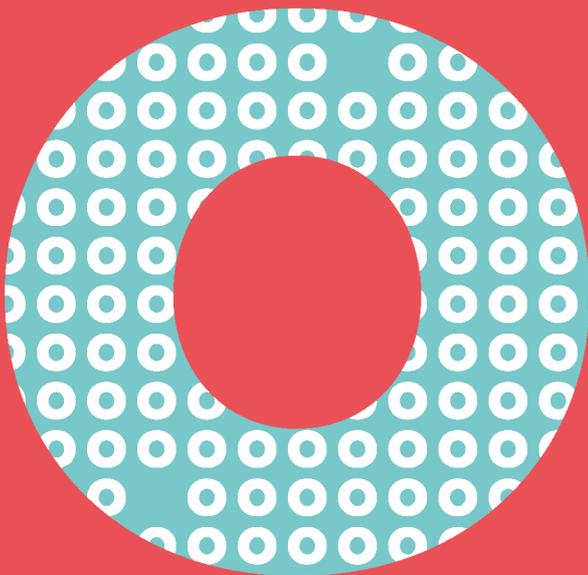


INSIDEOUT

Institute for Eating Disorders

Nursing Care

Engagement and
Observation for People
with Eating Disorders in
General Inpatient Areas
including Emergency
Departments



www.insideoutinstitute.org.au

Nursing Care

Engagement and Observation for People with Eating Disorders in General Inpatient Areas including Emergency Departments

PURPOSE

This document is intended to provide directions on the engagement and observation level required for people with eating disorders when they are admitted to general wards or in the emergency department. People with eating disorders have a complex interplay of both medical and psychiatric issues, which require close observation and supervision to ensure patient safety and resolution of medical problems.

This document is intended to provide direction about supporting people with an eating disorder to reach medical stability. It is not intended to provide direction about psychiatric management of people with an eating disorder.

While Local Health Districts may already have policies regarding the use of nurse specials on general wards, this document specifically provides guidance for Engagement and Observation for people with eating disorders. It contains two parts; the first part specifies the requirements for the level of observation and the second part defines the role of the nurse special providing the engagement and observation.

KEY PRINCIPLES

Eating disorders are very serious illnesses and the patient will often present with major medical complications.

On admission to a medical ward, or in the emergency department, it is recommended that Level One Observation (Constant Observations) is required for all patients with an eating disorder;

The duration of the constant level of observation is a decision for the multidisciplinary treating team and should be reviewed on a regular basis

Any step down or up of such care should be assessed according to each individual's requirements. Key factors in the decision making include: consideration of their medical stability; progression towards treatment goals; and engagement in eating disorder behaviours.

USE OF THE GUIDELINE

The guidelines apply to all general inpatient areas including the emergency departments where there are no specialist eating disorder services.

Contents

1	INTRODUCTION	1
1.1	Background.....	
1.2	Purpose and Intent.....	
1.3	Scope of the Guidelines	
1.4	Policy context	
2	REQUIREMENTS FOR PATIENT ENGAEMENT AND OBSERVATIONS FOR PEOPLE WITH EATING DISORDERS	3
2.1	Determining Level of Patient Engagement and Observation Required	
2.2	Aims of Engagement and Observation in Eating Disorders	
2.3	Key Principles.....	
2.4	Who Should Provide the Observation?.....	
2.5	Documentation	
3	THE ROLE OF THE NURSE SPECIAL IN EATING DISORDERS.....	6
3.1	Issues to be Aware of when Conducting Constant Observation with Patients with an Eating Disorder	
3.2	Tasks Specific to Engagement and Observation of Patients with Eating Disorders	
4	Support for the Nurse Special Working with People with an Eating Disorder	9
4.1.1	Tertiary Support	
4.1.2	Recommendations for training in working effectively with people with an eating disorder.....	
	APPENDIX A – EATING DISORDERS BEHAVIOURS.....	
	APPENDIX B – WEIGHING PATIENTS WITH EATING DISORDERS	
	APPENDIX C – HELPFUL & UNHELPFUL THINGS TO SAY TO SOMEONE WITH AN EATING DISORDER	

1 INTRODUCTION

1.1 Background

People who present with an eating disorder are at a high risk of medical complications and/or psychiatric comorbidity (including suicidal ideation and deliberate self-harm). Close monitoring, supervision and support to ensure effective management and intervention is required to prevent further life threatening deterioration.

