their meal?
  - Can they choose to bring in ‘diet’ or ‘low calorie’ foods?

EXAMPLES OF GUIDELINES

Guideline	Rationale
Menus not altered after completion	To reduce anxiety, time spent deliberating decisions, avoids daily distress
Split / dropped or destroyed food will be replaced	To ensure completion of the agreed meal plan
Food portions not debated at the table	To avoid conflict at the table and to encourage trust in allowing someone else to make decisions
Encourage appropriate conversations	To distract from intrusive thoughts, to normalise the experience, to avoid unhelpful discussions
Meals to be completed within allocated time	To prevent prolonged meal times, to normalise eating
Food will not be reheated	Food safety and can be an ED behaviour
No bags / baggy clothing to be worn in dining room	To limit opportunities to hide food
Condiments limited	To prevent spoiling of food
Supplement will be used to replace any food not completed	To ensure nutritional needs are met

PRE-MEAL PREPARATION

- Difficult time - anxiety levels rise
- Concerns about the meal itself
- Offer relaxation prior to meals
- Everyone is different, spend time exploring what suits the individual
  - what would they find supportive during the meal and what would they like to do after
- Some people need to feel mentally prepared and will specify music, meditation or the need to make positive statements
  - *"I know I can do this"*
  - *"I need to just do the work of eating well today"* Point out eating disorder behaviour but discuss only after the meal

PRE-MEAL PREPARATION

- Ritualistic or compensatory behaviour:
  - OCD around how their room should look
  - Touching things in a set way prior to going for meals
  - Exercising
  - DSH
- Offer physical barriers to minimise opportunities for ritualistic behaviours
- Distraction

SUPPORT DURING THE MEAL

- Minimise distraction
  - no mobile phones, plan to ignore the ward phone or pager unless an absolute emergency
- If you suspect a possible distraction pre-warn the individual
- Ensure meal support takes place as calmly as possible on the ward
- Background noise can relieve tension
- Be confident what the meal should be and the portion sizes
- Be on time and have protected meal times

SUPPORT DURING THE MEAL

- Model "normal" eating behaviour
- Offer kind insistence
- Remain empathic to distress
- Be non-judgemental
- Be open and honest
- Validate how frightened or anxious they must be
- Normalise feelings of feeling full

SUPPORT DURING THE MEAL

- Directly challenge anorexic thoughts when client is struggling
  - Support and empathy
  - Avoid confrontational tone
- Point out eating disorder behaviour
  - Ask them to stop if appropriate
  - Discuss after the meal
- Casual reminders of time remaining
- Keep the conversation light
- Awareness of the patient – Meal Support Plan * Key!

CONVERSATION TOPICS

Try:

- News topics
- Films
- Trivia cards
- Places they might like to visit
- How their friend / family / pet is
- Career opportunities
- Interests
  - music
  - sport
- University / work

Avoid:

- Food
- Sensitive therapy issues
- Weight or body image
- Exercise
- Previous meal support issues or unresolved issues

PATIENT'S VIEWS ON MEAL TIME SUPPORT

WHAT HELPS IN THE DINING ROOM?

- Helpful things to hear:
  - 'You have to do this, your body needs the food.'
  - "This isn't going to hurt you. It's just one meal.'
  - 'You're doing the right thing. It's okay. You're allowed to eat this.'
  - 'Talk me through it, remind me of the benefits of health and recovery.'
  - 'The staff need to confirm that I have been doing well and to just keep trying.'
- Helps for everyone to be involved in a conversation in the dining room. Much lighter atmosphere
- Humour
- Chatting with patients
- Listening to the radio or music

POST MEAL SUPPORT/OBSERVATIONS - AFTER MEAL SUPPORT

- Structured time with staff +/- peer support
- ½ - 1hour after a snack or meal usually in the lounge or place of relaxation
- Helpful to support someone
  - After a difficult meal
  - To avoid opportunities for compensatory behaviours: purging, exercising, deliberate self harm
- No use of the bathroom or shower if vomiting or over-exercising is a concern
- Vigilant observation if self harm is a concern

POST MEAL SUPPORT

- May benefit from distraction
  - Suggestions: reading, TV, games, knitting, lap tops, texting, relaxation or craft activity
- May need reassurance about the meal they have just eaten
- Be cautious of praising but acknowledge the effort without being patronising
- Structured groups
- Goal setting
- Affirmations

