CONTENTS

INTRODUCTION

Welcome

Welcome to Cotswold House Specialist Eating Disorders Service.
Supporting someone who has an eating disorder can be challenging and can often leave you wondering if you are doing the "right" thing. This guide is here to try and make things clearer and give the information you may need to help support your friend or family member through treatment. Firstly, practical information about the service will be given followed by information about the team, leading to information about treatment and how we support families, and finally how families can support treatment.

What is Cotswold House?

Oxford Health NHS Foundation Trust runs Cotswold House Specialist Eating Disorders Service which is situated within Savernake Hospital in Marlborough. It is a multi-disciplinary service for males and females aged or 16 or over with severe eating disorders. Our specialist services offer inpatient, day patient and out patient treatment.

Friends and family often ask the following questions:

I can't get my head around this, what is going on?

One of the patients at Cotswold contributed this explanation of eating disorders:
Eating disorders are noted as being characterized by an abnormal attitude towards food that causes someone to change their eating habits and behaviours. The problem however, is that the above definition is only the tip of the iceberg. Eating disorders are an all consuming mental illness, they dominate the individual's thought process, decision making and cognitive ability. Days are consumed by an irrational drive to lose weight and gain control over the body. The illness targets people differently but common symptoms are: anxiety, panic attacks, rigidity, black and white thinking and an unhealthy fixation on food, weight and calories. The illness causes compulsive behaviour, usually around food, excessive exercise, vomiting and laxative abuse. As the illness progresses, fear of weight gain becomes greater. Many chose to hide their illness, this could be due to the individual's need for control, or embarrassment or uncertainty of what is wrong with them and a fear of causing arguments with those they are close to. The breakdown in relationships leads to further isolation and increasing dependence on their eating disorder.
The primary concern with eating disorders is the impact they have on physical health. Instead of fighting for survival like those without the illness would do, they continue to starve themselves and push their bodies to the extreme of what they can cope with. Taking the above into account, the obvious question is why would anyone want to do this to themselves? The answer is, they don't. Eating disorders have the highest death rate of all psychiatric illnesses and should never be underestimated, ridiculed or seen as a life style choice. It is a psychological cancer in dire need of research, resource and understanding. The person suffering is still there, trapped and alone, the same person you know and love just very ill and in need of help (Ffion Jones).

What caused this?

There is no definitive, identifiable cause of eating disorders, rather there are a set of risk factors. Risk factors may include: perfectionist personality, difficulty coping with change, life stressors, low social support, having a family history of eating disorders, values of “thin” ideals, physical illness prior to onset. However, it should always be noted that there are people who have all the risk factors and do not go on to develop eating disorders, therefore no factors can “cause” an eating disorder, rather make it more likely.

In treatment however, we focus more on what maintains the illness rather than what started it.

How do we treat eating disorders?

See treatment section. In short, treatment in incredibly difficult and many sufferers say it is one of the hardest things they have ever done.

How long will treatment take?

This question is difficult to answer as it is based purely on the individual and their aims and goals of treatment. Some patients may only be admitted until they reach a condition in which they are still underweight, but are considered to be medically stable. Other patients may opt for full recovery, whereby they commit to reaching a healthy weight. Regardless of each patient’s intentions of treatment, a time scale is impossible to predict, as it is dependent on many different factors.

VISITING & FACILITIES INFORMATION

Visiting

All family and friends are welcome to visit (subject to agreement with the patient). During the week, visiting hours are between 7.00pm – 9.00pm each evening. At weekends, visiting hours are between 2.00pm – 9.00pm avoiding meal times (see activity timetable). Visiting hours can be flexible under certain circumstances i.e. work commitments. This must be requested through clinical planning by the patient (see clinical planning further down).

Things to note about visiting:

- Often when we visit family in hospital we may want to take treats such as food, drinks etc. Due to the nature of the unit we encourage families not to bring any food or drinks onto the unit. This is because patients are on carefully monitored meal plans with specific calories and fluid intake. Again, due to nature of the unit we may search items that you bring in. If your loved one has asked you to bring in specific items for them, please ask the nursing team if you are unsure.
- When visiting you can use space on the unit such as their bedroom, the social areas, the courtyard and we do have group rooms available.
- If a child under 18 intends to visit, let us know in advance so that we can make any necessary arrangements to ensure their welfare and safety. We have toys and can also arrange for you to have use of an alternative room if your bedroom is not suitable.

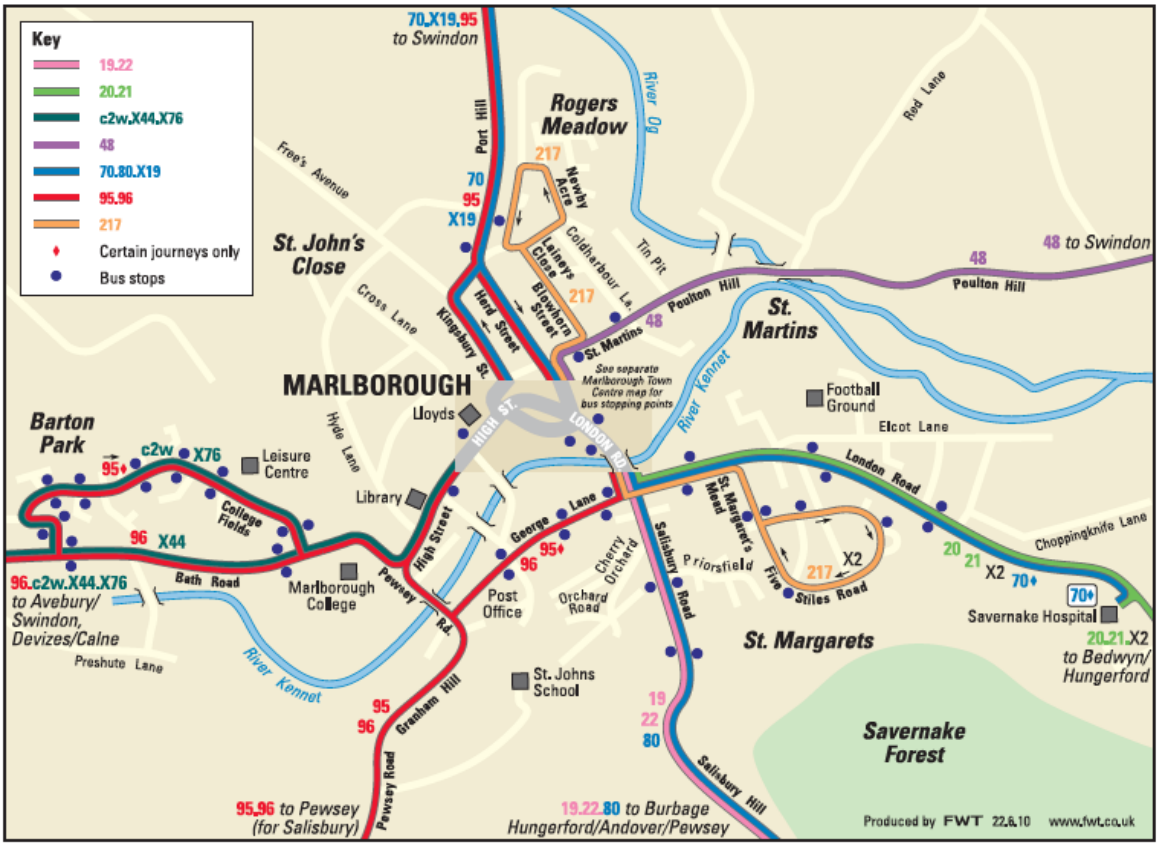
Finding the Hospital

Savernake Hospital is situated east of Marlborough town centre, in Wiltshire, on the A4 London Road and can be easily reached by the M4.

Travelling on the M4 from the east (London/Reading), turn off at junction 14 then follow the A338 (south) towards Hungerford. Turn right onto the A4 towards Marlborough and Savernake Hospital is on the left.

Travelling on the M4 from the west (Bristol/Swindon), turn off at junction 15 and follow the A346 (south) to Marlborough. Turn left onto the A4 towards Hungerford and Savernake Hospital is on the right.
NB. Satellite Navigation systems can make mistakes about the location of the hospital.
For bus timetables and local services, visit www.wiltshire.gov.uk for more information.

Parking
There is a pay and display car park for patients and visitors and disabled car parking is available near the entrance. Parking fees, at time of print, are 50p per hour.



Facilities

Patient phone

There is a patient phone on the unit, it is free to use and the number to this phone is 01865 904624.

Receiving post

Whilst at Cotswold House, patients can receive post. This will go to the main reception before being brought to the ward by staff. To ensure inappropriate items do not arrive on the unit all parcel opening needs to be overseen by staff.

To receive post, the address is:

Cotswold House
Savernake Hospital
London Road
Marlborough
Wiltshire
SN8 3HL

Canteen

The canteen is off the unit and open 9.00am – 3.00pm Monday to Friday. Here there is a selection of hot and cold meals, desserts, snacks and drinks. The canteen is for the use of anyone who visits the hospital and is also used by hospital staff and patients. If the canteen is closed, there is a hot drinks vending machine and a snacks and cold drinks vending machine located in the reception area.

