OPERATIONAL GUIDELINES

Inpatient Care of Children and Adolescents with Eating Disorders
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Section One: Introduction

1. Philosophy

The philosophy of the In-patient Program is to provide a supportive and therapeutic structure, which enhances the opportunity for patients with an eating disorder to move towards a healthy weight and eating patterns within the context of their families and peers. (1) The aims of the inpatient admissions are:

1. Medical stabilisation
2. Containments of eating disorder behaviours
3. Establish a healthy trajectory of weight gain

It is important to note that hospital admissions are only one part of a lengthy treatment process for young people with an eating disorder. As such, admissions are not viewed as ‘curative’, but necessary at times to restore mental, physical and social functioning to enable continued treatment in the community (2).

Engaging the whole family in treatment is critical during the in-patient phases and through on-going support.

The program at Gosford Hospital consists of a ‘level system’ with progression through the levels based on combination of weight gain, improvement in eating habits and medical and psychological wellbeing.

Section Two: Description of the Program

1. Admission and Care Planning

A patient with Eating Disorders may require admission for a number of reasons, including the need for medical stabilisation.

On presentation an initial health assessment will be attended by a medical officer to ascertain the level of health risks.

SIGNS INDICATING MEDICAL INSTABILITY
(Use as a guide to determine whether admission for inpatient care and stabilisation is required)

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperature &lt; 35.5°C, extremities appear cold/blue</td>
</tr>
<tr>
<td>BP &lt; 70/40 mmHg or postural drop &gt; 15 mmHg</td>
</tr>
<tr>
<td>HR &lt; 50 BPM or &gt; 100 BPM</td>
</tr>
<tr>
<td>&gt; 20 bpm increase in HR</td>
</tr>
<tr>
<td>Check for regularity as well as rate</td>
</tr>
<tr>
<td>BMI 16 or less BMI Centile &lt; 5th</td>
</tr>
<tr>
<td>Rapid weight loss (e.g., &gt; 1 kg per week over several weeks)</td>
</tr>
<tr>
<td>Low serum Potassium (3.0 mmol/L or less), low serum Phosphate, any significant electrolyte disturbance or BSL &lt; 3.0 mmol/L</td>
</tr>
<tr>
<td>ECG rate &lt; 50, prolonged QT interval, arrhythmias</td>
</tr>
<tr>
<td>Bulimia with out of control vomiting</td>
</tr>
<tr>
<td>Vomiting more than 4 times a day</td>
</tr>
<tr>
<td>Weight loss of more than 1 kg/week for 4 weeks</td>
</tr>
<tr>
<td>Moderate – severe dehydration or person has ceased fluid intake</td>
</tr>
<tr>
<td>Ketosis</td>
</tr>
<tr>
<td>Presence of other physical conditions such as pregnancy or diabetes</td>
</tr>
<tr>
<td>Moderate to high suicidal ideation</td>
</tr>
<tr>
<td>Active self harm</td>
</tr>
<tr>
<td>Moderate to high agitation and distress</td>
</tr>
<tr>
<td>Other psychiatric condition requiring hospitalisation</td>
</tr>
<tr>
<td>Abusive family relationships requiring hospitalisation</td>
</tr>
</tbody>
</table>

The admission may be required for other reasons such as a place of safety and support until other services are activated.

For all cases a flowchart (appendix 1) for Inpatient Care of patients with Eating Disorders has been developed. This flowchart will assist the health team with time frames and services that need to be involved during the inpatient episode.

2. **Delivery of Care**

The Eating Disorder Program has been developed to ensure continuity of care, best practice and ease of communication between both the practitioners and the clients.

Each inpatient will be commenced on the Eating Disorder program, variations are not recommended as they will cause confusion between health persons and patients.

The program consists of a “Recovery Level System”, comprising 5 separate levels.
Key Points

- Progression through the Levels is based on a combination of weight gain, improvement in eating habits, and medical and psychological well-being.
- The overall aim of the admission is for a gradual increase in weight at the rate of 1 kilogram per week.
- Management decisions are made by the treating doctor in consultation with the multidisciplinary team and/or with consultation with an eating disorder specialist from a tertiary centre.
- The management team will aim to meet twice weekly on Tuesdays and Friday mornings.
- Decisions made at these meetings are then conveyed to the patient by the medical and nursing staff.

Recovery System

The following program is instigated on admission. The level that the patient will follow will be determined by the paediatrician.

Medical Stabilisation

- Meals and snacks are to be supervised by the nurse.
- 30 minutes rest after main meals and 20 minutes rest period after snacks
- Patient is not allowed to leave the ward.
- Menu/Meals – Set meal plan developed by the dietitian. Calorie intake decided in liaison with medical team. Patient makes no food based decisions.
- Feeding regime to be decided by the treatment team – nasogastric tube required if patient is unable to orally consume 100% meal plan. Continuous feeding regime may be required. Please see attached regime in appendix.
- Complete bed rest with the use of the bathroom based on medical condition and decided in consultation by the nurses and doctors.
- Meals are not to be brought in from home
- Weigh Tuesday & Friday before breakfast at 6.30am.
- Visiting to occur after 4pm not at meal times or rest period – visiting between 4-7.30pm – weekdays. Weekends – after 10.00am– not at meal or rest times. (immediate family only)
- Phone calls to occur before 8.30am and between 4pm to 730pm and not at meal times.

LEVEL ONE

- Meals and snacks are to be supervised by the nurse.
- 30 minutes rest after main meals and 20 minutes rest period after snacks
- Patient is not allowed to leave the ward.
• Menu/Meals – Set meal plan developed by the dietitian. Caloric intake increased weekly if failing to achieve weight gain goals. Patient makes no food based decisions.
• Feeding regime to be decided by the treatment team – oral/nasogastric bolus consequences required if patient failing to consume 100% set meal plan. Please see attached regime in appendix 4.
• Individual activities and school work will be arranged and developed by the play therapist.
• Weigh Tuesday & Friday – before breakfast at 0630hrs.
• Visiting to occur after 4pm not at meal times or rest period – visiting between 4-7.30pm – weekdays. Weekends – after 10.00am– not at meal or rest times. (immediate family only or as decided by medical team)
• Bathroom visits– under supervision by nursing staff- may walk to the closest bathroom to bedroom. Limit to 2 toilet breaks per shift
• Wheelchair mobility to attend playroom activities or schoolwork. (wheelchair is to be pushed by staff)
• Phone calls to occur before 8.30am and between 4pm to 730pm and not at meal times or rest times.
• Physiotherapy – as prescribed by the physiotherapist

LEVEL TWO

• Meals and snacks are to be supervised by nurse.
• 30 minutes rest after main meals and 20 minutes rest period after snacks
• Movement around the ward should be monitored and still be purposeful but may be more often if weight gains have been positive.
• Patient is not allowed to leave the ward
• Menu/Meals – Set meal plan developed by the dietitian. Caloric intake increased weekly if failing to achieve weight gain goals. Depending on level of weight gain / progress, patient may start to participate in menu ordering under supervision of dietitian.
• Feeding regime to be decided by the treatment team – oral/nasogastric bolus consequences required if patient failing to consume 100% set meal plan. Please see attached regime in appendix 4.
• Bathroom visits– under supervision by nursing staff. Limit to 2 toilet breaks per shift
• Individual activities will be arranged by the play therapist – time table developed.
• Weigh Tuesdays & Friday before breakfast at 6.30am.
• Visiting to occur after 4pm not at meal times or rest period – visiting between 4-7.30pm – weekdays. Weekends – after 10.00am– not at meal or rest times. (immediate family only or as decided by medical team )
• Gate pass – 1 or 2 half or full days dependent on weight gain and progress as decided in case meetings
• Phone calls to occur before 8.30am and between 4pm to 730pm and not at meal times or rest times
  • Physiotherapy – as prescribed by the physiotherapist
LEVEL THREE

- Meals and snacks are to be supervised by nurse.
- 30 minutes rest after main meals and 20 minutes rest period after snacks
- May ambulate gently around ward.
- Is able to leave the ward with parents, or responsible adult for up to 20 minutes per day.
- Bathroom visits—under supervision by nursing staff. Limit to 2 toilet breaks per shift.
- Menu/Meals – Meal plan developed in consultation between patient and dietitian. Caloric intake dictated by dietitian and increased weekly if failing to achieve weight gain goals.
- Feeding regime to be decided by the treatment team – oral/nasogastric bolus consequences required if patient failing to consume 100% set meal plan. Please see attached regime in appendix 4.
- Individual activities will be arranged by the play therapist.
- Weigh Tuesday & Friday before breakfast at 0630hrs.
- Gate pass – 1 or 2 half or full days dependent on weight gain and progress as decided in case meetings.
- Visiting to occur after 4pm not at meal times or rest period – visiting between 4-7.30pm – weekdays. Weekends – after 10.00am– not at meal or rest times. (immediate family only or as decided by medical team)
- Phone calls to occur before 8.30am and between 4pm to 730pm and not at meal times or rest times.
- Physiotherapy – as prescribed by the physiotherapist.

