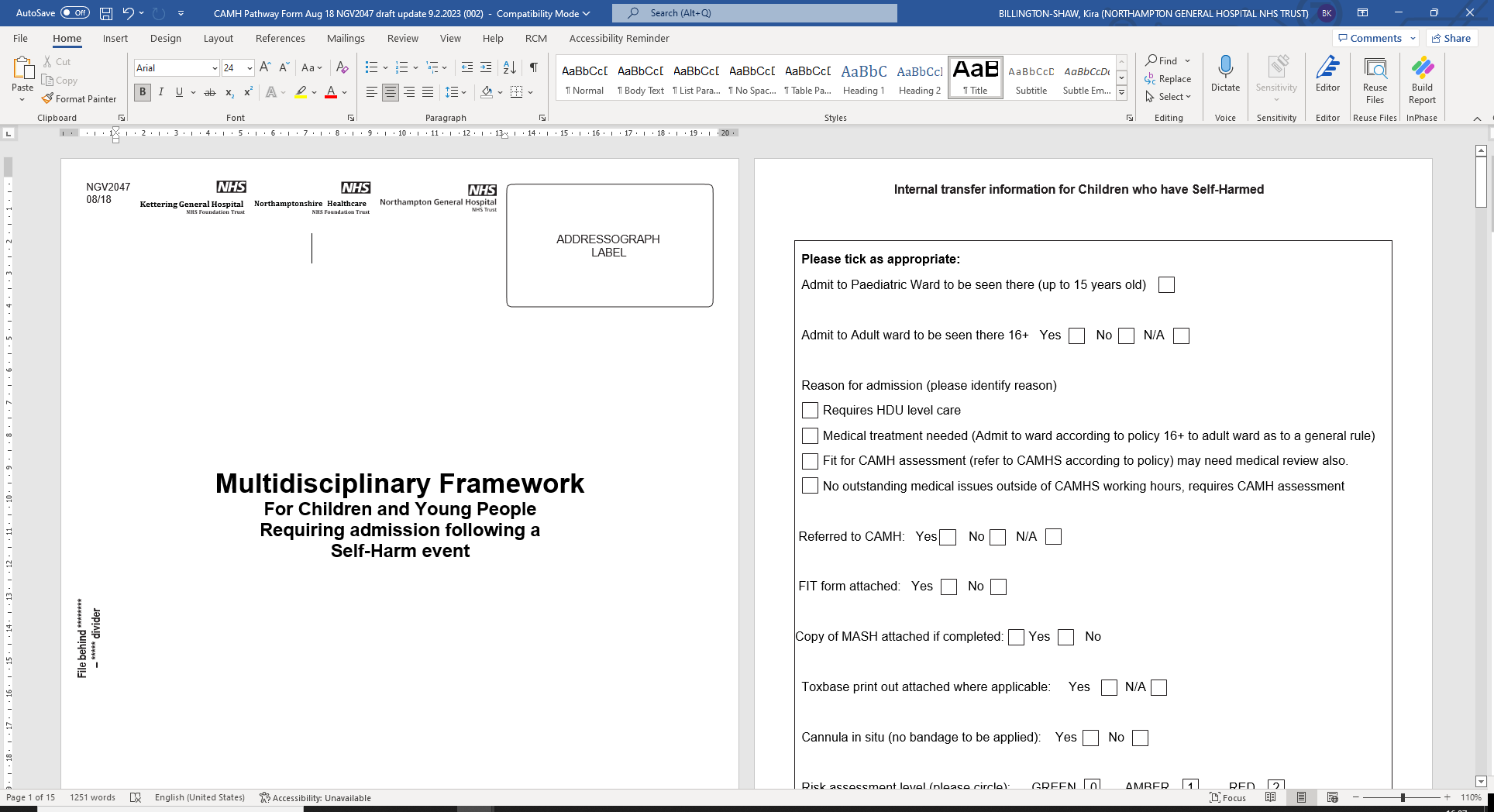
