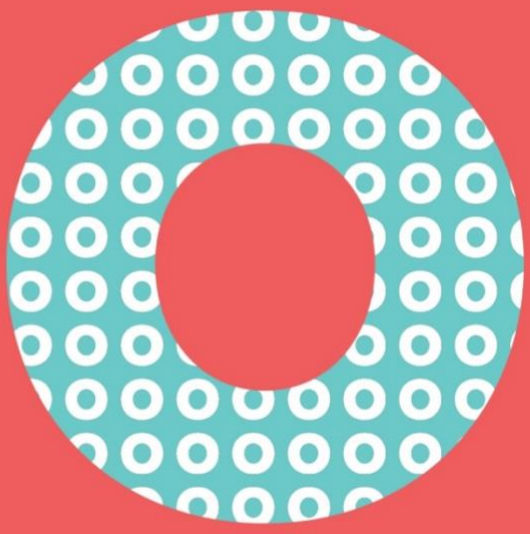
INSIDE OUT
Institute for Eating Disorders

# Nursing Care for Adults with Eating Disorders in Medical Inpatient and Emergency Department Settings



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## PURPOSE

This document is intended to provide directions on the provision of nursing care for adults with eating when they are admitted to general wards or in the emergency department. People with eating disorders experience a complex interplay of both medical and psychiatric issues, which can also present against a background of trauma, interpersonal and relational issues and personality vulnerabilities. Therefore, close supervision and targeted management on the ward, which considers the unique challenges that this population face, is required to ensure patient safety (both physical and psychological) and resolution of medical problems.

This document is intended to provide direction about supporting adults with eating disorders to reach medical stability safely and effectively. It is not intended to provide direction on specific medical or psychiatric treatment, as this should be decided by the individual's current multi-disciplinary treatment team in consultation with the individual, their family and/or carers as part of the development of a collaborative treatment plan.

## USE AND SCOPE OF THE GUIDELINE

The guidelines apply to all general inpatient areas including the emergency departments where there are no specialist eating disorder services. This document outlines best-practice standards for inpatient nursing care and management for adults with an eating disorder and is intended as a guideline. It is acknowledged that significant challenges with resourcing exist amongst the Local Health Districts (LHDs)/Speciality Health Networks (SHNs). Thus, the reader is encouraged to consider how the best-practice standards outlined in this guideline can be adapted to their specific setting and the available resources of this setting. These guidelines are intended to be read in conjunction with the LHD's/SHN's relevant protocols and policies as well as clinical expertise.

While at the time of writing empirical research in the area is in its preliminary stages, it has been observed clinically that close, supportive monitoring and supervision reduces patients' engagement in eating disordered behaviours, which in turn promotes a quicker rate of improved medical outcomes, weight gain and medical stability. These are key factors in reducing the length of stay and optimising patient outcomes. Close supervision and 1:1 nursing care is therefore important when caring for patients with eating disorders. Therefore, considerations for 1:1 nursing care have been specifically outlined in this document.

This document contains five parts:

- The first part outlines the background and key principles
- The second part outlines the role of the nurse when working with patients with eating disorders in general wards or in the emergency department
- The third part outlines considerations for 1:1 nursing when providing supervision and ward management
- The fourth part outlines available supports for nursing staff
- The fifth part is tools and resources section containing user-friendly summaries and practical handouts for clinician use

For comprehensive inpatient management guidance, including guidelines on medical and nutritional management, clinicians should refer to the following:

- Guidelines for the Inpatient Management of Adult Eating Disorders in General Medical and Psychiatric Settings in NSW 2014; Developed by the Centre for Eating and Dieting Disorders (now InsideOut Institute) (https://www.health.nsw.gov.au/mentalhealth/resources/Publications/nsw-eating-disorders-toolkit.pdf).

As this guideline is for inpatient admissions, it largely refers to eating disorder diagnoses associated with severe medical compromise or emaciation. These are typically AN, BN along with mixed and atypical presentations classed in EDNOS and ARFID. Guidelines for nursing care of Binge Eating Disorder, Pica and Rumination Disorder are beyond the scope of this document, as are guidelines for outpatient, intensive outpatient or day program nursing of people with eating disorders. Child and Adolescent nursing management is beyond the scope of this document, however comprehensive guidelines and a toolkit for this subset of patients is available on the NSW Health website (https://www.health.nsw.gov.au/mentalhealth/resources/Publications/nsw-eating-disorders-toolkit.pdf).

*This guideline was produced for NSW Health by the InsideOut Institute in consultation with the NSW Eating Disorders Outreach Service, NSW Local Health Districts and Speciality Health Networks, and in particular the Eating Disorders Coordinators across NSW.*

# Contents

# 1 INTRODUCTION

## 1.1 Background

Eating disorders comprise a group of illnesses that range from moderately-severe through to critical and life threatening, including anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), as well as sub-threshold, mixed and atypical cases (known as eating disorders not otherwise specified - EDNOS). People who present with an eating disorder are at a high risk of medical complications and/or psychiatric comorbidity (including suicidal ideation and deliberate self-harm). Close monitoring, supervision and support to ensure effective management and intervention is required to prevent further life-threatening deterioration.

The cause of medical complications can be due to the amount and rapidity of weight loss, the duration of under-nutrition and its effects, and the compensatory behaviours (vomiting, laxative abuse, diuretic abuse, diet tablets and compulsive exercise) that may be used.

For people with an eating disorder, controlling food intake and engaging in other disordered behaviours are their primary coping strategy and safety mechanism. Hence, hospitalisation and treatment, which directly challenge the eating disorder behaviours, are often perceived as threatening to these patients, and ambivalence or distress towards treatment is part of their overall presentation. People with an eating disorder will require additional support to reduce engagement in their unhelpful behaviours and to cope with the distress associated with letting go of them. Both tasks are essential so that these patients can engage in treatment.

Psychiatric comorbidity is experienced in high rates in the eating disorder population, with trauma, mood and anxiety disorders commonly co-occurring. It is important therefore that any ward management be informed by the collaborative treatment plan developed by the local treating team first and foremost. Local trauma-informed care policies and practices should be adhered to alongside this guideline's recommendations.

## 1.2 Considerations for Working with People with ARFID

Avoidant/Restrictive Food Intake Disorder (ARFID) is defined as an eating or feeding disorder characterised by a persistent and disturbed pattern of feeding or eating that leads to a failure to meet nutritional/energy needs. People who present with ARFID can and do face a high risk of medical complications. While people with ARFID do not present with body image concerns, medical complications can occur due to the amount and rapidity of weight loss and the duration of under-nutrition and its effects. People with ARFID also experience psychiatric comorbidity in high rates, including suicidality, neurodevelopmental, disruptive and conduct disorders, anxiety-related disorders and trauma (Kambanis et al., 2020).