The cause of medical complications can be due to the amount and rapidity of weight loss, the duration of under-nutrition and its effects, and the compensatory behaviours (vomiting, laxative abuse, diuretic abuse, diet tablets and compulsive exercise) that may be used.

For people with an eating disorder, controlling food intake and engaging in other disordered behaviours is their primary coping strategy and safety mechanism. Hospitalisation and treatment threatens this, making treatment exceptionally challenging. People with an eating disorder will require additional support to reduce engagement in their behaviours and to commence treatment.

With the right amount of intensive nursing care required while in hospital, the person will reach medical stability much quicker, thereby reducing the length of stay and potentially reducing the need for multiple repeated admissions.

People in treatment for an eating disorder deserve:

1. Protection from the illness

The eating disorder deprives the person of adequate nutrition putting their life at risk. It is the treating team's responsibility to protect the person from the eating disorder.

2. To be separated from their eating disorder

The person may want to get better and receive support, but the eating disorder will make it very difficult for them to accept it. Often, the person will be very wary and ambivalent about treatment and recovery. It is helpful to separate the person from the eating disorder when you are talking to them.

3. A non-judgmental approach

People with eating disorders do not cause their illness, nor do they choose to have an eating disorder. The individual is fighting a battle at all times with the eating disorder and your empathetic, kind, non-judgmental support and nursing care are critical to the success of the treatment process.

4. Respect and empathy

All people with eating disorders deserve respect and empathy from everyone involved in their care.

5. A collaborative approach

The person with an eating disorder is fearful of treatment. Ensuring that you communicate constantly with the person in a warm and caring way about the necessity of delivering the treatment is crucial.

This guideline was produced for NSW Health by the InsideOut Institute in consultation with the Peter Beaumont Outreach Service, Sydney Local Health District, Sydney Children's Hospital Network; the Eating Disorders Coordinators across NSW; and the Queensland Eating Disorders Service, Royal Brisbane Women's Hospital.

1.2 Purpose and Intent

This document is intended to provide directions on the engagement and observation level required for people with eating disorders when they are admitted to general wards, paediatric wards or in the emergency department. People with eating disorders have a complex interplay of both medical and psychiatric requirements, which require close observation and supervision to ensure patient safety and medical stability.

The main aim of a medical hospital admission is to manage the medical complications but also to begin weight restoration and interrupt the eating disorder behaviours. While in hospital the patient requires constant medical monitoring, meal supervision, monitoring of ambulatory issues and the eating disorder behaviours, and weighing. This document is intended to provide direction about supporting people with an eating disorder to reach medical stability. It is not intended to provide direction around psychiatric therapy for people with an eating disorder.

This document specifically provides guidance for engagement and observation levels required for people with eating disorders. It contains two parts:

- the first part specifies the requirements for observation levels; and
- the second part defines the role of the nurse special providing the engagement and observation.

1.3 Scope of the Guidelines

These guidelines apply to all general inpatient areas including emergency departments.

These guidelines pertain to children, adolescents and adults suffering from a Diagnostics and Statistical Manual of Mental Disorders 5th Edition (DSM 5) eating disorder diagnosis requiring an inpatient admission.

These guidelines are designed to be used in conjunction with local protocols and clinical expertise.