KEY COMPONENTS

- Knowing what the person should be eating at the meal in advance
- Supervising what is being eaten
- Providing encouragement and reassurance while eating
- Observing and challenging ED behaviours
- Modelling normal eating behaviours
- Gaining an understanding of what is going on for someone when they eat
- Meal support can be a fluctuating need
- Assessing when appropriate to move forward with unsupervised or independent eating


KEEP
CALM
AND
HELP
OTHERS

Mealtime Support

Information for parents and carers

This is a short guide to help parents/carers support their loved one in the task of re-establishing regular eating. This is not an easy task, but it is an essential aspect of their care and treatment. This resource is a summary of the key points to consider, you may wish to access more detailed information by accessing this information leaflet:

Supporting a Young Person with a restricted eating disorder

https://policyonline.nhslothian.scot/wp-content/uploads/2023/03/Supporting_a_young_person_with_a_restricted_eating_disorder.pdf

SCAN ME

Other parents and carers have found **Eva Musby's videos** helpful:

www.youtube.com/watch?v=2O9nZAWCkLc

SCAN ME

Points to note before a meal or snack

1. An eating disorder creates significant anxiety and distress for your loved one, particularly during meal and snack times. It is helpful to plan ahead, be organised and be consistent in your approach.

2. Discourage your loved one from checking food labels, weighing out foods or having access to calorie tracking apps. This behaviour only strengthens the eating disorders hold. Foods should not be low-fat or diet versions unless agreed with the dietician. Normal wholesome foods are encouraged. Ideally you are wanting your loved one to eat the same food as the rest of the family or their peers, as they did before they became unwell.

3. Provide 3 regular meals, that is breakfast, midday lunch and an evening meal and 3 snacks in between these meals. Never leave more than 3 hours without eating. Even if there has been a binge episode, it is important to continue with the expectation of regular meal and snack times.

4. Plan how you will provide support for your loved one at each meal and snack. Avoid allowing them to eat alone or in their room.

5. Considerations around their environment, setting clear expectations of where they will sit, who will be sitting with them and ideally include them in your family mealtimes.

6. Ask your loved one what is helpful or not helpful for you to say or do during times when they are eating.

Points to note during the meal

1. Those supporting mealtimes can be good role models. By modelling normal eating behaviour, you will encourage your loved one to do the same.

2. It is best to keep mealtimes as relaxed as possible. To do this, avoid discussing feelings, food related topics, portion sizes or negotiating at mealtimes.

3. Utilise distraction with light-hearted conversations and encourage others to be included in these conversations too. Continue to prompt by firmly encouraging your loved one with positive comments, such as “you can do this”, “I am here for you, you are safe” or “keep going”.

4. Try to stay calm throughout the meal or snack. It is important to find a balance between being understanding and remaining firm.

5. It might be helpful to set reasonable timeframes around meals and snacks. For example, 30 minutes for meals and 15 minutes for snacks. Find what works for you, as some young people need a little longer than this. However, it is important to ensure there is an end point and ensure you are consistent in implementing this.

Points to note after meal or snack

1. After eating, your loved one will require support as they may be feeling extremely anxious and guilty. It is important to continue to support them at this time, again, utilising distraction like card games, crafts, going for a drive or watching a programme together.

2. There may be physical discomfort experienced around fullness. This is a normal process as the body adapts to regular eating. Encourage distraction and utilise self-soothing strategies like a hot water bottle or using their favourite blanket and reassuring them that it will pass.

3. It is helpful to avoid the use of the toilet after eating, so encourage your young person to use the toilet prior to meals and snacks.

It is also essential to remain alert to and direct away from eating disordered driven behaviours, for example:

- Hiding food in clothing or up sleeves
- Smearing food on body/hair/clothes
- Sticking food under table or chair
- Spreading food around the plate or up to the edge
- Feeding food to a pet
- Crumbing food items and spreading over the plate/table
- Pretending to cough into a tissue while spitting out food
- Using a straw instead of drinking from a cup
- Segregating food e.g. peeling apart lasagne
- Picking out solids from sauces
- Excessive drinking
- Only using specific cutlery/plates. For example a very small/large bowl.