ARFID is characterised by individuals who have developed some type of problem with eating (or for very young children, a problem with feeding). This may be due to a variety of reasons, such as sensory sensitivity, food-related trauma (e.g: a traumatic experience of choking on food) or a lack of interest in eating (e.g: forgetting to eat, not feeling hungry or a lack of pleasure in eating). As a result of the eating problem, the person is not able to eat enough and/or a wide enough variety of foods to get adequate calories or nutrition through their diet. A central feature of ARFID is the absence of body image disturbance and concern with weight and shape. However, for people with ARFID, eating often remains highly distressing. This may be due to difficulty tolerating feelings of fullness or a tolerating certain textures/tastes/sensations associated with certain foods or due to a fear of aversive consequences related to eating e.g: fear of choking or vomiting. People with ARFID

therefore require additional support to help them to adhere to their dietetic plan and tolerate the distress associated with this.

### 1.3 Aims and Purpose of Inpatient Admission

Purpose of admission: The aim of a medical hospital admission is to manage the patient's medical complications but also to begin weight restoration (if underweight) and interrupt the eating disorder behaviours. While in hospital the patient requires medical monitoring, meal supervision, monitoring of exercise and eating disorder behaviours, and weighing.

The primary aims of nursing care when working with people with eating disorders are:

- to ensure that the treatment recommended in the collaborate treatment plan is being received by the patient during admission
- to maintain patient safety, which may be at risk due to their medical condition, refeeding or acute mental health risk such as self-harm or suicide
- to assist the patient to utilise their skills and resources to manage distress associated with the treatment

### 1.4 Key Principles

The following are key principles for all staff working with people with an eating disorder:

- Ensuring Safety: A primary priority of care is to ensure that the person is safe. This will include assessment and management of both the medical and psychological safety aspects of the individual.
- Creating a Therapeutic Alliance: Successful treatment is dependent on the creation of therapeutic alliance. A therapeutic alliance involves developing an empathic, supportive and trusting relationship with the patient. It is critical in reducing resistance and facilitating change. A positive therapeutic experience for the person may also mean that they will access appropriate care at a later stage if required.
- Involving Families and Carers: The patient's family and carers are an essential resource to help support the person throughout treatment. It is important that family and carers are included throughout the treatment process and are appropriately communicated with. It is important to discuss who their family, carers and support networks are and how they would like them to be involved in their treatment. Determining which family members, carers and support people are involved in the treatment, and what their roles in treatment will be is best determined on a case by case basis, and in discussion with the patient. Care should be taken to avoid making families or carers feel blamed for any aspect of the patient's illness.
- Maintaining Realistic Expectations: Eating disorders are chronic illnesses. Having realistic expectations about the hospital admission helps to contain family and staff anxiety. Patients will not be "cured" of their eating disorder at discharge.
- Managing Fear and Distress: Patients with an eating disorder experience an intense fear of weight gain and/or shape change, and this fear extends to eating. Recognising and assisting the patient and their support network to manage fear and distress is essential.

- Working with Strengths: Focusing on strengths enhances assessment, treatment and building therapeutic alliance. Strengths should be assessed in terms of individual, family/carer or support network and psychosocial perspectives.
- Respecting cultural diversity: Eating disorders affect people from a variety of cultural, spiritual and ideological backgrounds. Taking time to understand the impact of cultural and spiritual diversity on the patient's eating behaviour and presenting concerns is an essential part of patient care. Use of interpreters is important to aid effective communication with patients and families/carers with limited English proficiency. The team's local Aboriginal Hospital Liaison Service should be consulted where appropriate.

# 2 THE ROLE OF THE NURSE CARING FOR PEOPLE WITH EATING DISORDERS IN MEDICAL UNITS

Patients with eating disorders present to Emergency Departments medically compromised and may require admission to a medical ward, so nurses in varied settings need skills and knowledge in caring for these patients. There are medical and psychiatric risks associated with eating disorders, so a multidisciplinary, goal orientated and collaborative treatment approach is required. In addition to the ward staff, there will often be multiple consulting teams and disciplines involved when patients with an eating disorder are admitted to medical units. Nursing staff have a continuous presence with shifts around the clock, so they play a crucial role in providing continuity and consistency in the delivery of safe and effective treatment for patients with eating disorders.

## 2.1 The Role of Nurses Caring for Patients with Eating Disorders

Nurses caring for patients with eating disorders are to:

- Engage with the patient in a non-judgmental and collaborative manner to build a trusting relationship to support treatment and recovery
- Provide information as often as required with an awareness that memory/cognition is affected by starvation and anxiety
- Ensure there is a clear plan and documentation for the purpose of admission, what risk factors are present and update documentation as treatment progresses
- Facilitate multidisciplinary team communication and consistency to ensure the correct treatment is delivered and to minimise potential for splitting
- Apply the treatment plan by involving the patient and wherever possible and appropriate, the family/carers
- Deliver care in the same manner as with any other patient - e.g supporting a patient who is struggling at mealtimes as one might a patient who is anxious about an upcoming procedure; with comfort, empathy and clear information
- Provide meal support as treatment
- Provide 1:1 'special' nursing

It is beneficial for nurses caring for patients with eating disorders to have:

- A basic understanding of eating disorders and the effects of malnutrition
- An understanding of anxiety and its comorbidity with eating disorders
- An understanding of the fear associated with eating/feeding that contributes to distress and behaviours patients may engage in (for example, this could be an extreme fear of weight gain in AN or a fear of vomiting as seen with ARFID).
- An understanding of how to separate the eating disorder from the person
- Awareness of countertransference and stigma and how this affects the therapeutic relationship (see Section 4.1 for explanation of countertransference)
- Some knowledge of distress tolerance/reduction strategies (see Resource D)
- Basic counselling skills and responding to resistance through validation
- An awareness of helpful & unhelpful things to say to someone with an eating disorder (see Resource B).

See Section 4.1 for training and resources to assist with developing these skills.

## 2.2 Basic Counselling Skills

Counselling assists the individual to move away from disordered eating thoughts and behaviours, and to develop a healthy relationship with food, eating and the body. The process depends on the patient forming a trusting, professional relationship with the clinician and the clinician showing a genuine interest in the whole person. Good counselling skills, in line with general nursing skills, will help the engagement process, including the individual's engagement with management on the ward.

LISTEN WELL. Employ active listening skills such as asking questions to get more information and use reflective or summarising statements that are designed to demonstrate that you are interested in the person.

Be RESPECTFUL of the person's emotions, culture and personality. When there is evidence that certain beliefs are maladaptive, these can be discussed respectfully with time, using questioning to help the patient to gain insight.

GENUINE POSITIVE REGARD. Being able to experience and convey a positive regard for the patient will aid rapport and trust. This will also enable you to discover and focus on their strengths, which can be used as coping strategies, as well as for them to feel comfortable with being honest with you.

EXPRESSING EMPATHY. Empathy means forming an emotionally based understanding of some aspect of the other person's emotional experience or their opinion about things. It is similar to putting yourself in their shoes (e.g., imagine living at home, interacting with parents, dealing with friends at school).

