NHS GG&C Adult Eating Disorder Service

STANDARD OPERATING PROCEDURE

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To Be Approved By:	**Mental Health Governance Group**
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Contents

Introduction

The NHS Greater Glasgow & Clyde Adult Eating Disorder Service (AEDS) was developed in response and in conjunction with the National Mental Health Framework for Scotland (Eating Disorders) (2000), NICE Guidelines for Eating Disorders NG 69 (2017), NHS QIS (Eating Disorders in Scotland: Recommendations for Management and Treatment 2022), and the Mental Health (Care and Treatment) (Scotland) 2003.

Service Aims

- The service adopts an evidence-based psychological approach to the assessment and treatment of eating disorders (ED) (Matrix 2015 currently being updated) across NHS GG&C.
- Provide Person Centred Care as outlined in Person Centred Standards of Care.
- Reduce the stigma associated with mental health care and eating disorder (see Appendix 5).
- Work in partnership with patients and carers.
- Focus upon improving the mental and physical wellbeing of patients.
- Utilise the experience and knowledge of all team members to help facilitate a holistic approach to patients.
- Ensure care is delivered in the least restrictive and least disruptive manner as possible.
- Maximise occupational functioning
- Stabilise social functioning and protect community tenure.
- Work in collaboration with partners in care.
- Support patients to maintain employment – AEDS will support patients to access services while minimising disruption to current employment and involve carers where applicable.

Functions of the Team

- Provide assessment, diagnosis, formulation and treatment working within relevant Mental Health legislative processes.
- Work jointly with other services to manage cases with moderate to severe eating disorders (ED) and other co-morbid difficulties.
- The service is designed to complement existing community services in several key ways:
- By supporting clinicians working with ED and providing consultation on ED cases within any NHS GG&C setting.
- By providing direct, intensive community based care for patients with severe eating disorders (see Appendix 1). This can include some assertive outreach to engage patients with low insight or low motivation but AEDS has no capacity for more assertive outreach i.e. home visits (as the service has no CPN provision).
- By offering an option for 'stepping up' of moderate ED cases for whom Tier 2 (CMHT) interventions have not proven effective.
- Provide service users with an allocated key worker who works collaboratively to agree appropriate treatment, care and support.
- Develop a therapeutic relationship with service users to empower them to actively participate in their own care.
- Offer a wide range of psychosocial interventions (see section on interventions for further information).
- Occupational Therapy.
- Support planned discharge from AEDS (for further information see discharge section)

- Although responsibility for decision making around admission is retained by the Consultant Psychiatrist in the referring service for general beds, AEDS can provide specialist opinion on the necessity of inpatient care to inform treatment planning.
- AEDS Consultant Psychiatrist assesses AEDS patients when they are at higher risk of requiring potential admission, particularly when an AEDS bed is available. When an AEDS bed is not available, they will recommend and advise for local admission.

Aims of this SOP

- To promote a recovery based model of person-centered care that takes into account patients' needs, preferences, and strengths and drives consistency of service delivery processes as well as setting out a framework of key performance measures.
- To describe the pathway of care covering all aspects of the patient journey within the service and the quality assurance processes associated with that journey.
- To provide clear and transparent guidance on access to the service, the operation of the service, and decision making within the service.
- This operational policy has been subject to Equalities Impact Assessment (EQIA) to ensure that issues with regard to protective characteristics have been fully considered and described within this document (see Appendix 5 for further information).

Access and Referral System (AEDS)

The Adult Eating Disorder Service operates at the following times:

Community service: Monday to Friday 9am – 5pm

Within these hours:

- Regular service activities are delivered.
- Clinicians are encouraged to contact AEDS directly to discuss possible referrals.
- Staff supporting patients with ED can contact AEDS directly for support or consultation.
- Inpatient staff treating any patient with ED may contact AEDS for advice and consultation.
- On occasional basis certain community activities may be provided out with regular hours, e.g. Carers Group or meal supports.

Inpatient service: 24 hours a day, 7 days per week

Who can refer?

- All referrals are made via the local CMHT to provide a stepped care structure and include a named Consultant Psychiatrist.
- Direct referrals to the service are accepted from services that already have a designated Psychiatrist or contact with the CMHT including liaison psychiatry, perinatal, addictions, and forensics.
- CAMHS are able to refer directly into the service in order than transitions of these cases are prioritised.
- Referrers should consult with the AEDS traffic light form (see Appendix 1) to determine suitability of cases and to inform appropriate actions.
- Prior to referral, we encourage telephone discussion which may include information about the circumstances and details of the person being referred. This enables the suitability of the referral to be checked and enables clarification of the information required for a referral.

It also enables the referrer to discuss the case so that risk and response time can be known in advance.

- The referral paperwork should include a referral letter, a completed AEDS Risk Indicator Form (see Appendix 2) and a completed Clinical Risk Assessment Framework in Teams (CRAFT).
- The referral paperwork can be sent to AEDS via email, post or EMIS.
- If the referral is urgent, the referrer should contact AEDS by phone then notify the service that there is a new referral on EMIS for discussion at the next AEDS allocation meeting.

Which service users are suitable for referral to the service?

- AEDS is primarily a psychological service. Therefore, suitability for psychological therapy should be considered when referring patients to this service.
- AEDS will also undertake psychiatry assessments for providing second opinions for complex comorbid cases or diagnostic purposes.
- Table 1 below shows indicators that suggest a patient is ready to engage in psychological treatment and is suitable for referral to our service.
- People who meet the red, or in certain circumstances amber, criteria as per the AEDS traffic light system (see Appendix 1) are suitable for referral.
- People who meet green or amber criteria should be initially offered intervention and monitoring via the CMHT.

Table 1; *Factors to consider in assessing suitability for psychological intervention for eating disorder*

Positive Indicators	Contraindications
Able to talk about self, problems, and emotions.	Significant anxiety about discussing self and emotions, which would affect motivation for attending treatment.
Able to think about possible reasons for problems i.e. triggers.	Struggles to consider triggers or reasons for difficulties or unable to engage in discussion about what could help.
Has some desire for change or, at minimum, an ability to consider pros and cons of change.	Extremely low weight impacting cognitive function and, therefore, ability to meaningfully engage with talking therapies.
Able to engage with setting goals for change.	Weight loss or disordered eating behaviours driven by some other presentation such as clinical depression or psychotic Illness.
Clinicians have indicated that the patient has benefitted from previous psychological intervention.	Previous clinicians have indicated that the patient struggled to engage in therapy, is ambivalent/dismissive about need for change or there is a clear pattern of previous non–engagement.
	Substance misuse which is primary or substantial/other issues reflecting instability such as active suicidality which require intervention in the first instance or in circumstances where eating disorders interventions may be destabilising/harmful.

Processing of referrals and waiting list management

- When a referral is received it will be discussed at the AEDS allocation and multidisciplinary team (MDT) meeting. Discussion will include a senior RMN and Clinical Psychologist as minimum.
- Cases are triaged based on the red, amber and green indicators for anorexia and bulimia (see Appendix 1).
- Referrals are responded to on the basis on risk as per Table 2 below.
- Following the referral and discussion at AEDS MDT, the referrer may be contacted for further clarification or information relevant to presentation and risk. This will support appropriate allocation of cases in terms of routine or urgent assessment (see Table 2) and in terms of Keyworker skill set (see Appendix 9).
- Historically, AEDS has been in a privileged position of not having waiting list and was able to respond clinically according to risk i.e. assessment within 30 days but usually sooner for routine referrals and urgent referrals responded to within 1-2 days following receipt and the patient seen as soon as possible (usually within 10 days).
- Since March 2020, the incidence of eating disorders has escalated and the referral rate to AEDS has increased by 70%. This is likely a result of the effects of lockdown and associated restrictions during the Covid-19 pandemic. As such, the service has had to find a way to manage the addition of a waiting list.
- Current waiting list management involves assessing risk from the referral information, prioritising urgent and physically unstable cases for immediate allocation, and adding other amber and red cases to the waiting list. Both patient and referrer are sent letters to inform them that the patient has been placed on a waiting list.
- Services who have patients on the AEDS waiting list (i.e. CMHT) are asked to assess ongoing risk via medical monitoring including weight and bloods.
- AEDS MDT reviews the waiting list on a fortnightly basis and documents this on EMIS. This enables the service to alter input according to any change in presentation which would require more immediate action.
- Following allocation of the referral, AEDS arranges assessment. Where the patient is well known (e.g. to CAHMS or CMHT), a joint assessment between services is considered best practice and arranged where possible.