My Meal Time Support Profile

Name: _____ Date: _____

Fear foods (rate 1-5, 5 most difficult)

Signs I am struggling

Support I find helpful

Support I find unhelpful

Eating disorder behaviours/concerns

Specific goals

Challenges achieved

Other

Lothian Eating Disorder Service
NG Tube Feeding Care Plan

Patient Name:		**CHI:**		**Updated on:**		**Next review:**	
MHA Status:		**Locus of Care:**		**RMO:**		**MHO:**	
Named Person		**Therapist:**		**Dietician:**		**CPN:**	
Diagnosis				**Key Issues:**			

Aspect of care	Responsible	Factors to consider	Documentation	Signature and date:
Decision to start NG tube feeding	LEDS	Indications Contraindications Benefits Risks MDT discussion		
Consideration of capacity	LEDS	Are there any reasons to suspect lack of capacity? Has this been formally assessed?		
Informed Consent	LEDS	Has patient been provided with written and verbal information about NG feeding? Has the patient given written consent for NG Tube Insertion		
NG Tube Insertion		Place Time Responsible clinician Any complications? Nutricia NGT Care Plan completed (see below)	Medical Day Case Unit, Royal Infirmary Edinburgh on [date]	

NG Tube Position Checked		pH of nasogastric aspirate Chest X-Ray		
Equipment and Supplies	Lothian CENT Team	Have equipment and supplies been ordered? Have they been received by the patient?		
Patient Education	Nutricia Nursing Staff	Has patient received and understood appropriate training?		
Dietetic Plan	LEDS	Is there a clearly documented plan including type of feed, rate at which feed is delivered and time over which feed is delivered? Is there a plan for nutrition from other sources?		
Prescribing	LEDS	Are there any medications that need to be administered by NG Tube? Has this been discussed with a pharmacist?		
Monitoring	LEDS	Weight / BMI GI function / symptoms Fluid balance Overall intake and quantity of feed delivered Blood tests (FBC, U&Es, LFTs, refeeding bloods) Observations (pulse, blood pressure, temperature)		

Management of complications		Tube displacement Tube blockage Nausea & Vomiting Diarrhoea Constipation Acid Reflux Glycaemic Control		
Wider Care Plan	LEDS	Anticipated duration of NG feeding Ongoing dietetic review MDT discussion and review Discontinuation		
Tube removal				

Dr Andrew Lawton
Consultant Psychiatrist in Eating Disorders
Lothian Eating Disorder Service

…… Date …….

Nutricia Care plan for NGTs

Type of tube	
Brand of tube	
Size of tube	
How long is the tube to stay in situ for	
Date in of current tube inserted	
Who will replace this tube during the OOHs period or if Nutricia Nurse is unsuccessful	
NEX measurement Length of tube	
Is there any anatomy that would prevent a safe replacement in the community?	
Does the patient take any medication that would prevent a safe placement within the community setting such as PPI or blood thinners.	
Additional information	
Feeding regime and flushing	

REGIONAL EATING DISORDER UNIT

Patient information booklet

St John's Hospital, Livingston

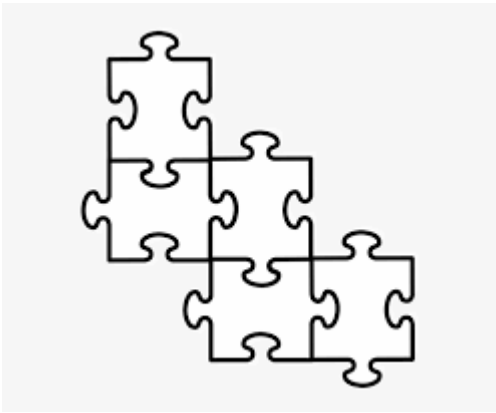
REDU Patient Information Booklet
Revised: March 2023

REDU Mission Statement

The Regional Eating Disorders Unit (REDU) was established in 2012 to offer an inpatient service for people within Borders, Fife, Forth Valley and Lothian. We offer a highly trained service for females and males over the age of 18 with a diagnosis of an eating disorder who have been assessed by their community teams and are considered to need a more intensive period of support.

We aim to provide a patient centred approach to meet the individual needs of the patient, based on clinical expertise and good clinical practice. We pull on expertise from an experienced multi-disciplinary team including psychiatrists, psychologist, mental health nurses, dietitians, occupational therapist and physiotherapist.

Within a therapeutic environment, individuals may be offered treatment to address acute physical concerns; to support recovery; or to enable them to live safely with their eating disorder.



Introduction

The Regional Eating Disorders unit is for adults who need to come into hospital for treatment of their eating disorder. The purpose-built unit has 12 beds and is on the lower ground floor of St John's Hospital in Livingston.

REDU Patient Information Booklet
Revised: March 2023

Facilities at the unit

When you come to stay at the unit you will have your own bedroom with en-suite bathroom and shower. During the initial period of assessment (approximately 2 weeks) it is common practice that the bathroom door is locked and patients are supervised by the nursing team in the bathroom. There are also many communal areas on the unit where you can spend time with others or relax on your own.

- The 'hub' is a central area in the unit, staffed by the nursing team. It has a seating area where patients, staff and visitors can socialise and access the outside courtyard.
- The courtyard is an enclosed, outdoor space with seating which is very pleasant in fair weather. Access to the courtyard may be restricted at times.
- The lounge has a large soft-seating area with a wide screen TV, and DVD player. There is a DVD library in the lounge and access to games, art and craft materials, books and magazines. There is also a large activity space with table and chairs.
- The family room is a smaller lounge with sofas and a TV that you can use when you have visitors. This space can also be used for independent eating or family meals.
- The main dining area is a spacious room where patients and staff eat all meals and snacks together. It has a small kitchen and radio/CD player. Tea and coffee making facilities are available for patients.
- The self catering kitchen is used for Cooking Skills groups and for one to one self catering sessions. It can also be used as a space to practice independent eating and family meals.
- The group therapy room is a comfortable space where most of the therapeutic groups are held.

- The laundry room contains a washing machine, dryer, and iron/ironing board for you to do your laundry. Please bring your own laundry powder, fabric conditioner, etc.

Smoking is not permitted anywhere in the hospital or on the hospital grounds. The hospital has an excellent stop smoking service, if you would like more information or help to stop smoking.

What to bring with you

Please check the website for further information:
https://services.nhslothian.scot

Please bring with you:

- Comfortable clothing to wear every day; night wear to sleep in, your own toiletries
- Any personal belongings that may help you to settle in, such as photographs or music player with headphones
- Your mobile phone to keep in touch with friends and family
- An internet dongle if you wish to access the internet
- Any medication you are currently taking. **Please hand any medication to a member of staff when you arrive.**

Electrical items such as hair dryers or phone chargers can be brought with you, but need to be checked by hospital electricians to ensure they are safe before you use them on the unit. This can usually be done within a few days of arrival. We ask you not to bring in anything of value, large sums of money, or food items.

Arriving on the unit

A member of staff will welcome you on to the ward when you arrive. You will be able to put your belongings in your bedroom and then someone will show you around the unit.

A staff member will stay with you to complete your admission paperwork, answer any questions you may have & help you to settle in. You will also have a physical health check on your first day at the unit.

The Multi-disciplinary team on the unit

You will meet with various members of our multi-disciplinary team throughout your stay:

- Consultant Psychiatrist
- Specialty Doctor
- Weekly Input from Consultant Physician
- Expert Nursing Team
- Clinical Psychologist and Assistant Psychologists
- Specialist Dietitians and Dietetic Support Worker
- Specialist Physiotherapist
- Specialist Occupational Therapist
- Administration staff

Your care at the unit

Many people will be involved in your care at the unit. You will meet with different members of the team in your first few days to discuss and jointly develop a treatment plan that is based on your individual needs. If you would like, other people such as a family member or friend can also have input into your treatment plan.

You will be introduced to your key and co worker from the nursing team who will individually support you during your stay at the unit.

The expert team at the unit will provide you with information and advice about many different aspects of your treatment to support you to make informed decisions about your care. The team can help you to better meet your nutritional and physical needs, emotional needs, and also any social care needs that you may have.

The nursing team are also on hand 24 hours a day to provide practical, social and emotional support.

Each week you will be encouraged to provide feedback to the ward round and then meet with the team overseeing your care at the unit to discuss and review your treatment plan.

A review meeting will be held 4-weekly throughout your admission to review your treatment goals and make plans for home. Your referring team and family/carers will be invited to participate in this meeting. At times you may meet with members of your community team whilst you are an in-patient.

Groups and activities

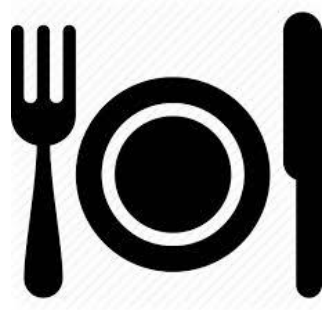
During the week a full group programme runs on the unit. Each morning a member of staff will let you know what groups and activities are planned for the day and invite you to attend these.

The group programme offers you the opportunity to learn new skills during your stay which will be beneficial to you in your recovery journey. The nursing team can also help you to organise recreational and social activities throughout the week, and also at weekends when you will have more leisure time.

Meal support

Meals and snacks are at set times on the unit. The nursing team will support you throughout meal times, and encourage you to develop a healthier relationship with food. The nursing team also provide support after all meals and snacks in the main lounge area of the unit.

Meal times on the unit are considered 'protected time,' which means that the staff providing meal support cannot be interrupted or take any phone calls during this time. Visitors are also not permitted to be on the ward during meal times.



REDU MEALTIMES

Breakfast	8:30am until 9am
Morning Snack	10:45am until 11am
Lunch	12:30pm until 1pm
Afternoon Snack	3pm until 3:15pm
Dinner	5:30pm until 6pm
Supper	8:45pm until 9pm

THE WARD OPERATES A PROTECTED MEALTIME POLICY

This means that we ask any appointments or visits are made out with mealtimes. Visitors will be asked to leave the ward during mealtimes to ensure patient dignity, safety and security are maintained.

Technology and social media policy

During your stay on the ward, we will ask you to follow our social media and technology policies. We do appreciate you want to be able to keep in contact with friends and family through social media, but if you could please avoid posting anything with information about the ward, such as the location, photos or videos. This is important to protect your own privacy and safety, as well as that of the other patients on the ward.

Whilst you're on the ward, we ask you not to use pedometers, exercise tracking watches, or any calorie or nutrition tracking apps. Our goal for your admission is recovery, and we know the dangers of tracking nutrition and exercise for people with eating disorders. We know this might be difficult if you have been used to using them, but it is important to try to stop tracking during your admission.

Visiting hours

Family and friends are welcome to visit you on the unit during visiting hours. As our ward runs a therapeutic group programme and set mealtimes, we would encourage visits to be arranged out with these times. Please speak with staff who can inform you of the best times to visit. We aim to be as flexible as possible, but we do need to ensure that nutrition and therapy are prioritised.

Visiting may be subject to change with any COVID restrictions and visitors are encouraged to follow any relevant COVID guidelines.

Visiting takes place in the group room, family room and sitting room.

Children and toddlers are also welcome to visit, but do require to be supervised during visits. Visits with children will be in the family room.

Time off the unit and discharge from hospital

An important part of your treatment at the unit will be preparing for when you leave hospital.

Time off the unit will be part of your treatment plan to help you to maintain your life outside of hospital. As you work towards discharge from hospital, you can increase the length of time you spend off the unit and also spend some nights at home.

To ensure that you have support in place to continue your recovery at home, the team at the unit will share information about your treatment with the person or team responsible for continuing your care at home. This may be your local Community Mental Health Team, a specialist Eating Disorder service, or your General Practitioner (GP).

The team can only share information with other healthcare professionals who are directly involved in your care if the information is relevant to your ongoing treatment and with your consent.

If you wish your relatives or carers to also be kept informed about your treatment, you will need to give permission for information about you to be shared with them.

Advocacy

Advocacy is provided by West Lothian Mental Health Advocacy Project and CAPS independent advocacy for anyone receiving treatment as an inpatient at St John's hospital. Advocacy is free of charge and can help with a range of issues including welfare and benefits, housing, or access to legal services.

Advocacy workers visit the ward regularly and there is information available on the ward to advise you on how to access this service.