Show an INTEREST in how they are feeling and other issues in their life. While the main focus of any admission (in AN) is to restore weight and other health factors, it is helpful to convey that the team is concerned with more than weight. For example,

"We know that you're very distressed about what we're getting you to eat in hospital, and because weight gain is essential for your physical recovery we can't actually change that but we still absolutely want to know how you are feeling about that and will do what we can to help you to manage that."

Help them to utilise distress tolerance strategies. Given that the refeeding process is highly stressful for patients, work on personalised distress tolerance strategies with them to help manage their feelings (e.g. distraction, mindfulness, relaxation etc.)

TRUST. There are several ways that trust can be formed, including the discussion of confidentiality. Demonstrate to your patient in real ways, over time, that you mean what you say and say what you mean e.g. being clear about what you can and cannot do for the patient.

LISTENING. This involves using the 'micro skills' of verbal and non-verbal communication to demonstrate that you are interested and listening. These include things like nodding one's head, body posture (open and oriented to the person), appropriate eye contact, and verbal gestures. It can also be useful to use open questioning techniques such as "Can you help me to understand …better?" and "How is … difficult for you?" when engaging in this process. For example, "It sounds like you are finding it tough to follow the meal plan".

REFLECTIVE LISTENING. This refers to the way the clinician reflects back some of the things the patient is saying.

1. It demonstrates interest in the patient (e.g., "Aha. I see. So what you are saying is…").
2. It demonstrates empathy (e.g., "I can tell from what you are saying – given how you feel – that gaining two kilos REALLY is a scary thing that you want to avoid at all costs").
3. It provides an opportunity to clarify what the person's thoughts and feelings are (e.g., "It sounds like when I told you that you need to gain one more kilo, you felt scared and angry at the same time, is that right?" and "So you are saying that having the nasogastric tube makes you feel out of control and that we don't care about what you want, is that right?").

## 2.3 Externalising the Patient from the Illness

It is helpful to separate the person from the eating disorder. This emphasises that it is the eating disorder that is the problem, not the person living with it.

Patients often view the eating disorder as one of the few aspects of their lives that is actually working – it seems to help them fulfil important needs, such as the need to feel successful and in control. Thus, the patient may see the eating disorder as the most valuable aspect of the self. In more extreme cases, the eating disorder is not only seen as a highly valued aspect of the self but is seen by the patient to be their entire self (e.g., "I am an anorexic. I don't know who I would be or what I would feel if I wasn't an anorexic").

Although behaviours associated with the eating disorder are carried out by the patient, the confusion that the disorder is an aspect of their self (rather than a disorder or illness) can make it difficult for them to detach sufficiently from the disorder. Being able to detach from the disorder means that they can evaluate the role of the eating disorder in their life: both the positive and negative aspects. For this reason, a helpful strategy can be to externalise the eating disorder whereby both clinicians and patients are encouraged to talk about the disorder as a separate entity from the patient. Externalisation also enables clinicians to have empathy for patients even when the eating disorder behaviours are very difficult.

In the case of ARFID, the illness tends to be serve a different function (see section 1.2), and is therefore less integrated into one's identity, values and ideal self-image. Therefore, there is less need to utilise externalising language with patients who have ARFID, as they are generally already able to see the illness as separate from themselves. However, clinical judgement and the local treating team's assessment should always guide decision-making about whether or not to use externalising language with this population.

Separating the person from the eating disorder involves speaking about 'the eating disorder', rather than addressing the individual as if the eating disorder is part of them. When discussing treatment plans and goals, talk about the eating disorder as a 'thing' - an entity in itself - that can be controlling of the individual and in some ways harmful.

See Resource C for examples of externalising language when working with people with an eating disorder.

## 2.4 Setting Non-Negotiables and Responding to Resistance

It is important for the treating team to be aware of the 'non-negotiables' of treatment. These may include decisions made by the team as per the collaborative treatment plan, such as re-feeding, meal plans, weight, how much physical activity is allowed, and so on. It is not uncommon for patients to argue about these things.

Ways to respond may include:

- "This isn't my decision (or anyone in particular), it's just what needs to happen. You can have some choice in how it's done though."
- "It sounds like you are doing it tough, and this is really difficult. What do you think could help when it's hard like this?"

## 2.5 Tasks Specific to Nursing Care for Patients with Eating Disorders

### 2.5.1 Meal Support

Food is medicine for patients with eating disorders; therefore, treatment and nursing care for these patients involves meal supervision and support. Staff should sit with patients during meal/snacks to monitor intake, offer support and assist to normalise eating patterns and behaviours. If necessary, staff should prompt patients to finish their meal or cease abnormal eating behaviour with the aim of normalising eating patterns and promote recovery. Being observed while eating is often uncomfortable and at times distressing for patients. It is important that meal support and supervision is done discretely and in a way that respects the patient's privacy particularly if other staff and patients are present during the meal.

Patients may experience high levels of distress at mealtimes, which can make it difficult for them to focus on the task at hand, i.e., eating. Importantly, this distress may not always be overt but may be present as appearing 'shut-down', detached and unreactive. It is therefore important to remain focused on helping the patient to eat and containing the patients' and one's own anxiety. Conversations about what to expect before meals will reduce anxiety and confusion. See Resource E for specific strategies to support meal supervision in an inpatient setting. Staff can role model normal eating behaviours by joining the patients for meals. This can have benefits for patients, but it is not mandatory, and staff can be supportive without this practice.

### 2.5.2 Weighing the patient

Patients are often highly anxious about being weighed. Weighing should therefore be done in a sensitive and standardised manner, twice per week on the same, calibrated scales.

- Weighing is an essential part of treatment.
- Patients should be weighed twice per week first thing in the morning, after voiding in gown and underwear (no bra, socks, shoes, hair accessories or heavy jewellery).
- Weighing can be extremely anxiety provoking for the patient. Distraction and distress tolerance/reduction methods should be utilised. It is helpful to discuss with the patient what they find helps their anxiety or distress early in admission, (e.g., do they prefer conversation or none, activities for afterwards such as crosswords/knitting or sensory distraction such as music or ice).
- If you suspect the weight has been falsified (water loading, secreting weights in underwear), share concerns with team and document. In this instance a specific gravity and /or 'spot weigh' should be conducted.

    - A spot weight involves weighing the patient at a time when they are not expecting to be weighed.
- In some cases, 'blind weighing' may be collaboratively decided upon, which involves withholding the weight from the patient. This may be helpful in early stages of treatment/rehydration when weight will fluctuate. The team should agree on the weight approach and document clearly in the treatment plan and progress notes to avoid confusion.

# 3 CONSIDERATIONS FOR 1:1 NURSING FOR PATIENTS WITH AN EATING DISORDER

In the early stages of treatment and/or when medical or psychological risks are identified, patients with an eating disorder require high levels of supervision through 1:1 nursing to enhance the assessment, stabilisation and initiation of treatment. LHDs/SHNs will have policies and protocols regarding the provision of 1:1 supervision and these should be adhered to. The scope of this document is to provide specifics and strategies for the provision of 1:1 nursing (often referred to as therapeutic supervision or care levels) for patients with an eating disorder in medical settings.