Table 2; Response time for referrals to AEDS

Category of Referral	Response Time	Criterion
Routine	Referrals are allocated to the waiting list and reviewed fortnightly to identify any change in priority. AEDS aims to adhere to the psychological therapies HEAT target requiring patients to receive psychological treatment within 18 weeks (126 days) of referral.	See AEDS traffic lights (Appendix 2)
Urgent	Referrals are responded to within 1-2 days following receipt and the patient is seen as soon as possible usually within 10 days.	See AEDS traffic lights (Appendix 2). The referrer should call AEDS to discuss the case in advance of completing the referral

Assessment

- Prior to assessment, AEDS will review the relevant case notes and liaise with other appropriate professionals before inviting the patient to participate in a comprehensive psychological assessment.
- Assessments are allocated to clinicians based on i) capacity and urgency criteria (see Table 2) and ii) initial MDT discussion regarding possible appropriate interventions (see Appendix 9) and clinician skill set.
- Service users are offered an assessment over two sessions with two professionals from the MDT (e.g. nursing and psychology). The first assessment appointment will be face to face and the second may be online via Near Me or face to face.
- The assessment process involves collecting information on current presentation and risk as well as consideration of suitability for psychological intervention.
- AEDS clinicians feedback their clinical assessment at the weekly AEDS MDT meeting. AEDS MDT discuss the information gathered via the assessment and agree the outcome. This includes discussing suitability for psychological treatment, what level of psychological treatment is required (see Appendix 9), and which clinician within the service would be best placed to deliver the intervention.
- If the patient is considered appropriate for the service (see Table 1 and Appendix 1), they will be offered a 4 session engagement period with the service.
- Following assessment, a letter detailing the assessment, outcome, treatment plan, and any recommendations for patient care (including physical monitoring) will be compiled by the key worker and forwarded to the referrer, GP, and other relevant agencies.

- For each new assessment carried out, a CRAFT risk assessment is completed and recorded on EMIS.
- For those suitable for intervention with the service, a care plan document is collaboratively developed and stored within EMIS records.
- Figure 1 below provides an overview of AEDS input from referral to treatment.

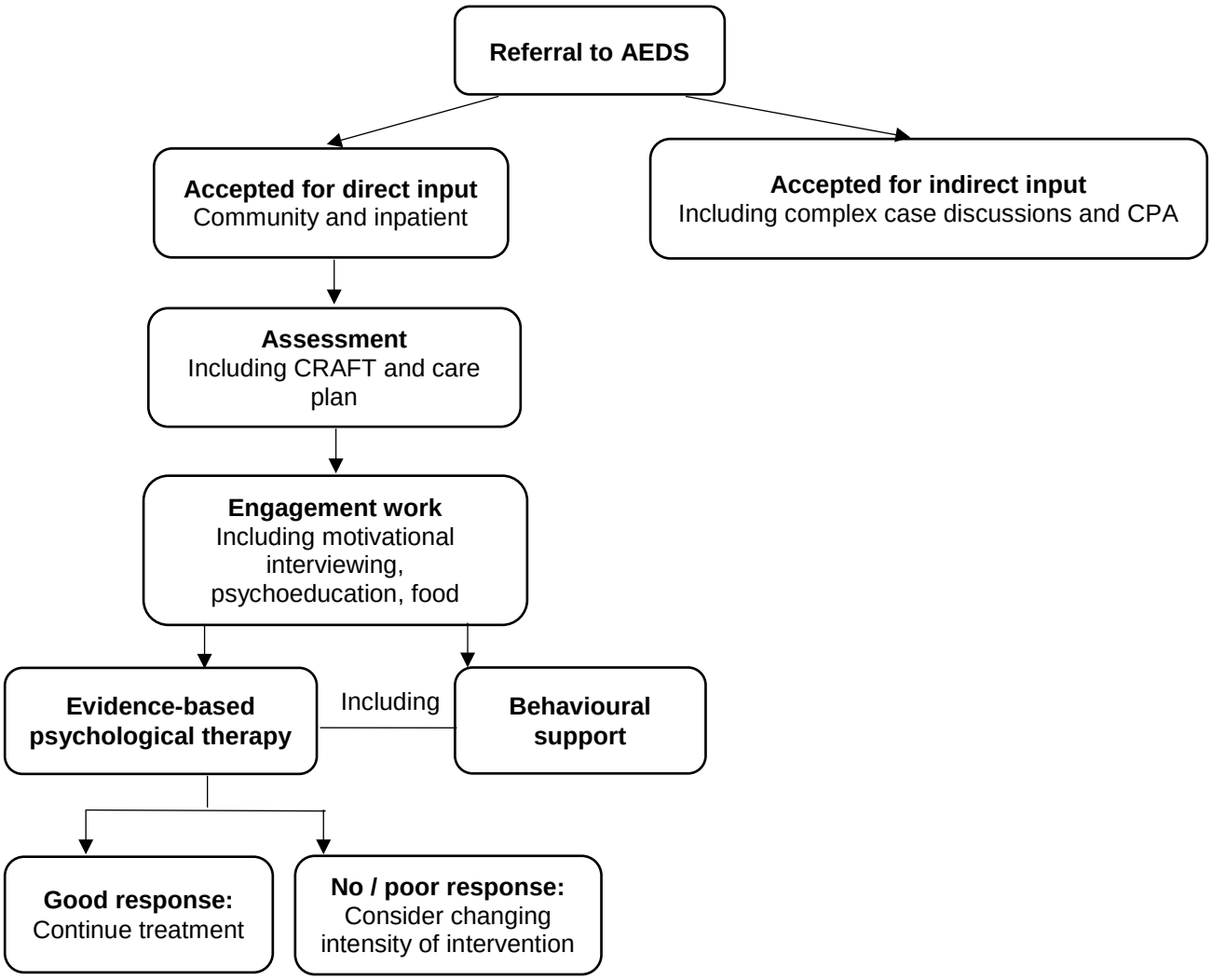

Figure 1. Overview of AEDS input from referral to treatment

AEDS Staffing Profile and Multidisciplinary Care

- AEDS functions using an integrated multidisciplinary approach. The team is composed as below in Figure 2. For profiles of the AEDS staff structure, see Appendix 13.
- The MDT holds a number of meetings to facilitate patient care and clinical governance. The meetings held and the function of these is described in Table 3 below.
- At a minimum, senior Clinical Psychology, senior Registered Mental Health Nursing and Medical staff are present at all MDT discussions.

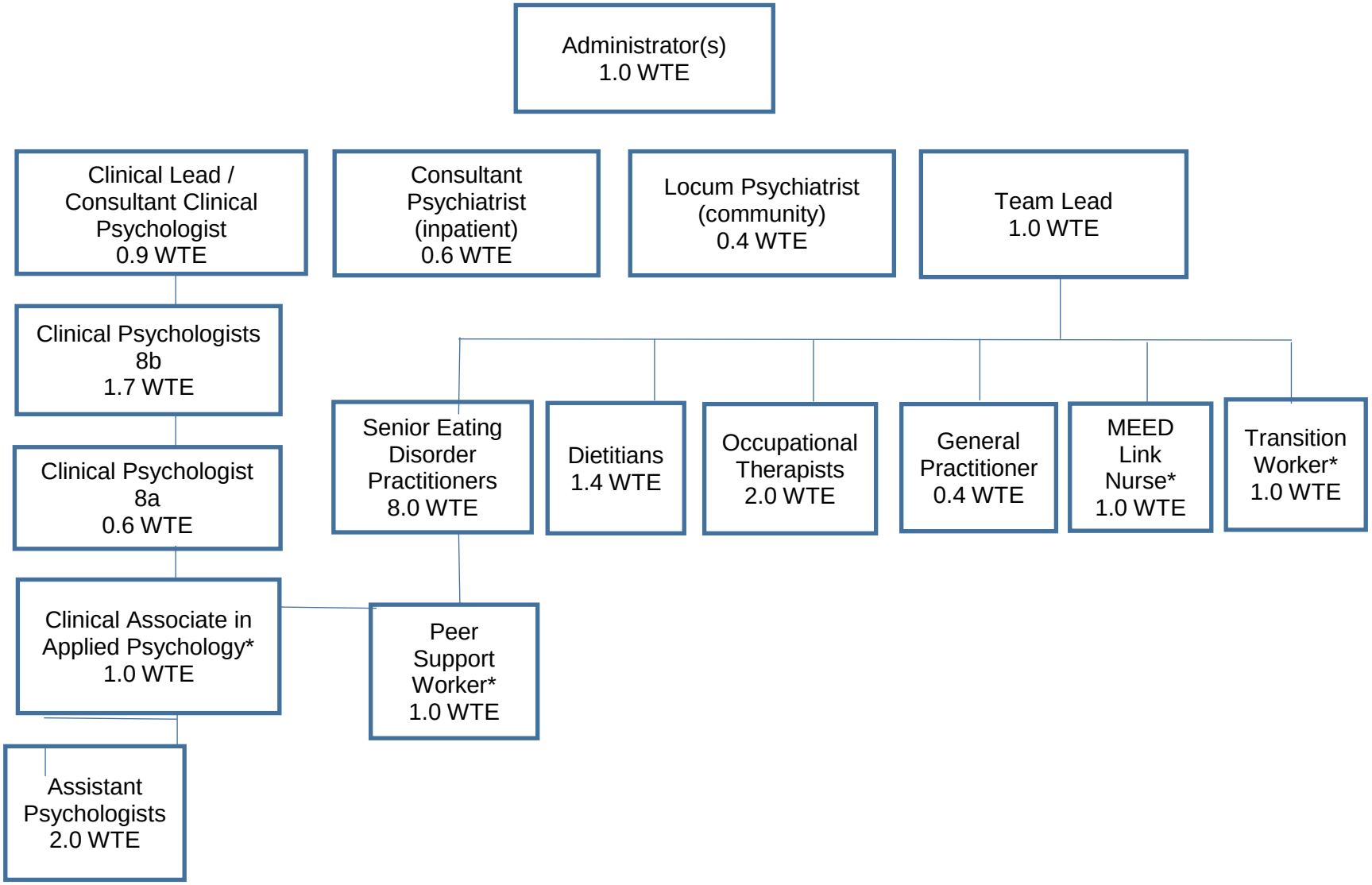

Figure 2; AEDS staffing profile (*2 year fixed-term post)