For comprehensive inpatient management guidance, clinicians should refer to the following:

- **For adults with eating disorders:**

Guidelines for the Inpatient Management of Adult Eating Disorders in General Medical and Psychiatric Settings in NSW 2014; Developed by the Centre for Eating and Dieting Disorders (now InsideOut Institute) (<https://insideoutinstitute.org.au/resource-library/guidelines-for-the-inpatient-management-of-adult-eating-disorders-in-general-medical-and-psychiatric-settings-in-nsw>)

- **For children and adolescents with eating disorders:**

Eating Disorders Toolkit: A Practice-Based Guide to the Inpatient Management of Children and Adolescents with Eating Disorders found on the Centre for Eating and Dieting Disorders (now InsideOut Institute) (<https://insideoutinstitute.org.au/resource-library/nsw-eating-disorders-toolkit-a-practice-based-guide-to-the-inpatient-management-of-children-adolescents-with-eating-disorders>)

1.4 Policy context

This policy should be read in conjunction with PD2017_025 *Engagement and Observation in Mental Health Inpatient Units*, which describes the levels of observation

2 REQUIREMENTS FOR PATIENT ENGAGEMENT AND OBSERVATIONS FOR PEOPLE WITH EATING DISORDERS

2.1 Determining Level of Patient Engagement and Observation Required

Eating disorders patients will often present to hospital with major medical complications.

On admission to a medical ward, or in the emergency department, it is recommended that Level 1 observation (Constant Observations) by a nurse special is required for all patients admitted with an eating disorder.

The duration of Constant Observation by a nurse special is a decision for the medical treating team (in consultation with the psychiatry/Eating Disorder service)

- at a minimum for the first 48 hours of admission (72 hours if commences on Friday to cover over weekend); and
- throughout an admission as required.

The need for the constant observation can be reviewed every 2-3 days by the multidisciplinary treating team, with the possible recommendations to step down care in a progressive manner from:

- 24 hour support
- 7am-10pm support
- Support at meal & snack times, and for 1 hour post meals & snacks (*NB* meal and post meal support remains important for the duration of the admission)
- No Level One Observation required

Any step down or up of such care should be assessed according to each individual's requirements by the treating medical officer in consultation with the multidisciplinary team. Key factors in the decision making include: consideration of their medical stability; progression towards treatment goals; and engagement in eating disorder behaviours.

When a decision has been made to observe a patient at risk, the medico-legal requirements and responsibilities of the hospital are to provide a nurse. Where additional staff are required and are unable to be sourced, redistribution of nursing workloads to balance clinical requirements should be considered to ensure patient safety. This needs to be in line with the NSW Nursing Award and the governing Nursing Hours Per Patient Day for inpatient areas.

2.2 Aims of Engagement and Observation in Eating Disorders

The main aims of conducting higher level engagement and observation with admitted patients with eating disorders are to:

- maintain patient safety for those patients because of their medical condition, refeeding or acute mental health risk such as self-harm or suicide.
- provide short term additional nursing support when the patient is medically unstable and requires a greater nursing resource than the usual nurse-patient ratio.

The close supportive monitoring and supervision reduces the person's engagement in eating disordered behaviours, promoting a quicker rate of improved medical outcomes, weight gain and medical stability, therefore reducing the length of stay and optimising patient outcomes.

2.3 Key Principles

Eating disorders are very serious illnesses and the patient will often present well despite grave medical compromise.

The family and carers are an essential resource to help support the person throughout treatment. It is important that family and carers are included throughout the treatment process and are appropriately communicated with.

Observation includes engagement with the patient as well as visual observation.

When carrying out observation of people with an eating disorder the following key principles should apply:

- The person with an eating disorder should be supported, managed and observed in a manner that minimises risk of harm to self and other patients, staff and visitors, whilst maintaining principles that optimise the person's privacy and dignity.
- Patient observations can be very intrusive and a negative experience for the person. It is essential that the nurse special attempt to engage with the person rather than simply follow and watch them. Engagement includes forming a therapeutic relationship, conveying acceptance and tolerance and listening, hearing and understanding. It is not about providing therapy or counselling, but about being supportive and encouraging.
- The person under observation should be informed about the process, the reasons for being observed and introduced to the nurse special. This will help to clarify to all parties what is to be expected.
- The nurse special providing the Observation should have the appropriate knowledge and skills to deliver the care required by the person with an eating disorder.

2.4 Who Should Provide the Observation?

The staff selected to provide the constant observation must appropriately meet the patient's need. Generally the level of observation needed will require a skilled and knowledgeable nurse. The level of experience of the nurse special should be determined by the level of risk identified and should be discussed and clearly documented in the health care record by the senior clinician involved in the initial assessment.

The nurse special should ideally be a Mental Health Nurse (if available and if scheduled under the NSW Mental Health Act 2007) or a Registered Nurse who is a regular staff member of the ward (not an Agency or casual pool nurse) that the patient is admitted to. This will build the wards capacity and confidence in managing people with eating disorders.

When appropriate an Assistant in Nursing (AIN) (in accordance with NSW Health Policy Directive PD2010_059 Employment of Assistants in Nursing (AIN) in NSW Health Acute Care) might be utilised - responsibilities of the nurse will be delegated as per their scope of practice. For example an AIN may be able to do general observation but the person may require a more experienced nurse to provide the meal support. It is most important that any AIN involved in constant observation of a patient with eating disorders has the appropriate knowledge and skills to provide care for this patient group.

2.5 Documentation

Documentation of observations should be recorded on locally developed forms that align with these guidelines. The documentation of each engagement and assessment should be reflective of the targeted rationale for observation.

The level of observation required, its rationale and reviews of the level of observation must be clearly documented by the responsible medical officer within the medical record so clinicians may easily identify the level of observation and the ongoing targeted nursing assessments required as part of this observation level.

3 THE ROLE OF THE NURSE SPECIAL IN EATING DISORDERS

A nurse special is an identified clinician who has delegated responsibility to provide continuous one-to-one observation and to provide care consistent with their scope of practice to a person in hospital who, without this level of observation is at risk of imminent harm to self or others. The nurse special works with the allocated ward nurse responsible for the patient's care, but must remain with the patient at all times. The nurse special is responsible for one patient only. It is unsafe to be responsible for two or more patients at a time due to the identified risks.

The primary role of the nurse special is to fulfil the treatment needs of the individual patient with an eating disorder including:

- provide the patient with the highest level of safety, within the least restrictive setting, which is also supportive and therapeutic;
- establish a therapeutic relationship through empathy, active listening, open communication and respectful collaboration;
- provide a sense of safety and containment for the patient, without being authoritarian or punitive;
- assist the patient to regain a sense of personal control and autonomy by clarifying treatment processes; and
- enhance the assessment, stabilisation and initiation of treatment through close observation, supervision and support

Families and carers while forming an integral part of the care of the person with an eating disorder cannot assume the responsibility to the level of observation required. The nurse special must remain present during family/friend visits, unless negotiated with the multidisciplinary team.

3.1 Issues to be Aware of when Conducting Constant Observation with Patients with an Eating Disorder

1. Understanding eating disorders and mental health

- Basic understanding of eating disorders.
- Basic understanding of the function of an eating disorder.
- Understanding of why people with an eating disorder protect their illness by engaging in disordered behaviours.

2. Know how to effectively communicate with someone with an eating disorder

- Understanding of how to separate the eating disorder from the person: remember the person is not their illness, they are experiencing an illness and need your support to protect them from the symptoms of that illness.
- Ability to engage a person with an eating disorder in a warm and professional way.
- Understanding of helpful & unhelpful things to say to someone with an eating disorder (see *Appendix C*).
- Understand and respond to resistance by using simple strategies such as expressing empathy, validating the person's struggles, being non-judgemental and supporting self-efficacy.

- Refrain from taking an authoritative and dictatorial stance.

3. Awareness of strategies to manage distress

- Understanding of anxiety and its comorbidity with eating disorders.
- Knowledge of distress tolerance strategies required to assist the patient to engage in more helpful ways of coping with the feelings that the illness generates (as opposed to engaging in eating disorder behaviours).

3.2 Tasks Specific to Engagement and Observation of Patients with Eating Disorders

1. Safety

- Suicide and self-harm are common in people with eating disorders. The nurse's role includes minimising the risk of such behaviours by monitoring the environment for ligatures, sharps, chemicals or other possible means for self-harm and removing access to them.
- The eating disorder will deprive the person of adequate nutrition and your role is to protect them from the life threatening symptoms of the eating disorder by supporting them to adhere to treatment.

2. Medical monitoring

- Medical monitoring of observations to be conducted as per the treating medical team's instructions.

3. Meal Supervision

- Eating is very difficult for the person with the eating disorder. Please remember they need gentle, non-judgemental support throughout the meal to ensure they get the nutrients they need.
- Monitor and document food and fluid intake, do not take the patient or carer's description of what was eaten as sufficient.
- Patients may struggle being observed and may even protest, it is essential food and fluid intake is observed and they deserve your support to ensure they receive all the nutrients they need.
- Sit with patients during meal/snacks to offer support and assist to normalise eating patterns and behaviours. This should be provided with an encouraging, calm, non-judgemental, and recovery focused approach.
- If the patient is unable to complete their full meal, please notify the managing Dietitian so that they are able to create a management plan around ensuring adequate intake. This may involve the use of supplements if the patient is unable to complete 100% of the meal or snack.
- It is helpful to let the patient know in advance that they have 30 minutes to consume the meal and that you will give a prompt at 25 minutes (5 minutes left). You may need to remind them of the dietetic plan.
- Redirect and/or discourage patients focus on weight, diet and food during meals.
- Monitor physical behaviour and mood changes before, during and after meals.

4. Monitor eating disorder behaviours

- Awareness of eating disorder behaviours including engagement in restrictive eating, bingeing, exercise, vomiting, using laxatives & diuretics and tampering with nasogastric feeds (see *Appendix A*).
- Discourage engagement in eating disorder behaviours with a kind, empathetic and a non-judgemental approach and instruction to stop. Avoid arguments or ultimatums. If it persists note it and pass this on to the treating team at the end of the shift to manage.
- Develop an understanding of the patient's individual eating disorder related thought, feelings and behaviours which will assist the team in effectively treating the individual.
- Ensure bathroom visits are fully supervised to reduce engagement in eating disorder behaviours.

5. Weighing the patient

- Sensitivity & empathy around weighing a person with an eating disorder – acknowledgement that this will be one of the most distressing and anxiety provoking aspects of treatment.
- Awareness of methods of weight falsification (see *Appendix A*).
- Ensure standard routine around weighing – (see *Appendix B*).
- Refrain from making any comments about the number on the scale, the patient's progress or lack thereof (see *Appendix C*).
- Try at all times to not reveal information (verbally or non-verbally) that is the responsibility of the treating team (e.g. weight, BMI goals, food changes). If the patient requests information, pass this on to the treating team to manage. It should be decided on admission and documented in the management plan which member of staff will disclose the patient's weight to them post weighing. It is important to the patient to know who this information will come from.

6. Set the tone and environment for treatment

- Convey empathy for the person with the eating disorder, their family and carers & always maintain a non-judgemental stance.
- Provide a supportive environment for treatment to be established.
- If a patient is distressed, upset or angry or is attempting to argue or negotiate their treatment plan with you it is always useful to validate their feelings and let them know you will pass on their request to the treatment team (rather than engage in the negotiations).

7. Document & communicate with treatment team

- Food & fluid intake, complete bowel chart, and document any engagement in disordered behaviours.
- Any mood, affect, behaviour and engagement changes and when they occurred.
- Any expression of self-harm or suicidal thoughts or urges, or their absence.
- Any interventions used and what the patient's response was to help the team to work more effectively with the patient.

