Ashford and
St. Peter's Hospitals
NHS Foundation Trust

PAEDIATRIC GUIDELINE:

DETAILED GUIDANCE FOR WARD MANAGEMENT OF PATIENTS ADMITTED WITH KNOWN OR SUSPECTED ANOREXIA NERVOSA INCLUDING PATIENT/ PARENT CARE PLAN

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GUIDANCE FOR WARD MANAGEMENT OF PATIENTS ADMITTED WITH KNOWN OR SUSPECTED ANOREXIA NERVOSA
(With permission from Dr. Pippa Hugo, Consultant Paediatrc Psychiatrist, SGH)

It is well recognised that management of patients with Eating Disorders can be extremely physically and emotionally challenging, both for staff as well as patients and their families. It is therefore imperative that staff work openly with patients and their families, but also provides a consistent approach to management. Although this can be taxing, it is in the best interest of the patient as these patients are at a high risk of death due to their Eating Disorder.

1. Communication

A care plan will be formulated by the management team: Paediatric Consultant, Psychiatrist (Eating Disorders Service), Nurse in charge, Dietician. Ensure the plan of care is explained to the child/young person and parents, **and be clear that there will not be a deviance from this care plan unless decided by the management team.** The management team should review progress every 48 hours during the working week and make revisions to the care plan accordingly. Continue to reinforce the care plan with the patient and parents, constantly supporting them through this. Details of discussion with parents and child/young person should be documented.

2. Feeding

The management of mealtimes on a Paediatric ward is a crucial part of the child/ young person's medical treatment and it is important that staff is able to recognise this and see it as similar in importance to any prescribed treatment such as application of wet wraps and time spent giving feeds to a reluctant infant feeder. Often it is the only intervention which is likely to lead to an improvement in the child/ young person's medical state and hence speed recovery and discharge.
All children and young people must be assessed for their nutritional needs by the Paediatric Dietician. A decision must be taken with the whole team as to how to feed the child/young person e.g. via normal meals or naso-gastric feeding.
The Paediatric Dietician will prescribe the appropriate re-feeding diet/feed. Patients will be allowed dislikes that preceded the development of Anorexia Nervosa according to parental history. The eating regime should be presented to the patient as the prescribed medicine that they require because their low weight has such a serious impact on their physical health. If a patient is not under constant nursing observation they should be supervised for 30mins after all meals to prevent vomiting.
†A decision should be made with the whole team as to whether the parents do or do not have any involvement with the feeding regime. The extent of this involvement should be clearly documented e.g. are parents responsible for supervising meals?

b. Naso-gastric feeding

Naso gastric feeding (NG) should be seen as a very last resort to the dietary management of a young person with Anorexia Nervosa. If it needs to be used due to the child/young person's medical needs, then the aim is to use it for the shortest time possible and to continue to encourage the patient to eat if physically able to tolerate it. Initiating nasogastric feeding should be based on a review of the child/young person's progress, taking into account their level of compliance with the prescribed meal plan and deterioration in their medical condition below parameters set at admission. The decision would normally be made at the review meeting with the whole team unless the medical state requires more urgent intervention. The Paediatric Dietician should oversee the NG feeding regime.

a. Oral feeds

ALL food and fluids must be documented clearly describing in detail the exact amount taken.
ALL meals including snacks must be closely supervised by either professionals or parents (see below†).
The following time limits should be adhered to –

- 30 mins breakfast
- 20 mins snacks
- 30 mins main meal
- 20 mins dessert

At the end of these times the plate should be removed.
The child/ young person should be aware that if the meal is not completed they are expected to drink a prescribed supplement drink. If they are unable to manage this then the team will have to **consider** feeding via naso-gastric tube. Staff should be aware that mealtimes will be very difficult and distressing for patients and patients may require a great deal of reassurance. *(See guidelines on How to manage mealtimes*) Staff should be aware that the patient may attempt to distract them and / or negotiate in order to get rid of food, e.g. place food in sleeves, pockets, hair, into the bed and surrounding receptacles. It is helpful for staff to provide a consistent message about what is expected from the patient.