## 3.1 Safety

- The role of 1:1 nurse (or 'nurse special') is to support the patient to receive treatment for a life-threatening illness – this involves:
    - Ensuring they are receiving treatment, through nutritional rehabilitation, (either via a nasogastric feeding regime or an oral meal plan)
    - Medical monitoring and assessment of medical risk
    - Ensuring adherence to treatment by observing for treatment interfering behaviours
- The nurse special will also support and monitor the psychological symptomatology associated with eating disorders, which may include suicidal ideation, and self-harm that may fluctuate with the re-feeding process.
- The nurse special will monitor the patient for agitation and distress, particularly at high-risk times such as during or after meals or during weighing and provide support. The nurse special must be supported by the broader team and Consultation Liaison Psychiatry service when available.
    - Minimise risk by sweeping the bedside for means to self-harm such as ligatures, sharps and removing them. Sweeps should be done discretely and a rationale should be explained to the patient beforehand
    - Request psychiatric review when risk is identified

## 3.2 Monitor Eating Disorder Behaviours

It is important that the nurse special is aware of the potential eating disorder behaviours their patient may engage in. Every patient is an individual, and so their illness will present in different ways and the ways in which they struggle will also vary. As outlined in Section 1, eating disorder behaviours, can be a reaction to a perceived threat to what has become a very important and often long held coping mechanism. Patients may feel shame about these behaviours - they may become argumentative, or they may deny it when confronted.

When approaching someone who is engaging in these behaviours, convey empathy and provide containment by gently reminding them of their treatment goals, providing a rationale, (e.g., they are on bed rest because they are bradycardic), and utilise the skill of externalising by separating the person from the illness to reduce shame and allow for clinician objectivity.

Eating disordered behaviours should be documented in the treatment plan when this is developed if they are already known. If there is rapport, the nurse could explore these behaviours with the

patient and add to the treatment plan. See Resource A for a description of treatment interfering behaviours and their management.

### 3.3 Documentation and Communication with the Team

Medical monitoring and supervision requirements are to be conducted as per the collaborative treatment plan, documented and handed over to the team at regular multi-disciplinary team meetings, as well as to the allocated Registered Nurse and nurse providing the 1:1 nursing care.

Documentation and handover should include:

- All food and fluid intake
- Observations
- Medication (including compliance and side effects)
- Weight
- Nasogastric feeding regime (including if patient has tampered with same)
- Bowel charts
- Eating disorder behaviours (see Resource A for description of behaviours)
- Mood, affect or engagement changes
- Expression of self-ham urges or suicidal thoughts
- Interventions used to support, reduce distress or compensatory behaviours
- All physical activity, movement and fidgeting

### 3.4 Bathroom Supervision

If bathroom supervision has been prescribed by the treating team, ensure the patient (and family/carers), are aware and provide a rationale. Explain that this is for their safety and to ensure treatment will be effective and remind them that this is a temporary measure.

Unless a patient has been prescribed arm's length 1:1 supervision, in which case the nurse must remain with the patient at all times, bathroom supervision may be done sensitively by keeping the door ajar and having the patient in one's peripheral vision in order to see if they are engaging in activity, purging or tampering with the feed. It is important to adopt a trauma-informed approach to bathroom supervision, which considers the patients' potential trauma history and need for emotional safety and personal boundaries, while balancing this with the need to assist them to contain life-threatening eating disorder behaviours. Being supervised while using the bathroom is often highly distressing for patients and can feel like an invasion of privacy, despite its necessity in some cases to interrupt eating disorder behaviours. Maintaining the patient's privacy as much as possible (e.g., by keeping the door ajar as to wide open) during the supervision is therefore important. Explaining the rationale and what bathroom supervision will involve before commencing supervision, as well as taking an empathetic approach are also key.

### 3.5 The Nasogastric Tube and Feed

An important role for the nurse special is to ensure the nasogastric (NG) tube is running at the prescribed rate and is not tampered with. Observe the patient for the following behaviours:

- Removing the NG tube
- Emptying feed (in the toilet, sink, shower, in cups, bed linen)

- Diluting the feed or replacing it with other liquids e.g., tea
- Changing the feed rate or turning it off
- Using sharps to puncture tube
- Using a syringe to draw feedback

Tips to ensure feed is being delivered:

- Inspect NG tube at the start of shifts and as required
- Make sure no flush syringes are left in the room or near the bed
- The tubing should be visible at all times, not covered by clothing or bed linen
- Observe the tube for kinking or holes
- Tape the joins or moveable parts, including the bag to the tube

# 4 SUPPORT FOR NURSES

## 4.1 General Nursing

Caring for this complex patient group can bring up strong emotions for staff. Countertransference is the clinician's emotional response toward the patient. It may be observed as unreasonable dislike or excessive positive feelings towards the patient. Countertransference is a normal experience and is likely to occur when caring for someone who is engaging in challenging and confronting behaviours that often accompany eating disorders. Reflective practice, self-awareness and engaging in self-care is vital to ensure these feelings do not come in the way of delivering therapeutic and professional care or lead to burn out for the nurse. Nurses need organisational support to receive clinical supervision, education/training, and opportunities to debrief with colleagues or with external services such as the Employee Assistance Program, (EAP) available in all LHDs.

Online and face-to-face trainings are available in a variety of packages and can be facilitated via the LHD's Eating Disorder Coordinator. A list of Eating Disorder Coordinators and their contact details is available at: https://insideoutinstitute.org.au/local-health-coordinators.

Some recommended training for eating disorder management includes:
eLearning from The InsideOut Institute:

- Eating Disorder Inpatient Management- Adult
- The Essentials: Training Clinicians in Eating Disorders
- Meal Support in the Hospital Setting

The above online training packages are free for NSW Health clinicians and are provided by The InsideOut Institute. Further information available at: https://insideoutinstitute.org.au/e-learning.

Face-to-Face:

- Inpatient Management for Eating Disorders- face to face training facilitated by The InsideOut Institute. Contact your LHD's Eating Disorder Coordinator for further information.

## 4.2 Nurses Providing 1:1 Care

It is important that the nurse providing the 1:1 supervision receives support from other nursing staff and the broader team. Malnourished patients can present with challenging behaviours, which can be difficult to manage for lengthy time frames. A balance of continuity in care from regular staff with sufficient breaks and alternating staff is beneficial for the patient and staff member. In addition to delivering treatment, the Registered Nurse allocated to the patient, is responsible for providing the special nurse with handover, updates and ensuring they have breaks and opportunity to debrief if needed.

## 4.3 Service Support

All LHDs in NSW have access to the NSW Eating Disorders Outreach Service. The Outreach service will support medical and mental health teams in treatment planning and management for patients with an eating disorder through clinical consultation, multidisciplinary case conferences via tele-health and education and training. If you require clinical support or advice regarding a patient with an eating disorder, you can ask your LHD's Eating Disorder Coordinator to assist you to access this or contact: The NSW Eating Disorders Outreach Service via the intake clinician for the Peter Beumont Eating Disorder Service on 0484 346 291.