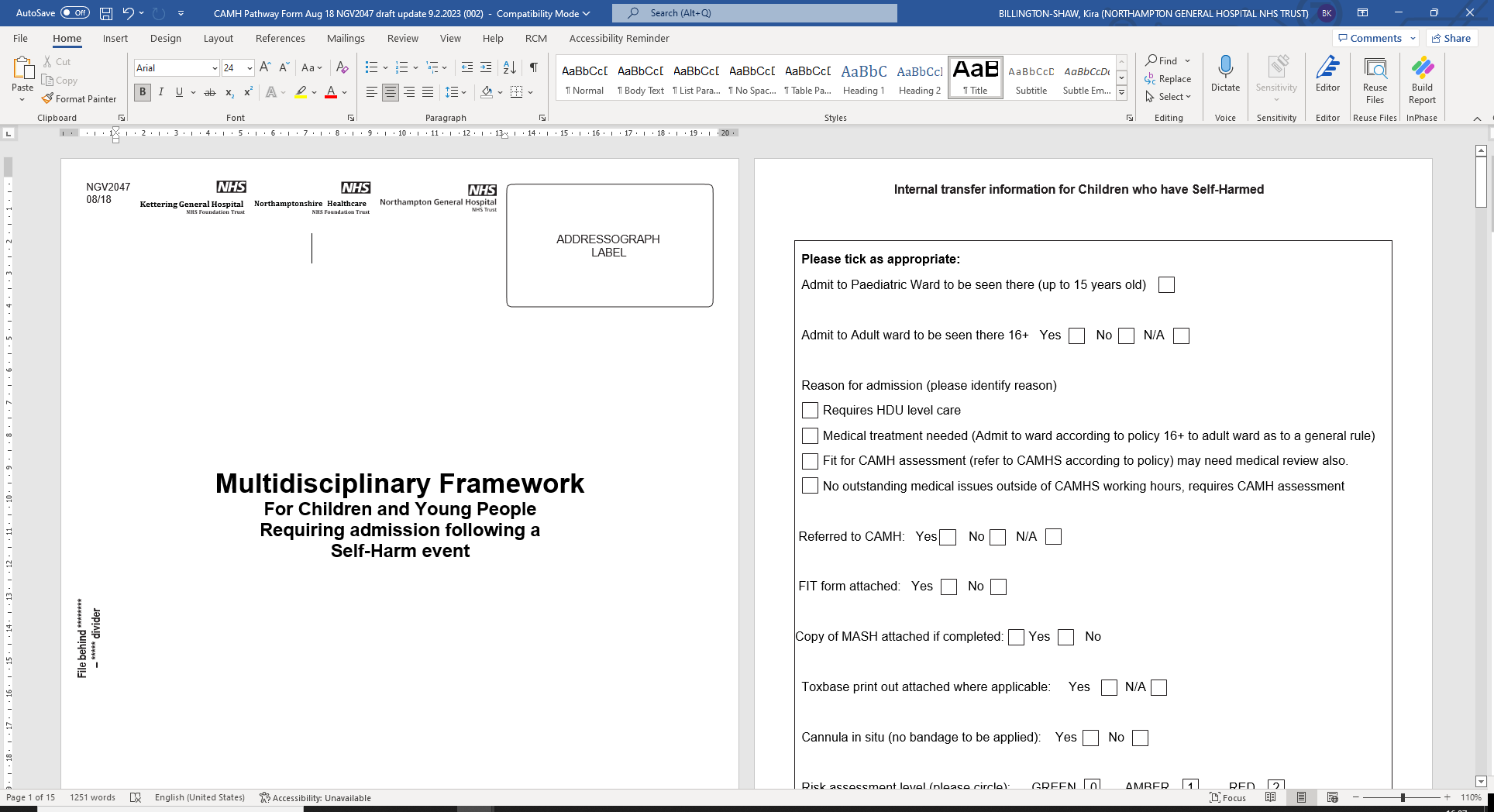
ADDRESSOGRAPH LABEL