LEVEL FOUR

- Meals and snacks are to be supervised by nurse.
- 30 minutes rest after main meals.
- Able to leave the ward with parents, or responsible adult for one 40 minute period a day.
- Bathroom unsupervised and monitored by nursing staff.
- Menu/Meals – Meal plan developed by patient. Dietitian continues to monitor and make additions if required in consultation with the patient. Caloric intake dictated by dietitian and increased weekly if failing to achieve weight gain goals.
- Feeding regime to be decided by the treatment team – oral/nasogastric bolus consequences required if patient failing to consume 100% set meal plan. Please see attached regime in appendix 4.
- Weighed Tuesday & Friday before breakfast at 6.30am.
- Gate pass - Full day or overnight gate-passes dependent on weight gain and progress as decided in case meetings.
• Visiting to occur after 4pm not at meal times or rest period – visiting between 4-7.30pm – weekdays. Weekends – after 10.00am – not at meal or rest times. (immediate family only or as decided by medical team)
• Phone calls to occur before 8.30am and between 4pm to 7.30pm and not at meal times or rest times
• Physiotherapy – as prescribed by the physiotherapist

Medical and Physical Management

On Admission to ward

Recovery level: Medical stabilisation or Level 1 (this will be decided by the Paediatrician)

Observations: Full set of Observations Pulse, Temperature, Respirations, lying and standing BP (Postural BP)
Continuous cardiac monitoring (until stable)
Urinalysis
Blood Sugar Monitoring TDS

Weigh: Bare Weight (should wear undies and gown) attended on admission (note the scale)
Height attended. Plot on growth chart

Investigations: Full blood count, ESR, EUCs, LFTs, phosphate and magnesium
ECG

Medications: Multivit – 1 daily
Sandoz phosphate – 500mg BD

Key point:
Patients admitted with Eating disorders who are medically unstable consider care in the High Observation Unit on Children’s Ward
## Overview

### Parameters

<table>
<thead>
<tr>
<th>Parameter</th>
<th>ALERT</th>
<th>On Admission</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vital Signs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse</td>
<td>&lt;50bpm/irregular or &gt; 100 bpm/irregular</td>
<td>YES</td>
<td>4/24 medical stabilisation then 8/24 (3 times a day) or as per medical team</td>
</tr>
<tr>
<td>Respiration</td>
<td></td>
<td></td>
<td>4/24 medical stabilisation then 8/24 (3 times a day) or as per medical team</td>
</tr>
<tr>
<td>Temperature</td>
<td>&lt;35.5 C</td>
<td>YES</td>
<td>4/24 medical stabilisation then 8/24 (3 times a day) or as per medical team</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Standing</td>
<td>YES</td>
<td>4/24 medical stabilisation then as per medical team</td>
</tr>
<tr>
<td></td>
<td>Sitting</td>
<td>YES</td>
<td>4/24 medical stabilisation then as per medical team</td>
</tr>
<tr>
<td></td>
<td>Postural Drop</td>
<td>&gt; 15mmHg</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Biochemistry</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electrolytes</td>
<td>K &lt; 3.0mmol/L</td>
<td>YES</td>
<td>Daily Medical stabilisation then weekly</td>
</tr>
<tr>
<td>Phosphate</td>
<td>&lt; 0.8mmol/L</td>
<td>YES</td>
<td>Daily Medical stabilisation then weekly</td>
</tr>
<tr>
<td>Magnesium</td>
<td>&lt; 0.6mmol/L</td>
<td>YES</td>
<td>Daily Medical stabilisation then weekly</td>
</tr>
<tr>
<td><strong>General Observation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Glucose Level</td>
<td>&lt; 3.0mmol/L</td>
<td>YES</td>
<td>TDS medical stabilisation then daily</td>
</tr>
<tr>
<td>Urinalysis</td>
<td></td>
<td>YES</td>
<td>Tuesday and Friday</td>
</tr>
<tr>
<td>Continuous Cardiac</td>
<td>Flattened T wave</td>
<td>YES</td>
<td>While on medical</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Prolonged QT interval</td>
<td>stabilisation</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>----------------------</td>
<td>---------------</td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td>BMI &lt; 5th percentile or 14</td>
<td>YES</td>
<td>Tuesday and Friday before breakfast 0630</td>
</tr>
<tr>
<td></td>
<td>Disproportion in height and weight centiles</td>
<td>YES</td>
<td>On arrival</td>
</tr>
<tr>
<td>Height</td>
<td>Weight loss&gt; 1kg/wk</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>12 Lead ECG</td>
<td>Prolonged QT interval</td>
<td>YES</td>
<td>Repeat only if abnormal on arrival</td>
</tr>
<tr>
<td>Fluid Balance Chart</td>
<td></td>
<td>YES</td>
<td>Throughout admission</td>
</tr>
<tr>
<td>Food Intake</td>
<td></td>
<td>YES</td>
<td>Daily</td>
</tr>
<tr>
<td>Skin integrity</td>
<td></td>
<td>YES</td>
<td>Daily</td>
</tr>
</tbody>
</table>

**What is Refeeding Syndrome?**
Refeeding Syndrome arises when severe electrolyte and fluid shifts associated with metabolism abnormalities occur with refeeding to treat protein calorie malnutrition. Cardiac failure and arrest, delirium and death may result. Generally this occurs within the first 2 weeks of refeeding.

**Clinical signs of refeeding:**
- Congestive heart Failure
- Seizures
- Arrhythmia
- Delirium

**What patients are at Risk of Refeeding Syndrome?**
**Risk Factors may include the following:**
- Those with no oral nutrition for 7-10 days
- BMI < 14 or those severely underweight
- Abnormal electrolytes
- Prolonged QT interval

The principle biochemical benchmark of refeeding syndrome is severe acute hypophosphataemia which usually occurs within 3-4 days of refeeding.
Nutrition Management

On admission

- An Eating Disorder Admission special diet checklist needs to be completed and faxed to the nutrition department on 2828 and a Dietitian referral placed in EMR. Please refer to appendix (2) for a copy of the checklist.

- The patient is placed on either a 2000kcal or 2700kcal non-negotiable set meal plan devised by the dietitian. This consists of 3 meals and 3 snacks. The patient will not receive a menu.

- True food allergies and conditions such as Coeliac Disease will be acknowledged, but not self-diagnosed intolerances (e.g. wheat, lactose) or recent changes to vegetarianism or veganism as these are considered part of the eating disorder.

- Failure to consume 100% of meal plan from time of admission requires insertion of a nasogastric tube as supplemental feeding may be required. Please see feeding regimes below for more information.

- The calorie content of the meal plan will increase each week if the patient fails to achieve their weight gain target.

- Any food negotiations or discussions about food with anyone other than the dietitian will result in a warning/consequence – please see consequences section.

- The patient will have opportunities to be involved with menu planning and making food based decisions as they gain weight and progress through the treatment levels.