## RESOURCE A – MANAGING TREATMENT INTERFERING BEHAVIOURS

### Approach to Treatment:

- Requires understanding, planning, consistency and unwavering confidence.
- Patients will struggle when limits are placed on their eating disorder, regardless of the most thorough planning and efforts (as that is the nature of the illness), but structure and predictability will provide containment and lessen distress.
- Document in care plan, local weighing guidelines and the nutrition management plan to promote a coordinated and consistent multidisciplinary response.
- Be aware of the potential for splitting within the team, i.e. when the illness sees an opportunity to split the team approach - this can be an issue when there are inconsistencies in practice.
- 'Reframe kindness'

| BEHAVIOUR | RECOMMENDED MANAGEMENT |
|---|---|
| **Restriction/food:** hoarding food, disposing of food (e.g. in pockets, in the toilet, in bed clothes, serviettes, pot plants), choosing low calorie or diet foods, chewing gum, picking at food, cutting food up into small pieces, eating at a very slow pace, chewing & spitting food out, regurgitating food & then re-swallowing, food refusal. | • Validate struggle and distress<br>• Redirect to shared goals - leave/discharge<br>• Provide psychoeducation; regarding effects of starvation, comorbid psychological and medical complications, the need for adequate variety of food to correct nutrient deficiencies<br>• Meal support as therapy/coaching<br>• Enteral feeding regime - replace blocked/removed tubes and missed nutrition predictably and promptly |
| **Fluid:** excessive or inadequate fluid intake, consuming diet soft drinks, consuming significant quantities of artificial sugars in drinks as well as drinks that have a laxative/diuretic effect. | • If you have concerns someone is consuming excessive fluids, increase overall supervision or if required implement 1:1 nursing. For inadequate fluid seek a plan from the medical team as IV or NG hydration may be required.<br>• In consultation with dietitian, limit non-nutritive beverages e.g: tea and coffee. |
| **Activity:** excessive movement (shaking/jiggling legs), pacing around bedroom or ward, secretive exercise (in bathroom, sit ups in bed or leaving the ward to go for walks/runs), excessive standing. | • Outline levels of activity clearly in care plan; if medically unstable this will be none<br>• Provide supervision and have consistency within the team<br>• Conduct spot heart rate<br>• Handovers/communication<br>• Counselling, be goal oriented towards weight gain/recovery |
| **Bingeing:** consuming excessive food in a discrete period of time (e.g: consumed on leave or gate leave and/or purchased on leave and hidden on ward), non-meal plan/non-hospital food observed in patient's possession | • Meal plan and hospital food only (unless otherwise prescribed by dietitian)<br>• Promote regular eating<br>• Develop plan with patient to identify triggers, high risk times with support plan/distraction techniques |

| | |
|---|---|
| | •Increase overall supervision or if required implement 1:1 nursing. |
| Vomiting: the eating disorder will force the person to look for opportunities to purge (e.g., in pockets, the bathroom, cups or bags, pot plants or vases) so try to minimise vessels in the room and be aware purging can be silent.<br>Vomiting may also be seen in patients with ARFID due to sensory issues, difficulty tolerating feelings of fullness or fear of choking. | • Supervision<br>• Restrict fluids with and post meals<br>• Lock bathrooms, limit access to sinks<br>• Awareness of other areas, e.g., pockets, drawers, bed linen, skip<br>• Pathology (Potassium, Amylase)<br>• Conduct searches<br>•Validate struggle and distress. Assist the patient to use distress tolerance strategies to resist the urge to vomit |
| Regarding nasogastric feeds: compromising nasogastric feeds by removing tube, emptying feed (in the toilet, sink, shower, in cups), diluting the feed, changing feed rate or turning the feed off, using sharps to puncture tube, or a syringe to draw back on tube. It is recommended that to decrease the opportunity and urge to tamper with the tube feed, you tape the joins or moveable parts of the tubing (including the bag to the tube). | • Inspect NGT at the start of shifts and as required.<br>• Make sure no flush syringes are left in the room or near the bed.<br>• The tubing should be visible at all times, not covered by clothing or bed linen.<br>• Observe the tube for kinking or holes.<br>• Tape the joins or moveable parts, including the bag to the tube. |
| Weight: methods of weight falsification include fluid loading (increasing fluid intake the day prior to & the day of weighing), increasing salt intake prior to weigh days, hiding heavy objects on body (putting batteries in underpants/bra), gripping the scales (e.g: with toes). | • Follow weighing guidelines (first thing, post void, hospital gown)<br>• Spot weighs if concerned (be transparent and use non-judgemental language)<br>• Specific gravity and sodium levels |
| Medications: self-medication of laxatives, diuretics and diet pills. | • Provide psychoeducation regarding the effects of self-medicating- physiological, ineffectiveness overall at weight and shape control, maintenance role in over-valuation weight and shape and its importance<br>• Set limits and non-negotiables on restricted access to medication, and clearly communicate this to patient and family/carers (so that family/carers understand importance of not providing access to these medications when visiting/when patient is on leave)<br>• In collaboration with treatment team, consider conducting searches of patient belongings to check for medications for an agreed upon period of time. Explain rationale to patient and family/carers before implementing (i.e., to help them to reduce reliance on self-medication) |

## RESOURCE B – HELPFUL & UNHELPFUL THINGS TO SAY TO SOMEONE WITH AN EATING DISORDER

| UNHELPFUL SAYING | MORE HELPFUL SAYING |
|---|---|
| *"You better eat your meal, otherwise you'll be scheduled"* or *"You better stop pacing otherwise you'll get in trouble"*<br><br>Try to refrain from making threats and taking an authorative stance. This will only alienate the person, and will reinforce to them that you have little understanding of their illness. | *"Finishing your meal will be a great step forward in showing your eating disorder that you are in charge"*<br><br>*"I know how hard this is for you but finishing your meal will be a great step towards getting out/going home"*<br><br>This puts the control and power in the hands of the person and links it to their goals and provides hope. |
| *"Just eat"*<br><br>This reinforces to the person that you have little understanding of their illness and how difficult it is to overcome. Always remember that eating a meal is their phobia. | *"Why don't you try to take a few more bites– we can see what a struggle this is for you but remember we're trying to get you to a safe place and get you home"*<br><br>This provides encouragement and support, but still allows the person to make their own decision. |
| *"You don't look that sick"* or *"you don't look like you have an eating disorder"* or *"you look good/well"* or *"you look healthy to me"* or *"you're looking so much better!"*<br><br>This reinforces to the person that they are not sick enough, not good enough, are fat, and any comment about the person's appearance, body, weight or shape will fire up the eating disorder. | Try not to comment on the person's physical appearance. This emphasises the importance of appearance and almost always will be misinterpreted and will fire up their eating disorder regardless of your good intentions and leaves the patient thinking and feeling he/she is fat. Don't go there. |
| *"You've barely gained any weight"* or *"Oh great, you've gained weight"* or *"Oh dear, you've lost weight again!"*<br><br>This reinforces to the person the importance of weight, and highlights that you are judging them based on their weight. | Try to refrain from making any comments about the number on the scale, the person's progress or lack there of. This can be managed by the team. |
| *"I wish I had a bit of Anorexia in me"* or *"I wish I could lose weight like you can"*<br><br>This is insensitive and highlights your lack of understanding of the horrors of this illness. These types of comments glamorise and idealise the illness. No one 'chooses' to have | Try to refrain from making any comments about the person's weight or appearance. Regardless of your good intentions this will only trigger the person's eating disorder. |