**File behind \*\*\*\*\*\*\*\* – \*\*\*\*\* divider**



**Multidisciplinary Framework**

**For Children and Young People**

**Requiring admission for medical stabilization of an eating disorder**

|  |
| --- |
| **Referral information:**  Referred by: ……………………… Date & time: …………………... Designation: ……………………………  Accepted by: ……………………… Date & time: …………………... Designation: …………………………  Reason for admission (please identify reason, consider number of MEED red / amber flags)  Is the young person known to the eating disorder services: Yes ….. No …….. – if no, please refer.  Referral made by: …………………………………….. Date: …………………. Time: ………………..  Risk assessment level (please circle): GREEN 0 AMBER 1 RED 2  (See next page for assessment tool)    Requires enhanced care: Yes / No    Ward advised of level of risk and can meet requirement: Yes / No / N/A  If NO, to be escalated to senior management team/ site team out of hours  CIPS check: Yes / No |

**All patients being transferred to the acute inpatient wards require an initial assessment to determine their initial care needs prior to a full review by CYP eating disorders service (CEDS)**

**Risk Assessment Grid, Management of Medical Emergencies in Eating Disorders (MEED) Guidelines**

|  |  |  |  |
| --- | --- | --- | --- |
| **Risk** | **Green** | **Amber** | **Red** |
| Weight loss and median BMI | Weight loss <500g/week  >80% median BMI | Weight loss of 500-999g/week for 2 consecutive weeks in an undernourished patient  70-80% median BMI | Weight loss of >1kg/week for 2 consecutive weeks in an undernourished patient  <70% median BMI |
| Heart rate (awake) | >50bpm | 40-50bpm | <40bpm |
| Cardiovascular health | * Normal standing systolic BP for age and gender with reference to centile charts * Normal orthostatic cardiovascular changes * Normal heart rhythm | * Standing systolic BP <0.4th centile * Postural drop in systolic BP of >15mmHg or increase in HR of up to 35bpm | * Standing systolic BP below 0.4th centile * Recurrent syncope and postural drop in systolic BP of >20mHg or increase in HR of up to 35bpm |
| Hydration | * Minimal fluid restriction * No more than mild dehydration (<5%), may have dry mouth or concerns re risk of dehydration | * Severe fluid restriction * Moderate dehydration (5-10%), reduced urine output, dry mouth, postural BP drop, normal skin turgor, some tachypnoea, some tachycardia, peripheral oedema | * Fluid refusal * Severe dehydration (10%): reduced urine output, dry mouth, postural BP drop, decreased skin turgor, sunken eyes, tachypnoea, tachycardia |
| Temperature | >36.C | <36.C | <35.5.C tympanic or <30.C axillary |
| Muscular function – SUSS test | Able to sit up from lying flat and stand from squatting position with no difficulty (score 3) | Unable to sit up or stand from squatting without noticeable difficulty (score 2) | Unable to sit up from lying flat, or get up from squat at all or only by using upper limbs to help (score 0 or 1) |
| Other clinical state | Evidence of physical compromise, e.g. poor cognitive flexibility, poor concentration | Non-life-threatening physical compromise, e.g., mild haematemesis, pressure sores | Life-threatening medical condition, e.g., severe haematemesis, acute confusion, severe cognitive slowing, diabetic ketoacidosis, upper gastrointestinal perforation, significant alcohol consumption |
| ECG | QTc <460ml (female), 450ms (male) | QTc >460ms (female), 450ms (male) | QTc: >460ms (female), >450ms (male)  And any other significant ECG abnormality |
| Biochemical abnormalities |  |  | * Hypophosphataemia and falling phosphate * Hypokalaemia (<2.5mmol/L) * Hypoalbumineamia * Hypoglycaemia (<3.0mmol/L) * Hyponatraemia * Hypocalcaemia * Transaminases >3x normal range * Inpatients with diabetes mellitus: HbA1C >10% (86mmol/mol) |
| Haematology |  |  | * Low white cell count * Haemoglobin <10g/L |
| Disordered eating behaviours |  |  | * Acute food refusal * OR estimated intake <500kcal/day for 2+ days |
| Engagement with management plan | * Some insight and motivation to tackle eating problems * May be ambivalent but not actively resisting | * Poor insight or motivation * Resistance to weight gain * Staff or parents/carers unable to implement meal plan prescribed * Some insight and motivation to tackle eating problems * Fear leading to some ambivalence but not actively resisting | * Physical struggles with staff or parents/carers over nutrition or reduction of exercise * Harm to self * Poor insight or motivation * Fear leading to resistance to weight gain * Staff or parents/carers unable to implement meal plan prescribed |
| Activity and exercise | Mild levels of or no dysfunctional exercise in the context of malnutrition (<1hr/day) | Moderate levels of dysfunctional exercise in the context of malnutrition (>1h/day) | High levels of dysfunctional exercise in the context of malnutrition (>2h/day) |
| Purging behaviours |  | Regular (=>3x per week) vomiting and/or laxative abuse | Multiple daily episodes of vomiting and/or laxative abuse |
| Self-harm behaviours |  | Cutting or similar behaviours, suicidal ideas with low risk of completed suicide | Self-poisoning, suicidal ideas with moderate to high risk of completed suicide |
|  | Initial assessment carried out by – Nurse: ………………………………………………………………  Date: …………………………… Time: …………………………… Level: ..…………………………... | | |