Spiritual Care

St John's hospital has a chapel that is open 24 hours a day and welcomes visits from people of all faiths and of no faith. If required please call the switchboard on 01506 523000 and ask for the Duty Chaplain/Priest.

Your Rights during Admission

Consent to Treatment

Usually, admission to REDU will involve your agreement that coming into hospital for specialist inpatient treatment is necessary as part of your recovery from eating disorder.

There are various rules and boundaries that you need to agree to as part of being in REDU. Following these boundaries are known to be helpful in supporting your work in battling an eating disorder. If you are not able to adhere to the ward boundaries, this may impact on whether an admission to REDU is going to be an effective part of your recovery. In this situation, there may need to be a review on whether the admission can continue. Sometimes there can be some flexibility possible for your individual care plan but at other times this may not be possible or appropriate.

At all times, it is important that the team at REDU can see that you are consenting to the admission and the treatment plan. Your right to consent to treatment is important to us.

If you are unhappy with decisions being made with regard to your treatment at any point, you can request a second opinion from an independent consultant psychiatrist. We will do our best to try and accommodate your request if appropriate to do so.

Rights under the Mental Health Act

Occasionally, it may be necessary to use the Mental Health Act. We try to do this as little as possible. Your right to choose is important to us and we would only ever detain anybody under the Mental Health Act if

we felt that your health, safety and possibly even your life might be at risk.

Under the Mental Health Act, we would over-rule your right to refuse lifesaving and/or health-saving treatment for as short a time as needed. Whilst under the Mental Health Act, you have rights. These include the right to advocacy, the right to appeal your section under the Mental Health Act and the right to nominate a Named Person. It is also important to know that even if you are not able to refuse specific treatment to save your life and health, we still try our best to incorporate your views on other aspects of your treatment.

Advocacy workers regularly visit the ward. They are not part of the REDU team and are independent from us. They are there to help make sure that your views are respected and heard as part of making decisions. Feel free to ask REDU staff that you would like to speak to an advocate at any time.

A Named Person under the Mental Health Act is somebody you can nominate who has special rights under the Act. Usually, a key family relative (such as a parent) or a close friend is nominated. This person has rights under the Act for their view to be considered when making decisions about treatment. They also have special rights about being able to attend any Mental Health Act Tribunals with you.

Interpreting Services

If your main language is one other than English, and particularly if you have difficulties with communicating in English, you have the right to request an interpreter as part of your care. Also, if you are D/deaf and British Sign Language is your primary language, you also have the right to request an interpreter as part of your care and for us to accommodate this as much as possible.

How to View Your Records

If you wish to see your patient records, there is an NHS Lothian-approved process for this. Please speak to our REDU administrator and they can supply you with the application form to request this.

Useful resources for parents and carers of young people with an eating disorder

Beginning treatment for an eating disorder can be overwhelming. Here are some selected external resources which may be of help and are recommended by NHS Lothian CAMHS. Visit the websites or scan the QR codes below:

EVA MUSBY

Eva Musby is a source of support for parents and carers of young people with eating disorders. The website 'the Anorexia Family' includes helpful resources. It is primarily aimed at families who are receiving Family Based Treatment.

There is also a book available which many parents and carers have found to be helpful too.

https://anorexiafamily.com/?v=79cba1185463

Beat is the UK's leading eating disorder charity who provide information, support and helplines for young people, adults and carers who are suffering from an eating disorder.

www.beateatingdisorders.org.uk

FEAST is a global network of parents of young people with eating disorders. The website provides information and hosts a forum called 'Around the Dinner Table' to support each other. There are articles and resources for parents and carers which can be helpful for navigating an eating disorder.

www.feast-ed.org/

Name: DoB: Date: Agreed by: (staff member)