3.3 Support for the Nurse Special Working with People with an Eating Disorder

It is important that the Nurse Special working with people with eating disorders:

- receives support from senior staff members, the nurse educator, nursing unit manager and colleagues;
- a daily check in with a more experienced onsite nurse (who ideally works in mental health) to deal with individual patient factors;
- receives training in eating disorders to remain up to date with evidence based practice

Local procedures should clearly outline the reporting line for the nurse special.

3.3.1 Tertiary Support

If you require support or advice regarding a person who presents with an eating disorder you can contact:

- For adults with eating disorders: The Peter Beaumont Outreach Service. Contact the intake clinician for the Peter Beaumont Eating Disorder Service on 0484 346 291.
- For young people: Contact the Clinical Nurse Consultant, Eating Disorder Network Coordinator: Sydney Children's Hospital Network (SCHN).
joanne.titterton@health.nsw.gov.au or 9845 2446

3.3.2 Recommendations for training in working effectively with people with an eating disorder

For further training in working effectively with people with an eating disorder, refer to:

- Spot the red flags – eLearning training available on My Health Learning
- Eating Disorder Inpatient Management – eLearning training available at the Centre for Eating and Dieting Disorders (now InsideOut Institute) (<https://insideoutinstitute.org.au/e-learning>)

APPENDIX A – EATING DISORDERS BEHAVIOURS

Common eating disorder behaviours include:

Regarding food:

hoarding food, disposing of food (e.g. in pockets, in the toilet, in bed clothes, serviettes, pot plants), choosing low calorie or diet foods, chewing gum, picking at food, cutting food up into small pieces, eating at a very slow pace, chewing & spitting food out, regurgitating food & then re-swallowing.

Regarding fluid:

excessive or inadequate fluid intake, consuming diet soft drinks, consuming significant quantities of artificial sugars in drinks as well as drinks that have a laxative/diuretic effect.

Regarding activity:

excessive movement (shaking/jiggling legs), pacing around bedroom or ward, secretive exercise (in bathroom, sit ups in bed or leaving the ward to go for walks/runs).

Regarding nasogastric feeds:

compromising nasogastric feeds by removing tube, emptying feed (in the toilet, sink, shower, in cups), diluting the feed, changing feed rate or turning the feed off, using sharps to puncture tube, or a syringe to draw back on tube. It is recommended that to decrease the opportunity and urge to tamper with the tube feed, you tape the joins or moveable parts of the tubing (including the bag to the tube).

Regarding vomiting:

the eating disorder will force the person to look for opportunities to purge (e.g. in pockets, the bathroom, cups or bags, pot plants or vases) so try to minimise vessels in the room, and be aware purging can be silent.

Regarding medications:

self-medication of laxatives, diuretics and diet pills.

Regarding weight:

methods of weight falsification include fluid loading (increasing fluid intake the day prior to & the day of weighing), increasing salt intake prior to weigh days, hiding heavy objects on body (putting batteries in underpants/bra), gripping the scales

APPENDIX B – WEIGHING PATIENTS WITH EATING DISORDERS

Follow a consistent and standard routine of weighing patients. The excerpt below has been taken directly from the Guidelines for the Inpatient Management of Adult Eating Disorders in General Medical and Psychiatric Settings in NSW 2014; Developed by the Centre for Eating and Dieting Disorders (now InsideOut Institute) (<https://insideoutinstitute.org.au/resource-library/guidelines-for-the-inpatient-management-of-adult-eating-disorders-in-general-medical-and-psychiatric-settings-in-nsw>)

- Weighing is a non-negotiable part of treatment.
- Weighing is often extremely anxiety provoking for the patient, distraction and distress tolerance methods should be utilised (e.g. engaging the patient in light conversation during the weight, encouraging them to do crosswords or knitting etc. afterwards).
- Patients should be weighed wearing a hospital gown with underwear only and hair accessories removed, on consistent predetermined days.
- Ideally patients are weighed in the morning prior to breakfast.
- Patient should be instructed to empty their bladder prior to being weighed.
- If you suspect the weight has been falsified (water loading, salt loading, secreting weights in underwear, and/or bra) share concerns with team and document. In this instance a 'spot weigh' should be conducted. This involves weighing the patient at a random time, when they are not expecting to be weighed.
- In some cases 'blind weighing' or deciding collaboratively with the patient that it may be best for them to not know their weight can be helpful in these early stages of recovery where immediate weight restoration is essential (later exposure to weight and shape as an outpatient will be important). Discussing its advantages with the patients may be important. The team should agree on the weight approach and it be clearly outlined in the progress notes and treatment plan to avoid confusion and splitting.
- Patients should be weighed no more than 3x per week (frequent weigh-ins can overemphasise the importance of weight) on the same scales.

APPENDIX C – HELPFUL & UNHELPFUL THINGS TO SAY TO SOMEONE WITH AN EATING DISORDER

UNHELPFUL SAYING	MORE HELPFUL SAYING
<p><i>“You better eat your meal, otherwise you’ll be scheduled” or “You better stop pacing otherwise you’ll get in trouble”</i></p> <p>Try to refrain from making threats and taking an authoritative stance. This will only alienate the person, and will reinforce to them that you have little understanding of their illness.</p>	<p><i>“Finishing your meal will be a great step forward in showing your eating disorder that you are in charge”</i></p> <p><i>“I know how hard this is for you but finishing your meal will be a great step towards getting out/going home”</i></p> <p>This puts the control and power in the hands of the person and links it to their goals and provides hope.</p>
<p><i>“Just eat”</i></p> <p>This reinforces to the person that you have little understanding of their illness and how difficult it is to overcome. Always remember that eating a meal is their phobia.</p>	<p><i>“Why don’t you try to take a few more bites– we can see what a struggle this is for you but remember we’re trying to get you to a safe place and get you home”</i></p> <p>This provides encouragement and support, but still allows the person to make their own decision.</p>
<p><i>“You don’t look that sick” or “you don’t look like you have an eating disorder” or “you look good/well” or “you look healthy to me” or “you’re looking so much better!”</i></p> <p>This reinforces to the person that they are not sick enough, not good enough, are fat, and any comment about the person’s appearance, body, weight or shape will fire up the eating disorder.</p>	<p>Try not to comment on the person’s physical appearance. This emphasises the importance of appearance and almost always will be misinterpreted and will fire up their eating disorder regardless of your good intentions and leaves the patient thinking and feeling he/she is fat. Don't go there.</p>
<p><i>“You’ve barely gained any weight” or “Oh great, you’ve gained weight” or “Oh dear, you’ve lost weight again!”</i></p> <p>This reinforces to the person the importance of weight, and highlights that you are judging them based on their weight.</p>	<p>Try to refrain from making any comments about the number on the scale, the person’s progress or lack there of. This can be managed by the team.</p>
<p><i>“I wish I had a bit of Anorexia in me” or “I wish I could lose weight like you can”</i></p> <p>This is insensitive and highlights your lack of understanding of the horrors of this illness. These types of comments glamorise and idealise the illness. No one ‘chooses’ to have</p>	<p>Try to refrain from making any comments about the person’s weight or appearance. Regardless of your good intentions this will only trigger the person’s eating disorder.</p>

<p>an eating disorder. Keep in mind the high rate of mortality & suicide in people with eating disorders.</p>	
<p><i>"I'm also gluten free" or "I'm trying to lose weight for my friends wedding" or "I'm trying this new detox"</i></p> <p>Talking about your own diet is inappropriate, and reinforces to the person that 'dieting' or cutting foods out is 'normal'.</p>	<p>Try to refrain from making any comments about your own weight, diet or exercise patterns. Regardless of your good intentions this will only trigger the person's eating disorder.</p>
<p><i>"Why won't the team let you exercise, exercise is healthy" or "I go for a 45 minute walk everyday"</i></p> <p>When you agree with the person on a topic (even if you are just trying to be empathic) against a team decision it 'splits' the team. This gives power to the eating disorder to work against the person and the team.</p>	<p>-</p> <p>Although you may not agree with team decisions, keep these comments to yourself or clarify their purpose with the team, never with the person.</p>
<p><i>"I can't believe the Dietitian makes you eat dessert everyday, that's not healthy" or "Hospital food is so fatty, I wouldn't want to eat that either"</i></p> <p>This 'splits' the team, infers that you know better than the Dietitian and team and creates inner turmoil for the person. This will result in the person either refusing to eat the entire meal or feeling horribly guilty for having eaten.</p>	<p><i>"The Dietitian is there to work with you not against you. Trust her/him. She/he knows what will be medically safe for you. Let's try to trust them and take each day at a time."</i></p> <p>Try to refrain of making any comments about the person's food, their meal plan and your own food/taste preferences. <u>Always support the decisions of the team.</u> Show the person that you are all a united front in fighting their eating disorder.</p>
<p><i>"You're back again" or "That wasn't long between admissions"</i></p> <p>This will make the person feel that they are a failure and not worthy of treatment, and that you have no belief in their ability to get better.</p>	<p><i>"Good to see you, lets find some time today to talk about your goals for this admission"</i></p> <p>Focus on what small steps the person made between admissions. Always maintain 'hope' for the person's recovery.</p>
<p><i>"The doctor wants you to be a BMI of"</i></p>	<p>Do not at any stage discuss the weight goal and be mindful not to pass on such information to the person. Leave this to the team</p>
<p>Ignoring small progress</p>	<p>For instance after a meal acknowledge progress carefully:</p> <p><i>'I know that's been a real struggle – it is so hard but you've done really well'</i></p>

<p>Doing or saying nothing after meals</p>	<p><i>'I can see how hard this has been. Would you like to do some knitting or what about watching (for instance) 'Game of Thrones''</i></p> <p>- Offer a distraction of some sort and try to encourage such activity.</p> <p>Such a comment may or may not work depending on the person but to be quietly distracted after a meal is very helpful as that is when the thoughts are at their worst.</p>
<p><i>"Do you want to have breakfast?"</i> (this could equally apply to lunch or dinner)</p>	<p><i>"How about giving breakfast a go? I know you don't feel like it but just give it a try".</i></p>
<p>Saying to other staff <i>"Well she/he is not eating very well/ she is not doing what she/he is meant to"</i></p>	<p>When relaying information to doctor/nurse about oral intake be mindful to use similar language – <i>"Patient X trying to get through her meal. It's a struggle but she/ he is trying"</i></p>
<p><i>"You've been 100% compliant"</i></p> <p>This is somewhat demeaning and makes the person feel like a naughty school child.</p>	<p><i>"She's done really well so far' – it's so good to see her trying."</i></p> <p>This is respectful and acknowledging.</p>
<p><i>"I need to see everything I will be watching"</i></p>	<p>Try to be respectful when observing a person. <i>"I'm aware this is difficult for you with me watching and I'm sorry if that adds to your distress. I've just been reminded that I need to observe. I'll try to be as discreet as I can be"</i></p>
<p>When handing over to the nurse special <i>"You have to watch the food"</i></p> <p>This makes it seem and feel more scary and heightens the anxiety around the experience</p>	<p><i>"Please support the patient to do their very best to complete the meal as set out on the meal plan"</i></p>
<p>Standing over/ hovering over the person when meals are taking place and saying, <i>"I have to do this – it's my job"</i></p> <p>This stance does not contribute to ensuring safety and can increase anxiety.</p>	<p>The person needs to know that the role of the nurse special is to ensure their safety.</p> <p>Be discreet as you observe from an appropriate distance and engage in some conversation during the meal so as to lessen the anxiety and punitive experience of observed eating (this may be rejected – obviously it depends on the individual patient).</p>