**Professionals Involved**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name (PRINT)** | **Designation** | **Signature** | **Initials** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Paediatric Admission Nursing Form**

**Use a new form for each admission**

Parent/carer address: ……………………………………………………………………………………………………………

Telephone Number: ………………………………………………………………………………………………………….…..

|  |  |  |  |
| --- | --- | --- | --- |
| Ward: Consultant: Ethnic code:  Date: Time: Religion: | | | |
| ADRESSOGRAPH LABEL | | | GP:  Practice Name: |
| Have you been a resident in the UK for more than 12 months? Y / N | | |
| Social worker involvement: Yes No School / education:  CAMHS involvement: Yes No Eating disorders team involved: Yes / No | | | |
| **On Admission:** Weight: ……………… kg Height ………………….. cm  Heart rate: …………….bpm (when sat down) Heart rate: ……………..bpm (on standing)  Blood pressure …………….. (when sat down) Blood pressure …………………… (on standing)  Capillary refill………….. PEWS……………. O2 sat level ……………..% Temperature ……………oC  GCS: …………………… Pupil Size …… R …… L Reacting …… R …… L | | | |
| Drugs: | | | |
| Allergies: | | | |
| **Family Structure** | **Name** | **Occupation** | |
| Parent / carer 1 |  |  | |
| Parent / carer 2 |  |  | |
| Parental responsibility: | | | |
| Who accompanied this child today? | | | |
| Any siblings and ages: | | | |
| Who is looking after these children now? | | | |
| Who lives in the home with the child? | | | |

Informed RE: Parents Room Parking Toilets

**Nursing care plan:**

**Bed allocation:**

If there are more than one eating disorder patient on the ward they should be in separate bay’s if possible.

**Pressure area care:**

Observe for signs of discoloration/evidence of skin breakdown daily. Nurse on a pressure mattress if bed rest necessary or pressure sores detected. Skin may be dry, cracked, and broken areas slow to heal. If pressure sores are apparent, referral to a tissue viability nurse is mandatory.

**Weighing and measuring patients**

The patient’s need to be weighed ONLY TWICE A WEEK and weight chart kept away from the patient e.g., in notes trolley or in the nursing station. As many patients will be distressed at finding out their weight and seeing potential weight gain.

Staff to be aware that patients may try to add weight to their clothes / water load (by trying to consume excessive amounts of fluid prior to weighing) and patients are to be weighed in their underwear by a same sex member of staff. No footwear to be worn. Explain the procedure to the young person on admission so they understand what will be expected. Do not make comments about the weight on the scales. Stay neutral with your opinion. General support and distraction is more useful as many patients with Anorexia will be very anxious at this time.

Every patients’ height to be recorded on admission; ensure they are standing straight and not slouched as this can affect BMI / Expected body weight for age and height.

**1:1 nursing**

Registered Mental Health Nurses (RMN’s) or HCA’s can helpful if a patient is at risk of self-harming, suicide or if parents/carers are not able to attend the ward. However, they are not always necessary for all patients if there are no identified risks, and their parents or carers are willing and able to support their child or young person on the ward.

* If a 1:1 member of staff is required, please ensure they read this care plan at the start of their shift to ensure they can support the young person as best as possible.

**Baths and showers**

Baths and showers present a particular risk, as hot water hitting the skin can cause ‘vasodilation’ which causes the blood pressure to suddenly drop leading to fainting. The strategies below can help reduce the risk of this happening.

* **Patient should be seated where possible when bathing or showering.** Patient should be supported by a staff member when they are getting up from the seated position due to the risk of blood pressure drop.
* When Patient is bathing or showering, **the door should remain unlocked,** and staff should be made aware of where they are. This will allow quicker access should there be a problem
* The **temperature of the water should be ‘cool to warm’** not hot, as this can trigger the body to dilate veins close to the skin, resulting in a sudden drop in blood pressure. This can lead to fainting and injury.

**Use of the toilet**

Use of the toilet can present similar risks of blood pressure drops due to the changes in the body as it expels waste (actual volume etc.).