| | |
|---|---|
| an eating disorder. Keep in mind the high rate of mortality & suicide in people with eating disorders. | |
| *"I'm also gluten free" or "I'm trying to lose weight for my friends wedding"* or *"I'm trying this new detox"*<br><br>Talking about your own diet is inappropriate, and reinforces to the person that 'dieting' or cutting foods out is 'normal'. | Try to refrain from making any comments about your own weight, diet or exercise patterns. Regardless of your good intentions this will only trigger the person's eating disorder. |
| *"Why won't the team let you exercise, exercise is healthy"* or *"I go for a 45 minute walk everyday"*<br><br>When you agree with the person on a topic (even if you are just trying to be empathic) against a team decision it 'splits' the team. This gives power to the eating disorder to work against the person and the team. | If you may do not agree with team decisions, raise this with the team or seek clarification from the team as to their rationale. Do not raise disagreements on team decisions with the patient directly. |
| *"I can't believe the Dietitian makes you eat dessert everyday, that's not healthy"* or *"Hospital food is so fatty, I wouldn't want to eat that either"*<br><br>This 'splits' the team, infers that you know better than the Dietitian and team and creates inner turmoil for the person. This will result in the person either refusing to eat the entire meal or feeling horribly guilty for having eaten. | *"The Dietitian is there to work with you not against you. Trust her/him. She/he knows what will be medically safe for you. Let's try to trust them and take each day at a time.'*<br><br>Try to refrain of making any comments about the person's food, their meal plan and your own food/taste preferences. <u>Always support the decisions of the team</u>. Show the person that you are all a united front in fighting their eating disorder. |
| *"You're back again"* or *"That wasn't long between admissions"*<br><br>This will make the person feel that they are a failure and not worthy of treatment, and that you have no belief in their ability to get better. | *"Good to see you, let's find some time today to talk about your goals for this admission"*<br><br>Focus on what small steps the person made between admissions. Always maintain 'hope' for the person's recovery. |
| *"The doctor wants you to be a BMI of ……."* | Do not at any stage discuss the weight goal and be mindful not to pass on such information to the person. Leave this to the team |
| Ignoring small progress | For instance, after a meal acknowledge progress carefully:<br><br>*'I know that's been a real struggle – it is so hard but you've done really well"* |

| | |
|---|---|
| Doing or saying nothing after meals | '*I can see how hard this has been. Would you like to do some knitting or what about watching (for instance) 'Game of Thrones''*<br><br>- Offer a distraction of some sort and try to encourage such activity.<br><br>Such a comment may or may not work depending on the person but to be quietly distracted after a meal is very helpful as that is when the thoughts are at their worst. |
| *"Do you want to have breakfast*?" (this could equally apply to lunch or dinner) | *"How about giving breakfast a go? I know you don't feel like it but just give it a try".* |
| Saying to other staff "*Well she/he is not eating very well/ she is not doing what she/he is meant to"* | When relaying information to doctor/nurse about oral intake be mindful to use similar language – *"Patient X trying to get through her meal. It's a struggle but she/ he is trying"* |
| *"You've been 100% compliant"*<br><br>This is somewhat demeaning and makes the person feel like a naughty school child. | *"She's done really well so far' – it's so good to see her trying."*<br><br>This is respectful and acknowledging. |
| *"I need to see everything I will be watching"* | Try to be respectful when observing a person. *"I'm aware this is difficult for you with me watching and I'm sorry if that adds to your distress. I've just been reminded that I need to observe. I'll try to be as discreet as I can be"* |
| When handing over to the nurse special<br><br>*"You have to watch the food"*<br><br>This makes it seem and feel more scary and heightens the anxiety around the experience | *"Please support the patient to do their very best to complete the meal as set out on the meal plan"* |
| Standing over/ hovering over the person when meals are taking place and saying, *"I have to do this – it's my job"*<br><br>This stance does not contribute to ensuring safety and can increase anxiety. | The person needs to know that the role of the nurse special is to ensure their safety.<br><br>Be discreet as you observe from an appropriate distance and engage in some conversation during the meal so as to lessen the anxiety and punitive experience of observed eating (this may be rejected – obviously it depends on the individual patient). |

## RESOURCE C- USING EXTERNALISING LANGUAGE

It is helpful to separate the person from the eating disorder. This emphasises that it is the eating disorder that is the problem, not the person living with it.

An eating disorder can be a very strong driving force that can cause a person to behave in ways that are not usual for them. This many involve secrecy and lying, and even aggression, frustration and anger. This may also involve self-destructive behaviours that are seemingly irrational, such as a refusal to eat and compulsive exercise. This can be difficult to understand for both the person with the eating disorder and their loved ones.

Separating the person from the eating disorder can help you to see the eating disorder as having a separate voice and thinking pattern to the individual. This will help the individual to feel that the eating disorder is the problem and will provide relief that they are not the problem. This helps to remove feelings of blame, guilt and shame, and means that the individual may be more open to confide in you about what is happening for them.

If the eating disorder can be seen and addressed as separate from the person, it means that together you can stand and look at the problem. You can develop more of an understanding of the eating disorder and its intricacies whilst not judging the individual. This will help the individual to consider what they actually think about what the eating disorder is saying and will help them to begin to challenge it. Separating the person from the eating disorder involves speaking about 'the eating disorder', rather than addressing the individual as if the eating disorder is part of them.

### Examples of Externalising the Illness

### General Comments:

- "Our job is to give you back some control over the 'eating disorder' and keep you healthy no matter what."
- "You are here because the 'eating disorder' has made staying healthy impossible for you."
- "What does the 'eating disorder' tell you about yourself?"
- "We've spoken about the ways that the 'eating disorder' can seem like a best friend to you. I wonder if you can see any ways in which it is making life harder for you?"
- "It sounds like the eating disorder is tricking you again. What do you think?"
- "It seems like the eating disorder is making things really hard for you at the moment. That must be difficult for you."

### During Meal Support:

- "Has the eating disorder played any tricks on you or tried to trip you up in any way during this meal?"
- "How much of the time is the 'eating disorder' in control of what you're eating?"
- "I can see that the eating disorder voice is really loud at the moment. What can we do to help you to be wiser and cleverer than the eating disorder in this moment?"
- "Don't let the eating disorder win. Food is medicine. You need to take another bite."

## RESOURCE D- DISTRESS TOLERANCE STRATEGIES

Managing distress is an important part of treatment. Being in hospital is often distressing both for the patient and their family and/or support network. Recognising distress requires close attention, as distress felt by the individual may not always be evident or demonstrated directly, e.g., anger may be expressed when feeling sad, rather than crying or looking upset. Sometimes, distress is expressed in problematic behaviour.

People with an eating disorder may experience distress due to the fear of the treatment, particularly weight gain and reduction of exercise, denial of illness, interactions with the treatment team or other patients on the ward, low self-esteem or comorbid psychiatric illness.

### Distress can be managed as part of a ward program as follows:

- Reassure the patient and their next of kin that treatment is for the safety and wellbeing of the patient. Involve the patient and their family/support network in discussions and decision-making.
- Identify difficult times or situations (e.g., the evening meal) and assist with strategies to manage distress. Document these as part of the management plan and intervene early to avoid escalation of distress.
- Interpret behaviours as an understandable response to a perceived threat (rather than personally motivated). Externalise the eating disorder and other problem behaviours (the person is not the problem; the problem is the problem).
- Teach strategies to cope with distress, e.g., distress tolerance (see below), and relaxation skills.
- Encourage the patient to express emotions in a healthy, appropriate manner.
- Provide a structured plan for the day.
- Encourage regular visiting and phone support from appropriate family and friends within the treatment guidelines.
- If medically stable, incorporate regular short periods of supervised leave.
- Conduct regular risk assessments.
- If the patient becomes a risk to their own or others' safety, consider 1:1 nursing care or in extreme cases use of the Mental Health Act and transfer to a secure unit.

### Examples of strategies to teach patients to cope with distress include:

- Distraction: Help the patient engage in a distracting activity such as:
    - Board games, card games, puzzle, crossword
    - Colouring in books
    - Talking to a friend
    - Crocheting or knitting
    - Television
    - Reading a book
- Pros and Cons:
    - Encourage the patient to make a list of the pros and cons of acting on their urges to engage in eating disordered behaviours. These might be to engage in restriction, binge-eating, purging; or they might be to give in, give up, or avoid doing what is necessary to recover.

    - Make another list of the pros and cons of resisting urges to engage in eating disorder behaviours—that is, tolerating the distress and not giving in to the urges
- Paced breathing: teach the patient to pace their breathing by slowing it down:
    - Breathe deeply into your belly
    - Slow your pace of inhaling and exhaling way down (on average, five to six breaths per minute)
    - Breathe out more slowly than you breathe in (for example, 5 seconds in and 7 seconds out)
- Paired muscle relaxation: teach the patient to calm down by pairing muscle relaxation with breathing out:
    - While breathing into your belly deeply tense your body muscles (not so much as to cause a cramp).
    - Notice the tension in your body.
    - While breathing out, say the word "Relax" in your mind.
    - Let go of the tension.
    - Notice the difference in your body
- Altering body temperature:
    - Hold a cold pack (or zip-lock bag of cold water/ice cubes) on your eyes and cheeks. Hold for 30 seconds.

References:
Kambanis PE, Kuhnle MC, Wons OB, Jo JH, Keshishian AC, Hauser K, Becker KR, Franko DL, Misra M, Micali N, Lawson EA, Eddy KT, Thomas JJ. Prevalence and correlates of psychiatric comorbidities in children and adolescents with full and subthreshold avoidant/restrictive food intake disorder. Int J Eat Disord. 2020 Feb;53(2):256-265. doi: 10.1002/eat.23191. Epub 2019 Nov 8. PMID: 31702051; PMCID: PMC7028456.

## RESOURCE E- STRATEGIES TO SUPPORT MEAL SUPERVISION IN THE INPATIENT SETTING

Mealtimes can be one of the most distressing parts of treatment for the patient. It is important to have consistent structures in place around mealtimes and to communicate them to the patients and their carers/families at the outset of treatment. It is also imperative that the rationale for these guidelines are clearly explained so they do not come across as punitive but rather as a necessary and helpful part of treatment. Below are some examples of the type of information you might provide to patients about mealtimes and the reasons for specific guidelines:

| MEAL GUIDELINE | RATIONALE |
|---|---|
| Only food prescribed by the dietitian is to be consumed | The dietitian has calculated all your body's requirements for re-nutrition. Adding in or taking away foods makes it difficult for us to determine how to modify the meal plan. Talk to the dietitian about your food preferences and we will try and accommodate these as much as possible. Families, please remember, no food from home – including teas, coffee, water, soft drinks, food, fruit, dessert items, chocolate etc. If you are unsure, please speak to the nursing staff. |
| Meals will be delivered to the nursing staff, not directly to the patient. | Nursing staff understand that mealtimes can be difficult and that the eating disorder might try and influence you to dispose of food or hide food. The nurse will sit with you while you eat your meal, to support you and to help distract you from the eating disorder thoughts if necessary. |
| The nurse will record all the food you eat (the type of food and the amount) | We want to make sure you are eating a balanced diet and that if supplements are needed, that we record those too. As above, your meal plan has been calculated to meet your nutritional needs. |
| If you can't finish your meal, uneaten food will need to be replaced by a supplement. | The dietitian will outline how many supplements you need to have as part of your regular diet. This may vary depending on the stage of illness, how much you are able to eat, whether you are having any nutrition through a nasogastric tube, your weight gain etc. Talk to the dietitian about your preference for type of supplement. The nurse who sits with you during the meal will follow the dietitian's instructions around replacing food with supplements. |
| There will be an allocated amount of time for each meal: main meals = 30 minute; snacks = 15 minutes | Meals and snacks are to be eaten within the timeframe outlined. Having regular meals helps the body to repair damage that has been done by starvation. One of the eating disorders strategies is to get people to prolong the meal for as long as possible… we want to help you to reduce the eating disorder's influence over your behaviours. |
| Use appropriate cutlery | Another of the eating disorders tricks is to make demands around the type of cutlery you use – for example, using teaspoons for main meals. Returning to normal eating behaviours is possible and that means changing what you do in response to the eating disorders demands. |

## Summary of the meal support process:

### 1. Maintain an empathic and non-judgemental approach

Ensure your tone of voice is calm, firm and warm.

- Lower the tone of your voice
- Be patient, kind, gentle and firm
- Be positive, focus on positive reinforcements rather than punishment
- Remember how excruciatingly difficult this is for the patient
- Keep your focus on finishing the meal

### 2. Validate distress

If the patient is distressed, scared, upset or angry, validate their experience.

- “I can see that this is really difficult for you right now.”
- "I know it is hard. But look how brave you are standing up to the eating
- disorder."
- "I know you can do it, and I am here to support you."
- "I can see you are hesitant to eat any more. Take a deep breath in with
- me and a deep breath out."
- "This is so tough, but you are ok, you're getting through it."

### 3. Support the patient to eat more

Explain to the patient that you are going to help them get through their meal or snack.

- “I’m going to stay right here and help you get through this. Can you pick up your fork and have another bite?”
- "Pick up your fork... now take a bite."
- "You need to eat some more, can you try take another bite. Let's try now."

