**Assessment phase**

**Working phase**

**Preparing for discharge or transfer**

Physical Obs. and blood tests to be taken. Medium weight for height to be calculated.

Weighing to occur regularly and randomly.

Food & Fluid Chart to be started & supplements considered if indicated.

Observe meal time behaviour.

As per core pathway and

Consider co-existing mental health conditions.

Sensory screening assessment (ASP, ASH, SPM, SIPT, Clinical Observations)

Consider risks towards the young people associated with internet use & social media.

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Individual Therapies: to follow on from Formulation and diagnoses of co-morbidities.

The psychological treatment of eating disorders is secondary to the medical risks of starvation & dehydration. Psychological treatment should only take place once minimum physical health has been established and is best undertaken in the community or in a specialist eating disorder unit. Therefore individual therapy work during an acute generic admission should be limited to distress tolerance around feeding and weight restoration, and identifying contributory comorbidities.

Eating Disorder focused Family Therapy to include ED Psychoeducation, Family communication patterns, relationship to emotional expression, and validation problem / solving dialectic. Styles of parental feeding support and direct family support around managing meals and meal plans.

Share recommendations regarding environmental adaptations, continuation of sensory approaches & routine / structure.

Maintain all interventions from assessment phase.

Consider Menstrual Cycle & Bowel Movement chart.

Monitor at meal table to ensure young person not “getting rid of food” (e.g. dropping it under table).

Devise and revise restoration or stabilisation calorie calculated meal plans including clear behavioural expectations at meals.

Provide table meal support. Encourage Patients to use their distraction & distress tolerance skills around feeding/ meals.

Consider placing on ‘golden hour’ level 3 observations following meals if evidence of purging.

Minimise opportunities for ‘weight loading’ and ‘water loading’ by routinely searching patients with unexplained weight changes.

Weigh patients before breakfast when dressed in consistent light clothing.

Agree an individual feeding/hydration escalation plan with the RC Medic. If underweight (less than 85% W4H) or losing weight rapidly

Limit opportunities for formal and informal exercise.

Support families to manage meals using meal plans and sharing strategies and techniques.

Consider running a training ‘Family Meal’ session.

Ensure the psychological formulation is shared with the community team, particularly regarding the hypothesized role of restriction / starvation.

FT to support the nursing team in handing over meal plans and feeding strategies to family members’ .FT to offer families ‘Family Meal’ coaching sessions, enacting real meals.

Psychological and psychosocial assessment: including developmental history, socio cultural attitudes towards body image and diet, and adverse life events.

Consider ED specific assessments to establish ED profile.

Consider comorbid/ contributory factors. Particularly Complex Trauma and/or ASD, dependent upon nutritional status – (ASD assessment will not be valid if YP is significantly underweight acutely distressed or has extreme rigidity of thinking due to malnourished state).

If presenting as low weight or restricting food and fluid for over 5 days, carry out the appropriate full range of ED blood tests as specified by Specialist guidance such as ‘MEED’.

Test for muscular weakness (sit up stand test & squat, test weekly).

Consider general admission for hydration and/or feeding if refusing food or fluids.

Maintain an oversight of physical observations and intervene in case of any abnormalities. E.g. Refeeding Syndrome).

Gather background information and history including requesting further information about support with unmet needs. Assess with plan to refer for further support from Local Authority.

Assessing & planning for possible difficulties (e.g. feelings around cooking sessions, physical activities, possible tendency to overwork, perfectionism).

Focus on distress tolerance skills including developing a personalised distress scale.

Consider stress management techniques such as sensory room/ relaxation techniques before meals & as part of a structured routine.

Encourage engagement in meaningful occupation to support development of non-mental health identity, self-esteem & positive body image & reduce risk of institutionalisation.

Support and oversee the nursing team’s medical management of the medical risks of starvation & dehydration. Ensure all appropriate regular physical checks are undertaken and recorded in a way that shows patterns i.e. W4H chart and postural drop blood pressure chart.

Consider further investigations if presenting with amenorrhea for a significant period of time.

Set out limits of individual feeding and hydration escalation plan regarding what medical circumstances would require transfer to general hospital or other interventions based on GM principles and the MEED guidelines. Be mindful of the balance between immediate physical risk and likely symptom maintenance.

Consider general hospital admission or other interventions for hydration and/or refeeding if refusing all food & fluids.

Consider medication to help general mood and distress tolerance.

As per the core pathway

Ensure any physical health complications that have occurred as a result of restriction are shared with the community team.

As per the Core pathway

As per the core pathway.

**Nursing**

**Occupational Therapy**

**Psychological Therapies**

**Medics**

**Social Work**

PSHE &/or 1:1 teacher time to sensitively address relevant issues including education around cultural & historic attitudes & pressures on body types & body image, what constitutes a healthy diet, natural body variations & body pride. Encourage student to achieve balance between academic work & therapeutic activities. Address any perfectionism.

**Education**