* Patient should make it known to ward staff that they intend to use the toilet.
* **The toilet door should be left unlocked** to aid access should the patient need assistance.
* The patient should be **accompanied** to the toilet in case they need assistance.
* Remember, patients should use **a wheelchair to mobilize to the toilet.**

**Keeping warm:**

When the body is in starvation, the core body temperature can lower to conserve energy. It’s important to keep the **patient in a warm room with warm clothes**. Avoid the use of hot water bottles next to the skin. This can cause vasodilation and move the blood flow away from vital organs diverting it to the surface of the skin. Also, the skin can be less sensitive to heat resulting in burns. The body can also become less sensitive to cold, so if you see the patient underdressed for the temperature; encourage them to put on extra layers e.g., a dressing gown or jumper.

**Use of the playroom and education**

Do not forget, that when the Paediatric doctors are happy that someone is medically fit enough to go to the playroom or participate in education that these activities provide structure to the day and are a good distraction.

|  |  |
| --- | --- |
| **Nursing Assessment** | |
| **Food and Nutrition** | Normal Diet Special Diet On a refeeding meal plan  Special Diet: ………………………………………………………. |
| **Appetite / oral intake** | Good Poor Refusing |
| **Mobility** | Yes  Yes  No  No  Fully mobile    Requires assistance  NOTE: to promote physical health recovery all eating disorder patients should mobilize via a wheelchair until paediatrician allows otherwise. |
| **Sleep** | No  No  No  Yes  Yes  Yes  Unable to sleep  Wakes frequently  Sleeps well |
| **Skin Assessment** | No  No  Yes  Yes  Intact  Scarring |
| **Communication** | Yes  Yes  Yes  Yes  No  No  No  No  No difficulties  Coherent  Withdrawn  Uses special communication tools |
| **Elimination** | No  No  No  Yes  Yes  Yes  Continent  Incontinent  Requires support for toileting |
| **Pain** | Yes  No  Complete Pain Assessment Tool |
| **Risk of Falls or Fainting** | Yes Complete Manual Handling Assessment  No |
| **Level of risk** | 0 1 2  No  No  Yes  Yes  Enhanced observations required  *(Refer to local policy)*  Environmental risk assessment required  *(Refer to local checklist)* |

**Doctors Paediatric Clerking Pro forma**

Date: ………………………………………………… Time: ……………………………………………

Admitting consultant: ……………………………… Seen by: ……………………………………….

Print name: …………………………………………. Referral route: ………………………………..

Seen with: ……………………………………………

|  |  |  |
| --- | --- | --- |
| **History of Presenting Condition** | | |
|  | | |
| **Past Medical History** | | **Development History** |
|  | |  |
| **Family/Social History** | | |
|  | | |
| **Drug History/Allergies** | | |
|  | | |
| **Immunisations up to date?** | **Yes No** | |

|  |  |  |
| --- | --- | --- |
| **Clinical Examination:** | | |
| **General Description:** |  | |
| **Level of Alertness:** |  | |
| **CVS:** |  | |
| **Respiratory System:** |  | |
| **Gastrointestinal**  **System:** |  | |
| **CNS:** |  | |
| **Summary:** |  | |
| **VTE Assessment required in all children ≥ 16 years:** | Medical patient NOT expected to have significantly reduced mobility compared to normal state: | Yes VTE Assessment Complete  No Refer to VTE Guidelines |
| **Impression/**  **Differential Diagnosis:** |  | |
| **Medical plan:** | Refeeding program needed: Yes / No  Referral to eating disorders team required: Yes / No  Physical activity limitations (please circle)   * Complete bedrest / minimal activity / normal activity   Baseline bloods   * FBC, LFT’s, U&E’s, Ca, Mg, PO4, K+, urinalysis, serum proteins   ECG   * Consider if 24hr cardiac monitor needed   Other medical instructions: e.g., nutritional supplements (if managing refeeding risk), IV fluids etc… | |

Signature: ………………………………………… Print Name: ……………………………………………

|  |
| --- |
| **Discussion with parents:** |
|  |

|  |
| --- |
| **Paediatric Consultant Review:** |
|  |

**Community Eating Disorders Service (CEDS) Assessment Summary and Outcomes**

|  |  |
| --- | --- |
| Name of Assessor: | Date of Assessment: |
| Known to CAMH services: Yes / No  Known to eating disorder services: Yes / No  Parent / carer present: Yes / No If no, reason: …………………………………………………… | |
| **Summary of CEDS assessment:**    **Outcome**  Fit for discharge with community follow up: Y / N  Discharge Plan completed: Y / N  Concerns identified in relation to risk and discharge: Y / N  Outcome of management plan discussed with nurse in charge  Name of nurse: ……………………………………………………………………………………………………….  Date & time: ………………………………………………………………………………………………………….. | |