Unit computer

There is a designated computer for patient use. To use the Unit computer and Internet, each patient will need an individual password. There is a form to fill in and this needs to be handed to a member of the admin team. The passwords take approximately a week to arrive. There is no direct printer access, but work can be printed off from a memory stick at staff discretion.

Electrical equipment

Patients can have up to 5 electrical items on the ward. These need to be PAT tested, as per hospital policies, before being used on the unit. This can take up to several days depending on availability of PAT testers.

Personal cars

Inpatients are not routinely allowed to bring their own car to the Hospital site, as there is not enough room to park it. Patients need to discuss individual driving needs with the team as driving at a low BMI will be deemed as unsafe, patients may be asked to contact the DVLA to inform them of their current medical circumstances. Patients who drive to the Unit need to apply for a parking permit to use in the Hospital car park. This will aid the car park attendant and will allow a discounted rate of parking.

Personal bedding/towels
Personal bedding and towels are not permitted as they are considered a fire hazard. All patient bedding and towels are supplied, stored and washed by the trust. If a patient ever wants to change their bedding or wants clean towels, new supplies can be found in the laundry room.

Property check
Each patient will undergo a property check when coming to the ward as an inpatient. This means all of their personal belongings will be searched and listed.

Items patients can bring
Patients can bring in their own tea, coffee and squash (only one item due to storage). This must not be low calorie or “diet” option.

Smoking
Please note that from Monday 27th October 2014 Cotswold House Marlborough is completely non-smoking. This means that smoking will not be permitted anywhere in the grounds and the outside smoking shelter will be decommissioned.

Oxford Health NHS Foundation Trust is committed to becoming completely non-smoking by 2015, in accordance with NICE guidance PH48 November 2013.

Senior nursing, occupational therapy and medical staff have all trained as Stop Smoking Advisers, and we are able to offer a full range of support and medication options for our patients, whether they opt for temporary abstinence or aim to use their admission to stop smoking altogether. We will ask patients bringing in tobacco or cigarettes to give them to staff for safekeeping during their stay.

If you have any queries you are welcome to contact us to speak to one of the Stop Smoking Advisers, listed below:
Dr Christine Vize - Consultant Psychiatrist
Julia Rossiter - Acting Modern Matron
Helen Mills - Acting Clinical Nurse Lead
Katie Gale - Occupational Therapist and Deputy Team Manager
Ruth Collier - Occupational Therapist.

THE COTSWOLD HOUSE TEAM

Treating eating disorders is a complex process and multi team approach. Our team consists of:

Consultant Psychiatrist
The Consultant Psychiatrist has medical responsibility for the care of patients. She takes a lead, along with other senior members of the team, in assessment and multi-disciplinary team reviews, providing support in diagnosis, planning treatment, liaison with other agencies, teaching, research and monitoring work practices and performances. She is part of the Eating Disorders Management Team and is involved in the development of the unit. She also takes on the role of Responsible Clinician (RC) according to the requirements of the Mental Health Act (1983).

Modern Matron
The Modern Matron manages and organises the unit to ensure it offers safe and effective high quality services to people with eating disorders. She manages most non-medical staff, provides leadership and expertise to deliver services within an agreed service model, working with both service users and carers.

Clinical Nurse Lead
The Clinical Nurse Lead is responsible for the co-ordination and management of the clinical team in providing a safe, structured and therapeutic environment for service users. In conjunction with all clinical leads, the clinical nurse lead is also expected to contribute to the development of the eating disorder service and to provide, maintain and develop nursing care to the optimum standard.

Charge Nurses
The Charge Nurses work with the unit manager to manage the day-to-day running of the unit. They use their leadership skills to lead and motivate staff and are involved in the running of the Group Programme.

Consultant Psychologist
The Consultant Psychologist provides clinical leadership to the inpatient team and manages the Wiltshire Community Eating Disorders Team. She has a leading role in running the Group Programme that Cotswold House offers, as well as individual treatment and overseeing data collection and audit.

Clinical Psychologists
The team of Psychologists offer assessment, formulation and psychological treatment. They play a key role in the multi-disciplinary team and with the delivery of the Group Programme.

Family Therapist
The Family Therapist provides systematic assessments and therapy to patients and their families, whilst also contributing to the Group Programme.

Dietician
The Dietician is a specialist source of expertise in the dietetic management of eating disorders. She works with the patients to develop an agreed clinical nutrition and diet plan, whilst also contributes to the running of the Group Programme.

Occupational Therapist
The Occupational Therapist takes a lead role in the development of the Group Programme provided by Cotswold House. She works with inpatient/outpatient and community patients offering skill development in sandwich making, food preparation, food shopping and cooking.

Technical Instructors
The role of the Technical Instructors is to assist the Occupational Therapist in the group therapy programme and to offer individual support for occupational therapy activities, both within the unit and away from the unit.

Staff Nurses
The Staff Nurses are responsible for coordinating and managing the nursing shift. Primary Nurses on a care team act as the first point of contact for the patient, Secondary Nurses act as the point of contact for the family.

Support Workers
Support Workers are members of the team who provide patient care under the supervision of the registered Staff Nurse. The duties of the Support Workers include supported eating and offering high quality care.

Admin Team
Office Manager, Team Secretary & Admin Assistant
Our admin team provide an efficient and comprehensive secretarial and administrative service to the unit. They manage all administrative duties and ensure all systems are in place for the effective running of the unit. Their duties include arranging meetings and sending out clinical information securely.

GPS
Cotswold house is linked with a team of local GPs who attend to the medical needs of our patients. The GP will be involved in the assessment process, clinical planning meetings and daily ward visits. On Thursday, the GP will hold a clinic offering patients 10 minute slots between 4.30-5.30pm.
Cotswold House is covered out of hours by Wiltshire Medical Services.

Pharmacy Technician

The Pharmacy Technician attends the unit weekly on Tuesdays. The visit will include checking the medication stock and orders in the clinic room and processing home leave medication for patients on leave.

TREATMENT

Treatment plans differ regarding each person, what their treatment goals are and the stability of their physical health. Our treatment is based on the current evidence base for eating disorders. Links to this can be found here:
NICE (National Institute of Clinical Excellence) link:
http://publications.nice.org.uk/eating-disorders-cg9/guidance

Here is an overview of the treatment we offer.

Monitoring and stabilisation of physical health
Eating disorders carry a high level of physical risk and thus the monitoring of this is prioritised in treatment. People are weighed twice weekly, have bloods taken regularly, have an ECG (reading of the heart), have their physical observations taken regularly (temperature, pulse, blood pressure etc) and a dexa bone scan is arranged (to ascertain any osteoporosis). The Unit is linked with a local GP Practice and GPs visit daily during the week. In the evening and at weekends there is an out of hours medical service that can be contacted.
Weighing takes place on a Monday and Thursday morning between 6-7am. Patients must be in underwear alone and be void of urine.
There is an expectation that patients will gain approximately 0.5-1kg per week. Weight gain is done in a careful way through the dietician to avoid re-feeding syndrome. This can occur as a result of food being reintroduced to the body after periods of starvation. Renourishing the body is traumatic for the body and person experiencing it. Patients can experience oedema (water retention), colicky symptoms, fluctuating body temperatures, nausea and intense mood swings.

Meal Plans
Meal plans support the stabilsation of physical health. When someone is admitted they will have an assessment with the dietician who will devise a meal plan based upon their current level of eating and their physical health needs. We have 4 different types of meal plans based on medical knowledge beginning with renourishing plans which consist of high amounts of milky drinks and little and often portions, building to maintenance meal plans which offer more choice. All meal plans consist of 3 main meals and 3 snacks. Many families are surprised by the calorific content of the meal plans. We would advise that healthy eating guidelines from the government (5 portions of fruit and vegetables day, high amounts of water etc) are aimed at an overweight population. The nutritional needs of someone who is underweight are vastly different and high amounts of calories need to be consumed to gain weight and stabilise health. On the unit we frame food as “medication”; meal plans are not about likes and dislikes but necessary for physical health. There is always a vegetarian option and we can cater for religious or cultural requirements or any prescribed diets (for example nut allergies or gluten free diets).
Cotswold House cannot accommodate for Vegan diets as part of a recovery treatment plan; this is not recommended by medical advice.

Fluids are also included as part of the meal plans. This is so fluids are spaced out throughout the day to avoid fluid loading and managing the symptoms of re-feeding syndrome.
Meals are completed in the dining room. Attendance to meals is a key part of treatment as this is where many of the eating disordered behaviours will be challenged (see appendix 4 for guidelines given to patients regarding their behaviour at the table). For instance, patients are expected to eat appropriately (not pulling food apart, smearing, using incorrect cutlery, not spoiling foods with condiments etc). We understand that for many patients these behaviours have become automatic and are based around emotions of fear and thus we challenge this is a safe, empathetic and understanding way. The extent to which we challenge will also be based on where that individual is in their treatment.
The dining room has three tables; high, medium and low support. Patients aim to work towards lower support tables where they will be taking more responsibility around eating, less support from staff and showing more healthy attitudes towards food.
Rest periods follow meal times and again are a key part of treatment. Often people with eating disorders will over exercise, stand a lot and constantly move limbs. Rest periods challenge these behaviours and give the food time to digest. Rest periods are often the most difficult part of the day as patients are sitting with feelings of fullness and the negative emotions that surround that. We encourage patients to learn distraction and self soothing techniques to practice at this time.