	Date to change	Breakfast	Mid-am	Lunch	Mid-pm	Dinner	Supper
Stage 1		Cereal & milk	100 milk	Soup	100 milk	Yogurt or milk pudding	100 milk
Stage 2		Cereal & milk	100 milk	½ portion m/c	100 milk	Yogurt or milk pudding	Supper option
Stage 3		Cereal & milk	200 milk	½ portion m/c 100 milk	200 milk	½ portion m/c 100 milk	Supper option
Stage 4		Cereal & milk 200ml juice	200 milk	½ portion m/c 200 milk	200 milk	½ portion m/c 200 milk	Supper option
Stage 5 *		Cereal & milk 200ml juice	200 milk	Full portion m/c 200 milk	200 milk	½ portion m/c 200 milk	Supper option
Stage 6		Cereal & milk 200ml juice 1 bread + spreads	200 milk	Full portion m/c 200 milk	200 milk	½ portion m/c 200 milk	Supper option
Stage 7		Cereal & milk 200ml juice 1 bread + spreads	200 milk	Full portion m/c 200 milk	200 milk	Full portion m/c 200 milk	Supper option
Stage 8		Cereal & milk 200ml juice 2 bread/1 roll/1 bread & banana + spreads	200 milk	Full portion m/c 200 milk	200 milk	Full portion m/c Full pudding	Supper option
Stage 9		Cereal & milk, 200 juice 2 bread/1 roll/1 bread & banana + spreads	200 milk & 1 biscuit OR yoghurt	Full portion m/c	Snack rota	Full portion m/c Full pudding	Supper option Fruit
Stage 10		Cereal & milk, 200 juice 2 bread/1 roll/1 bread & banana + spreads	Snack rota	Full portion m/c Full pudding	Snack rota	Full portion m/c Full pudding	Supper option Fruit

KEY:
m/c = main course, eg soup and a sandwich OR sandwich and a pudding OR hot meal
½ portion m/c = ½ portion of hot meal OR ½ portion of soup and ½ portion of sandwich OR ½ portion sandwich and ½ pudding
* Unless your dietitian advises differently, from stage 5 onwards you can swap 200mls milk to 200mls fruit juice/banana/raisins/cereal bar/crisps/fruit + biscuit
200ml fluid will be encouraged with every meal and snack (milk, fruit juice, water or diluted juice)

Name: DoB: Date: Agreed by: (staff member)

	Date to change	Breakfast	Mid-am	Lunch	Mid-pm	Dinner	Supper	kcal
Stage 1		Cereal & milk	100 milk	Soup	100 milk	Yogurt or milk pudding	100 milk	600
Stage 2		Cereal & milk	100 milk	½ portion m/c	100 milk	Yogurt or milk pudding	Supper option	900
Stage 3		Cereal & milk	200 milk	½ portion m/c 100 milk	200 milk	½ portion m/c 100 milk	Supper option	1200
Stage 4		Cereal & milk 200ml juice	200 milk	½ portion m/c 200 milk	200 milk	½ portion m/c 200 milk	Supper option	1400
Stage 5 *		Cereal & milk 200ml juice	200 milk	Full portion m/c 200 milk	200 milk	½ portion m/c 200 milk	Supper option	1700
Stage 6		Cereal & milk 200ml juice 1 bread + spreads	200 milk	Full portion m/c 200 milk	200 milk	½ portion m/c 200 milk	Supper option	1900
Stage 7		Cereal & milk 200ml juice 1 bread + spreads	200 milk	Full portion m/c 200 milk	200 milk	Full portion m/c 200 milk	Supper option	2100
Stage 8		Cereal & milk 200ml juice 2 bread/1 roll/1 bread & banana + spreads	200 milk	Full portion m/c 200 milk	200 milk	Full portion m/c Full pudding	Supper option	2400
Stage 9		Cereal & milk, 200 juice 2 bread/1 roll/1 bread & banana + spreads	200 milk & 1 biscuit OR yoghurt	Full portion m/c	Snack rota	Full portion m/c Full pudding	Supper option Fruit	2600
Stage 10		Cereal & milk, 200 juice 2 bread/1 roll/1 bread & banana + spreads	Snack rota	Full portion m/c Full pudding	Snack rota	Full portion m/c Full pudding	Supper option Fruit	2800

KEY:
m/c = main course, eg soup and a sandwich OR sandwich and a pudding OR hot meal
½ portion m/c = ½ portion of hot meal OR ½ portion of soup and ½ portion of sandwich OR ½ portion sandwich and ½ pudding
* Unless your dietitian advises differently, from stage 5 onwards you can swap 200mls milk to 200mls fruit juice/banana/raisins/cereal bar/crisps/fruit + biscuit
200ml fluid will be encouraged with every meal and snack (milk, fruit juice, water or diluted juice)