**Working with Risk 1 Categories: CEDS or CAMHS**

To inform the risk assessment prior to completing the Risk 1 form on SystmOne.

|  |  |
| --- | --- |
| **Risk to Self:** |  |
| **Risk to others:** |  |
| **Risk from others:** |  |
| **Physical health risks in line with MEED guidelines:** |  |
| **Risk of neglect:** |  |
| **Relevant risk history:** |  |
| **Overall risk rating:** |  |

**CAMHS Discharge Plan**

Safeguarding procedures followed: Yes No

|  |  |
| --- | --- |
| Contact number given for key contact during working hours |  |
| Information leaflets given to young person and parents / carers including contact numbers for help  and advice |  |
| Discussed how to manage the meal plan on discharge |  |
| Discussed with family ways in which they could support the young person |  |
| Liaise with other professionals (health and social care, education, voluntary sector etc.) |  |
| Plan/contract i.e., no suicide contract |  |
| Family advised of CEDS follow up plan |  |

**Additional Information:**

Signed (client): Print Name: Date:

Signed (parent/carer): Print Name: Date:

Signed (CEDS clinician): Print Name: Date:

Signed (Social Worker): Print Name: Date:

**Management plan**

Date of CEDS follow up:

**Discussed with:**

Health and Social Care: Name:……………………… Date/Time: Contact Detail:………………………..

Voluntary Sector: Name:……………………… Date/Time: Contact Detail:………………………..

Education: Name:……………………… Date/Time: Contact Detail:……………………….

Other: Name:……………………… Date/Time: Contact Detail:……………………….

Child/Parent aware and agree to plan: Yes No

Information discussed with Ward staff (*please tick to confirm)*

Name of staff member: ………………………………… Date/Time: ……………………………………………….

Signed (CEDS Clinician) ……..…………….. Name: …………………………… Date/Time: ……………………

|  |
| --- |
| **Paediatric Discharge from Hospital Checklist** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Signature** | **Date** | **Comments** | | |
| **Has the Interagency Referral to Social Care been completed, faxed and receipt checked, or emailed** |  |  | Yes | No | N/A |
| Medicines dispensed (check if Thiamine and Forceval needed on discharge) |  |  | Yes | No | N/A |
| Paediatric follow up appointment made, if needed, and given to child/parent/carer  Follow up with CEDS confirmed |  |  | **Appointment date and with whom:** | | |
| Transport from hospital |  |  | **Arrangements made:**  Own Other | | |
| Paediatric liaison Form completed |  |  | Yes | Time: |  |
| **If applicable** telephone call to social worker to inform them of discharge date. |  |  | **Name of person spoken to:**  Yes No NA  **Tel:** | | |
| **Intravenous cannula removed** |  |  | Yes | No | NA |
| **Hospital name bands removed** |  |  | Yes | No |  |
| **Parent/carer/child agreeable to discharge** |  |  | Yes | No |  |
| **Address where child has been discharged to if different from addressograph:** |  |  |  | | |
| **Date & time child and family left the ward:**  …………..……………………………………… | Name of discharge Nurse: ………..…  Designation: ……………………..……. | | | | |

**Clinical / Evaluation Notes**

**For Completion by Nursing Staff and to Include Summary of Any Contacts with External Partners (Including Telephone Conversations)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Time** | **Progress** | **Sign and Stamp** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Clinical / Evaluation Notes**

**For Completion by Nursing Staff and to Include Summary of Any Contacts with External Partners (Including Telephone Conversations)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Time** | **Progress** | **Sign and Stamp** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Clinical / Evaluation Notes**

**For Completion by Nursing Staff and to Include Summary of Any Contacts with External Partners (Including Telephone Conversations)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Time** | **Progress** | **Sign and Stamp** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Clinical / Evaluation Notes**

**For Completion by Nursing Staff and to Include Summary of Any Contacts with External Partners (Including Telephone Conversations)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Time** | **Progress** | **Sign and Stamp** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |