Paediatric Inpatient Eating Disorder UHL Guideline

Trust Ref:C28/2023

Contents

1. Introduction and Who Guideline Applies to:

1.1 This guideline is intended to assist in the appropriate assessment and management of children/ adolescents admitted to UHL with anorexia and other eating disorders (ED).

1.2 As per NICE guideline (NE69, 2017), individuals with an eating disorder whose physical health is severely compromised should be admitted for medical stabilisation and to initiate refeeding. (See appendix 3 for risk assessment framework).

1.3 The aim of this guideline is to improve and provide consistent care for all patients presenting with an ED and to highlight the role of each speciality involved, primarily Medical teams (both inpatient and emergency department), Nursing teams, Dietetics and the Children and Adolescent Mental Health Service (CAMHS).

1.4 This guideline is suitable for use in all paediatric patients (up to 16 years of age) who present with a suspected/ confirmed diagnosis of an ED.

1.5 Eating disorders in children and young people are associated with significant physical and psychological morbidity and mortality. Those who present with an eating disorder will often be very under-nourished and refeeding syndrome can occur in this vulnerable group of patients if it is not identified and treated appropriately. It is the responsibility of the medical team (and the Dietitians if already involved in the care of an inpatient) to identify patients who are at risk of refeeding syndrome. Each patient will require a risk assessment for re-feeding syndrome as part of their overall ED assessment (see Paediatric refeeding guideline trust ref: B19/2019). Risk assessment should be completed by the medical team to first assess the individual on presentation.

1.6 This clinical guideline does not replace an individual dietetic assessment and referral to the Dietitian is required as soon as possible for assessment. Referrals must be made via ICE (electronic referral system) and a follow up telephone call/ answerphone message can be left informing team of admission on 0116 258 5400. Dietitians will respond within 48 hours of receipt of a referral.

1.7 If food and oral nutritional supplements (ONS) are refused for 24 hours after Dietetic assessment, a Nasogastric tube should be considered following discussion with the wider team (Psychiatrists, 2022), balancing risk and wishes of the parent/ young person. Such a discussion may help to improve co-operation in accepting normal diet or ONS. If an NGT is placed, feeds should be commenced as per re-feeding guidelines and re-feeding bloods monitored daily. Please follow the plan provided and contact the Dietitian if there are concerns that the feed is not tolerated (e.g. causing vomiting/diarrhoea).

1.8 Oral and enteral feeds must not be started in patients on specialised diets such as those on Ketogenic diets for intractable epilepsy, or an inherited metabolic disease/disorder e.g. Phenylketonuria or patients with a known food allergy until assessed by a Dietitian who will advise on feeding in these patient groups. **Please note**: Fictitious reporting of food allergies/ intolerances and dietary restrictions are extremely common in this patient group. Any restriction should be clarified with a parent/guardian who can advise that it was in place prior to development of ED symptoms and have an underpinning diagnosis.

1.9 CAMHS referrals should be made promptly once an ED is confirmed. A named Consultant should be allocated to the patients case to ensure the appropriate referrals are made and that care is escalated as needed.

2. Suspected/Confirmed Eating Disorder Pathway, Management & Referral

Eating Disorder - Confirmed
Medical team Inform named UHL Paediatric Consultant for eating disorders
Medical team to contact CAMHS on 0116 295 0310 & ask for a transfer of care handover if admitting to the ward.

Eating Disorder - Suspected
Medical team to inform named UHL Paediatric Consultant for eating disorders.
Medical team to refer to CAMHS 0116 295 0310.

Medical Team to Complete Risk Assessment Framework – Adapted from Medical Emergencies in Eating Disorders Guideline 2022 (Appendix 3) using appendix 1 (parameters) and 2 (% Median BMI)

Patient fits moderate to low risk criteria (Based on outcome of appendix 4)

If patient is medically fit, medical team to discharge:
- Contact GP to monitor patient in community.
- Ensure patient referred to CAMHS and inform them of discharge

Patient fits high concern to high risk criteria (Based on outcome of appendix 4)

Patient is at high risk of refeeding syndrome and requires nutritional rehabilitation

Admit to acute Paediatric Ward

UHL Medical
- Manage risk of refeeding syndrome and monitor daily - follow Paediatric UHL Guideline: Trust ref: B19/2019