Table 3; *AEDS Meetings*

Meeting	Description and Purpose	Documentation Required (see Appendix 9 for minimum documentation)
MDT Meeting	Held weekly and chaired by a senior clinician. All new cases, inpatient cases, and outpatient cases (as required) are discussed. The aim is to inform decision making about care and to robustly communicate risk both within the team and with other services. It is not possible to discuss all outpatients; however, a system of case reviews ensures all cases are regularly discussed (see section below on Case Reviews).	Team discussion is documented on EMIS following the MDT meeting. The outcome of assessment is feedback to the referrer and GP via an assessment letter.
Allocations Meeting	Held weekly and chaired by a senior clinician. New referrals are triaged as per AEDS traffic light system (see Appendix 2) to determine level of risk. Referrals without adequate risk information will not be accepted. See Appendix 1 and Appendix 2 for referral paperwork.	The outcome of MDT discussion about referrals is documented on EMIS. If a referral is not accepted, this will be followed up in writing including the rationale for the referral not being accepted.
Case Reviews	Held fortnightly at which keyworkers present cases for review by the MDT. This enables the MDT to discuss treatment plans to collaboratively reformulate cases. Two to three cases are reviewed per week to allow appropriate time for team discussion. AEDS aims to review each patient in the caseload on a 6 month basis to ensure all cases held by AEDS are discussed by the MDT.	Case reviews are documented using a Case Review Template (see Appendix 7) which is uploaded to the patient's EMIS record.
Team Formulation	Held weekly and chaired by AEDS Clinical Psychology staff. Each patient attending AEDS will have an individualised treatment plan informed by a psychological formulation.	The facilitating Clinical Psychologist will oversee the completion of a team formulation document and will maintain a record of the formulation meeting on EMIS. See Appendix 10 for relevant paperwork and guide to team formulation.
Groups Meeting	A one to two monthly meeting facilitated by AEDS Occupational Therapist. The purpose of this meeting is to discuss and plan new and existing AEDS groups and to feedback patient and carer participation in groups to the team.	Minutes are recorded for the meeting by AEDS Occupational Therapist and are saved on the team shared drive. Keyworkers also document relevant discussion on EMIS.
Team CPD	Monthly sessions held for the purpose of team development and education. Sessions are facilitated by different team members and are planned according to the team's needs and interest areas.	A record of sessions held is stored within the AEDS shared drive for reference.

Overview of Interventions Offered

- AEDS is primarily a psychological therapy service. AEDS aims to offer high quality psychosocial interventions for people with moderate to severe eating disorders (see Appendix 1 for assessment of severity/ risk).
- The psychological treatment offered by AEDS is formulation driven and governed by local and national standards for the treatment of eating disorders (The Matrix, 2015; NICE, 2014; SIGN, 2022). Treatment draws upon the best available evidence for the management of complex cases, e.g. where co-morbid mental or physical health difficulties are present.
- Information on types of psychological interventions offered and by whom is included in Appendix 9.
- Decisions about interventions offered are made based on MDT discussion within assessment feedback, case review, and formulation meetings. The service uses a matched care approach to allocate key workers to patients based on presentation, complexity, and appropriate treatment (see Appendix 9).
- AEDS offers a whole MDT intervention (see Figure 3 below). Input such as medical monitoring and dietetic input is only available if patients are engaging in psychological treatment.
- Occupational Therapy works with patients to assess areas where the eating disorder is affecting everyday occupational functioning and supports the patient in a range of areas, e.g. grocery shopping, meal preparation, leisure interests, remaining in or returning to work/study, and daily structure. Where appropriate, a sensory assessment will also be undertaken.

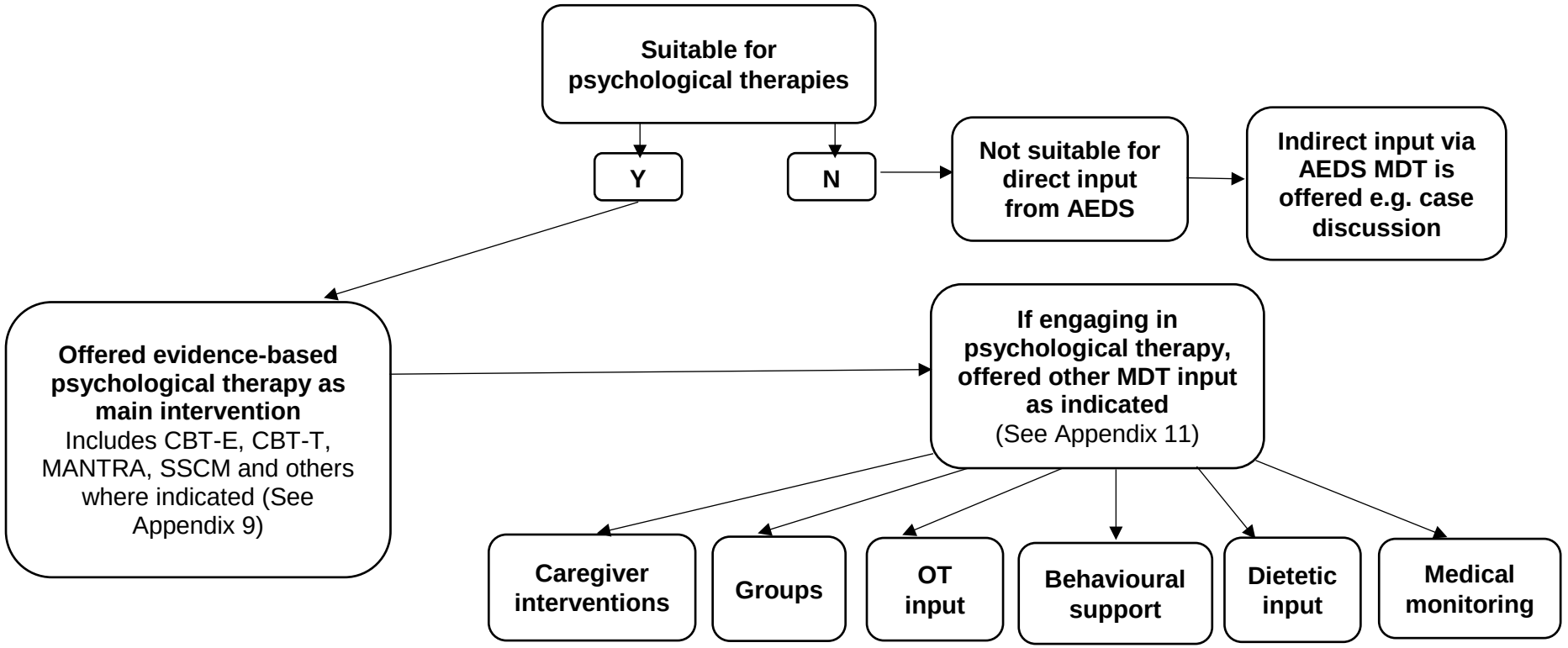

Figure 3. Interventions offered by AEDS MDT

Overview of Interfaces with Other Services

- AEDS routinely interfaces with a range of services across primary, secondary, and tertiary care within both mental health and physical health settings. This includes services such as GP practices, CMHT, Perinatal Mental Health, locality physical and mental health wards, and physical health teams such as Diabetes. This list is of course not exhaustive. See Appendix 6 for further information on clinician roles and responsibilities in NHS GG&C working with adults with eating disorders.
- All cases open to AEDS require to be under the care of a Consultant Psychiatrist in the referring service. Where a service user is not under the care of a Consultant Psychiatrist, a referral should be made to the appropriate CMHT for assessment prior to referral to AEDS.
- Where there are significant co-morbidities, AEDS work jointly with other services to enhance patient care. This would include joint involvement with the relevant Consultant Psychiatrist and/or key worker in contributing to care planning meetings, case conferences, and co-ordination of shared care and treatment planning.
- AEDS patients have access to locality out of hours and crisis services (via their CMHT). AEDS staff will liaise with crisis services as required for out of hours follow up or for ongoing input to support the management of risk/avoid hospital admission.
- AEDS is currently undertaking a pathway change to hold psychiatric care of its patients with primary diagnosis of eating disorder. Once this is complete, the SOP will be updated.

Inpatient Care

- AEDS has access to four inpatient beds in Armadale Ward at Stobhill Hospital (Mackinnon House) reserved for AEDS service users (see Appendix 3). The process for inpatient admission is shown in Figure 4 (see Appendix 6 for information on clinician roles and responsibilities).
- Where Armadale Ward AEDS capacity is at maximum or where clinical presentation does not indicate treatment within a specialist ED setting, service users are admitted to locality wards.
- Where a locality admission is agreed/appropriate but the locality ward would be Armadale, it is recognised that admission should be arranged to an alternative ward to maintain transparency in treatment.
- Inpatient treatment is provided where AEDS service users are motivated to make changes but have been unable to do so after a period of outpatient treatment or where medical or psychiatric risk is high and an inpatient admission is required.
- The necessity for inpatient treatment is discussed at each AEDS MDT. AEDS key workers will utilise these discussions to advise the Responsible Consultant on current risk to inform the decision making process regards admission.
- While important for determining risk, inpatient admission is not principally determined by numerical criteria such as body mass index (BMI) or weight.
- Final responsibility for decisions related to admission sits with the local inpatient Consultant Psychiatrist and the local inpatient team.
- Individuals with an eating disorder who have acute physical health needs may require a medical admission to safely stabilise their physical health. In these circumstances, the individuals care will be transfer to the local acute service medical team.
- Frequently, individuals will be at high risk of refeeding syndrome and will require a carefully considered menu plan with regular medical monitoring to recover. AEDS Specialist

Dietitian will offer consultation to the Acute Dietician who remains clinically responsible for the menu plan.

- The inpatient Occupational Therapy team liaise with AEDS Specialist Dietitian so that grocery shopping and lunch preparation have clear links to AEDS dietetic care plan goals.
- It is recommended that wards follow the Managing Emergencies in Eating Disorders (MEED, 2022) Guidance. https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2022-college-reports/cr233
- AEDS provides direct and indirect input for individuals with an eating disorder who are receiving inpatient care on general Adult Mental Health wards or medical wards across NHS Greater Glasgow & Clyde.
- AEDS offers indirect input (consultation) in circumstances in which local teams have requested advice or guidance for patient care where the individual is not currently open to AEDS. This includes both inpatients and community patients. Inpatient guidance on safe treatment can be requested from AEDS as required. AEDS can attend case reviews, team formulation/MDT meetings or ward rounds to provide specialist advice for those who are not open to AEDS.
- AEDS provides specialist training to mental health inpatient staff in the support and clinical care of individuals with an eating disorder receiving inpatient treatment.

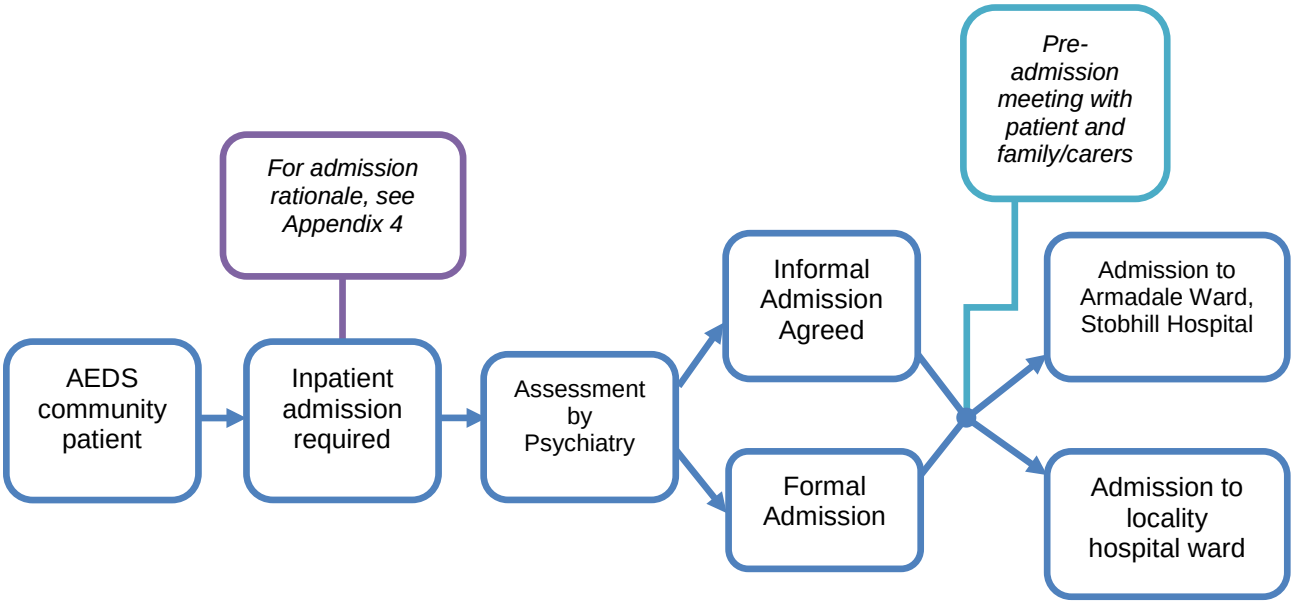

Figure 4. Inpatient treatment process

Risk Management

- The assessment and management of risk is an integral part of AEDS screening and assessment processes and is ongoing throughout a service user's journey with AEDS.
- CRAFT risk assessment documentation is completed at assessment, on change in presentation/significant incident, and at point of discharge as per NHS GG&C policy.
- The role of Responsible Medical Officer (where required) is held by a Consultant Psychiatrist within the referring team. Commonly this would be a named Consultant Psychiatrist within a CMHT. All cases open to AEDS require to be under the care of a Consultant Psychiatrist within their CMHT.
- The role of AEDS is to provide information and updates to the named Consultant Psychiatrist to inform risk management, with responsibility for decision making and

consideration of admission being held by the CMHT Consultant Psychiatrist. AEDS Consultant Psychitrist can also offer expert advice around this.
- In order to support risk management, at minimum AEDS will communicate in written form to the Consultant Psychiatrist and GP at the point of assessment and discharge as well as at 6 monthly intervals throughout a service user's contact with AEDS.

Discharges/Transfers

- Length of treatment within AEDS can vary widely depending on the individual psychological formulation and treatment plan. Patients with a severe and enduring course of illness could be with the service for up to two years.
- AEDS is currently undertaking a pathway change to include a clinic for patients unable to engage in active therapeutic change (severe and enduring). This will be run by Psychiatry and include medical monitoring. This part of the pathway will also be time-limited. Once this part of the service is active, the SOP will be updated.
- Patients are discharged in consultation with the CMHT (or relevant team) from AEDS when:
- Treatment with the service is considered complete by the multi-disciplinary team. Completion of therapy will have been negotiated and agreed in advance between the therapist and the patient.
- 'Active' therapy has ceased and a period of review undertaken.
- When active *psychological treatment* is not possible. Examples would include non-attendance at treatment appointments or when the service user is unable to work within a psychological model.

To facilitate smooth transitions between services:

- Where discharge is planned, the AEDS key worker will provide an update to the appropriate Consultant Psychiatrist responsible for the patient's care or Nurse Team Leader in the CMHT. This will include discussion of the rationale for discharge, e.g. treatment complete or unsuitable for ongoing psychological intervention. This update will be via telephone or email in advance of the discharge. This discussion should also be documented in the patient's care records.
- A formal discharge letter is then sent to the relevant Consultant Psychiatrist, other clinicians involved, and GP from the AEDS key worker alongside any recommendations for ongoing care.
- AEDS can attend case reviews prior to or during the discharge period.
- AEDS can provide advice/guidance on physical risk assessment and management upon discharge if required.
- An updated CRAFT risk assessment will be completed upon discharge from AEDS.

Where the patient chooses not to attend the service or disengages from the service unexpectedly, AEDS will ensure:

- All effort will be made to encourage patients who fit eligibility for the service to remain in active treatment with the service. This would include making contact via telephone and/or letter to try to re-engage the patient.
- AEDS will discuss a recommended management plan based on presenting risk with the relevant Consultant Psychiatrist.
- Patient care will resort to the locality CMHT who retain responsibility for assertive outreach

and risk management based upon the clinical judgement of their MDT. This is because AEDS is not currently resourced to provide more assertive outreach across GG&C (the service has no CPNs).
- Should the patient opt out of treatment with the locality CMHT, patient care will rest with the GP.
- The referrer, GP, and all other relevant agencies will be informed by letter with recommendations about risk management.

Transitions from CAMHS:

- AEDS aims to support a timely and streamlined transfer of care between Child and Adolescent Mental Health Service (CAMHS) and Adult Mental Health Services. AEDS will contribute to transfer planning meetings from Child to Adult services up to 6 months in advance of planned transitions.
- Any referrals from CAMHS will be prioritised by AEDS due to increased risk at the time of transition.
- It is good practice to also refer the patient to their local CMHT in case other generic mental health input is required.
- CAMHS referrals with primary diagnosis and presenting problem of eating disorder will be held solely by AEDS.
- CAMHS referrals with dual diagnosis will require to be jointly held between AEDS and CMHT for full access to all services. Usually for these cases, the CMHT will have allocated a Consultant Psychiatrist who will take overall responsibility.
- Transitions from CAMHS to Adult services should be in line with national guidance as per the Responsibilities of Services to Ensure Good Transition document (Scottish Government, 2018).

Transfer to/from another specialist eating disorder service:

- When a patient moves out of area, arrangements will be made to transfer patient care from AEDS to relevant agencies within the patient's new health board.
- AEDS will liaise with the other specialist eating disorder services prior to planned transfer of care to share relevant information regarding risk and to support a smooth transition between services.
- Transfers from other specialist eating disorder services will be prioritised due to increased risk around transition.
- As appropriate, a discharge report will be completed by the AEDS key worker and forwarded to all relevant persons.
- For patient's moving to GG&C, we ask that AEDS be alerted in advance to facilitate a joint planning process to support a smooth transition between services.

Discharge from inpatient treatment:

- Discharge from Armadale ward will be jointly planned with the appropriate Community teams by ward staff and followed up formally with a letter from AEDS Consultant Psychiatrist.
- AEDS will offer psychiatric follow-up in the immediate period following discharge then, once more stable, the patient will be transferred back to their locality Consultant Psychiatrist.
- The psychiatry pathway is under review and any changes will be updated here as they

occur.

- Follow-up via crisis teams will be requested where appropriate to facilitate transitions from in to outpatient settings.
- Inpatient Occupational Therapy service regularly liaise with AEDS Occupational Therapist to agree when transfer of patients is appropriate.

Service Evaluation and Governance

AEDS regularly collects data to support service evaluation and improvement (see Appendix 4).

Appendix 1

NHS Greater Glasgow and Clyde

ADULT EATING DISORDER SERVICE

NHS Greater Glasgow and Clyde

Individuals receiving in-patient treatment for an eating disorder are viewed as a priority for access to the Adult Eating Disorder Service and will already have CMHT contact

Indicates referral to AEDS for joint assessment with CMHT to determine level of input & management plan.
Assessment within 10 working days

Indicates management within CMHT and if this input has not resulted in progress towards recovery refferal to AEDS for assessment.
Assessment within 30 working days

This would indicate mamagement witin CHMT or Primary Care Team with advice and support from AEDS

ANOREXIA

SIGNIFICANT increase in symptoms in AMBER risk indicator:

- Dietary intake is restricted resulting in continuing weight loss more than 1kg per week
- BMI less than 14

Plus one or more of the following:

- Vomiting – once per day or more
- Purging – once per day or more
- Exercise – more than once per day
- Significant Depressive symptoms

- Frequent/recurring suicidal ideation and/or self harm and/or impulsive behaviours
- Co-morbidity ie. Diabetes, pregnancy
- Significant disruption to daily functioning
- PCT/CMHT input has not resulted in progress to recovery
- Physical complications
  - i. Abnormal blood results
  - ii. Hypotension
  - iii. Low core temp
  - iv. Muscle weakness
  - v. Bradycardia
  - vi. ECG abnormalities

MODERATE increase in symptoms on GREEN risk indicator:

- Dietary intake is restricted resulting in continuing weight loss
- BMI less than 16

Plus one or more of the following:

- Vomiting – approx 2-3 per week
- Purging – approx 2-3 per week
- Exercise – not more than once/day
- Moderate Depressive symptoms
- Physical complications (Abnormal blood results e.g. electrolyte imbalance)

- Frequent suicidal ideation, self harm or impulsive behaviour
- Co-morbidity i.e. Diabetes, pregnancy
- Moderate disruption to daily functioning
- CMHT/PCT input has not resulted in progress to recovery

- Dietary intake is restricted resulting in gradual weight loss
- BMI more than 16 < 17.5

Plus one or more of the following

- Occasional vomiting &/or laxative/diuretic use approximately once per week
- Exercise—no more than 3 times per week
- Mild to Moderate Depressive symptoms

BULIMIA

SIGNIFICANT increase in symptoms in AMBER risk indicator:

- Bingeing – once per day or more
- Vomiting – once per day or more
- Purging – once per day or more

Plus one or more of the following:

- Significant fluctuations in weight with/or without rapid weight loss
- Exercise – more than once per day
- Significant Depressive symptoms
- Frequent/recurring suicidal ideation and/or self harm and/or impulsive behaviours

- Co-morbidity ie. Diabetes, pregnancy
- Significant disruption to daily functioning
- PCT/CMHT input has not resulted in progress to recovery
- Physical abnormalities

MODERATE increase in symptoms on GREEN risk indicator:

- Bingeing – approx 2-3 times per week
- Vomiting – approx 2-3 times per week
- Purging – approx 2-3 times per week

Plus one or more of the following:

- Weight Loss – moderate fluctuations in weight/moderate weight loss
- Exercise – no more than once per day
- Moderate Depressive Symptoms
- Physical complications (Abnormal blood results e.g. electrolyte imbalance)

- Frequent suicidal ideation and/or self harm and/or impulsive behaviours
- Co-morbidity i.e. Diabetes, pregnancy
- Moderate disruption to daily functioning
- PCT/CMHT input has not resulted in progress to recovery

- Occasional (approx once/week) Bingeing & vomiting and/or laxative/diuretic use (purging)
- Weight Loss – minimal fluctuations in weight/minimal weight loss
- Exercise – no more than 3 times per week
- Depressive Symptoms – mild to moderate

Appendix 2

Adult Eating Disorder Service

Indicator Form

NHS Greater Glasgow and Clyde Mental Health Partnership

Name:		CHI N°:	

Height:		Weight:		BMI:	
BP:		Pulse:		Temp:	

1. Are you referring this person because they are an in-patient? Yes ☐ No ☐

   If an in-patient, is the person maintaining their weight? Yes ☐ No ☐

2. How much weight has the person lost over the past three months? ☐

3. On average how much weight does the person lose in a week? ☐

4. If female, is she amenorrhoeic? Yes ☐ No ☐

5. Are the blood results available? Yes ☐ No ☐

Please give details below of any abnormalities found in the blood results FBC, U&E, LFT, Glucose, Ca, Mg, and Phosphate.

6. Briefly describe what the person eats on an average day?

Exercise: (Please Circle the Appropriate Choice)

7. How often does the person exercise? Once per week | 2-3 Times per week | Once per day | > Once per day

8. How long does the person exercise? < 30 minutes | 30 minutes | 1 hour | 1½ hours | > 2 hours

9. Is the activity at an appropriate level for this person's weight? Yes ☐ No ☐

Binge Pattern:

10. Does the person eat an excessive amount over a short period of time? If yes please complete below Yes ☐ No ☐

    Approximately how often does the person binge? Once per week | 2-3 per week | Once per day | > Once per day

    Please circle as appropriate

Purge Pattern:

11. Does the person vomit or regurgitate food? If yes please complete below, Yes ☐ No ☐

    Approximately how often does the person purge? Once per week | 2-3 per week | Once per day | > Once per day

    Please circle as appropriate

    Does the person use laxatives, diuretics or diet pills to help them lose weight? Once per week | 2-3 per week | Once per day | > Once per day

    Please circle as appropriate

Muscle Weakness/Mobility:

12. From your clinical observations can the person rise from a sitting position with ease or is assistance required? Yes ☐ No ☐

    Is person's mobility restricted or limited due to muscle weakness? Yes ☐ No ☐

13. Using the traffic light indicator tool, is the risk GREEN | AMBER | RED

Appendix 3

Inpatient Treatment within Armadale Ward

- Inpatient treatment combines food and nutritional support with more intensive medical, psychological, and nursing care than can be provided by outpatient attendance.
- Therapy is delivered through a combination of individual sessions for psychological therapy by the patient's AEDS key worker, supported by an inpatient named nurse, along with therapeutic groups (at the AEDS community base and within the ward if available).
- Occupational therapy interventions are provided by the inpatient Occupational Therapy service within a framework of motivational enhancement. This is relevant for food prep groups only.
- Treatment is person-centred, compassionate, and recovery focused. Length of stay is guided by individual patient need.
- Many components of the community service for AEDS are accessible to inpatients and community patients in order to facilitate flexible and graduated transition between these two tiers of care.
- Transitions are graded with periods of increasing passes home in preparation for discharge.
- Timing of transition is determined by progress (including ability to restore weight, maintain a dietary plan, manage eating disordered behaviours, and manage distress) during periods of home leave and not by fixed length of stay or body mass index (BMI) criteria.

Appendix 4

KPIs

The clinical measures currently used include:

- BMI and weight
- Blood results
- Self-reports regarding frequency of eating disorder behaviours
- CORE-10 Clinical Outcomes in Routine Evaluation Outcome Measure (Mental Health Foundation, 1993)
- EDE-Q Eating Disorder Examination Questionnaire (Fairburn & Beglin, 2008)

Data Improvement Plan

- Current service priority is to deliver high standard, evidenced-based psychological treatment for people living with eating disorders.
- Current board priorities are to reduce bed use and to improve the efficiency and effectiveness of CMHTs.
- Current national priority is to provide increased access to psychological therapies in line with the 18 week referral to treatment target.
- Gaps identified in data recording relevant to service, board, and national priorities include:
- Demographic information particularly in relation to diagnosis
- Recording of service activity, particularly in relation to indirect working
- Lack of application of clinical change (treatment effectiveness) measures
- Need for collection of data in relation to service and board strategic aims

Appendix 5

Equality

- The Equality Act 2010 imposes a duty on public bodies to have due regard to the need to eliminate discrimination and to advance equality of opportunity and foster good relations between people who share certain protected characteristics and those who do not.
- The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Act provides an important legal framework that should improve the experience of all mental health patients, particularly those from black and minority ethnic communities.
- All patients and carers will be provided with information in a manner which is relevant and accessible as part of the individual's engagement with the service.
- Formats could include:
- Need based
- Leaflets in plain language
- Information in languages other than English
- Large print documents
- Information on DVD/CD or on audiotape
- Interpreter services

Recovery and Social Inclusion

- People who are struggling with a mental health disorder are often among the most excluded people in our society. Therefore, Mental Health Services should have a positive and timely response to individuals with mental health difficulties.
- AEDS has a part to play in promoting opportunities for people who have or have had a mental illness or personality disorder. This includes the opportunity to work, learn, make a home of one's own, engage in leisure pursuits, and build friendships as well as support/education for carers. All aspects of our service should go towards enriching services user's lives.
- Individuals with mental health difficulties can find it difficult to obtain and sustain paid employment and may face a number of challenges such as stigma and discrimination. Occupational Therapists can support patients to remain in or return to work/education through assessment and formulation of reasonable adjustments of worker's role and environment and engage in discussion with employer/educational establishment. For employment, this may include the completion of an AHP Health and Work Report.

Appendix 6

Appendix 6 - Summary Roles/Responsibilities for Clinicians in NHS GG&C working with Adults with Eating Disorders

Tier and Risk	Clinicians	Responsibilities	Medical Responsibility
Tier One Green = Low	GP	Assessment Diagnosis Medical Monitoring	GP
	Primary Care MH Team	Guided self-help	
	Primary Care Community Dietitian	Dietary assessment & intervention	
Refer to mental health services if tier 2 indicated using AEDS criteria			
Tier Two Amber = Mild / Moderate	GP	Medical monitoring Referral to CMHT	GP
	Primary Community Dietitian	Dietetic assessment & intervention	
	CMHT Consultant Psychiatrist CMHT key worker	Psychiatric assessment / Diagnosis Care co-ordination and treatment	CMHT – Consultant Psychiatrist
Consultation / liaison with Adult Eating Disorder Service (AEDS) and refer to tier 3 if indicated			
We recognise there are a significant number of patients with the same level of risk described at Tier 3 & 4 who for a variety of reasons are not open to AEDS. Clinicians working with these patients can access AEDS for advice and consultation, overall medical responsibility remains with the GP or Local Consultant			
Tier Three Amber Red =Moderate / Severe (in AEDS)	GP	Medical monitoring & liaison with AEDS	GP
	CMHT Consultant Psychiatrist CMHT key worker	Psychiatric assessment / Diagnosis Care co-ordination & treatment & liaison with AEDS	CMHT – Consultant Psychiatrist
	Adult Eating Disorder Team including AEDS Dietitian	Formulation based psychological assessment & intervention Specialist dietetic intervention	
Discuss with AEDS Consultant Psychiatrist for access to specialist inpatient bed if indicated			

Extracted from NHS GG&C AEDS Operational Policy May 2016

Appendix 6 - Summary Roles/Responsibilities for Clinicians in NHS GG&C working with Adults with Eating Disorders

Tier and Risk	Clinicians	Responsibilities	Medical Responsibility
Tier Four **Inpatient specialist AEDS bed** Red = Severe / Complex (in AEDS)	AEDS Consultant Psychiatrist MH Inpatient Nurses and AEDS Inpatient nurses AEDS inpatient Dietitian AEDS community key worker	Specialist Psychiatric/ Medical Care 24 hour specialist Nursing Care & Psychological Interventions Dietetic intervention Maintain therapeutic contact and liaison with Inpatient Team	AEDS – Consultant Psychiatrist
Tier Four **Inpatient Psychiatric bed Active to AEDS** Red = Severe / Complex (in AEDS)	CMHT Consultant Local Dietitian	Medical / Psychiatric Dietetic care	CMHT Consultant Psychiatrist
	AEDS Dietitian - consultation AEDS key worker	Consultation / Supervision AEDS to support staff via ward round, education and liaison	
Tier Four **Inpatient Medical bed** Red = Severe / Complex (in AEDS)	Medical Consultant Nursing Acute Dietitian in consultation with AEDS Dietitian	Medical & Nursing Care/Management Dietetic Assessment and Intervention	Medical Consultant
	Liaison Psychiatry	Consultation with CMHT, AEDs and provision of supervision, information & psychiatric support to inpatient services	Liaison Consultant Psychiatrist
	AEDS key worker	Ward round / education / liaison with medical / nursing team and liaison psychiatry	

Extracted from NHS GG&C AEDS Operational Policy May 2016

Appendix 7

AEDS Multidisciplinary Case Review

Patient Name		
Date of Assessment Length of time in AEDS		
Brief summary of formulation and original plan		
Diagnosis (EMIS)		
Summary of individual intervention and session frequency		
Summary of group Intervention		
Last CRSMT completion date		
Last care plan completion date		
Last update letter		
Any admission dates and venues		
Current presentation		
Main ED symptoms		
Current physical risk		
BMI		
Other service involvement		
CORE EDE-Q (and previous results)		
Plan		

Appendix 8

AEDS Criterion for Outpatient Management

	Adult Eating Disorder Service Criterion for Outpatient Management	**Date completed by and whom**
Referral	Assessment appointment offered according to risk Within 10 days (RED/Urgent) and 30 days (AMBER/Routine) Minimum information required from referrer to ensure acceptance of referral EMIS: Referral accepted and clinicians identified for assessment or placed on waiting list (waiting list letters sent to patient and refer)	
Assessment	Discussion at MDT meeting of two assessment appointments/proposed care plan and therapy recommendation agreed Outcome measures – CORE-10 and EDE-Q recorded on EMIS Consider joint working with other services CMHT, Perinatal, diabetes, PD, Addictions, etc. Assessment letter to Referrer and GP within 4 weeks of completion of full assessment Risk screen completed at first assessment appointment Care plan and Diagnosis on EMIS at end of assessment period	
Engagement	4 engagement sessions offered and reviewed Keyworker to agree a working formulation of patients difficulties Discussion of treatment including consideration of requirement for OT, psychology and groups (document rationale) AEDS medical monitoring appointments documented and/or guidance to GP re. shared monitoring Care plan, risk screen and diagnosis updated as clinically appropriate Dates for case review and formulation booked in AEDS team diary	
First 6 months of treatment	3 months after assessment letter completed an update letter to be sent to referrer and GP Case discussion within MDT meeting documented every 3 to 4 months MDT case review completed within initial 3-4 months and repeated every 6 months thereafter Psychology led team derived formulation completed within 6 to 8 months of completion of assessment AEDS medical monitoring appointments documented and/or guidance to GP re. shared monitoring Care plan, risk screen and diagnosis updated as clinically appropriate	
6-12 months	Update letters to referrer and GP every six months MDT case discussion every 3 to 4 months Case reviews scheduled in AEDS team diary 6 monthly AEDS medical monitoring appointments documented and/or guidance to GP re. shared monitoring Care plan, risk screen and diagnosis updated as clinically appropriate (care plan 6 monthly minimal update and risk screen minimal annual update)	