### 4. Validate progress and provide encouragement

Encourage the patient with positive reinforcement to keep going.

- “That was great, well done. Now, can you have another bite?”
- "You are so brave. Keep going."
- "You are doing such a great job so far, let's keep it up."

### 5. Avoid negotiating with the eating disorder

Deflect any negotiations for discussion with the team at a later date and refocus on finishing the meal.

- Be familiar with the hospital's meal guidelines and abide by these
- "I understand that you think this is too much food, but this is what has been specifically prescribed for you. Let's focus on finishing this meal, and when the team comes in you can speak to them about it."
- "The Dietitian has individually tailored this meal plan for your specific health requirements. It is important that you finish it."
- "This food is medicine for your body."
- "I can't make any changes to your meal plan, so let's focus on eating what is here."

### 6. Refocus on their goals of treatment

If the patient is unable to eat more, help them to refocus on their goals of treatment.

• “Can we take a step back from this meal right here and think about your goals. Is completing this meal going to help you to achieve your goals”

• "Is completing this meal going to get you one step closer to discharging?"
• “Can I help you to get through this meal? Let’s start by taking another bite – you can do it.”

### 7. Encourage normal eating behaviours

Provide gentle reminders or instructions to prevent the patient from engaging in eating disorder behaviours.

- "Rather take bigger bites please."
- "It's more normal to use your hands to eat your muesli bar, can you put down the knife and fork."
- "Please don't break up that piece of toast into more than 4 pieces."
- Maintain a supportive tone of voice

### 8. Address eating disorder behaviours aimed to minimise food intake

Deal with eating disorder behaviours in the moment as they occur.

- "Please don't smear food in your napkin, here I'll take the napkin until you are finished."
- "Please pick that up from your lap and put it back on your plate."
- "Please take off your jumper so that you cannot use your pockets to hide food."
- Maintain a supportive tone of voice

### 9. Provide distraction

Distract the patient away from the distress of the meal when they are eating.

- Engage in light conversation
- Trivia questions, a puzzle or card game
- Music
- Radio, audio books or television if necessary

Find the balance between providing distraction but always remaining focused on the task of completing the meal.

### 10. Stay focused on completing the meal

Whilst providing support, distraction and monitoring eating behaviours, remember that the goal is to complete the meal.

- Keep an eye out for delayed breaks between mouthfuls, playing with food
- or procrastinating eating
- Remember every mouthful counts
- Stay calm, confident, consistent and compassionate

## RESOURCE F- HOW TO DEVELOP A COLLABORATIVE TREATMENT PLAN

### Where to start?

- Collaborative approach: as much MDT involvement as possible at each case conference to write / review each point in the plan
- Consult families, friends and carers as much as the team possibly can in preparing the treatment plan each week
- The degree of collaboration will depend on the patients' level of malnutrition and the effect of this on their brain and thinking.
- General rule of thumb is twice-weekly reviews of the plan to start then can drop back to weekly if treatment is progressing well

### What are some common areas to cover in treatment plans on non-specialist units?

- Date the plan; give a copy to the nurse special (if there is one) at the start of each shift if there; place a copy in the patient file; give the patient a copy plus their carers / family members if patient consents, to minimise repetitive questions from the patient - their brain is starved and it is normal for them to have deficits in short-term and working memory, planning and problem-solving
- Any changes to the treatment plan over the next 7 days e.g. "Julia will remain on ward A until Wednesday 23 March, when she will be transferred to ward B, providing she is medically stable. If not medically stable, Julia will remain on ward A indefinitely."
- Some kind of statement about when the teams are next meeting to review the treatment plan and when the patient and family will have an opportunity to ask questions of the team about the plan.

| Patient Details |
|---|
| • Full name<br>• MRN |
| **Treating Team Members** |
| • Specify which teams are involved in the treatment plan e.g., Staff on Ward A where they are currently being treated; CL Psychiatry; Dietetics; Endocrinology.<br>• Specify if any external clinicians involved.<br>• It may be helpful to specify the clinician's name, designation and contact number |
| **Medications** |
| • Medications – what type and when they will be administered.<br>• PRN medications |
| **Observations and Monitoring** |
| • Frequency and timing of obs, blood sugar levels, bloods and who these results will be communicated to e.g., GP, external psychiatrist<br>• CERS criteria<br>• A statement of whether there is a 1:1 nurse special; if so, where the nurse will sit e.g. "*The nurse special needs to be able to see you, so they will sit next to your bed. Please do not shut your curtain and block their view of you or the area around your bed.*"<br>• Bathroom use if the patient is mobile – what is allowed and what is not; any time constraints if needed e.g., 10 mins for a shower; whether toileting and showering needs to be discreetly supervised or not, if the bathrooms need to be locked. |
| **Nutrition** |

Feeding Regime: Nasogastric feeding /Oral Diet

- State the exact plan e.g., "*NG feeds will run 24 hours/day @ 50ml/hour. No changes to this plan will be discussed until the next case conference on (date). A dietitian will be meeting you on (date) this week."*
- Meals and snacks – state how long the patient has to complete a meal e.g., 30 mins for a meal and 15 mins for a snack; if they are to be supervised by staff, if the tray will be removed when food is not completed, if an oral nutritional supplement drink will be provided in exchange for an incomplete meal.
- If a meal plan has been devised, discuss with the patient whether it's helpful for them to have a copy, if so, provide a paper copy for them to have.
- Whether food brought from home by family / friends is allowed or not
- Whether the patient can have water or fluids outside of mealtimes and if so, how much e.g., one water bottle maximum
- What to do when the patient wants to eat when on NG feeds

## Weighing Practices

- Frequency of weighing, but not specifying a set day
- Specify whether the weighing is to be post-void in hospital gown only
- Specify whether the patient is blind weighed
- Specify whether any feedback will be given about the weight (e.g. increase / decrease / stable or BMI band feedback given

## Patient Goals for Admission

Work with patient to set SMART goals for the week

## Eating Disorder Behaviours

- Discreet exercise in the bathroom
- Bedside hoarding e.g., no food is to be kept from meal trays after a meal or snack
- OCD behaviours
- Tampering with NG feeds or negotiating the nutrition plan e.g., stopping NG feeds overnight; requesting whole meals or specific foods are changed once they are delivered
- Bathroom use
- Physical activity e.g. pacing, walking, standing, long showers

## Distraction Techniques

- Distraction techniques for patients e.g., board games, crocheting, puzzles, knitting
- Distraction strategies for staff e.g., asking the patient to count/sing in the shower if they struggle with purging.

## Patient Risks

- AWOL or absconding risk
- Falls risk
- Mention if a patient requires a wheelchair to mobilise
- Self-harm/suicide risk

## Leave

- Specify if any leave has been granted from the ward; usually no leave is given for at least 1-2 weeks if the patient has been admitted for the medical sequelae of an eating disorder. So a statement such as "*no independent or escorted leave is permitted at the present time due to medical risk; this will be reviewed in the team case conference on (date).*"

## Discharge Planning

- Specify follow-up plan