Daily meal times and rest periods on the unit

Time	Meal	Completion	Rest
8.00am	Breakfast	30 minutes	45 minutes
11.00am	Morning Snack	15 minutes	30 minutes
12.30pm	Lunch	30 minutes (20 minutes main meal, 10 minutes dessert)	1 hour
3.30pm	Afternoon Snack	15 minutes	30 minutes
6.00pm	Supper	30 minutes (20 minutes main meal, 10 minutes dessert)	1 hour
9.30pm	Bedtime Snack	15 minutes	30 minutes

Medication
Eating disorders are primarily an emotional disorder and thus there is a low evidence base for the role of psychiatric medication. As part of supporting physical health patients will often be prescribed vitamin and mineral supplements. Psychiatric medication may be prescribed if the person has another mental health diagnosis secondary to the eating disorder such as depression.

Physical Activity
Cotswold House has specific activity guidelines (see appendix 1) to ensure a safe level of activity. The decision to increase a patient's activity level is dependent on medical state and their ability to manage and comply with treatment. However, for the first week it is expected that all patients remain on the unit – irrespective of their BMI.
Initially, activity restrictions are designed and put in place purely to minimize medical risk. Bed-rest and the use of wheelchairs will be avoided wherever possible, but may be necessary as a short-term measure for patients with very low BMIs.
Activity levels are designed to enable patients to gain weight at the required rate per week, whilst also promoting wellbeing and aiding a 'normal' redistribution of body weight. Patients are encouraged to avoid any aerobic activity until their BMI is approaching target range (generally above 18.5). Advice will be given to patients regarding suitable exercise.

Nursing Care
Throughout the day, each patient is allocated a named nurse. This worker takes on the role of supporting the patient throughout the day, providing support as required. Part of nursing care involves observation levels. Depending on level of risk patients will be on hourly, 15 minute or within eyesight observation. The observation time is another chance for nursing staff to interact with the patient and see how they are doing. Allocated nurses will offer one to one time every shift.

Once physical health is more stable treatment can incorporate more psychological and occupational therapy work (see below).

Group Programme
Cotswold House runs a well established group therapy programme with sessions running each day on week days. Groups are helpful is sharing experiences, increasing interpersonal skills and supporting new coping techniques. Groups are run by our psychologists, occupational therapists, nurses, support workers, family therapist and dietician. The full group programme consists of: Dialectical Behavioural Therapy, Cognitive Behavioural Therapy, Self Esteem, Nutrition, Bodywise (body image), Goal Setting, Motivation, and Relationships. This is not an exhaustive list; we do add other groups in as required.

Individual Therapy
Patients are assigned an individual therapist to focus on psychological treatment or, "talking therapy". Psychologists will meet a patient for an assessment, use formulation (understanding the patient's problems) and will then form a psychological treatment.

Most psychological work will look to develop different coping strategies for triggers. Work into childhood etc is not always appropriate and is not looked at as standard.

Occupational Therapy (OT)

Once patients are assessed as ready to begin managing their food intake again, the OT team support this. To begin with patients will start serving their own portions. This develops to having meals and snacks off the unit, support with food shopping and cooking their own food. A group snack and sandwich making group occur weekly.

Family Therapy

Family Therapy is available to all families of patients receiving treatment at Cotswold House. It is also available for individuals, couples and other people who may be involved with a patients care. Family therapy is important in the recovery of eating disorders as it is a condition that affects family life and relationships. The aim of family therapy is to help families find constructive ways of helping each other that may not have previously existed. The purpose is to identify problems which may arise and support change to promote progress towards recovery. Family therapy is not about 'treating' or blaming the family/relations of those with an eating disorder; it is about supporting both sufferers and those who they are in contact with and demonstrating their role in aiding and assisting prolonged recovery.

Therapeutic Leave

As part of treatment, patients are encouraged to take time off the unit to primarily practice what they have learnt on the unit and transfer those skills back to a home setting.

Any leave will follow the Cotswold House activity guidelines (see guidelines and criteria); these guidelines take into account BMIs and medical stability for taking any leave away from the unit.

Before leave patients are expected to prepare with their care team and family, discussing meal planning, activity levels and any other concerns that you may expect to encounter.

It is not expected to go smoothly as first. With practice however, the expectation is that patients will be able to manage a meal plan, remain in their weight band and repeat any individual food preparation work they have been practicing on the unit.

When patients begin having home leave, this will be taken over a weekend period to ensure full group attendance during the week. The patient is responsible for sorting out transport; usually this involves asking family or using public transport.

A typical day

Timetable	Monday	Tuesday	Weds	Thursday	Friday	Sat	Sunday
8.00 – 8.30am	Breakfast					Medication	
8.30 – 9.00am	Medication					Breakfast	
9.10am or 9.30am	Community Meeting 9.10		Community Meeting 9.30		Community Meeting 9.30	Free Time	
10.00 – 11.00am Group	Start The Week	DBT	Psycho Ed/ Bodywise	Nutrition / Baking	Motivation		
11.00-11.15am	Snack					Snack	
11.30am – 12.15pm	CPM Feedback	Individual Therapy		Sandwich Making	Individual Therapy	Free Time	
11.45pm – 12.15pm	Medication					Medication	
12.30 – 1.00pm	Lunch					Lunch	
1.30 – 2.30pm	Individual Therapy / Free Time					Visiting Hours - 2.00pm-9.00pm	
2.30 – 3.30pm Group	Goal Setting	CBT	Relationships	Life Skills	Group Snack		
3.30 – 3.45pm	Snack					Snack	
4.00 – 5.00pm	Individual Therapy / Free Time					Visiting / Free Time	
5.00 – 5.30pm	Medication					Medication	
6.00 – 6.30pm	Supper					Supper	
7.00 – 9.00pm	Visiting Hours / Free Time					Visiting / Free Time	
9.30 – 9.45pm	Snack					Snack	
10.00 – 10.30pm	Medication					Medication	
10.30 – 12.00pm	Free Time / Bed					Free Time / Bed	

MEETINGS THAT SUPPORT TREATMENT

Community meetings

Community meeting is held four times per week and is a space for staff and patients to meet together to discuss any issues that may arise concerning the running of Cotswold House as a whole. This meeting is often used as a forum for discussion and information giving and patients are encouraged to provide feedback, both positive and negative. There is a patient 'Community Meeting' book located in the social area for any issues to be noted anonymously which will then be read out at these meetings.

Clinical planning meetings (CPM)

Every Monday morning the multi-disciplinary team gathers together to attend a Clinical Planning Meeting. During these meetings each individual patient's care is discussed and appropriate action is taken to ensure the smooth running of their treatment.
As well as discussing medical issues, this meeting is also where any requests from patients are considered and decided upon. Every Sunday, each patient must hand in a Clinical Planning Form, detailing 3 realistic weekly requests (in accordance with the BMI guidelines) and providing additional information and experiences on the past weeks groups and meals. If unsure, patients are advised to speak to their Primary Nurse or a member of their team to discuss their clinical planning forms, so that their requests are realistic, practical and reasonable. These forms must be handed in to a member of staff by Sunday evening so that they can be read and typed up in preparation for the CPM.
CPM runs from approximately 9.30am – 11.30am. Following the meeting, each patient will be called into the group room individually to discuss the outcome of their requests and changes to care plan for the week. Monday mornings can be stressful and an emotional time if patients are disappointed with the results of the CPM. There may need to be meal plan increases, changes in observation levels, or the requests may not have been granted. We remind patients that although they may be angry or disappointed about a decision, there is a logical and justifiable reason for them and they are made in the best interest of the patient.

Care programme approach (CPA)

Formal reviews of treatment occur approximately every five to six weeks during admission. These reviews are called CPA's and include the patient, their individual therapist, their primary nurse and other key people involved in their care.
Members of the home team are also invited to attend these meetings. Patients invite their carers/ family members to these meetings if they would like them to attend. Even if they do not agree to your attendance, you can still contribute any views you have.
At these reviews, patients will have the opportunity to give and receive feedback from the team about the changes they have made and continue to keep making. These reviews monitor and detail the progress of each patient, focusing on how they can next move forward towards recovery. CPAs are also forums to identify personal aims, aspirations and goals they expect or want from treatment. The treatment plan is discussed and towards the end of your stay a post-discharge plan will be agreed.

OTHER USEFUL INFORMATION RELATING TO TREATMENT

A note on the person's goal: stabilsation or recovery

Full recovery: Cotswold House encourages and advocates that all patients aim for full recovery from their admission. Full recovery consists of reaching a healthy BMI of 18.5+ and re-establishing a balanced life, which would include a maintenance meal plan, a moderate amount of physical activity and regaining a sense of normality through activities away from the unit.

Stabilsation: Some patients enter Cotswold House and do not feel ready to aim for full recovery. For these patients, stabilisation is the aim of their admission. Stabilisation is where the patient works toward reaching an agreed BMI that is below what is considered healthy and normal, but means that they are medically stable enough to be discharged. If patients choose to maintain lower than a healthy BMI range a maintenance meal plan may be introduced when it is deemed safe to do so. Discharge would then be discussed and planned after two weeks of maintaining at Cotswold House.

A note on the Mental Health Act

The Mental Health Act (1983) allows for the detention and treatment of individuals suffering from a mental illness. The individual must be seen to be posing a risk to either themselves or others to be assessed and detained. Within the context of eating disorders the risk is usually in regard to physical health and that if treatment is not commenced it could be life threatening. If a patient is medically stable and can show capacity (ability to make informed decisions about treatment, demonstrating ability to weigh up costs and benefits of treatment) then The Mental Health Act cannot be used. This can be frustrating for families as you may feel things will deteriorate again and that current weight will not be maintained, however, The Human Rights Act overrides The Mental Health Act (1983).

A note on nasogastric (NG) feeding

Nasogastric feeding is a technique whereby a narrow plastic tube is placed through the nose, directly into the stomach. Once in place, the tube can be used to provide nutrition by giving liquid food directly into the stomach. If NG feeding is required our trained staff will do it on the unit. This ensures minimum disruption for patients and means we can keep the period of NG feeding as short as possible.

NG feeding is seen as a last resort to support eating and every attempt will have been made prior to this to try and get the patient to be able to eat themselves. Under The Mental Health Act, NG feeding can be enforced as emergency treatment but this is rare and a last resort.

A note on contraband items on the ward and rationale

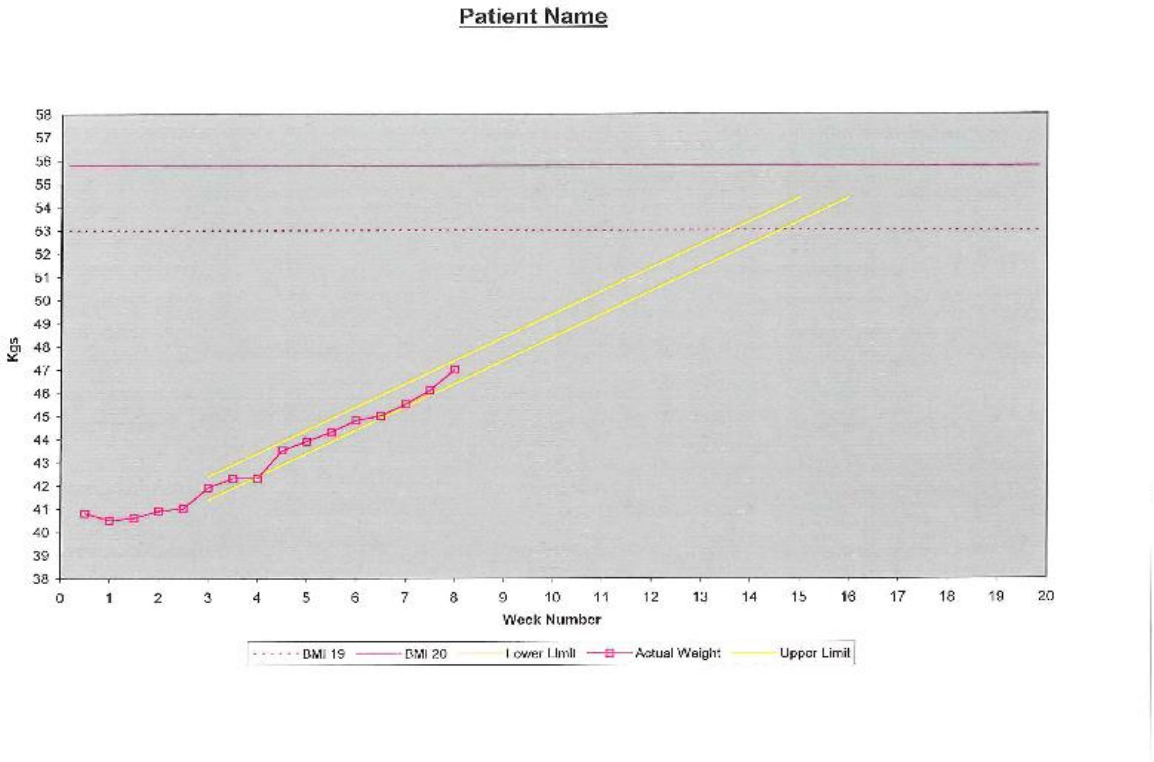
Patients are made aware that the following items are not allowed on the ward.

Laxatives-may support eating disordered thinking and behaviour

Alcohol-can worsen depressive symptoms, lower inhibitions (can lead to binging and self harming behaviours)
Fizzy drinks-these can be used to suppress appetite
Chewing gum-these can be used to suppress appetite
Diet medication- can support eating disordered behavior and thinking
Illicit drugs-mood altering and lower inhibitions
Food-no food allowed other than meal plan items, this is to discourage binging

A note on weight bands

Weight graphs detail weight bands that individual patients should be within during their treatment. A weight band of 0.5kg either side of existing weight will be plotted. Patients are expected to remain within weight bands and if weight drops below this a meal-plan adjustment may be needed. The idea behind the weight band is to ensure that weight restoration occurs in a predictable, controlled way.



A note on treatment breaks

Weight bands are reviewed each Monday by the multi-disciplinary team. If patients continually fall out of their weight band and are unable to meet the expectations of their treatment plan, a treatment break might be suggested if appropriate. This will give patients time to review overall aims and goals for treatment and to decide whether they wish to continue with it.

HOW WE SUPPORT FAMILY MEMBERS/CARERS AT COTSWOLD HOUSE

Your rights as a family member/carer

Under guidance in working with families you are entitled to information about the illness, treatment options and what to do in a crisis. You are also entitled to information regarding support for yourself and other family members, information about Carers Assessments and information on other organisations that may be of help.

If the person you are supporting consents to their treatment information and progress being shared with you, you can have an active role in CPAs, discharge planning and care planning. If the person you are supporting does not consent to information being shared you can still share your views about treatment but progress/options may not be shared with you. You always have the right to be listened to.

Friends and Family Group

This group is open to friends, family and carers as a source of support, advice and information. People find it helpful to attend to get specialist support but to also recognise other families are having similar experiences. The group runs between 11am and 12:30 midday every third Saturday of the month at Savernake Hospital. The topic of the group changes monthly. A flier is sent out prior to the group each month giving details of the topic.

Secondary Nurse

As part of a person's care team; the secondary nurse role is specifically for family communication and support. The secondary nurse should contact you shortly after admission. They are your first point of contact for any concerns, queries, support or information you need.

Family Therapy

Family Therapy is available to all families of patients receiving treatment at Cotswold House. It is also available for individuals, couples and other people who may be involved with a patients care. Family therapy is important in the recovery of eating disorders as it is a condition that affects family life and relationships. The aim of family therapy is to help families find constructive ways of helping each other that may not have previously existed. The purpose is to identify problems which may arise and support change to promote progress towards recovery. Family therapy is not about 'treating' or blaming the family/relations of those with an eating disorder; it is about supporting both sufferers and those who they are in contact with and demonstrating their role in aiding and assisting prolonged recovery.

Carers Assessments

A Carers Assessment is your one legal right as a carer. It involves individual time with you talking through your caring role and seeing if anything can be done to support you.

The responsibility of completing Carers Assessments lies with community teams; as such we do not complete Carers Assessments within our service but can refer you for one.
More information about Carers Assessments can be found here:
http://www.nhs.uk/CarersDirect/guide/assessments/Pages/Carersassessments.aspx

Helpful Resources
These resources aim to give more information about eating disorders
For families specifically:
Skills-Based Learning for Caring for a Loved One with an Eating Disorder: The New Maudsley Method. J. Treasure (2007).

Anorexia Nervosa

- Anorexia Nervosa: A Survival Guide for Families, Friends and Sufferers.
- J. Treasure (1997). Psychology Press.
- Overcoming Anorexia Nervosa: A Self-Help Guide to Using Cognitive Behavioural Techniques. C. Freeman (2002). Robinson.
- Anorexia Nervosa: The Wish to Change. A. H. Crisp, N. Joughin, C. Bowyer (1996). Psychology Press.
- Anorexia Nervosa. R. Palmer (1989). Penguin.
- Mealtimes and Milestones: A Teenager's Diary of Moving on from Anorexia. Constance Barter (2010). Robinson.