12 -18 months	As above: update letters, MDT case discussion, case reviews, care plan, risk screen, and medical monitoring appointments Outcome measures as indicated in service review Discuss at AEDS discharge planning meeting if patient is working towards discharge in any 6 month time period	
18 -24 months	As above: update letters, MDT case discussion, case reviews, care plan, risk screen, and medical monitoring appointments Full discussion at MDT meeting and/or discharge planning meeting if patient continuing treatment beyond 2 years	
At discharge	Completion of outcome measures at time of discharge Discharge letter to referrer and GP Discharged from AEDS caseload on discharge letter being sent	
Guidance	Care plan and risk screen documentation are mandatory for GG&C AEDS MDT discussion and correspondence email/letters to CMHT re. possible disengagement from AEDS documented on EMIS and management plan agreed at AEDS MDT Update letters to include summary of care plan, progress/difficulties with treatment, and information re. medical management Include evidence of discussion re. treatment intensity/frequency and any proposed changes including step down	

Appendix 9

Psychological Treatment Offered by AEDS

Overview:

The NHS Greater Glasgow and Clyde Adult Eating Disorder Service (GG&C AEDS) is primarily a psychological therapy service. We aim to offer high quality psychosocial interventions for people with moderate to severe eating disorders (see Appendix 1 for traffic light assessment of severity/risk). The psychological treatment offered by AEDS is formulation driven and governed by local and national standards for the treatment of eating disorder. The psychological treatment provided also draws upon the best available evidence for the management of complex cases, e.g. where co-morbid mental or physical health difficulties are present.

We offer everyone accessing the service one to one psychological input (further details below). The intervention offered is based on clinical need, service user goals, and psychological formulation. We aim to match the service user to an appropriate clinician for treatment based on these factors as well as clinician skill set and training as is detailed below.

We also offer a range of group interventions, examples of which include behavioural support for eating, coping skills, and psychoeducation.

For patients who are engaged in psychological treatment, we also offer multidisciplinary team (MDT) input as is appropriate. Examples include dietetic review, occupational therapy interventions, and medical monitoring.

Psychological therapies:

A range of evidence based psychological therapies is offered by AEDS. First line psychological interventions for eating disorder offered by AEDS include:

- Cognitive Behavioural Therapy for Eating Disorder (CBT- E)
- Maudsley Anorexia Nervosa Treatment for Adults (MANTRA)
- Specialist Supportive Clinical Management (SSCM)

First line treatments are those recommended within local and national guidelines (NICE, SIGN) with the highest evidence ratings. These are manualised treatment approaches which can be delivered by practitioners with experience working with eating disorder, training in the approach, and accessing appropriate psychological therapies supervision. Appropriate supervision can be provided by a Clinical Psychologist or an alternative accredited practitioner (such as an accredited Nurse Therapist).

Where first line treatments have not proven effective or in cases where the evidence supports alternative approaches (e.g. longer duration of illness or complex presentations), AEDS offer a variety of alternatives. These would be formulation driven interventions drawing upon treatment models including but not limited to:

- Schema Therapy (ST)
- Mentalization-based Therapy (MBT)
- Acceptance and Commitment Therapy (ACT)

- Compassion Focused Therapy (CFT)
- Interpersonal Therapy (IPT)
- Trauma informed interventions (phased-based approaches)

Consideration of novel or emerging approaches as well as integrative approaches are appropriate where standard treatments have not been effective or are not indicated.

Second line treatments would be delivered by Clinical Psychologists or experienced psychological therapists with additional relevant training and supervised clinical practice. Appropriate clinical supervision for these approaches would be delivered by a Clinical Psychologist or an alternative accredited practitioner (such as an accredited Nurse Therapist).

Appendix 10

AEDS MDT Formulation

This document is designed to provide an overview of the rationale and purpose of MDT formulation sessions within AEDS. In addition, it was felt that a document clarifying expectations of participants would be helpful to support development of formulation within the team as well as supporting new staff to the service.

What is a formulation?

A psychological formulation is the process of pulling together information known about a person, drawing upon psychological theory and models to develop an understanding of the possible reasons a person's difficulties have arisen and mechanisms by which they are kept going (Division of Clinical Psychology, 2001).

What is the purpose of a formulation?

To support the development of a shared understanding of a person's difficulties and to work out what interventions might be helpful in targeting factors maintaining those difficulties.

Is there evidence for this approach?

Studies cite evidence of a range of benefits of team formulation in areas such as improved staff-service user relationships, improved team working, and better understanding of service users (Hollingworth & Johnstone, 2014). Hollingworth & Johnstone (2014) also found that staff members found the approach helpful in developing a consistent team approach and in improving ability to work collaboratively with service users and their families.

Why formulate as a team?

Team formulation creates an opportunity to create a safe space, to develop a shared understanding of service users, drawing upon the experience, knowledge and different skill sets of all team members. It also provides a chance for us to learn from one another!

When should we formulate?

Ideally, formulation guides the development of a treatment plan. Following assessment and at some point during engagement would therefore make sense. We can also bring cases where we are feeling stuck, to reformulate as a team, to try to work out what else to try. This represents best practice in terms of ensuring good clinical governance (i.e. safety and effectiveness) of psychological interventions.

So what do I need to do?

<u>Key worker:</u>

You do not have to know the formulation in advance! The focus is on giving an overview of the case so the team can share ideas together. It would be helpful if you have an idea about what you would find it useful to focus on or bring suggestions about what you want out of the session. This might include a direction for treatment, an order of things to address in treatment, a better understanding of the person, or ways to address barriers. Areas of information it's helpful to have an idea of for the session would be:

1) Current context – a bit about the service user e.g. do they work, are they in a relationship, previous treatment, who do they live with
2) Presenting problems – what are the person's key difficulties (i.e. a description of their current presentation) and, if it's a reformulation, is there a key problem emerging in therapy

you want to discuss (e.g. non engagement, resistance to change etc.)? Do they have goals for their treatment?
3) Predisposing factors – information on their upbringing and background, experiences, development, and coping style
4) Maintaining factors – what are the thoughts and behaviours they rely on that keep them stuck. Are there interpersonal relationship patterns that play a part? What is the possible function of their eating disorder?
5) Protective factors – key strengths or supports?

Remember that:

- This does not replace the development of a collaborative formulation on an individual basis with your service users. Team formulation is designed to facilitate thinking about cases and to provide some clinician support to guide the individual formulation process.
- The document we produce (see sections below) is for clinician reference and should not be given in this format to service users. The team document serves as a record of the team discussion rather than representing an agreed upon, collaboratively developed formulation.
- The team document can be used as basis to inform collaborative discussion with service users about the purpose and maintenance of their eating difficulties.
- Team formulation is in addition to the requirement for 1:1 psychological therapies supervision.

<u>Team Members:</u>

You can say as little or as much as you like during the session. There are no wrong suggestions or silly ideas. The purpose of the session is to develop our shared way of thinking about people using the service. Remember that we all have different backgrounds and experiences and so we all bring different and valuable contributions to the formulation sessions.

You can help by:

1) Bringing cases
2) Prioritising formulation sessions
3) Contributing in any way you can during the sessions

<u>Facilitators:</u>

The Clinical Psychology team will facilitate the team formulation sessions. This does not mean we have all the right answers (!) but means we will try to guide the discussion and to keep the session running to time. This will include:

1) Acting as a type of chair to protect the time boundaries of the session
2) Documenting (or overseeing the documentation) of the team discussion
3) Keeping a record of cases formulated
4) Keeping a record of attendance at sessions (via EMIS)
5) Completing a formulation document with a summary of the key discussion and any recommendations identified by the team
6) Uploading the team formulation document to EMIS for clinician reference. Whilst the document has been compiled by AEDS, it is recognised that clinicians from other services working with our service users might also find this helpful in informing their understanding of a person's difficulties. Uploading the document to EMIS allows for this sharing of understanding.

Appendix 11

Interventions Offered by AEDS

Consultations

- AEDS offer consultations to other services working with eating disorders to give specialist advice and support on referral, formulation, and treatment.
- AEDS also contribute to CPA meetings, professional meetings; complex case reviews and can inform inpatient treatment planning (see section on inpatient treatment).
- Delivers education, training and supervision.

Behavioural Support

- If behavioural work is indicated, then it will be agreed between the patient, their key worker, and the Occupational Therapist and may include supported meals. If the individual needs more intensive input, then they will be considered for groups within the AEDS day programme.