Naso-gastric Tube Feeding Regimes

Patients are required to eat 100% of their prescribed meal plan, or drink the equivalent amount of Ensure plus as detailed below, on admittance to the Children’s ward. If they refuse or are unable to, a nasogastric tube will be placed immediately following the first missed or incomplete meal.

Continuous Enteral Feeding Regime

A continuous regime should be considered depending on the degree of malnutrition or if the patient fails to consume 100% of their meal plan whilst on medical stabilisation. Continuous feeding can be weaned down by the dietitian when the patient starts increasing their oral intake or when the Bolus Consequence Regime may be indicated. Please see the regime below.
Day 1-2 (2000kcal)
1330ml Ensure Plus – 55ml/hour 24/24

Day 3-4 (2200kcal)
1470ml Ensure Plus – 60ml/hour 24/24

Day 5-6 (2500kcal)
1670ml Ensure Plus – 70ml/hour 24/24

Goal Rate (2700kcal)
1800ml Ensure Plus – 75ml/hour 24/24

Please flush tube with 40ml water every 4 hours during continuous feeding.

Refer to appendix (3) for further information

Bolus Consequence Regime (Oral/NGT)

This regime is usually commenced after the medical stabilisation phase of treatment, when the patient is attempting to follow their prescribed meal plan. If the patient is unable to consume 100% of a meal or snack in their prescribed meal plan, a bolus of Ensure Plus is provided to make up the deficient calories. The bolus should be offered first orally, if refused it should then be given via NGT (may need NGT insertion if there is not one insitu). can be given orally or via the nasogastric tube. Please see regime below.

2000kcal Meal Plan

<table>
<thead>
<tr>
<th>Breakfast</th>
<th>Ensure Plus</th>
<th>Lunch / Dinner</th>
<th>Ensure Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cereal and milk</td>
<td>130ml</td>
<td>Main Meal (meat, chicken, fish portion)</td>
<td>130ml</td>
</tr>
<tr>
<td>Fruit (fresh/snack pack)</td>
<td>60ml</td>
<td>Rice, potato, noodle etc.)</td>
<td>65ml</td>
</tr>
<tr>
<td>Yoghurt</td>
<td>80ml</td>
<td>Vegetables</td>
<td>20ml</td>
</tr>
<tr>
<td>Juice</td>
<td>30ml</td>
<td>Dessert</td>
<td>80ml</td>
</tr>
</tbody>
</table>

- If a patient on the 2000kcal plan refuses to eat any of the main meal 300ml Ensure Plus is required.
- If a patient refuses to eat 100% of the snack provided - 160ml Ensure Plus is required.

2700kcal Meal Plan

<table>
<thead>
<tr>
<th>Breakfast</th>
<th>Ensure Plus</th>
<th>Lunch / Dinner</th>
<th>Ensure Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Slices bread + spreads</td>
<td>130ml</td>
<td>Main Meal (Meat, chicken, fish portion)</td>
<td>130ml</td>
</tr>
<tr>
<td>Cereal and Milk</td>
<td>130ml</td>
<td>Rice, potato, Noodle etc.)</td>
<td>65ml</td>
</tr>
<tr>
<td>Fruit (fresh/snack pack)</td>
<td>60ml</td>
<td>1 slice bread + spread)</td>
<td>65ml</td>
</tr>
<tr>
<td>Yoghurt</td>
<td>80ml</td>
<td>Vegetables</td>
<td>20ml</td>
</tr>
<tr>
<td>Juice</td>
<td>30ml</td>
<td>Dessert</td>
<td>130ml</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Juice</td>
<td>30ml</td>
</tr>
</tbody>
</table>
• If a patient on the 2700kcal plan refuses to eat any of a main meal – **440ml Ensure Plus is required.**
• If a patient refuses to eat 100% of the snack provided - **160ml Ensure Plus is required.**

Refer to appendix (4) for further information

**Section Three: Roles and Responsibilities**

The Program is supported by a multi-disciplinary team which includes nurses, dieticians, physiotherapists, play therapist, mental health support (CYPMH) and social workers.

**Roles and Responsibilities of Health Team**

**Medical Director – Paediatrician**
The paediatrician will be responsible for the medical management and will direct the program throughout the inpatient’s hospitalisation. The paediatrician is required to facilitate the twice weekly management team meetings usually on Tuesdays and Fridays. (However this can be negotiated with the Paediatrician)

**Paediatric Medical officers**

**Medical Management**
Day to day medical management will be the responsibility of the paediatric registrar and resident who will perform regular physical examinations, request investigations and follow up results. Attendance at twice weekly management meetings will be at the direction of the Paediatrician

**Nursing**

**Nursing Staff Directorate**
At commencement of the patient’s program one of the following; NUM, CNC or CNE will be appointed to guide the planned program on a daily/ regular basis. This person will be responsible or if unable to attend, delegate another to the management meetings. It MUST be documented who is coordinating the program in the patients progress notes

**Core Paediatric Registered / Endorsed Enrolled Nurses**
Responsible for:
• Allocation of patient to core paediatric staff member only
• Providing all nursing care as required
• Supervision of meals / snacks
• Supervision of patients mobility and all activities
• Attending patient weight recordings on designated days
• Encouraging patient’s compliance with ‘Recovery Level’ programs
• Ensure other staff members compliance with ‘Recover Level’ Program
• Support of patient and family
• Attendance at management meetings

**Play Therapist**  
Role is to provide stimulation and therapeutic activities suitable for the patient.  
A daily activity program will be developed by the play therapist in conjunction with the treating team members. Assistance and supervision to attend schoolwork will be included in their roles.

**Dietitian**  
The dietitian will conduct a nutrition assessment of the patient, including assessment of refeeding syndrome risk. Meal plans will be prescribed, ensuring nutritional adequacy and ensuring weight gain targets are met. Negotiations with the patient regarding the meal plan will commence as treatment levels progress. The dietitian will assess the need for nasogastric feeds in consultation with the treatment team, and which regime would be most appropriate.

As the patient progresses, the dietitian will start to provide nutrition education for the patients to support changes in behaviour, food beliefs and thinking towards recovery.

Prior to discharge and depending on outpatient therapy, education and a meal plan may be provided to patient and parents to assist them with continuing the re-feeding process at home.

If being discharged to another service, a detailed nutrition summery will be provided.

**Physiotherapist**  
The physiotherapist’s role is to provide an activity program that help’s rebuild a healthy musculoskeletal and cardiovascular system. The aim of the program is to maintain flexibility, cardiovascular fitness, balance and co-ordination. The physiotherapist will progress/regress the program in consultation with the team depending on the patient’s progress. The physiotherapist will also educate the patient and parents about safe and appropriate activity levels (addressing over-exercising).

**Social Work**  
The Social Worker provides practical and emotional support to the patient, family and carers. Where appropriate the Social Worker will assist parents’ liaison with schools to provide school work during admission and to facilitate return to school.

**Mental Health**
Mental Health will provide the initial mental health/risk assessment and formulate ongoing management for any co morbid mental health disorders. During business hours this will be completed by The Children & Young Peoples Mental Health Service via ypage (0414192876). After hours/weekend mental health assessments (including urgent assessments) are arranged via the Mental Health Access Line 1800 011 511 - 24 hours a day.

Section Four: Explanation of Care

Explanation of General Care

1. Bed Rest:
   Patients are confined to bed for a variety of reasons, such as medical instability, or minimisation of energy utilisation. Bed rest is defined as sitting or lying on the patient’s own bed. If able to use the toilet and bathroom the patient will be accompanied to the bathroom/toileting by a nurse. This will necessitate the patient “buzzing” for the nurse. Bed rest time can be used for individual therapy or any structured ward program.

2. Bathroom/Toileting:
   Use of the toilet is a way for the patient to undermine their programme of weight gain. To minimise the patient’s opportunities to eliminate food after meals and also to conserve their energy it is important for the nurses to supervise toileting, especially in the early days of their admission.
   The patient will need to buzz for nurse assistance to attend the bathroom.
   Supervision should not take away a patient’s privacy however the nurse is to remain outside the bathroom and inform the patient of your presence. Their time will be monitored and limited, for a bathroom/shower visit the limit is 10 minutes and once per day (for a shower). Toilet visits will be recorded and limited to 2 per nursing shift to discourage inappropriate behaviour.
   Compliance issues need to be discussed with the patient in a positive and encouraging manner, always assisting them to focus on their goals for recovery. It is recommended that if there is evidence of non-compliance and purging then the number of visits to the bathroom maybe restricted. This will be determined by the management team.

3. Weight
   Patients are weighed on Tuesdays and Friday mornings before breakfast at 0630hrs. Prior to being weighed, patients are asked to void into a bedpan so that the urine can be measured and a urinalysis completed. The patient is weighed wearing a hospital gown in their own underwear and barefoot.
4. Medication
Patients admitted with an eating disorder maybe placed on vitamin and nutrient supplements. Other medication may be prescribed if there is evidence of depression, or anxiety. The medication will be commenced after consultation with the patient, the family and relevant team members.

5. Meals and Snacks
Meals and snacks will be supervised by core nursing staff to encourage the patient during this challenging time. This time is also beneficial in allowing socialising time with the patient.
For this reason all main meals and snacks are eaten at the bedside or in the allocated dining area in the adolescent lounge. Nursing staff remain beside the patient during their meal to encourage normal eating patterns and to supervise the meal. (Meals and snacks can be consumed sitting in a chair next to the bed ONLY if staffing does not allow supervision in the adolescent lounge for meals and snacks)
Excessive water consumption is to be discouraged (bottle water is NOT to be given to the patient)
Nutrition Notes will be maintained to document intake including volume of bolus consequence given, if required
30 minutes allowed to eat meals and 20 minutes allowed to eat snacks
NO chewing gum allowed
To permit monitoring and supervision of nutritional requirements, it is requested that families do not bring any food to the hospital.

(Note: example Patient Information Sheet regarding meals and snacks appendix 3)

6. Oral Intake
Alterations to meal plans are made by the dietitian, in consultation with the team, and patient when appropriate. No substitutions are allowed at ward level unless discussed with dietitian. Each week the patient will be expected to increase the quantity and scope of foods eaten. Individual energy requirements will be decided by the professional team at the weekly review meeting, with the aim of gaining 1 kg each week.

7. Supplemental Feeds
Supplemental feeds can be given orally, however if refused, they are usually administered via a naso-gastric tube using a feeding pump. The pump is attached to the non-mobile pole connected to the bed, and the patient will remain on bed rest while the feeds are in progress. When the patient wishes to use the toilet, they will be required to “buzz” for the nurse who will assist by disconnecting the feed if required.

8. Post Meal Rest
After each main meal patients have 30 minutes of supervised rest and 20 minutes rest period after snacks. Use of the bathroom is not permitted during this time. Rest time can be used for therapy or any structured ward program.

9. Leaving the Ward
Nursing Staff are responsible for the well-being of patients on their ward and therefore must know the patient’s whereabouts, who they are with and if off the ward their expected time of return. Permission to leave the ward will depend on the Program Level the patient is on. They may only leave the ward with their parents, nursing staff or a responsible adult.

10. Visitors
Family relationships, in the presence of a young person with an eating disorder become strained and intense with an overwhelming sense of responsibility to have the patient eat sufficient food. An important part of the treatment process is for families to relinquish this responsibility to the staff. The aim of this restriction is to facilitate the development of therapeutic relationships between patient and staff, and to provide respite for both patient and family, visiting is initially limited to immediate family (parents/guardian, siblings and grandparents) for a total of two hours each day. This creates an atmosphere of time and space in which the family is able to “reconnect” with the child/adolescent and re-establish more normal relationships where food and eating cease to be a major focus.

11. Visiting Rules and Restrictions

- No visitors during meal times or post meals rest times

<table>
<thead>
<tr>
<th>Days</th>
<th>Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday- Friday</td>
<td>Between 4pm-730pm</td>
</tr>
<tr>
<td>Weekend</td>
<td>After 10am</td>
</tr>
</tbody>
</table>

The patient’s participation in all aspects of the Program is essential and so visiting must occur outside Program times. This is usually in the evenings; remembering meal times are included in the Program.

Visitors Restriction as per Level Program

- **Medical Stabilisation** - immediate family only
- **Level One and Two** - immediate family only
- **Level Three** - include other relatives
- **Level Four** - as negotiated with family / medical team

12. Gate Passes
Depending on weight gain and progress the patient may begin to receive gate passes on Level 2. For half-day passes the patient may leave the ward after morning tea and return before afternoon tea. Full day passes are taken after breakfast with return before supper. Towards the end of a patient’s admission they may have overnight leave, leaving after breakfast on Saturday and returning after dinner on Sunday. Gate passes may also be considered on special occasions such as Birthdays. Gate passes are designed for young people and their families to share meals prior to discharge to assess both readiness to leave hospital and highlight support needs upon discharge.
The dietitian and social worker will liaise with the family prior to gate passes to assist with the transition back into the family environment.

**The family should also be linked into the Eating Disorders service at Wyong prior to discharge and ideally have a visit prior to discharge from the ward.**

13. **School**
School work and therapeutic play/activities are an important part of the therapeutic process. It is recommended that parents arrange for school work to be available in the ward. The Social Worker is available to assist parents to liaise with the school. The play therapist will assist in monitoring work.

14. **Psychological Therapy**
Therapy may be commenced in the first 3 weeks of admission. The frequency of therapy is based on individual patient and family needs.

15. **Physiotherapy:**
The restoration of muscle is a key element in nutritional recovery. This program has been devised to support rehabilitation, flexibility, muscle development and strengthening. Education will also take place during activity sessions re: safe and healthy activity vs. excessive exercise. See Appendix 2 Physiotherapy- Staff Guidelines – Inpatient Stay and Levels of interventions, for a brief explanation. A physiotherapy booklet will be given to each patient by the physiotherapist.

16. **Ward Mobility and Exercise**
All ambulation/ward activities are considered an exertion of energy. For patients on Recovery Levels One and Two there needs to be a reason as why a patient may ambulate or attend activities that will impact on energy conservation. The nurse is required to monitor and encourage the patient to remain within the program’s constrictions.
Every attempt is made to minimise the temptations and opportunities for excessive exercise while still respecting the patient’s right to privacy. Patients are not usually supervised in the bathroom, but time in the bathroom for a shower is limited to 10 minutes and once per day.
Stretching activities under the guidance of the physiotherapy program is acceptable.

17. **Falls Prevention**
Due to a patient’s compromised health status there is an increased risk of falls/trips occurring. To minimise and control this risk a patient risk assessment is required. This is to be reassessed prior to moving between the recovery levels.