Bulimia Nervosa/Binge Eating

- Bulimia Nervosa and Binge Eating: A Guide to Recovery. P.J. Cooper (1995). Robinson.
- Overcoming Binge Eating. C. Fairburn (1995). Guildford Press.
- Getting Better Bit(e) by Bit(e). U. Schmidt, J. Treasure (1993). Lawrence Erlbaum Associates Ltd.

General Titles

- Eating Your Heart Out. J. Buckroyd (1994). Optima.
- Families and How to Survive Them. R. Skynner, J. Cleese (1993). Vermillion.
- Feel the Fear and Do It Anyway. S. Jeffers (1997). Rider & Co.
- The Dance of Anger. H. G. Lerner (1989). Perennial Library.
- The Dance of Intimacy. H. G. Lerner (1989). Perennial Library.
- Diet Breaking: Having it All Without Having to Diet. Mary Evans Young (1995). Hodder & Stoughton.
- Fear of Food. Genevieve Blais (1995). Bloomsbury.
- The Secrets of Self-Esteem. Patricia Cleghorn (1996). HarperCollins.
- My Body, My Enemy. Claire Beeken (2000). HarperCollins.

Links to Specific Eating Disorder websites –

http://www.b-eat.co.uk/
Beat offer a helpline for sufferers and anyone supporting them. Families have said they have found this to be a valuable resource. 0845 6341414
Beat also have a forum for carers:
http://www.b-eat.co.uk/get-help/online-community/carer-s-forum/

http://mengetedstoo.co.uk/
www.eatingresearch.com

Other resources:

Carer's Trust
Carers support is a national organization that supports anyone is a caring role, they usually have a specific Mental Health Support Worker and can give you support regarding your caring role and can inform you of your rights and anything you may be entitled to. You can usually access pampering sessions, days out and support groups.
Their website: http://www.carers.org/
On the website there is an option to find your local office.

More on your rights as a carer can be found here:
http://www.direct.gov.uk/en/CaringForSomeone/CarersRights/index.htm

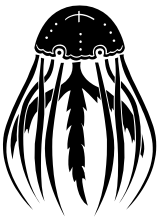
HOW YOU CAN SUPPORT TREATMENT

We like this statement from beat in regard to supporting people with eating disorders "You alone can do it but you can't do it alone". This strikes the balance between the need for change has to come from the person with the eating disorder but acknowledging they will need support with this journey. People who do the best have supportive family and friends, a good care team and take responsibility for their treatment.

The Metaphors of Caring

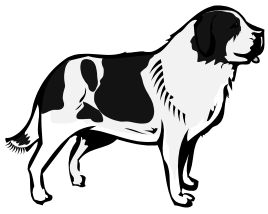
People supporting someone with an eating disorder can get drawn into certain responses. Janet Treasure is a consultant psychiatrist who works with eating disorders at The Maudsley in London. She has come up with these responses and talks more about them in her book: **Janet Treasure: Skills Based Learning for Supporting a Loved One with an Eating Disorder.**

First set is in relation to how we express our emotion.



Jelly Fish

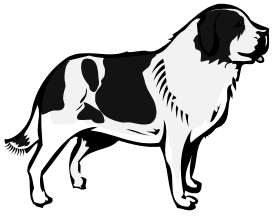
Ostrich



St Bernard's Dog

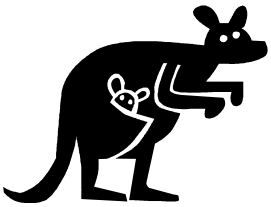
The Jellyfish can get engulfed in intense and transparent emotional reactions. Their sensitive and often tearful response may also be due to exhaustion and despair. This tends to come from self blame – they may believe they have failed as a parent, partner etc, or maybe they are perfectionists in your skills and expectations, and hold themselves responsible for the life and happiness of another.

An ostrich finds it difficult to cope with the distress and upset of challenging and confronting mental health behaviours. They will try to avoid thinking or talking about the problem at all, with their head firmly in the sand! Whilst trying to ignore the situation the ostrich may or may not be aware of the consequences for the family. They may avoid the home situation, by working or being busy rather than confronting difficult symptoms or behaviours.



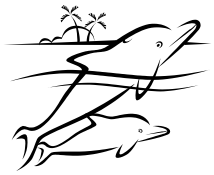
A St Bernard's dog is made of 3 Cs : Calm, Compassionate, and Consistent. They are dedicated to the welfare and safety of those who are helplessly lost. They provide companionship, warmth and nurture. They are unfailing, organized, reliable and dependable in all circumstances, remaining collected even when the situation is dangerous. They do not panic or shout – which may cause an avalanche.

Second set is in relation to how you give direction to your loved one.

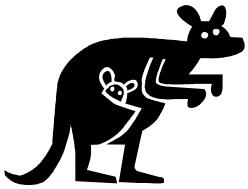


Kangaroo

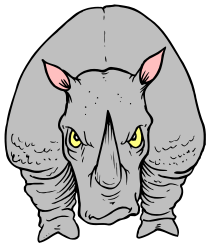
Rhino



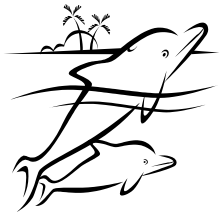
Dolphin



A kangaroo wants to put the cared for person in their 'pouch', to keep them safe. They will do everything possible to support and protect, taking over all sorts of aspects of life in an attempt to help. They will wear kid gloves to try to avoid causing any possible upset or stress, accommodating all demands, whether they are rational or driven by the illness. They will offer to do things for the cared for, when really they could have done it themselves e.g. I'll phone the GP for you, etc



A rhino will attempt to persuade and convince someone to change by charging at disordered behaviors and beliefs and trying to smash them with logic and common sense. They are exhausted and frustrated by not being able to make things change – when they think there are simple solutions, e.g. attend appointments, see the therapist, take medication, get a job/vocation.

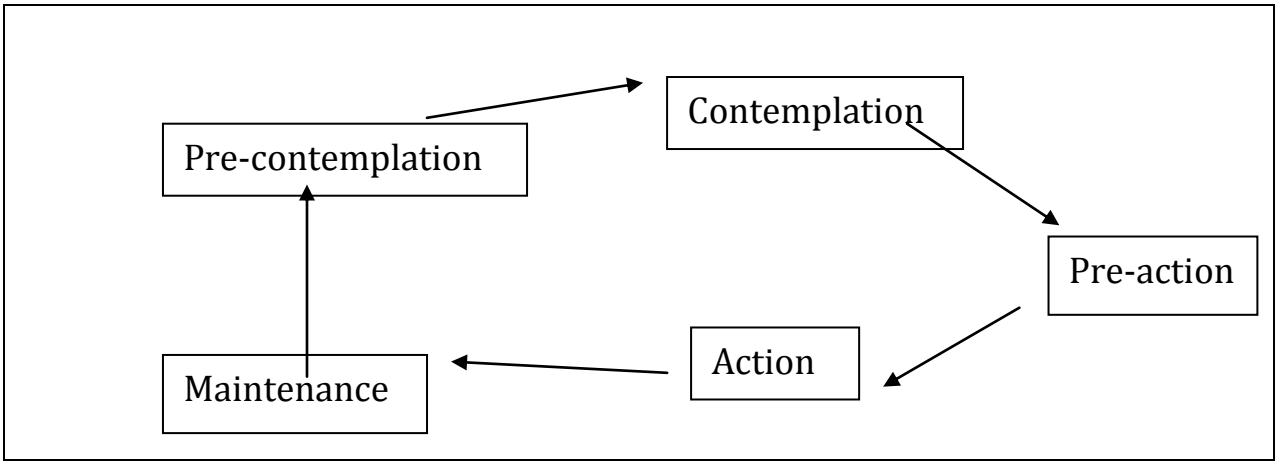


A dolphin will swim alongside, sometimes in front, sometimes behind. A dolphin encourages, giving support when necessary but withdrawing to allow positive risks-taking. A dolphin knows when to do something for someone, with someone and when to let them do it on their own

Understanding Change

Changing any behaviour is difficult, for example think about the time you tried to go to the gym more often, keep more on top of the housework, stopped smoking etc. For someone with an eating disorder we are asking them to change their current ways of coping and try new ones. Due to the strength of eating disorders, asking someone to give it up their illness is similar to asking someone to give up a child. If we can understand what happens when people consider change we can support it better.

Stages of change:



Pre-contemplation: they will not think there is a problem, be in denial. Here you can talk about broader aspirations in life e.g. do you want to ever have a relationship, go on holiday, have a job etc?

Contemplation: they will be very much in two minds. One day they will say they are frustrated, the next they may say nothing is wrong. At this stage the best thing you can do is reflect back what they are saying, "so on one hand you think this but on the other you think that?". If you start pointing out what is not helpful about the illness they will get defensive and more go back to pre-contemplation.

Pre-action: they are thinking about making a change and are thinking about how this could happen. If someone is at this stage you can help them think about what will be difficult and obstacles they will have to overcome, e.g. if you want to start a job how will you deal with questions about your illness if you are asked?

Action: thank goodness! You can help by praising what they are doing and be prepared to see the small steps.

Maintenance: is the last phase and the most difficult. You can help by not letting a relapse turn into a collapse. Reminding them of their coping strategies will be helpful, as will having a relapse prevention plan in place.

In short we cannot force, cheerlead or convince someone to change, this needs to come from them. It is helpful to think about what stage they are at so we don't take too much responsibility for them being in the right place.

Supporting Home Leave

What role leave plays in treatment?

During their time at Cotswold House, patients are encouraged to take therapeutic leave as part of their treatment and discharge planning process. Therapeutic leave allows the patient to be able to practice how they will manage at home on a day to day basis following discharge. They can utilise the new skills they have learnt on the unit during leave, for example, serving their own food, preparing their own food, food shopping etc.

Patients need to request home leave in the weekly clinical planning meeting on a Monday. Their request will be discussed and agreed by the Cotswold House team. Leave will be granted by the team based on whether or not the patient is medically stable and fits the necessary criteria (based on the BMI guidelines).

It is advised that patients take home leave over the weekend in order to avoid interruption to the group programme

What can you do?

It is a good idea to establish with the patient how *they* would like to be supported by you while at home. In the following sections titled “things to consider”, we provide you with a list of items you may need to address with them and/or their care team.

Before leave

When requesting their leave, patients will need to ensure that they have arranged suitable transport for getting to and from home. The team advise that ideally patients are transported by a relative or carer to and from the hospital to home.
Patients will need to plan a food diary which they will complete while on leave. They can plan this with the dietician or with someone from their care team.
Patients will also need to discuss their plans for food shopping, activity levels and any other concerns they think they may have while at home.
Staff will arrange for the patient to be written up for medication that they can take home with them; these are called TTAs.

Things to consider for relatives and carers:

You may want to liaise with a member of their care team (preferably their secondary nurse) prior to home leave commencing, so they can address any concerns or answer any questions you may have. Please call the unit to arrange this ahead of time.
You are welcome to get involved in the planning of home leave this with them and their care team if they are happy for you to do so.
You can request literature on the medication they are currently taking, including information on side effects etc. This can be provided by their care team or the pharmacist for the unit.

Tools to assist with leave

Patients and carers may find it helpful to take the following resources home with them to which they can refer:

- A copy of their current meal plan
- A copy of the recommended portion guidelines
- A copy of the activity guidelines
- Their food diary for the leave period

During leave

Meals
We expect patients to eat 3 meals and 3 snacks per day while in treatment. This includes breakfast, AM snack, lunch, PM snack, dinner and an evening snack.

Things to consider for relatives and carers:
You may need to consider whether or not they will require prompting to have their meals. It is worth discussing if and when they would like to be prompted.
You may want to discuss if and how they would like to be challenged when eating, e.g. if they are secreting food, not completing etc. Some people like to be gently challenged during the meal, some like to talk about this after the meal.
You also may need to plan ahead for meal times. For example, if you are planning an activity away from the home you may need to take a snack with you for them to eat if you think obtaining one while out may be difficult.

Food Preparation
Patients are expected to eat similar portions and similar foods to that of the unit whilst on home leave. For example, patients are encouraged to eat a variety of snacks such as crisps, chocolate bars, biscuits and cakes.
For their meals, patients should stick to the food portion guidelines and should be including all the elements of food into their meals.
If patients are in the process of learning to prepare food for themselves on the unit, it is important that they use their leave as an opportunity to practice this.

Things to consider for relatives and carers:
If they are not yet ready to prepare food for themselves you may be required to prepare it for them. You can seek guidance for this from staff and it is helpful to use the tools detailed above.
If they are preparing and serving their own food they may require support for this, if they so wish. You may need to help them ensure they are using the correct amount of food and are following their meal plan etc.
They may also require support from you to go food shopping or to buy ingredients. Some people may prefer that food is bought-in in preparation for them going on home leave. This is something that can be planned before home leave commences.

Activity Levels
Patients are expected to maintain activity levels similar to that on the unit and to complete rest periods as per unit guidelines.

If patients are going to be engaging in more activity than they would on the unit we would advise that their food intake accounts for this.

Things to consider for relatives and carers:
You may want to refer to the activity guidelines and where they are with their activity allowance at the time. You may feel that they are doing more than they should be. In this case you can either challenge them on this or this can be something that is addressed after leave with staff.

After leave
Patients will need to hand in their completed food diaries to staff who can then review them at the following clinical planning meeting.
Staff will talk to the patient about how home leave has gone and identify any issues that may need addressing in light of the next home leave.

Things to consider for relatives and carers:
On return to the unit staff may request a brief chat with you to talk about how you feel the leave has gone. It is beneficial for staff to receive feedback on how the leave has gone, and staff can offer you support and advice around this, addressing areas that went well and that may need improving.

FAQ

Do we have to eat what they eat?
It is a good idea to ask them what they would find most supportive. They tend to feedback that at the early stages of their treatment they find it most helpful for families to eat at the same time as them and generally eat the same food.
If you really do not want to or cannot eat the same as them it may be helpful to at least eat something or have a drink at the same time as them for support.

But I'm on a diet, how can I eat the same?
You need to remember that you have not got an eating disorder and that you are therefore able to eat what you want. However, it is important to be mindful of your conversation around this in front of them. Generally conversations about weight, dieting, calories, exercise etc are unhelpful and at times, triggering, for them.

What if they don't eat?
Do not panic! Usually they are only on home leave for a short time and we don't expect it to go perfectly. When they return to the unit we can address the issues they had and get them back into the routine of eating.
The best thing you can do in this situation is to continue to model normal eating, gently prompt them to eat at meal times in a supportive way and if you need to you can telephone the unit for support.

I don't think they're being honest about what they're eating, what can I do?
Primarily, it is their responsibility to eat what they should be and home leave is the best way for them to learn to eat responsibly.
If you are concerned, asking them direct questions about what they have eaten is the best way to tackle this issue, if you feel comfortable to do so. Although, you may still not get the answer you were expecting and it is important to bear in mind that due to the nature of the illness they may be deceptive.
It is also important that you feed this information back to the team.

What should I do if they won't eat what they should be eating?
Whilst on home leave they may have lower calorie alternatives to what they should be having according to their meal plans for example, skimmed milk instead of semi-skimmed, sweetener instead of sugar etc. We encourage them to stick to agreed meal plans and portion sizes as much as possible and would expect them to follow the same rules at home as they do on the unit. They may experience difficulty with this the first few times they go on home leave but as they near discharge they should be achieving this more consistently.
If you are supporting with leave you can gently challenge them on these points however, it may be more beneficial to look at what they are achieving rather than what they're not managing well. Ultimately the responsibility of complying with meal plans etc lies with them.

I think they are over exercising or doing too much physical activity, what can I do?
Be aware of the rest periods they are expected to follow on the unit and their current activity allowance. You may want to remind them that they should be sticking to this. You may also want to plan activities with them that mean they will be doing something to distract them whilst on rest, for example, doing a crossword, watching a film etc.

I think they are vomiting, what can I do?
Don't panic! If there is direct evidence that they have vomited it is best dealt with in a direct, non-emotional way, for example, tell them you have seen vomit in the toilet and ask them to clean it up (this is how we would deal with incidents of vomiting on the unit in the first instance). Later, you can offer them emotional support and reassurance.
If there isn't direct evidence but you have a strong suspicion it is better to ask them directly if they have been vomiting.
Again, feed this back to the team.

I want to comment on how well they look/are doing but am worried it will upset them.
This is a difficult issue for both sides to deal with as relatives and carers naturally want to comment on physical wellbeing but someone with an eating disorder will interpret this as failure.
If you want to stick on safe ground, it is okay to give praise and compliments but try to avoid commenting on their physical appearance. For example you may want to tell them their hair looks nice or that they are wearing a nice outfit.

As treatment progresses we would encourage people to accept physical changes, take compliments on board, understand why these comments are being made and accept they have worked hard to stabilise their physical wellbeing.

FEEDBACK

COMPLAINTS

If you are unhappy or have concerns about any aspect of the Cotswold House service, you can either write to or call any of the senior nursing team.

Julia Rossiter: Acting Modern Matron
Helen Mills: Acting Clinical Nurse Lead
Estelle Hyde: Charge Nurse
Tracey Hunt: Acting Charge Nurse
Telephone: 01672 517470
Address: Cotswold House, Savernake Hospital, London Rd, Marlborough SN8 3HL

If you feel you would like someone to speak to the team on your behalf if you would prefer not to do it directly you can contact PALS (patient and liaison service). We would encourage you to speak to us or PALS as many concerns can be easily and quickly remedied.

SUGGESTIONS/PRAISE

We also appreciate positive feedback! This can be done via the previously mentioned way.

Appendix 1 - Guidelines for Activity & Time Out

The below guidelines were introduced in February 2013, in accordance with Government guidelines around healthy everyday activity and in accordance with recommendations from the Royal College of Psychiatrists. The below guidelines are also guided by patient physical health and blood results; this means if there are concerns about physical health, time out may be reduced.

BMI < 12
Mobilise around the unit and courtyard (weather dependant) in a wheelchair only

BMI < 14
Mobilise around the unit without wheelchair, but no time off the unit. Patients can have fresh air in the courtyard (weather permitting)

BMI 14-15
1 x 10 minutes escorted time off the unit on a daily basis (at specified times).

BMI 15-17
2 x 10 minutes escorted time off the unit on a daily basis (at specified times).

BMI 17+
30 minutes unescorted time off the unit on a daily basis. How this time is used will be assessed individually.

Escorted time off the unit is facilitated at 9.50am and 4.15pm.

In addition to daily time off the unit, patients may also have additional time out at the weekends, either for home leave or for activities either by themselves, or with their families (see below). Normal time out is not affected by this, but if patients are out at the specified times, they will not be able to take their time out at different times.

BMI 13-13.9
At weekends: on 1 day, for 1 hour - seated activities with visitors between meals and snacks, e.g. a drive. Must be seated at <u>all</u> times. Can be considered for snack in canteen with staff, followed by friends or relatives if this is considered therapeutic and agreed at OT clinic.
No overnight leave

BMI 14-14.9
At weekends: can go out between a snack and a meal, avoiding constant walking or other strenuous activity. Trips out must be non-strenuous, seated activities.
Graded exposure to therapeutic snacks and meals can be arranged accompanied initially by staff and following this with relatives/ friends if felt to be appropriate, and agreed at OT clinic.

Depending on personal circumstances and aims of treatment/discharge and medical stability **one** overnight leave during this BMI band can be arranged. However, this must be agreed at CPM and only if weight gain and physical obs are satisfactory, and with agreement of the GP.

BMI 15-15.9

Progressively more time off unit, depending on individual's ability to manage (keep to meal plan, stay within weight band) and their goals and stage of treatment. This may vary from accompanied trips out to meals away from the unit to overnight leave per week.
If appropriate, a referral may be made to Active Health, to encourage non-strenuous, gentle forms of exercise. Patients will also be eligible to join a healthy exercise programme, run by the occupational therapist.

BMI 16-18.5

Progressively more and more time off unit, building up to full weekend leave.
Gym programmes and swimming are not advised, and any exercise should be strictly non-aerobic.
Transfer to day-patient if appropriate.

BMI 18.5+

Moderate aerobic physical activity may now be allowed, after discussion with the team.
Try social, time-limited forms of exercise (eg. classes, team sports).
Be more cautious of more solitary forms of exercise e.g. gym/swimming, that can become driven.

Appendix 2 – Criteria for Snacks & Meals Out

Snack in the canteen with staff

- BMI > 13.5
- On snack rotation
- Began sandwich making
- Engaging as agreed in individual and group therapy
- Meal Plan B or above
- Must be completing all snacks as per meal plan.

Snack out with Staff

- Meeting criteria for snack in canteen with staff
- Practiced and managed snack in the canteen with staff without displaying ED behaviours.
- BMI >14
- Able to make appropriate choice of snack in the canteen
- Medium support table/self-serve.

Snack out with family/friends and group snack

- Meeting criteria for snack out with staff
- Practiced and managed snack out with staff without displaying ED behaviours

Snack in the canteen - unescorted/with other patients

- Meeting criteria for snacks out with family and friends
- Meal plan C
- Medium support table and managing self-serve
- BMI >14.5
- Practiced snack out with staff and managed well with decision making and completing snacks
- Able to have a variety of snacks and drinks.
- Managing on group snack
- Showing an ability to make a choice of snack based on preference.

Snack out in Marlborough un-escorted/with other patients

- Meeting criteria for un-escorted snack in the canteen
- Practiced unescorted snack in the canteen and managing well.

Meal in the canteen with staff

- Meal Plan c/full portions of main meals
- Practiced and managed well with snacks in the canteen with staff
- Completing meals on the unit within allocated time and showing minimal ED behaviours.
- BMI >14.5

Meal in town with staff

- BMI >15
- Meeting criteria for meal in the canteen with staff
- Practice and managed meal in canteen with staff.
- Medium support table/self-serve.
- Engaging in group snack

Meal in canteen – unescorted

- Meeting criteria for meal in town with staff
- Meeting criteria forum-escorted snack in canteen
- Practiced and managed well with meal in town with staff
- Practiced and managed well with un-escorted snack in the canteen
- Able to make appropriate choice of a variety of meals and puddings
- Able to base decision making on preference

Meal in town – unescorted

- Patient meeting criteria for unescorted meal in canteen
- Practiced and managed well with unescorted meal in the canteen
- Patient working towards recovery

All requests for snacks and meals out need to be discussed during the OT clinic on a Thursday.

Appendix 3 – Patient Guidelines for Completing Food Diaries

Please record everything that you eat and drink, what you consumed if you binged, bracketing all items together that make up one binge.

Try to take the diary wherever you go and fill it in at the time you are eating or drinking. If you fill it out at the end of the day or the day after it is very difficult to accurately remember what you have eaten.

In the * column, record the number of times you do any of the following:

- Binge (B)
- Vomit (V)
- Number of laxatives taken (L)
- Exercise (E)
- Restrict I

Recording thoughts, feelings and emotions
The way you use this column will change throughout your treatment, and can be used as a discussion point with your individual therapist. It may help to identify your Automatic thoughts when faced with difficulties around eating, and replace them with an alternative, more beneficial view of eating. You may also want to use it to help you plan what to do when you have finished eating (e. distractions, coping strategies).

At the back of the diary there is a space for you to write anything you would like to explain more about.

The food diaries will be given to you in preparation for home leave. Please request one of these from the ward office. If you would like support completing your diary your allocated nurse will do this with you prior to home leave.

On return you will be expected to go through your diary with your allocated nurse for the shift and the diary will then be taken into the Clinical planning meeting for review.

Appendix 4 – Patient Guidelines for Appropriate Eating Behaviours

One of the aims of meals is to restore normal eating behaviors and staff members are here to prompt and help you through this.

Do's and Don'ts at the dining table:

- Sit appropriately at the table.
- Napkins/tissues are not allowed to prevent secreting of food.
- Meals should be eaten appropriately e.g. sandwiches should not be pulled apart; food should not be chopped into small pieces or mashed together; meat should be eaten whole and not be dissected i.e. removal of fat.
- All the food should remain on the plate or in the bowl until you eat it.
- Biscuits and cakes should not be crumbled into small pieces – if they are you will be asked to eat the crumbs.
- Biscuits should not be dunked.
- Appropriate cutlery should be used e.g. teaspoons should not be used to eat cereal.
- Milk and other fluids should not be spilt and if significant amounts are, they will be replaced.
- Food should not be dropped or secreted. If this does occur, it will be replaced.
- Calorie content should not be looked at when making choices.
- Patients are reminded to be mindful of what they say and discuss at the table and its potential effect on other patients. It is expected for patients not to converse about food, weight or portion sizes whilst at the dining table.

Appendix 5 – Portion Guidelines

Use the foods listed, along with your meal plan to guide you in the amounts needed at each meal and snack to encourage variety in your diet.
Any weights are given as a guide when using bought food in packets, cartons or tins and you do not need to weigh food on a regular basis. It may help to weigh some foods initially e.g rice/pasta and then find a familiar cup to use as a portion guide.

Vegetables or salad served with meals should not fill more than 1/3 of the plate. Use 1 serving spoon vegetables if vegetables are separate or ½ bowl salad

Protein Foods
One portion is:-

100 g meat (cubed, minced or 3 slices)
4 slices (40g) continental meat e.g. salami
8 slices (80g) garlic sausage, corned beef
2 meat sausages
3 hot dogs or 1burger
2 rashers bacon
1 chicken portion
2 eggs (large)
1 portion (150g) white fish
3 fish fingers or 2 fishcakes
100 g oily fish, e.g. sardines, salmon, mackerel, fresh or tinned in oil
185g tinned fish in brine
Half large or 1 small (200 g) tin of baked beans or other beans/lentils
200g tofu
200g quorn (cubed, minced or portion)
2 tablespoons (60g) pate or hummus
2 vegetable grills
3 vegetarian sausages
2 tablespoons (30g) seeds or nuts
1 tablespoon peanut butter or tahini
Quarter of 7” sized quiche (100g)
200g tub cottage cheese
2 matchbox sized pieces of hard cheese (50g)
2 tablespoons (60g) full fat soft cheese e.g. Philadelphia, brie or feta

Please note:
Main course: use 2 serving spoons meat/quorn/beans in sauce eg. curry, bolognaise.
3 serving spoons protein+ carb meal (lasagna, fish or shepherd’s pie, macaroni cheese)
Sandwiches: Can use less protein (1/2 portion) and add mayonnaise (1/2 portion)
Eg. tuna/egg/chicken mayo