NOTE: Due to the increased risk of heart failure in severe malnutrition IV fluids should be used with caution.
- Bloods: FBC, clotting, U&E, PO4, Mg, Ca, LFT, TFT, Fe, B12, folate
- Micronutrient supplementation- Oral/ IV. See refeeding guidelines.
- ECG for QT interval & bradycardia (cardiac monitoring if rate < 50, QTC >450m sec, arrhythmia)
- Fluid assessment incl. oedema
- Commence meal plan as per appendices 6 and 7.
- Ensure care plan is adhered to throughout admission.
- Ensure appropriate referrals to CAMHS and Dietetic and Nutrition Service completed on ICE.
- NGT to be considered after 24hours if < ½ meal plan managed.

UHL Nursing
- Refer to Dietetic and Nutrition service for high concern to high risk patients via ICE.
- Refer / Inform CAMHS team of admission (0116 295 0485)
- Ensure care plan is adhered to throughout admission
- **Support and monitoring of the following in medical/ nursing notes:**

-Vital signs / EWS as condition dictates.
-Nutritional intake daily (3 day meal plan- no negotiation. See appendices 6 and 7) using UHL fluid balance chart (FBC).
-Fluid intake daily (UHL FBC)
-Blood glucose if hypoglycaemic on admission.
-Medication compliance
-Activity and bed rest
- Weighed twice weekly (Anthropometry sheet)
- NGT to be considered after 24 hours if <1/2 meal plan managed. Discuss with Medical team and commence feeds as per meal plan.

UHL Dietitian
- Nutritional Assessment and identify risk of re-feeding syndrome
- Identify nutritional intake prior to admission (focus on carbohydrates and B vitamins and identify any self- restrictions)
- Instigate build-up meal plan (oral) using foods permitted list. Allow for 3-5 food dislikes
- To provide an enteral feeding regimen (NGT) if non- compliant with meal plan.

CAMHS (Medical, nursing and Dietitian)
- Liaise with named UHL Consultant
- CAMHS staff to refer to CAMHS EDT-HIT.
- Review on acute ward/ arrange outpatient follow-up
- Liaise with ward staff re: discharge planning and transition

Ward staff to ensure the following is adhered to throughout admission:

Graded Meal Plans **(see Appendix 6 and 7)**	All patients are to start at 1200kcals and will reach 2000kcal or 2400kcals by day three for patients aged up to 13 and 17 respectively. (Standard meal plan- but may vary depending on age and will be determined by Dietitian on admission).Underfeeding increases the time period in which refeeding complications are most likely to occur and contributes to increased cardiac risk. On day 1 and 2 of meal plan, please pre-portion main meals before giving to patient to ensure a balanced meal is provided.
Time limits on Meals	Time Limits: Meals 30 minutes, Snacks 15 minutes, ONS 10 minutes.
Meal time distractions	Consider limiting the use of phones during meals and snacks- however these may be beneficial to help control and manage anxiety e.g. speaking with friends etc.
Weight Monitoring	Twice weekly weights - Minimal clothing (no shoes) - On waking and before food/ fluid consumed - After passing first urine of the day - Check pockets/ hems of clothes for heavy items N.B. Weight gain may be variable in the first week as often patients are dehydrated on admission. Expected weight gain after first week should be ~1kg per week. Adjustments may be made to the plan by the Dietitian to facilitate weight gain.
Foods brought into hospital	In the first week the nursing staff are to choose all meals and snacks with the parents. Foods brought into hospital should be agreed by the Dietitian only. All meals should be supplied from the hospital menu. See: **Food Hygiene for Ward/Department Kitchens Policy: B27/2004**
Fluid	Daily fluid intake should achieve 1800mls (but not exceed 2500ml). Include all drinks listed in the diet plan when calculating the total fluid intake. A suggested minimum intake is 1500ml
Nasogastric Feeds	Please contact Dietitian for review if needed (poor tolerance including pain, nausea, vomiting or diarrhoea related to feeds) If food and ONS are refused for 24 hours, an NGT should be placed and ONS can be given as a bolus feed immediately after each mealtime
Documentation	Use food, fluid and patient monitoring diary (see Appendix 5) to document any uneaten food and all fluid taken. Any unusual behaviours/ interactions/ relationships.
Exercise	Patient to be on bed rest- ensure no excessive standing at bedside or long toilet breaks.
Toileting	Toilet: Use before meals, should not be used during or one hour after meals and 30 minutes after snacks.

3. Education and Training

Additional training/ or experience in eating disorders, managing difficult behaviour or motivational interviewing would be beneficial when assessing and reviewing this patient group, but it is not essential.

The purpose for admission to an acute ward is for medical stabilisation only and psychological input should be given only by those suitable qualified e.g. CAMHS/ Psychiatry.

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Datix incidents – Paediatric Dietitians to Datix if children identified at being at risk of refeeding syndrome do not have their serum Na, K, Mg, PO4 , Ca checked initially or continued daily until full feeds are met and the above electrolytes are within range.	Number of Datix incidents related to refeeding syndrome/management of refeeding syndrome in paediatric patients. To be obtained via Patient Safety Team.	Senior Dietitian (Paediatrics)	Quarterly	To report back to the Childrens Hospital on trends as indicated.

5. Supporting Documents and Key References

National Institute for Health and Care Excellence (NICE Guidelines), 2017. *Eating disorders: recognition and treatment*. [online] Available at: <https://www.nice.org.uk/guidance/ng69> [Accessed 15 September 2021].

Royal College of Physicians, 2012. *Junior MARSIPAN: Management of Really Sick Patients under 18 with Anorexia Nervosa*. Approved by Central Policy Coordination Committee.

Starship Inpatient Eating Disorders Team, 2011. Starship Children's Health Clinical Guideline. ANOREXIA / EATING DISORDERS - INPATIENT MANAGEMENT.

University Hospitals of Leicester: Guideline to identify and manage paediatric inpatients who are at risk of refeeding syndrome. Trust reference: B19/2019

University Hospitals of Leicester: Guideline for Treating Patients with Anorexia Nervosa when Admitted as a Medical Emergency. Trust reference E2/2012

Psychiatrists, T. R. (2022, May). *Medical emergencies in eating disorders.* Retrieved October 2022, from rcpsych: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr233-medical-emergencies-in-eating-disorders-(meed)-guidance.pdf?sfvrsn=2d327483_52

6. Key Words

Paediatric Eating Disorder, Anorexia, Refeeding syndrome, Re-feeding, Meal plan, Nasogastric tube, NG, Enteral, CAMHS, Junior Marsipan, Malnourished, Underweight, food refusal.

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT		
Author / Lead Officer:	Harshidh Daya - Dietitian Hannah Harding - Dietitian Katie Sellens - Senior Dietitian	Executive Lead; Chief Nurse
Reviewed by:	Rachel Fox, Senior Specialist Dietitian Cathy Steele, Dietetic Head of Service.	

REVIEW RECORD			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
May 2023	1	Rachel Fox, Senior Specialist Dietitian Cathy Steele, Dietetic Head of Service Children's Hospital & ED clinical guidelines group.	New document

PATIENT IDENTIFICATION

NAME: _____

S NUMBER: _____

NHS NUMBER: _____

DOB: _____

Key Parameters	
Sitting blood pressure:	**Standing blood pressure:**
Sitting Pulse rate:	**Standing pulse rate:**
Respiration rate:	**Temperature:**
Weight:	**Height in meters:**
BMI = Weight kg/ (Height m)^2	**% Median BMI** = Actual BMI x 100 / Median BMI (50th percentile) for age and gender (see appendix 2)

Age (years)	*Male*	*Female*
9	16.037	16.399
9.25	16.125	16.515
9.5	16.219	16.637
9.75	16.318	16.765
10	16.423	16.898
10.25	16.533	17.036
10.5	16.648	17.179
10.75	16.768	17.327
11	16.892	17.478
11.25	17.02	17.634
11.5	17.154	17.793
11.75	17.291	17.954
12	17.433	18.117
12.25	17.579	18.281
12.5	17.729	18.446
12.75	17.881	18.61
13	18.037	18.772
13.25	18.194	18.932
13.5	18.354	19.09
13.75	18.514	19.244
14	18.675	19.395
14.25	18.836	19.542
14.5	18.997	19.684
14.75	19.158	19.822
15	19.317	19.955
15.25	19.475	20.083
15.5	19.632	20.206
15.75	19.786	20.324
16	19.938	20.438
16.25	20.087	20.547
16.5	20.234	20.652
16.75	20.378	20.751
17	20.519	20.847
17.25	20.656	20.938
17.5	20.791	21.026
17.75	20.923	21.11
18	21.052	21.19
18.25	21.178	21.267
18.5	21.301	21.342
18.75	21.422	21.413
19	21.54	21.482
19.25	21.655	21.548
19.5	21.768	21.612
19.75	21.878	21.674
20	21.986	21.735

a. Patients with inappropriately normal/high HR for degree of underweight are at even higher risk (hypovolaemia). HR may also be ↑purposefully by consuming excess caffeine in coffee or other drinks. Jackson et al, 2007.

Appendix 3: Risk Assessment Framework, Adapted from Medical Emergencies in Eating Disorders

University Hospitals of Leicester NHS
NHS Trust

	Red: High impending risk to life	Amber: Alert to high concern for impending risk to life	Green: low impending risk to life
BMI and weight	Under 18 years: m% BMI <70% Over 18: BMI >15	BMI and weight Under 18 years: m%BMI35 80%36 Over 18: BMI >15	BMI and weight Under 18 years: m%BMI35 80%36 Over 18: BMI >15
Weight loss	Recent loss of weight of ≥1kg/week for 2 weeks (consecutive) in an undernourished patient34 Rapid weight loss at any weight, e.g. in obesity or ARFID	Recent loss of weight of 500–999g/week for 2 consecutive weeks in an undernourished patient	Recent weight loss of <500gr/week or fluctuating weight
HR and rhythm	<40	40-50	>50
Cardiovascular health	standing systolic BP below 0.4th centile for age or less than 90 if 18+, associated with recurrent syncope and postural drop in systolic BP of >20mmHg or increase in HR of over 30bpm (35bpm in <16 years)	Standing systolic BP <0.4th centile or <90 if 18+ associated with occasional syncope; postural drop in systolic BP of >15mmHg or increase in HR of up to 30bpm (35bpm in <16 years)	• Normal standing systolic BP for age and gender with reference to centile charts • Normal orthostatic cardiovascular changes • Normal heart rhythm
Assessment of hydration status	• Fluid refusal • Severe dehydration (10%): reduced urine output, dry mouth, postural BP drop (see above), decreased skin turgor, sunken eyes, tachypnoea, tachycardia	Orthostatic ↓in systolic BP of ≥15mmHg Orthostatic ↑ in HR of up to 30 bpm	Normal orthostatic cardiovascular changes but pre-syncopal symptoms
Temperature	<35.5°C tympanic or 35.0°C axillary	<36°C	≥36°C
Muscular function SUSS Test	Unable to sit up from lying flat, or to get up from squat at all or only by using upper limbs to help (Score 0 or 1)	Unable to sit up or stand from squat without noticeable difficulty (Score 2)	Able to sit up from lying flat and stand from squat with no difficulty (Score 3)

Muscular function: Hand grip strength **Muscular function: MUAC**	Male <30.5kg, Female <17.5kg (3^{rd} percentile) <18cm (approx. BMI <13)	Male <38kg, Female <23kg (5^{rd} percentile) 18-20cm (approx. BMI <15.5)	Male >38kg, Female >23kg >20cm (approx. BMI >15.5)
EEG abnormalities	• **<18 years**: QTC > 460ms (female), 450ms (male) • **18+ years**: QTc >450ms (females), 430ms (males) • And any other significant ECG abnormality	• **<18 years**: QTC > 460ms (female), 450ms (male) • **18+ years**: QTc >450ms (females), >430ms (males) • And no other EEG anomaly • Taking medication known to prolong QTc interval	• **<18 years**: QTC <460ms (female), 450ms (male) • **18+ years**: QTc <450ms (females), <430ms (males)
Biochemical abnormalities	↓K (<2.5mmol/L),↓PO4, ↓Na,↓Ca, ↓alb, ↓gluc (<3mmol/L), HbA1c >10% in diabetes	none	None
Haematology	• Low white cell count • Haemaglobin <10g/L	none	none
Disordered Eating	Acute food refusal, or est. intake 500kcal/d for >2 days	None	None
Engagement	• Physical struggles with others over nutrition or exercise restriction • Harm to self • Poor insight or motivation • Fear leading to resistance to weight gain • Inability for staff/carers to implement prescribed meal plan	• Poor insight or motivation • Resistance to weight gain • Staff or parents/carers unable to implement meal plan prescribed • Some insight and motivation to tackle eating problems • Fear leading to some ambivalence but not actively resisting	• Some insight and motivation to tackle eating problems • May be ambivalent but not actively resisting
Activity & exercise	>2 hours a day uncontrolled exercise (in the context of malnutrition)	>1 hour per day (in the context of malnutrition)	<1 hour per day (in the context of malnutrition)
Mental health	Self-harm and suicidal ideation with moderate to high risk of completed suicide	Cutting or similar behaviours, suicidal ideas with low risk of completed suicide	
Total Score for each column			

Appendix 4: Action Plan

University Hospitals of Leicester NHS
NHS Trust

PATIENT IDENTIFICATION

NAME: _____

S NUMBER: _____

NHS NUMBER: _____

DOB: _____

Please consider admission as an inpatient if >1 high risk criteria are met.

Action Plan				
Risk Assessment discussed with senior clinician. *Please provide name*				
Overall Risk Assessment using senior clinician's clinical judgement and table above. *Please circle risk category*	Red Very High risk	Amber High risk	Green Moderate risk	Blue Low risk
CAMHS *Please circle if appropriate*	Referral to CAMHS		Known to CAMHS & contacted	
Discharge to GP for follow up				
Admit				

Appendix 5: Patient Monitoring Diary

University Hospitals of Leicester NHS
NHS Trust

Time	Food/Fluid given	Amount eaten	Notes on Activity/ Bed rest	**Bathroom trips** (note any concerns eg. long trips to the toilet, toilet directly after the meal)
00:00-01:00				
01:00-02:00				

NAME: _____ S NUMBER: _____ NHS NUMBER: _____ DOB: _____

Day 1:

Meal	Oral Diet Plan	Supplement (Fortisip Compact)
Breakfast (0830hrs)	1 x box cereal/ 30g ready brek/ 2 weetabix with minimum 100ml whole milk AND ½ slice toast with butter	100ml
Snack (1030hrs)	Snack from foods permitted list	60ml
Lunch (1230hrs)	½ hot meal portion or ½ Sandwich, Dessert option e.g. yogurt.	100ml
Snack (1430hrs)	Snack from foods permitted list	60ml
Dinner (1700hrs)	½ main meal portion, Dessert option	100ml
Snack (2000hrs)	Snack from foods permitted list	60ml
Total		480ml

The food is the treatment therefore ALL of the food given must be eaten.

If half of the meal/snack is <u>not eaten</u> within the time frames given below, then the full supplement is to be given immediately (snack = 15min, meal 30min).
DO NOT NEGOTIATE WITH THE PATIENT OR FAMILY.

Fluid
• Offer 250mls to drink with each meal and snack
• Include any ONS given in total fluid

Ideal intake: 1800mls – 2000mls. Do not exceed: 2500mls
Record all food and fluid consumed, and note any food not eaten.

- **If food and ONS are refused for 24 hours, an NGT should be placed and ONS can be given as a bolus feed immediately after each mealtime**
- **NG feeds can be administered via gravity bolus or pump for larger volumes (e.g. 300mls run at 400mls/hr)**
- **Mealtimes should never take longer than 1 hour**

Day 2:

Meal	Oral Diet Plan	Supplement (Fortisip Compact)
Breakfast (0830hrs)	2 x box cereal/ 60g ready brek/ 3 weetabix with minimum 100ml whole milk AND 1 slice of toast with butter and jam	170ml
Snack (1030hrs)	Snack from foods permitted list	80ml
Lunch (1230hrs)	¾ main meal portion, ¾ dessert portion	170ml
Snack (1430hrs)	Snack from foods permitted list	80ml
Dinner (1700hrs)	¾ main meal portion, ¾ dessert portion	170ml
Snack (2000hrs)	Snack from foods permitted list	80ml
Total		750ml
The food is the treatment therefore ALL of the food given must be eaten. **If half of the meal/snack is <u>not eaten</u> within the time frames given below, then the full ONS is to be given immediately (snack = 15min, meal 30min)** **DO NOT NEGOTIATE WITH THE PATIENT OR FAMILY.**		

Fluid
• Offer 250mls to drink with each meal and snack
• Include any ONS given in total fluid

Ideal intake: 1800mls – 2000 mls
Do not exceed: 2500mls

Record all food and fluid consumed, and note any food not eaten.

- **If food and ONS are refused for 24 hours, an NGT should be placed and ONS can be given as a bolus feed immediately after each mealtime**
- **NG feeds can be administered via gravity bolus or pump for larger volumes (e.g. 300mls run at 400mls/hr)**
- **Mealtimes should never take longer than 1 hour**

Day 3:

Meal	Oral Diet Plan	Supplement (Fortisip Compact)
Breakfast (0830hrs)	2 x box cereal/ 60g ready brek/ 3 weetabix with 100ml whole milk AND 1 slice of toast with butter and jam	170ml
Snack (1030hrs)	Snack from foods permitted list	80ml
Lunch (1230hrs)	1 full main meal portion 1 full dessert portion	300ml
Snack (1430hrs)	Snack from foods permitted list	80ml
Dinner (1700hrs)	1 full main meal portion 1 full dessert portion	300ml
Snack (2000hrs)	Snack from foods permitted list	80ml
Total		1010ml
The food is the treatment therefore ALL of the food given must be eaten. **If half of the meal/snack is <u>not eaten</u> within the time frames given below, then the full supplement is to be given immediately (snack = 15min, meal 30min)** **DO NOT NEGOTIATE WITH THE PATIENT OR FAMILY.**		

Fluid
• Offer 250mls to drink with each meal and snack
• Include any ONS given in total fluid

Minimum: 1500mls
Ideal intake: 1800mls – 2000mls
Do not exceed: 2500mls

Record all food and fluid consumed, and note any food not eaten.

- **If food and ONS are refused for 24 hours, an NGT should be placed and ONS can be given as a bolus feed immediately after each mealtime**
- **NG feeds can be administered via gravity bolus or pump for larger volumes (e.g. 300mls run at 400mls/hr)**
- **Mealtimes should never take longer than 1 hour**

Day 1:

Meal	Oral Diet Plan	Supplement (Fortisip Compact)
Breakfast (0830hrs)	1 x box cereal/ 30g ready brek/ 2 weetabix with minimum 100ml whole milk AND ½ slice toast with butter	80ml
Snack (1030hrs)	Snack from foods permitted list	60ml
Lunch (1230hrs)	½ hot meal portion or ½ Sandwich,	100ml
Snack (1430hrs)	Snack from foods permitted list	60ml
Dinner (1700hrs)	½ main meal portion,	100ml
Snack (2000hrs)	Snack from foods permitted list	60ml
Total		460ml

The food is the treatment therefore ALL of the food given must be eaten.

If half of the meal/snack is <u>not eaten</u> within the time frames given below, then the full supplement is to be given immediately (snack = 15min, meal 30min).
DO NOT NEGOTIATE WITH THE PATIENT OR FAMILY.

Fluid
• Offer 250mls to drink with each meal and snack
• Include any ONS given in total fluid

Ideal intake: 1800mls – 2000mls. Do not exceed: 2500mls
Record all food and fluid consumed, and note any food not eaten.

- **If food and ONS are refused for 24 hours, an NGT should be placed and ONS can be given as a bolus feed immediately after each mealtime**
- **NG feeds can be administered via gravity bolus or pump for larger volumes (e.g. 300mls run at 400mls/hr)**
- **Mealtimes should never take longer than 1 hour**

Day 2:

Meal	Oral Diet Plan	Supplement (Fortisip Compact)
Breakfast (0830hrs)	2 x box cereal/ 60g ready brek/ 3 weetabix with minimum 100ml whole milk OR 2 slice of toast with butter and jam	130ml
Snack (1030hrs)	Snack from foods permitted list	80ml
Lunch (1230hrs)	¾ main meal portion,	130ml
Snack (1430hrs)	Snack from foods permitted list	80ml
Dinner (1700hrs)	¾ main meal portion,	130ml
Snack (2000hrs)	Snack from foods permitted list	80ml
Total		630ml

The food is the treatment therefore ALL of the food given must be eaten.