18. **Patient’s Use of Phones/ Mobiles.**
The patient may receive phone calls from family and friends. Calls may be made and received before 8.30am and after 4pm.
Phones including mobiles cannot be used during Meal Times, Rest times or allocated school/activity times.
Mobile phones must be switched off until 4pm and during meals times. They cannot be used to take photos of food.
19. Timetable
When the child or young person is admitted to children’s ward once they are medically stable they should participate in a structured day/school work

Example of timetable Level 1

<table>
<thead>
<tr>
<th>Time</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Friday</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>0900-1030</td>
<td>School work or activity provided by Play therapist</td>
<td></td>
<td></td>
<td></td>
<td>Attend family meeting and then School work or activity provided by Play therapist</td>
<td>Free time with visitors</td>
<td></td>
</tr>
<tr>
<td>1030-1100</td>
<td>Morning Tea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1100-1130</td>
<td>Physio</td>
<td>Physio</td>
<td>Physio</td>
<td>Physio</td>
<td>Physio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1130-1230</td>
<td>School work or activity provided by Play therapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1230-1300</td>
<td>Lunch</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1300-1330</td>
<td>Bed rest</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1330-1400</td>
<td>School work or activity provided by Play therapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20. Consequences

The aim of any intervention such as consequences is to support the containment of the eating disorder behaviour. Consistency is the key if best outcomes are to be achieved

<table>
<thead>
<tr>
<th>Challenging Behaviour</th>
<th>Therapeutic Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hiding Food</td>
<td>Given 1 warning/explanation about the behaviour being unacceptable (use examples where possible) and then if continues receives consequence Bolus for full value (e.g. hides a few biscuits, receives bolus for full amount of the bread serve)</td>
</tr>
</tbody>
</table>
| Messy Eating          | Given 1 warning/explanation about the behaviour being unacceptable (use examples where possible) and then if continues receives consequence:  
| 1 Warning             | - Full bolus if related to 1 food item (refer bolus consequence regime in Nutrition Management page 2  
<p>|                       | - if general messy eating then receive a                                                 |</p>
<table>
<thead>
<tr>
<th>Issue</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interfering / kinking NG tube</td>
<td>50 mL ensure plus bolus</td>
</tr>
<tr>
<td>Exercise</td>
<td>50 mL ensure NG bolus</td>
</tr>
<tr>
<td>1 Warning</td>
<td>Given 1 warning/explanation about the behaviour being unacceptable if continues placed on 24 hour level 1 (bed rest)</td>
</tr>
<tr>
<td>Slow Weight Gain</td>
<td>Increased meal plan with consultation with dietitian</td>
</tr>
<tr>
<td></td>
<td>Reduction or no increase in recovery level</td>
</tr>
<tr>
<td></td>
<td>No Gate pass leave</td>
</tr>
<tr>
<td></td>
<td>Increased bed rest to 1 hour after meals</td>
</tr>
<tr>
<td>Not asking to use the bathroom</td>
<td>Given 1 warning warning/explanation about the behaviour being unacceptable if occurs again then 24 hours on level 1 (bed rest) with NO toilet privileges</td>
</tr>
<tr>
<td>Not Eating</td>
<td>Bolus for the whole value of the food portion</td>
</tr>
<tr>
<td></td>
<td>If not wanting to eat look at creativity around initiating eating, for example</td>
</tr>
<tr>
<td></td>
<td>- Start with one meal first eg morning tea</td>
</tr>
<tr>
<td></td>
<td>- Give gate pass as rewards</td>
</tr>
<tr>
<td>Emotional Distress</td>
<td>Time Out/distruction techniques</td>
</tr>
<tr>
<td></td>
<td>Medication as Charted</td>
</tr>
<tr>
<td>Self Harm- cutting</td>
<td>Explain that this is not acceptable behaviour</td>
</tr>
<tr>
<td></td>
<td>Offer support around setting up distractions</td>
</tr>
<tr>
<td></td>
<td>Medications as indicated</td>
</tr>
<tr>
<td></td>
<td>Consider transfer to tertiary centre</td>
</tr>
<tr>
<td>Self Harm – others / hitting</td>
<td>Try and de-escalate situation through talking</td>
</tr>
<tr>
<td></td>
<td>Give Time out/distraction techniques</td>
</tr>
<tr>
<td></td>
<td>Offer support around distractions</td>
</tr>
<tr>
<td>Taking photos of food or menu</td>
<td>No mobile phone for 48 hours</td>
</tr>
<tr>
<td>Complaining about food/ or attempts to argue and negotiate menus</td>
<td>Once menus completed by dietitian not to be discussed</td>
</tr>
<tr>
<td>1 Warnings</td>
<td>Give 1 warning/explanation about behaviour being unacceptable (use example where possible). If occurs again no toilet privileges</td>
</tr>
<tr>
<td>Not maintaining bed rest 1 warning</td>
<td>Give 1 warning/explanation about the behaviour (use examples where possible). If occurs again no toilet privileges</td>
</tr>
</tbody>
</table>
A 14 year old girl who has been a patient on the children's ward for a week, and is currently on level 1 recovery system. She has been asking other patients in the room to hide food and been very messy with her eating. The nurse sees she has spilt some milk on her tray and has been peeling her apple and pieces of apple have been found over her tray not eaten. What can you do?

- Have the rules/patient handout been given to the patient on admission and the key points covered by the case manager/Nursing staff.
- Explain to her that what she has done is considered messy eating. She needs to eat fruit whole or cut in half or quarters (only bananas and oranges can be peeled). She should not spread food over her plate or tray.
- Explain that there are consequences for messy eating which are designed to support containment of her eating disorder.
- This is considered her first warning.
- Document on the consequence form found on the front of her bedside notes and in the progress notes.
- Explain to her that asking other patients to hide her food is not following the eating disorder program (she is aware of this as she has been given the handout and this was covered by the case manager/nursing staff on admission.)
- Explain there are consequences for hiding food and this is a bolus for the full value of the food hidden).
- Complete bolus
- Document on the consequence form found on the front of her bedside notes and in the progress notes (refer appendix)
Procedure

Anyone of the team can follow the guidelines and implement therapeutic interventions for identified challenging behaviours. The following is a guide to how to complete this:

1. Give warning/explanation if required (using examples where possible).
2. If no warning and clinical intervention required inform nursing staff to perform bolus.
3. Implement intervention.
5. Inform nursing staff.

IF THE CHALLENGING BEHAVIOUR CONTINUES CONSIDER TRANSFER TO A TERTIARY CENTRE

21. Personal Belongs
The child or young person is encouraged to bring in personal items for the bed area such as doonas, photos.

Encourage the young person to get dressed in ‘day’ clothes every day. Parents can bring in toiletries and appropriate seasonal clothing.
Section five: Communication

The complex nature of an eating disorder requires the treating team and the family to provide a ‘united front’ in the treatment of the child’s eating disorder. To facilitate this process the treatment team need to meet regularly and involve the parents in the information sharing and discussion.

GOALS
Communication must be:

1. Timely
2. Clear
3. Documented
4. Transparent
5. Inclusive

Meeting Structure

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Time</th>
<th>Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team meeting</td>
<td>Tuesday 0900 (approx.)</td>
<td>Paediatrician, NUM, CNC, RN/EN caring for the child/young person, social worker, dietician, physiotherapy, CYPMH</td>
</tr>
<tr>
<td>Family Meeting</td>
<td>Friday 0900 (approx.)</td>
<td>Paediatrician, NUM, CNC, RN/EN caring for the child/young person, social worker, dietician, physiotherapy, CYPMH, parents and child/young person if team feels appropriate</td>
</tr>
</tbody>
</table>

Key Points
- Meetings will be held twice a week on the same days as weighing (Tuesday and Friday)
- If unable to meet twice then the meeting on Friday should take precedence
- The meetings are chaired/led by the Paediatrician in charge of the case (or nominated replacement)
Meeting Structure

- The Friday meeting would offer the parents the chance to clarify any issues raised during the week and seek advice regarding gate leave or other plans.

- Ideally the parents/family would be invited to attend after the initial meeting from health care professionals (usually the second half of the meeting).

- The parents should be encouraged to raise any concerns at the time with the appropriate person, not wait until the weekly meeting.

Outcomes from Meetings

- The allocated Nursing Case Manager/Coordinator (or representative) should document all changes to the care plan for the week in the progress notes.

- The Nursing Case Manager/Coordinator (or representative) should also complete the sticker (refer to the diagram below) and place in the progress notes also.

- The Paediatrician and team will feedback the outcome of the team meeting to the child/young person

- The Paediatrician and/or social worker will feedback the outcome to the family

The Nursing Case Manager/coordinator is responsible for updating any care changes to documents such as ‘recovery levels’ being used and feedback this information to the nursing staff.
What needs to be discussed in the meetings?

- Weight gain or loss
- Current diet/ calories
- Psychological condition of the patient
- Challenging behaviour/Issues
- If parents involved discuss there concerns/issues

Outcomes

1. Identify diet until next weigh in and meeting. (ie NGT or bolus exchanges etc.)
2. Recovery level
3. Gate pass/ or not
4. Goal weight
5. Necessary referrals (ie to Wyong Eating Disorder clinic etc)
6. Discharge Plan
Section Six: Physiotherapy and Eating Disorders

Supervised activity in a medically stable patient is an important component of the recovery program and can be beneficial during a hospital admission. The program should start with physiotherapy supervised stretching and progress to gentle strengthening exercise.

The role of exercise during recovery:
- Helps rebuild a healthy musculoskeletal and cardiovascular system
- Enhances trust in the team, reinforcing the idea that we are supporting them in reaching a state of health rather than “fattening them up.”
- Assist in managing constipation secondary to re-feeding
- Assist with anxiety reduction and mood elevation
- Provide an opportunity for positive physical experiences. Body oriented therapy can directly address body experience and improve body image.
- Promote general well-being
- Help facilitate responsibility for self, rather than cause more feeling of loss of control, helplessness and resentment.
- Assist the return to a normal balanced lifestyle
- Address bone mineral density
- Incentive to increase the meal plan

Physical activity is performed in the context of nurturing and supporting the body through the recovery process. Motivations to perform physical activity are redirected from anorexic to healthy ideals eg: pleasure, socialisation, general wellbeing.

Excessive exercise behaviours and the patient’s body perceptions should be identified early in the program. Education on anatomy and physiology, healthy types and amounts of exercise, motivations to exercise can be continuous throughout the physiotherapy sessions. Achieving a realistic self-concept and acceptance of the body are
essential to recovery. It has been suggested that by enabling the client to have positive physical experiences, body oriented therapy can directly address body experience and in turn improve a client’s body image (realistic self-concept and acceptance of the body).

**Goals of the physiotherapy program:**
- Improve posture and postural awareness
- Improve muscle control, balance and co-ordination
- Learn benefits and precautions of exercise
- Provide an environment to relax and have fun.

**Recover Systems**

**Medical Stabilisation**
- Bed rest – no mobilizing outside of bed, no physiotherapy
- Exercise Questionnaire

**Level One** – Stretching and Stabilisation – twice a week
- Posture & Body Awareness
- Active Stretches in lying & sitting
- Relaxation techniques
- Education

**Level Two** – Core Stability
- Body awareness & relaxation
- Core stability exercises using bed, exercise mat and swiss ball.
- Ward mobility- All ward staff are monitors
- Education

**Level Three** – Core Stability & Gentle Strengthening
- Continue with body awareness and core stability exercise
- Strengthening Exercise using body weight swiss ball
- Gentle exercise – yoga, tai chi
- Exercise associated with gate leave
The decision to move forward or backwards must be agreed on by the multidisciplinary team.

**Level four** - Most likely to occur in an outpatient setting
- Continue with core stability and resistive strengthening
- Gentle cardio conditioning eg Playful moderately paced walking or recreation (walking dog, swimming – for fun)

**Level five** – Healthy Body – return to activities
(includes return of menorrhea in adolescent girls)
- Continue stability and strengthening exercises
- Graduated return to sporting activities

**NB:** The % ideal body weight guides are only a guide. Progress should be determined by a number of physical, behavioral and psychological parameters. Medical stability, weight gain, adherence with the treatment program, motivation to change, insight into exercise behaviors and an ability to contain them should all be considered.

**Exercise guidelines for discharge should be discussed with the family and the community team.**

<table>
<thead>
<tr>
<th>General guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prolonged bed rest is inadvisable unless medically indicated.</td>
</tr>
<tr>
<td>2. As a general rule a physiotherapist should supervise exercise initially. Excessive exercise may lead to further strain on the cardiovascular system (serious medical complications, joints (osteoarthritic changes), and the skeletal system (stress fractures))</td>
</tr>
<tr>
<td>3. Appropriate activity levels for each patient should be decided on by the treating team, documented as part of the management plan and communicated clearly to the patient, their family and staff members.</td>
</tr>
<tr>
<td>4. Initially unless participating in supervised physio exercise, patients should be discouraged from exercise on the ward. With recovery patients may be allowed to walk slowly around the ward although this will need to be monitored to prevent excessive exercise such as, running, star jumps, sit-ups or pacing up and down the hall.</td>
</tr>
</tbody>
</table>

**Most importantly open collaboration is required with the team, the client and the family.**
First 24 Hrs
Baseline tests:
* UEC, Phosphate, magnesium, FBC ESR, LFTs
* ECG

In assessing risk consider nursing care in HOBs
Observations: Pulse, Temp, Resps, Postural BP Continuous cardiac Monitoring
Bare weight
U/A
BSL
Admitted under Paediatrican
MH risk assessment to be made within 24 hours
Checklist to be faxed to Nutrition Department

Within the first 48hrs
* Identify: Nursing Case Manager - CHW
* First Case Meeting date and time to be arranged
* Program to be implemented
* Parents and Patient informed of Provisional Diagnosis and plan of care

On going Inpatient Care
Case Meeting to review progress and treatment plans held every Tues and Fri am

Patient Admitted to CHW – CCLHD
Entry from ED / Paediatrician or community – EDC
Transfers from Tertiary Hospital

Paediatrician - leads case management and delegates through Paediatric MO Team

Arrange First Case Meetings (may not require all disciplines to attend)

Referral to services other than nursing/ medical
To be attended within 48 hours of admission

Physiotherapist
Mental Health - CYPMH
Social Worker
Dietitian
EDC Wyong

Program implemented. Treatment delivered within boundaries of individual discipline’s roles and responsibilities as outlined within pathway

Case Meetings to be held every Tues / Fri.
Note: changes in levels of care occur only on Fridays

Discharge/ transfer occurs when goals for stabilisation have been reached and continuing care options are available and organised

Patient discharged to home with ongoing care within Community options or transferred for ongoing inpatient care at tertiary hospitals Tertiary

Parents/ patient Communication
Information Packages to be given to family/ pt
1. If patient known to service give package within 24 hrs
2. If new patient, it is recommended within 48 hrs and after discussion with Paediatrician

First Meeting with family/pt within 48hrs by VMO, includes nurse case manager & SW

Parents and Patient
Continued involvement in care planning and goal setting. Including if agreed by team presence at or following case meetings
Eating Disorder Admission
Special Diet Checklist

Please tick appropriate boxes:
☐ High Energy Diet selected on EMR
  ☐ 2000kcal Meal Plan
  ☐ 2700kcal Meal Plan
☐ Any confirmed Allergy / Intolerance
__________________________________________________________

☐ Ensure Plus Supplements required
  ☐ Oral bolus consequence
  ☐ NGT inserted
☐ Dietitian Referral put in eMR
☐ Form faxed to the Nutrition Department: 2828
**Additional Information:**

- This patient will not receive a menu as they have a non-negotiable fixed menu plan of 3 meals and 3 snacks.
- As the patient advances in treatment levels, they may have opportunities to make their own food decisions.
- Food refusal within 24 hours of admission results in NGT insertion and continuous feeding – please follow Enteral Feeding regime.
- Food refusal at other times during admission result in an oral/NGT bolus consequence – please follow guidelines on volumes to administer.
- Food negotiations or discussions about food result in warnings/consequences – please follow guidelines.
- All meals and snacks should be delivered to nursing station and not directly to the patient.

**Any questions, contact:**
Paediatric Dietitian: #19342   or   Nutrition Department: 3691
Continuous Enteral Feeding Regime
Eating Disorders Patients

Patients are required to eat 100% of their prescribed meal plan on admittance to the Children’s ward. If patients fail to consume 100% in the first 24 hours of admission, a nasogastric tube will be inserted and continuous enteral feeds commenced. Please see the regime below.

