3:15:6 Considerations for an ED admission to a General Mental Health Ward.

Timing: Given the information in the previous section it is paramount to consider the timing of the admission of an ED patient to a mental health ward. Admission out with standard working hours, at weekends or on holidays may lead to a situation where a patient at risk of refeeding is admitted without the availability of dietetic input. Thus the admission may be unsafe. AEDS would therefore always recommend that an admission be planned in advance. Emergency admission on the basis of physical health may be necessary via a physical health ward. The dietitian for the admitting hospital should be consulted in this instance.

If an ED patient does require an unplanned admission, in the absence of dietetic support, a detailed assessment of their current food and liquid intake should be undertaken. Their current intake should then be replicated as closely as possible, until an appropriate refeeding plan can be arranged. This should be alongside frequent monitoring of bloods and other physical symptoms to ensure minimal risk to the patient. It could potentially be unsafe (even life threatening) to increase nutritional intake and therefore this should not be undertaken without proper dietetic assessment. AEDS dietitian can be contacted to provide consultation to mental health dietitians as required.

Aims of an admission: Treatment will be a structured symptom-focused treatment regime to support weight and health restoration. Aims of treatment include managing risk, enabling weight gain and healthy eating, restoring cognitive capacity and reducing other ED related symptoms including over-exercising, laxative misuse, vomiting, low mood and distress (AEDS, 2016).

Behaviours and cognitions to expect: Patients at low weight will often show psychological signs of starvation, including:

- Poor attention
- Poor concentration
- Confusion
- Rigid thinking
- Preoccupation
- Obsessionality
- Labile emotions

Staff must keep in mind the impact of the ED on cognitive function, despite the fact that many people presenting with ED will appear to retain a high level of functioning (AEDS, 2016). In addition to these features the person may present with low motivation for change. In addition ED patients will experience a range of unhelpful automatic thoughts and images related to food, eating and their bodies. Examples include:

- Failure to perceive themselves as underweight
- Perceiving parts of their body as larger than they objectively are
- Minimisation of the risks of ED
- Fearful thoughts about gaining weight/ becoming fat
- Inaccurate beliefs about certain types of food

These unhelpful and anxiety provoking thoughts tend to be associated with a range of behaviours which maintain the ED. Examples of these behaviours include:

- Avoidance of eating/ avoidance of certain foods
- Vomiting
- Laxative abuse
- Excessive and compulsive exercising (including micro exercising)
- Drinking excessively (to dampen hunger cues) or too little
- Watching cookery programmes
- Looking up calorie contents
- Looking at pro-anorexia websites/ blogs/ social networking sites
- Use of fitness apps

These behaviours are often hidden, and are extremely likely to become covert in a ward setting; staff therefore have a role in observation as discussed below. ED patients may also engage in behaviours to falsify their weight in order to avoid changes to their menu plans or weight restoration. Examples of this would include:

- Water loading (drinking excessive liquids to increase weight before weigh in)
- Adding additional weight to their bodies with extra or heavy items of clothing (such as belts), or by covertly carrying items on their person such as money, phones, weights.

The role of observations: Patients with ED present with a range of risky behaviours (as above) not typically seen in other mental health patients (in addition to those more commonly seen). These behaviours, alongside low weight, result in high physical risk levels, compounded by poor psychological health. In order to manage these risks ward staff should be involved in the assessment of risk, which would include review of physical health observations (as described in section 3:15:3) in addition to considering psychological wellbeing. Risk assessment would inform decisions about the level of observation required to safely manage an ED patient on the ward. This decision would be made as part of a weekly review by the treating multidisciplinary team.

Ward staff have a role in applying observation at the level agreed by the multidisciplinary team. This includes careful monitoring of behaviours (as described above), particularly before, during and following meals. These patients are at high risk of compensating for increased nutritional intake, usually via vomiting or exercise. In addition staff would play a role in supporting patients to adhere to their treatment plan, via the application of motivational, anxiety management and distress tolerance strategies .

Particular attention should be paid to meal time behaviours such as; non-completion; length of time taken to complete meals; secretion of foods (for example into pockets or under tables); spoiling of foods via the application of large quantities of salt or other condiments; playing with food (for example tearing food up or moving food

around on the plate) and micro exercising (for example jiggling legs). These behaviours reinforce the ED. Ward staff to have a role to play in compassionately challenging these. Maintaining boundaries about the timing of meals, the food to be eaten and acceptable behaviours is a key role of ward staff in the treatment of ED patients.

Special considerations for practice: In addition to playing a role in application of treatment plans and observations, staff must apply caution during interactions with ED patients. Many topics of conversation which in typical interactions may be viewed as normal, take on a different meaning and have a different impact for ED patients. Staff should avoid any conversation about food, diets and weight. This would include comments which might otherwise seem neutral or even positive. Examples would include stating that someone looks well or healthy; as this can be misinterpreted as meaning the patient has gained weight.

ED patients may want to discuss calories, content of food or weight. Staff should keep this conversation only to patient reviews (for example where discussion about weight restoration may be necessary). Staff should remind ED patients that it is unhelpful to engage in this type of conversation and try to divert to other topics, offer emotional support or guide the patient in applying strategies for managing anxiety (as in below).

Where staff have a role in supporting patients to eat (for example supported lunches), staff members must be aware to model positive behaviours around food, for example completing meals, in a timely fashion. Training on the appropriate provision of meal support can be provided to ward staff by AEDS.

The role of families: Understandably the families/ significant others of ED patients will often be very concerned about their loved ones. At times this can be expressed in ways which are not necessarily helpful. For example, without a proper understanding of the rationale for the ward boundaries put in place, significant others may inadvertently undermine treatment plans, for example by bringing additional food or drinks to the ward. Ward staff would therefore have a role in involving families in treatment planning where appropriate and in monitoring visits to ensure

adherence to treatment plans. Psychoeducation for families can also be a major aspect of treatment.

Anxiety management: Whilst not always notable visibly, ED patients on the ward will be likely to experience significant levels of anxiety. This may be due to the sense of loss of control related to admission, in addition to being faced with making changes to long standing behaviours which they rely on to cope. Patients may experience anxiety, before during and after a meal/ snack in addition to at other points of the day, for example around weight checks or related to restrictions such as bed rest. Ward staff have a role in recognising potential trigger points, and offering support to patients. Making use of formal strategies such as thought diaries, breathing exercises, distraction and relaxation will aid in supporting patients to tolerate their treatment plan. Additionally practicing these skills with patients will support them to develop more helpful strategies in the longer term.