Groups

- The group programme is facilitated by the MDT, providing a holistic and needs led programme that aims to address all aspects of an eating disorder.
- There are a range of groups offered that will meet the stage of change/recovery the patient is currently at. These stages are assessment/ engagement, intervention, and discharge planning. The criteria for these stages are discussed between patient and key worker then with the MDT to determine which groups are appropriate for the patient's treatment plan.
- The groups that run at any given time depend on the needs of the current service population.
- Examples of groups that may be offered by AEDS include:
- Motivation Group
- Anxiety Management Group
- Coping Skills Group
- CBT/IPT Group
- Self-Esteem Group
- Discharge Planning Group
- Goal Setting Group
- Body Image Group
- Book Review Group
- Carers Group
- Creative Group
- Occupational balance

Occupational Therapy

- Occupational therapy interventions can help promote confidence and self-esteem, increase motivation, introduce self-directed goal setting, reduce social anxiety and isolation, and establish a sense of physical and mental wellbeing.
- Other examples of support provided by the AEDS Occupational Therapist include:
- Meal preparation

- Creative activities
- Support for employability and vocational needs
- Support exploring leisure activities to regain social skills and confidence
- Rehabilitation back to home after inpatient stay

Dietetic Input

- AEDS Specialist Dietitian will provide a list of agreed food options for supported lunch preparation groups which AEDS staff will assist the group member to choose from.
- AEDS Specialist Dietitian will also run educational groups for patients on food nutrition and basic physiology.
- AEDS Specialist Dietitian may consult with other dieticians working with eating disorders in other services and provide advice and support.

Medical Monitoring

- AEDS has a medical monitoring clinic for routine physical health assessment of patients (e.g., weight, blood result analysis, ECG) and provides health education.
- Due to limited capacity, priority is given to patients most at risk of physical health complications and AEDS rely on the support of GPs and CMHTs to collaboratively ensure the safe monitoring of the physical health of patients.

Involving Family and Carers

- Family and carers are involved in decisions about patient treatment and care as appropriate and where consent is given by the patient. Families and carers should also be given the information and support they need.
- AEDS is an adult service. Therefore, the decision to involve families and carers lies with the patient and their decision will be respected.
- If patients do not have the capacity to make decisions, healthcare professionals will ensure that legal, organisational, and professional requirements for obtaining consent to treatment are followed.
- AEDS also offers a carers group, which runs on a rolling basis and provides support and psychoeducation on eating disorders to family and carers.

Appendix 12

AEDS Inpatient Recommendations for Daily Documentation

Listed below are some useful points to consider for daily documenting about patients who are being treated for an eating disorder whilst an inpatient.

Recording the following points will allow the consultant and AEDS to safely assess and monitor progress in treatment.

- What day of refeeding is the patient currently on?
- Blood results for that day. Ask duty doctor to document the blood results.
- Can they safely move onto the following day of the menu plan? If not, then why not? Action being taken?
- Meals – rate of eating, ease in choice, ritualistic eating, eating disorder behaviours?
- Food they are managing. Amount managed.
- Was a supplement required? Did they manage full amount?
- Any difficulties around the food? Eating disorder behaviours observed, anxiety, distress
- Activity levels? Micro-exercising, pacing, long periods in the toilet?
- Interventions from staff around difficulties? Did these help? Or not?
- Interactions at mealtimes? Do they need prompted to eat?
- Sleep – Time going to sleep? What time they wake up. Is sleep interrupted?
- Showers – amount of time, have they showered that day?
- Have they been weighed that day? – Any reaction to weight? Has their daily intake or behaviour been affected by this?
- Bowel movements? Requests for laxatives?

AEDS Recommendations for Inpatient Treatment of Eating Disorder Cases

- Urgent referral to dietitian who covers the admitting ward.
- Weigh the patient on admission and the next morning to obtain a true weight. Consult the dietitian if any change in weight.
- 10 day refeeding menu plan that has been devised by the ward dietitian. This should be followed exactly with no extra food/fluid or substitutions made to any choices. The patient can only progress onto the following day if all food and fluid prescribed for that day is completed and bloods are showing no signs of refeeding syndrome. Bloods must be monitored daily by the medical team and cannot progress onto next day if any signs of refeeding syndrome are present. Should remain on the same day of refeeding menu plan until bloods results show bloods have been corrected.
- Daily bloods – FBC, U+Es, LFTs, bicarbonate, magnesium, bone profile, glucose, amylase, and CK.
- ECG daily if abnormalities or symptomatic.
- Duty doctor should clearly record results on EMIS for both bloods and ECGs.
- Physical observations, erect and supine, including temp x4 daily.
- Skin assessment of any bony/prominent areas to identify any skin breakdown.
- Four times daily BMs as per MEED guidelines at 0200, 0600, 1030, 1530.
- Use GG&C management of hypoglycaemia guidance for correction of low BMs.
- All medication patient already receives with the addition of Forceval daily, Thiamine TID, vitamin B co strong TID.

- Fluid balance chart input and output.
- Bristol stool chart.
- Patient to be weighed on a Monday. Weight should be taken before breakfast, after urinating, before shower and hair dry and in underwear only.
- Bloods should always be taken on same days as weight to monitor for any weight altering/eating disorder behaviours.
- Symptomatic relief to be prescribed in half doses according to weight. No laxatives on symptomatic relief.
- Special observations – nurse should be inside the room with the patient.
- No food/fluid to be provided by family/visitors. NHS to provide all food/fluid consumed.
- Menu plan must be viewed as a prescription. Only the dietitian may make changes to it.
- All meals, snacks, and supplements must be in the dining room only. If patient refuses to attend the dining room, this is a refusal (exception of medical beds).
- Main meals will last no more than 30 minutes. Snacks last no more than 15 minutes. Remove food if this is not completed and supplement will be offered. 5 minutes only to complete supplement. Remove after 5 minutes.
- Staff should be sitting at the table with the patient during meals and snacks.
- All food includes scraping plate of all last crumbs and sauces on plate.
- Order appropriate airflow mattress for bed rest.
- Assess for risk of Venous Thromboembolism (VTE) as per GGC Thromboprophylaxis for medical and surgical patients guideline and the use of subcutaneous Enoxaparin Sodium should be considered for total bedrest (40mg daily).
- Please use height recorded on EMIS used by community AEDS.

Support can be provided around detailed eating disorder specific care plans around patient treatment plan.

I would recommend staff make these easily accessible to any RMN/HCA staff carrying out observations.

Appendix 13

Job Title	AEDS Staff Profile
Clinical Lead	Consultant Psychologist; responsible for the psychological ethos of the team and the application of an evidence-based treatment package. The Consultant is responsible for the clinical supervision of qualified Clinical Psychology staff within the team and the overall supervision of psychological therapy provision across the service. Reports to Head of Service (North).
Team Lead (RMN)	Oversees the general function and governance of the team. Also responsible for the line management and supervision of the nursing team as well as key working with AEDS patients.
Consultant Psychiatrist	Responsible for the four eating disorder beds in Armadale Ward, Stobhill Hospital. The community Consultant Psychiatrist assesses and manages psychiatric risk of AEDS community patients. Both Psychiatrists contribute to the overall service via MDT meetings.
Administrator	Co-ordinates and holds responsibility for AEDS administrative work.
General Practitioner	Oversees the medical monitoring of AEDS outpatients and liaises with GPs responsible for AEDS patients. They provide specialist advice on the medical management of patients for GPs.
Clinical Psychology	Provides the application of clinical psychology to the service via multidisciplinary working, clinical supervision, formulation, research and audit along with direct clinical management of more complex cases including trauma, personality disorder, and autism.
Senior Eating Disorder Practitioner (RMN)	Constitute the mainstay of the service providing key working and psychological therapy to AEDS patients.
Eating Disorder Practitioner (RMN)	Provides key working and psychological therapy to AEDS patients under the supervision of a Senior Eating Disorder Practitioner.
Occupational Therapist	Provides specialist occupational therapy assessment and treatment to AEDS patients. Oversees the group therapy programme. Delivery of groups. Provision for employability needs.
Dietitian	Provides specialist dietetic input to all AEDS patients. AEDS has two dieticians – one based in inpatient and one working with the outpatient team. They both offer a consultative role across GG&C.
Assistant Psychologist	Provides low-intensity psychological interventions to AEDS patients under direction of key workers and Clinical Psychology staff. They are also involved in patient screening and data collection for audit and research.
General Nurse	Co-ordinates medical monitoring clinics for AEDS. They are able to manage the clinics independently referring to AEDS medical staff for specialist medical interpretation. They play a key role in medical liaison with GPs.
MEED Link Nurse	Provides staff support, liaison, and training for the management of medical admission of patients with an eating disorder across any site in GG&C.
Transition Worker	Co-ordination and management of the transition of cases from Child and Adolescent Services to AEDS.

Clinical Associate in Applied Psychology (CAAP)	Provides key working and psychological therapy within the team and supports other clinical psychology activity including delivering clinical supervision to Assistant Psychologist and Peer Support Worker.
Peer Support Worker	Working under supervision with patients identified by AEDS MDT that would benefit from this support to work towards their recovery.