<table>
<thead>
<tr>
<th>Day</th>
<th>Calories</th>
<th>Volume</th>
<th>Rate (ml/hour)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>2000 kcal</td>
<td>1330ml</td>
<td>55</td>
</tr>
<tr>
<td>3-4</td>
<td>2200 kcal</td>
<td>1470ml</td>
<td>60</td>
</tr>
<tr>
<td>5-6</td>
<td>2500 kcal</td>
<td>1670ml</td>
<td>70</td>
</tr>
<tr>
<td>Goal</td>
<td>2700 kcal</td>
<td>1800ml</td>
<td>75</td>
</tr>
</tbody>
</table>

Please flush tube with 40ml water every 4 hours during continuous feeding.

At Goal rate 8 x 237ml cans of Ensure Plus are required.

To order Enteral Feeds:
Weekdays 8 - 4.30pm - Please page the Dietitian on #19342
Weekends / Public Holidays 7.30 - 4pm - Please call the Dietitian Assistant on extension 2250
Feeds cannot be accessed outside of these times.
Bolus Consequence Regime (Oral/NGT) Eating Disorders Patients

Patients are required to eat 100% of their prescribed meal plan during their admission for medical stabilization. If the patient is unable to consume the quantity of food required, or refuses to eat certain food or drink items, please provide the following volumes of Ensure Plus to make up the deficient calories. If the patient refuses to do this orally, an NGT needs to be inserted and utilised.

<table>
<thead>
<tr>
<th>2000kcal Meal Plan</th>
<th></th>
<th>2700kcal Meal Plan</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breakfast</strong></td>
<td><strong>Ensure Plus</strong></td>
<td><strong>Lunch / Dinner</strong></td>
<td><strong>Ensure Plus</strong></td>
</tr>
<tr>
<td>Cereal + milk</td>
<td>130ml</td>
<td>Main Meal (meat, chicken, fish portion)</td>
<td>130ml</td>
</tr>
<tr>
<td>Fruit (fresh/snack pack)</td>
<td>60ml</td>
<td>Rice, potato, noodle etc.</td>
<td>65ml</td>
</tr>
<tr>
<td>Yoghurt</td>
<td>80ml</td>
<td>Vegetables</td>
<td>20ml</td>
</tr>
<tr>
<td>Juice</td>
<td>30ml</td>
<td>Dessert</td>
<td>80ml</td>
</tr>
</tbody>
</table>

If a patient on the 2000kcal plan refuses to eat any of the main meal 300ml Ensure Plus is required.

<table>
<thead>
<tr>
<th><strong>Breakfast</strong></th>
<th><strong>Ensure Plus</strong></th>
<th><strong>Lunch / Dinner</strong></th>
<th><strong>Ensure Plus</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>2 slices bread + spreads</td>
<td>130ml</td>
<td>Main Meal (Meat, chicken, fish portion)</td>
<td>130ml</td>
</tr>
<tr>
<td>Cereal + milk</td>
<td>130ml</td>
<td>Rice, potato, noodle etc.</td>
<td>65ml</td>
</tr>
<tr>
<td>Fruit (fresh/snack pack)</td>
<td>60ml</td>
<td>1 slice bread + spread</td>
<td>65ml</td>
</tr>
<tr>
<td>Yoghurt</td>
<td>80ml</td>
<td>Vegetables</td>
<td>20ml</td>
</tr>
<tr>
<td>Juice</td>
<td>30ml</td>
<td>Dessert</td>
<td>130ml</td>
</tr>
</tbody>
</table>

If a patient on the 2700kcal plan refuses to eat any of a main meal – 440ml Ensure Plus is required.

The mid-meal snacks are the same for both meal plans. If a patient refuses to eat 100% of the snack provided - 160ml Ensure Plus is required.
To order Ensure Plus:

- Weekdays 8 - 4.30pm - Please page the Dietitian on #19342
- Weekends / Public Holidays 7.30 - 4pm - Please call the Dietitian Assistant on extension 2250
- Feeds cannot be accessed outside of these times.
# PAEDIATRIC Eating Disorder Consequences

This form can be completed by anyone from the Paediatric Eating Disorder team.

**Surname:** _____________  **MRN:** ______________

**Given Names:** _____________________________

**Date of Birth:** ____/____/____  **Sex:** ____________

## Challenging Behaviour

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>DATE</th>
<th>Initial for warning</th>
<th>Therapeutic Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hiding Food</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Messy Eating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercise</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Slow weight gain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not asking to use the bathroom</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Not Eating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Distress</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Harm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harm to others ie hitting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking photos of food</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complaining about food/or attempts to argue and negotiate menus</td>
<td></td>
<td></td>
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<tr>
<td>Not maintaining bed rest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not eating in the adolescent lounge or sitting in a chair next to bedside for meals/snacks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen and suction equipment functioning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Return to Sports:

Returning to sports is often a big question on the minds of patients and their families. We recommend a graduated return to healthy levels of physical activity with ongoing monitoring by the team. This will often begin with relaxed walks with family and gentle stretching and strengthening e.g. a yoga class with the family. With appropriate nutrition and maintenance of good health, more activities can be included with the aim of slowly returning to preferred activities. When planning return to sport certain things should be considered:

Risk of fracture or injury: The strength and muscle tone lost through malnutrition puts the young person at a greater risk of injury. This is why a graduated program of stretching and strengthening is important to prepare for other more vigorous activities such as team sports. Previous poor eating habits also lead to a loss of bone density, this puts young people at a much higher risk of fracture. It is important to avoid contact sports or sports with a risk of falling until fully recovered.

Energy needs: Young people recovering from an eating disorder have very high energy requirements to gain weight. Following discharge from hospital it can take some time for parents to be back in control of ensuring adequate intake for their children. Returning to energy burning exercises in this stage makes it much more difficult for the young person to gain or maintain weight. Inadequate nutritional intake can quickly lead to medical instability in young people during recovery, physical exercise is another demand on the body that is not necessary when beginning a recovery. It is often enough of a challenge for a young person to maintain their weight on discharge once they are back to doing their normal activities of daily living.

Motivation to exercise: Is it for healthy reasons such as enjoyment or are they still stuck in anorexic thoughts of weight reduction and control. Helping your child to set a nurturing intention for exercise, and to observe when more anorexic motivations come into play will help them be more aware of anorexia’s influence on exercise behaviour.

Information on different types of exercise: Return to sports should not occur until the patient is within a healthy weight range and is psychologically ready. It is important to remember that exercise is often closely linked with anorexic thoughts for these young people and that there is potential for relapse if they start exercising before they are ready. Sports or exercise that is solitary should be avoided. It is recommended to practice exercise in a group to ensure the aim of exercise is enjoyment. Similarly, competitive or vigorous sports should be avoided. Return to these sports should be graduated to suit physical health and psychological readiness and should be socially motivated.
Parents are encouraged to communicate openly with PE teachers and sports coaches regarding their child’s condition.

**Signs of Relapse:**

- Hiding exercise
- Debiting for exercise – eat with the idea of ‘working off’ calories or working off calories then eating
- Demonstrating a ‘need’ or pressure to exercise
- Counting or self monitoring time or repetitions whilst exercising

If you are noticing these signs talk to your child about their motivation to exercise. During recovery from anorexia nervosa it is normal to have to graduate their return to sports. Talk to your outpatient services if you are concerned that you are unable to manage your child’s over-exercising.

**Remember:** participating in physical exercise is a privilege for healthy bo
<table>
<thead>
<tr>
<th>Healthy Exercise</th>
<th>Unhealthy Exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>You exercise for fun, its enjoyable.</td>
<td>You exercise because you feel you have to or for weight control.</td>
</tr>
<tr>
<td>Exercising in groups</td>
<td>Hiding your exercise</td>
</tr>
<tr>
<td>You are in control of the exercise</td>
<td>You are not in control of the exercise</td>
</tr>
<tr>
<td>Stopping when you want to.</td>
<td>Continuing to exercise even though you are tired or hurt.</td>
</tr>
<tr>
<td>Exercise is flexible, it can be changed if you have social events, are tired or</td>
<td>Exercise is inflexible, you feel pressure to follow a routine. If you don’t you</td>
</tr>
<tr>
<td>injured.</td>
<td>feel stress and anxiety</td>
</tr>
<tr>
<td>Exercise is one of the things you might do to help with stress</td>
<td>The only thing you can do to help deal with stress.</td>
</tr>
<tr>
<td>There is a goal or clear end point, often not dependent on repetitions or time</td>
<td>There is no goal and you don’t stop until you are exhausted or in pain. It is often</td>
</tr>
<tr>
<td>spent exercising.</td>
<td>dictated by repetitions or time spent exercising.</td>
</tr>
<tr>
<td>Your exercise does not cause arguments or stress</td>
<td>Your exercise causes arguments.</td>
</tr>
<tr>
<td>You don’t feel the need to continue or repeat the task once the time is up/its</td>
<td>You feel the need to continue tasks unnecessarily or until they are perfect.</td>
</tr>
<tr>
<td>completed</td>
<td>Exercise causes isolation</td>
</tr>
<tr>
<td>Exercise encourages socialisation</td>
<td>Self prescribed exercise based on negative thoughts (as above), exceeds doctors</td>
</tr>
<tr>
<td>Exercise has been recommended by your health professionals, you follow any</td>
<td>limits.</td>
</tr>
<tr>
<td>limitations given.</td>
<td></td>
</tr>
</tbody>
</table>
Welcome to physiotherapy!

Goals of the physiotherapy program:
- Improve posture and postural awareness
- Improve muscle control and strength
- Improve flexibility, balance and co-ordination
- Learn benefits and precautions of exercise
- Provide an environment to relax and have fun.

Physiotherapy will begin when you are medically stable. This is decided by your doctor. Physical activity will only take place when it is safe and your body has started to recover. The team will decide when you are ready to progress in your program. It is possible to move backwards in the physiotherapy program.

Stage one: Stabilisation and posture

The initial focus is about enabling the body to recover and you to feel well again. In the early stages we will focus on relaxation and stretching to help with body flexibility and awareness. When your body is stronger we will introduce activities aimed at improving posture and strengthening the deep muscles that stabilise your body and enable you to move well.

Stretches
Until it is medically safe stretches may be carried out by the physiotherapist whilst you are resting in bed. When you are medically ready we will start doing stretches in sitting and standing.

The therapist will chose 5-8 exercise as appropriate.
Core stability

These activities are aimed at strengthening muscles that are important to maintain good posture.
Roles and Responsibilities

The Physiotherapist role and responsibilities:
- Help you to understand the way the body works and the benefits of physical activity and risk of excessive activity.
- Help you look after your body and feel good.
- Design an activity program for you. Monitor and discuss your progress with you and the team and alter the program accordingly.

Your role and responsibilities:
- Do only the activities that the physiotherapist prescribes.
- Discuss any concerns or problems you have with your activity program with your physiotherapist.

Family role and responsibilities:
- Let the team know if they are worried that you are doing some activities or exercise that is unsafe or not part of your program.

The team role and responsibilities:
- Monitor your health and progress.
- Report to the rest of the team if they are worried that you are doing some activities or exercise that is unsafe or is not part of your program.

Your physiotherapist is part of the team that is here to help YOU!
Please do not hesitate to talk to them about any questions or concerns you have during your stay.

Ph: 43287920

PHYSIOTHERAPY STABILISATION AND STRENGTHENING PROGRAM

LEVEL 1: Body awareness, stabilisation and posture.
Welcome to physiotherapy!

**Physiotherapy**

**Welcome to physiotherapy!**

Physiotherapy will begin when you are medically stable. This is decided by the medical team. Some of the things they consider are your heart rate, blood pressure and temperature. Physical activity will not take place until it is safe.

**Goals of the physiotherapy program:**
- Improve posture and postural awareness
- Improve muscle control and strength
- Improve flexibility, balance and co-ordination
- Learn benefits and precautions of exercise
- Provide an environment to relax and have fun.

**Stage one: Stabilisation and posture**

The initial focus is about enabling the body to recover and you to feel well again. In the early stages we will focus on relaxation and stretching to help with body flexibility and awareness. When your body is stronger we will introduce exercises aimed at improving posture and strengthening the deep muscles that stabilise your body and enable you to move well.

**Stretches**

Until it is medically safe stretches may be carried out by the physiotherapist whilst you are resting in bed. When you are medically stable we will start doing exercises in sitting and standing.

**Chose appropriately**

**Core stability**

These exercises are aimed at strengthening muscles that are important to maintain good posture.
Your physiotherapist is part of the team that is here to help YOU!
Please do not hesitate to talk to them about any questions or concerns you have during your stay.
Ph: 43287920

PHYSIOTHERAPY STABILISATION AND STRENGTHENING PROGRAM

LEVEL 2: Core Stability
Body awareness, stabilisation and posture.
Welcome to physiotherapy!

**Goals of the physiotherapy program:**
- Improve posture and postural awareness
- Improve muscle control and strength
- Improve flexibility, balance and co-ordination
- Learn benefits and precautions of exercise
- Provide and environment to relax and have fun.

Physiotherapy will begin when you are medically stable. This is decided by the medical team. Some of the things they consider are your heart rate, blood pressure and temperature. Physical activity will not take place until it is safe.

**Stage two: Stabilisation, posture and strengthening**

We will continue with relaxation and stretching to help with body flexibility and awareness. Now your body is stronger we will continue exercises aimed at improving posture and strengthening the deep muscles that stabilise your body and enable you to move well. However we will also add resistive strengthening with therabands and swiss balls and gentle gym exercises.

**Stretches**

Until it is medically safe stretches may be carried out by the physiotherapist whilst you are resting in bed. When you are medically stable we will start doing exercises in sitting and standing.

**Choose appropriately**

**Core stability**

These exercises are aimed at strengthening muscles that are important to maintain good posture.
YOUR PHYSIOTHERAPIST IS PART OF THE TEAM THAT IS HERE TO HELP YOU!
Please do not hesitate to talk to them about any questions or concerns you have during your stay.
Ph: 43287920

PHYSIOTHERAPY STABILISATION AND STRENGTHENING PROGRAM

LEVEL 3: Stability & Strengthening
Body awareness, stabilisation and posture
Contact List

CCLHD

Clinical Nurse Consultant Paediatrics  Mon-Friday available via page 18468 or extension 2197

Eating Disorder Early Intervention Outpatients Service

Address: Ground floor
Wyong Central Community Health Centre
38a Pacific Hwy
Wyong

Co-coordinator: Ph: 02 43569413
Fax: 02 43 569350

Service ‘Hotline’: Ph: 02 43569418

Children’s Hospital - Westmead

Child and Adolescent Psychiatrist – Dr Sloane Madden.
Contact through page Ph: 98450000

Paediatrician and Adolescent Medicine Specialist (for adolescents 16 yrs and over) Dr Simon Clarke – direct ph: 98456788

Paediatrician (15 yrs and under) Dr Michael Kohn
Ph: 0407 933467
References


2. The Children’s Hospital, Westmead. 2006 *CHW Eating Disorder Information Booklet for Parents*. Eating Disorders: It’s Epidemic, Program and Resources


The Inpatient Care of Children and Adolescents with Eating Disorders Working Party.

Karen Stevenson – CNC Paediatrics
Dr Vicki Burneikis – Staff Specialist Paediatrician
Judith Leahy – Eating Disorders Service Coordinator. CCLHD
Katherine Reeves – Psychologist Eating Disorders Clinic, Wyong
Alison Lord – Dietitian CCLHD
Robyn Wolski – Senior Paediatric Physiotherapist CCLHD
Erin Gehrig – Dietitian CCLHD
Josephine Ahearn = Social Work CCLHD
Shane Hoyland – CNC Y-page
Tim Moore – CNC Y-Page
Stacey Collins – CNE Paediatrics
Lorraine Love A/CNC Paediatrics
David Potter – NUM Children’s Ward
Courtney Alderton – RN Children’s Ward
Catherine Clews – EN Children’s Ward
Marie Spencer – RN Children’s Ward
Lucinda Sneddon – RN Children’s Ward