Starchy Carbohydrate Foods

One portion is:-

2 medium cut slices bread (large loaf)
1 bap sized bread roll or bagel or burger bun
1/3 ciabatta loaf or 1 pitta
1/2 part-baked baguette or 4” piece French stick
1/2 plain naan bread
1 large croissant or brioche bun
1 large (2 small) scone, muffin, crumpet, waffle, pancake, tortilla
2 medium potatoes or 4 small (new) potatoes
1 jacket potato (200g)
2 serving spoons (150g) oven chips
1 small Yorkshire pudding = 1 small potato
2 rounded serving spoons (1 teacup) cooked rice or pasta
1/3 teacup (40g) uncooked rice or egg noodles
1/2 teacup (50g) uncooked pasta e.g pasta shapes, macaroni, spaghetti
3 sheets lasagna
75g uncooked couscous
1½ teacups or 1 mug cornflake type cereal
½ teacup muesli or crunchy nut cereal
1 teacup ready brek + 2 tsp. sugar
2 shredded wheat or 2 weetabix
1/2 teacup porridge oats and 1tsp sugar

Fat Containing Foods

One portion is:-

2 rounded teaspoons margarine or butter
1½ portion packs margarine or butter
1 tablespoon oil
2 tablespoons ready-made dressing (in bottle)
1 tablespoon mayonnaise
2 tablespoons salad cream
2 tablespoons coleslaw
1 tablespoon (30g) pesto sauce/sundried paste
25g hard cheese (extra to protein choice)
150 ml tomato based sauce mix
100 ml sauce mix e.g. dolmio, stir-fry
1½ tablespoons double cream
3 tablespoons single cream
1 tablespoon crème fraiche or greek yoghurt

Milk based desserts

One portion is:-
1 Natural whole milk yoghurt
1 Fruit fool

1 Custard style yoghurt
1 Onken mousse
1 Crunch or Fruit Corner yoghurt
1 Chocolate mousse
1 Muller rice
1 Trifle
1 portion fruit and 1 Ski yoghurt
1 Crème Caramel
1 portion fruit and 2 tablespoons evaporated milk or cream
1 portion fruit and ¼ large tin (100ml) rice pudding or custard (not low fat)
1 portion fruit and 2 tablespoons Greek yoghurt or fromage frais
1 small pot or 1/3 large tin (150ml) rice pudding or custard (not low fat)
Ice cream – 2 scoops/1 brickette/1 individual, e.g. Cornetto, Choc Ice, Solero or slice of Vienetta

Fruit

One portion is:-

medium fruit eg apple or banana	1 fruit
large fruit eg melon, pineapple	1 large slice
small fruits eg plums, apricots, satsumas	2 fruit
berries (eg raspberries, strawberries) grapes	1 cup
fresh fruit salad, stewed	2 tbsp
tinned fruit	1/4 large tin (100g)
dried fruit	1 tbsp
fruit juice	1 small glass (100ml)

Snacks

One snack is:-

2 Digestive or 2 Hob Nob biscuits
2 crackers + 25g cheddar cheese
2 shortbread fingers or 2 cream biscuits
1 cup cereal +150 ml semi-sk. Milk
3 choc chip or 3 ginger nut biscuits
1 fruit + 200 ml semi-skimmed milk
1 penguin, club biscuit or kit-kat
1 fruit + 200 ml fruit juice
1 cereal bar e.g. Jordan's, Fruesli, Tracker
200 ml milk shake, e.g. Frijj
1 individual cake e.g. Mr Kipling slice
1 individual ice cream (as desserts)
1 piece of cake (40g) fruit, battenburg
1 slice toast + marg + jam
1 mini hot cross bun or ½ scone + marg
1 pkt crisps, mini cheddars or hula hoops
50g dried fruit or yoghurt coated dried fruit 20g nuts
200 ml semi-skimmed milk with 3 tsps hot chocolate, nesquick or ovaltine
Snack size chocolate bar e.g. curly wurly, milky way, toffee crisp, pkt maltesers

Appendix 6 - Meal Plan

Meal Plan – Inpatients

NB Only to be changed by Dietician or at Planning Meeting.

Patient Name:

Self-serving commenced (date & sign):

Start/End Date of Meal Plan						
	PreA	A	B	C	M1	M2
Breakfast						
1 'cup' Cornflakes or Rice Krispies						
1 'mug' any cereal						
150ml s/s milk						
200ml s/s milk						
1 slice toast + margarine + preserve						
2 slices toast + margarine + preserve						
100ml fruit juice and 100ml water						
200ml fruit juice						
Extra 200ml					N/A	N/A
Ensure						
Changes / additions (specify)						
Midmorning						
150ml s/s milk +/-coffee/hot choc/nesquik						
200ml s/s milk +/-coffee/hot choc/nesquik						
200ml tea/coffee with milk or squash						
1 snack from rotation						
Ensure						
Lunch						
½ portion main course						
1 portion main course						
No dessert						
1 pot yogurt						
1 portion dessert						
200ml water or squash						
Extra 200ml					N/A	N/A
Ensure						
Changes / additions (specify)						
Mid afternoon						
150ml s/s milk (as morning)						
200ml s/s milk (as morning)						

Start/End Date of Meal Plan						
	PreA	A	B	C	M1	M2
200ml tea/coffee with milk or squash						
1 snack from rotation						
Extra 200ml						
Ensure					N/A	N/A
Evening meal						
Sandwich: 1 slice white bread +5g marg + ½ portion protein						
½ portion main course						
1 portion main course						
Extra veg if available						
1 pot yogurt						
1 portion dessert						
Choice of fruit/yogurt/ice cream						
200ml water or squash						
Ensure						
Changes / additions (specify)						
Bedtime snack						
150ml s/s milk (as mid morning)						
200ml s/s milk (as mid morning)						
1 of the following • Milky drink (200ml s/s milk + 3tsp hot chocolate /nesquik • 250ml plain milk + 1 digestive/hobnob biscuit • 150ml s/s milk + 1 'cup' cereal • 200ml tea/coffee with milk or squash + 1 of: o 1 slice toast + margarine + jam o 1 cereal bar o 2 digestive/hobnob biscuits						
Milky drink (200ml s/s milk + 3tsp hot chocolate /nesquik **AND** 1 of the following: • 150ml s/s milk + 1 'cup' cereal • 1 slice toast + margarine + jam • 1 cereal bar • 2 digestive/hobnob biscuits						
Milky drink (200ml s/s milk + 3tsp hot chocolate /nesquik **Or** 250ml Tea/coffee with milk or squash plus 1 of the following: • 1 slice toast + margarine + jam • 1 cereal bar • 2 digestive/hobnob biscuits						
Extra 200ml					N/A	N/A
Ensure						
Total Maximum Daily Fluids					Free	Free

Notes (date & sign):

Appendix 7 - Complications of Anorexia Nervosa - Information for patients and carers

The malnutrition which results from anorexia nervosa can affect any organ or system in the body. Medical complications are more likely the lower the patient's Body Mass Index (BMI). Some of the most important are highlighted:

1. Recent research estimates the **mortality** from anorexia nervosa to be 5-10% per decade of illness.
2. **Osteoporosis** (significantly reduced bone mineral density) is very common, leading to a fracture rate in AN patients 7x higher than in normal weight women. Fractures can occur in the absence of trauma. There is no proven effective drug treatment; the best treatment is nutritional rehabilitation and weight gain.
3. There is some evidence to suggest that **fertility** is reduced in patients whose menstrual cycles have returned, and if pregnancy is achieved the rate of complications is increased. Some sources suggest women should aim to be at a normal weight for 1 year before trying to conceive.
4. The **heart** muscle is reduced in mass, which can cause a variety of abnormalities including arrhythmias. High pulse, breathlessness and oedema (swollen ankles) may be symptoms of **heart failure.** The risks of cardiac complications are increased by excessive exercise. Heart problems usually resolve with refeeding.
5. The **brain** shrinks, and the fluid spaces in the brain enlarge. This may be the cause of the cognitive impairment (slowed thinking, poor memory and concentration, loss of reasoning skills) which is seen. The atrophy reverses with refeeding.
6. The **stomach** function is impaired, with delay to gastric emptying. Dyspepsia and gastric emptying improve with refeeding, but this may take several months. 'Dumping' of food in the small intestine causes sudden rises in insulin production and low blood glucose.
7. Other **psychiatric** disorders are common. Low mood often improves with weight gain. The neurotransmitters in the brain associated with mood and obsessional symptoms are adversely affected by dieting.
8. **Growth** may be stunted, depending on when the disorder started and its duration. (Osteoporosis of the spine may also reduce height).
9. **Cholesterol** is often raised, and falls with refeeding. Refeeding is the only necessary treatment for hypercholesterolaemia in AN patients.
10. The **bone marrow** function is reduced; this may contribute to anaemia and make the patient more prone to infection. Infections may not be accompanied by fever, as **thermoregulation** is impaired.
11. Severely underweight patients may present with signs of **liver failure** or **renal failure.**
12. Vomiting can cause severe electrolyte abnormalities, putting the patient at risk of cardiac arrhythmias or **fits.** Small tears in the oesophagus causing **bleeding** are common; rupture of the oesophagus or stomach is rare but often fatal.