If half of the meal/snack is <u>not eaten</u> within the time frames given below, then the full ONS is to be given immediately (snack = 15min, meal 30min)
DO NOT NEGOTIATE WITH THE PATIENT OR FAMILY.

Fluid
• Offer 250mls to drink with each meal and snack
• Include any ONS given in total fluid

Ideal intake: 1800mls – 2000 mls
Do not exceed: 2500mls

Record all food and fluid consumed, and note any food not eaten.

- **If food and ONS are refused for 24 hours, an NGT should be placed and ONS can be given as a bolus feed immediately after each mealtime**
- **NG feeds can be administered via gravity bolus or pump for larger volumes (e.g. 300mls run at 400mls/hr)**
- **Mealtimes should never take longer than 1 hour**

Day 3:

Meal	Oral Diet Plan	Supplement (Fortisip Compact)
Breakfast (0830hrs)	2 x box cereal/ 60g ready brek/ 3 weetabix with 100ml whole milk AND 1 slice of toast with butter and jam	170ml
Snack (1030hrs)	Snack from foods permitted list	80ml
Lunch (1230hrs)	1 full main meal portion	200ml
Snack (1430hrs)	Snack from foods permitted list	80ml
Dinner (1700hrs)	1 full main meal portion	250ml
Snack (2000hrs)	Snack from foods permitted list	80ml
Total		860ml
The food is the treatment therefore ALL of the food given must be eaten. **If half of the meal/snack is <u>not eaten</u> within the time frames given below, then the full supplement is to be given immediately (snack = 15min, meal 30min)** **DO NOT NEGOTIATE WITH THE PATIENT OR FAMILY.**		

Fluid
• Offer 250mls to drink with each meal and snack
• Include any ONS given in total fluid

Minimum: 1500mls
Ideal intake: 1800mls – 2000mls
Do not exceed: 2500mls

Record all food and fluid consumed, and note any food not eaten.

- **If food and ONS are refused for 24 hours, an NGT should be placed and ONS can be given as a bolus feed immediately after each mealtime**
- **NG feeds can be administered via gravity bolus or pump for larger volumes (e.g. 300mls run at 400mls/hr)**
- **Mealtimes should never take longer than 1 hour**

Day 1 Snack options AND Day 1 & 2 Dessert Options		• 250ml whole milk • One pot full fat yoghurt • One digestive biscuit and piece of fruit • One slice of toast with butter • One packet crisps • Bourbon biscuits • Cake slice/flapjack • Ice cream (order from w27 menu) • Ambrosia custard pot
Day 2 & 3 Snack options		• 200ml whole milk / full fat yoghurt PLUS one digestive biscuit • Two digestive biscuits and one piece of fruit • One slice of toast with 2 x butter and jam • One croissant with 1 x butter and 1 x jam (order from w27 menu) • One packet of crisps with 1 x pre- portioned packet cheese
Day 3 Dessert Option	**Ward 27 Menu**	• Jam Sponge • Chocolate sponge • Apple sponge and raisin pudding • Apple crumble with custard • Croissant with 2 x butter and jam • 2 x pancakes with jam or chocolate spread • 2 x chocolate soya dessert / soya yogurt with 150mls full fat milk

Graded Meal plan 13+ years old

Day 1: ~1200kcal
Day 2: ~1800kcal
Day 3: ~2400kcal

Final aim:

Breakfast: ~400kcal

Morning snack: ~200kcal

Lunch: ~720kcal

Afternoon snack: ~200kcal

Evening meal: ~720kcal

Evening snack: ~200kcal

Graded Meal plan ages 13 and below

Day 1: ~1000kcal
Day 2: ~1500kcal
Day 3: ~2000kcal

Final aim:

Breakfast: ~400kcal

Morning snack: ~200kcal

Lunch: ~500kcal

Afternoon snack: ~200kcal

Evening meal: ~600kcal

Evening snack: ~200kcal