3. Weighing

Weigh the child/young person twice weekly on the same scales and wearing underwear or light pajamas after they have gone to the toilet. Check all pockets for contents before weighing. Weigh in the morning before feeds/meals. This will help minimize fluctuations in weight from non-nutritional variables. Weight should be entered on a weight chart. A weight gain of 1kg per week is optimal. Patients may "water-load" in order to mimic weight gain. Access to fluids should therefore be restricted. Patients may try to drink from other patients' drinks/ taps/toilets/showers and hence restriction to these may need to be arranged e.g. ensure that family does not bring in drinks and empty bottles are not left lying around. If there is ongoing concern, measurement of urine specific gravity at the same time as being weighed may be necessary. The patients should not have access to ward scales.
Any decision to initiate NG feeding should be made following consultation with the child/young person and their family. If the child/young person refuse to be NG fed, then consent of those with parental responsibility can be sought. Irrespective of age if the child/young person consistently and actively resists treatment consideration should be given to treating the child/young person under the Mental Health Act. (See section on Consent.)

Guidelines for naso-gastric feeding:

- The child/young person should be taken to a quiet, calm area to have the NG tube passed with as few people as possible present.
- The NG tube to be passed and then left in situ.
- Bolus feed would be the recommended method unless otherwise indicated.
- Staff should continue to offer food as per meal plan and communicate a high expectation that the food will be eaten. If food is refused, or no attempt is made to eat or complete the meal in the time limits set, then a bolus feed is to be given via the NG tube.
- If the child/young person does eat then they need to comply fully with the daily meal plan until the next review day, when a decision will be made as to whether the tube can be removed. The child/young person should be given a positive message that the tube will be removed if they comply fully with the

prescribed daily meal plan.
- If a patient is unable to tolerate bolus feeding then continual NG feeding may be required.
- The patient may require restraint to pass the NG tube and during feeding. If restraint is used, it must be carefully done ensuring that staff do not hurt or frighten the child. Constant reassurance throughout the procedure must be given. **SEEK THE HELP AND ADVICE OF SENIOR COLLEAGUES**.
- All due care for the NG tube should be given – checking position / state etc. of tube as per NG Feeding Policy.
- If the child/young person continues to pull out the tube and distress and agitation around feeding is too great to be managed through reassurance and talking, further discussion with the MDT must take place to decide the next course of action, which may include sedation.

4. Elimination

The child/young person will be on **strict bed rest** so will require a commode at all times. Every effort must be made to ensure the child/young person's privacy and dignity is maintained. However, if it is thought the child/young person is, for example, exercising behind screens then supervision may be required. Once the child/young person is more settled a decision may be taken by the MDT that they can begin to use the toilet under nursing supervision. Maintain accurate Fluid Balance Chart.

5. Activity and mobilization

The child/young person will be on strict bed rest. All schooling and play should come to the child/young person at the bedside until a decision is reached by the team that they are well enough to attend the school room for short periods. Staff should be aware that patients with Anorexia Nervosa will be driven to exercise at any opportunity which can often be achieved through subtle behaviours e.g. arm or leg movement, muscle tensing. The child/young person may need repeated reminders to rest. Patients will find bed rest distressing and will therefore need activities and support to help distract them and manage their distress. Play specialist input is vital in this regard.

6. Personal hygiene

The child/young person will be **on strict bed rest**, so it is essential that formal assessment of pressure areas is done on a regular basis and documented.
The child/young person may be allowed to have one supervised shower a week if agreed by the team. The nurse should stay outside the door listening for activity, or may need to remain in the room to ensure supervision. Again all possible action must be taken to maintain dignity and privacy.

7. Emotional, spiritual health

This will be a distressing and difficult time for these children and they should be offered full care and attention from staff for their emotional/physical /social and psychological needs to be met. Support from family and friends may be helpful but a clear plan for visitors should be negotiated, documented in the notes and adhered to. This plan can be reviewed in the weekly MDT review meeting. **Visits should not occur at meal times unless agreed.**

8. Play, education and development

The child/young person will have access to play and education at the bedside. This is imperative to give the patient some normality, and the opportunity to express themselves at this difficult time. If care is progressing well, and the patient is compliant, it is possible the child/young person may be allowed to visit the playroom or school room on their bed or wheelchair, once agreed with the team.

9. Maintaining a safe environment

All patients should be nursed in the open ward on **strict bed rest**

10. Physical monitoring (breathing, temperature, circulation and neurological state)

Ensure the child/young person does not suffer from any breathing difficulties, and provide appropriate care if required. Ensure the child/young person has adequate circulation and direct care accordingly if required. Maintain an accurate fluid balance chart throughout his/her stay. Observations must be recorded no less than 4 hourly and more frequently if the child is unstable. Patients may have trouble controlling temperature due to their physiological state. Ensure this is monitored 4 hourly and more frequently as required. **Staff should be particularly vigilant of a low temperature and escalate this to a senior doctor.**

Staff should be aware that patients may attempt to dress inappropriately to lose heat. Patients should be reminded to dress warmly and to have covering on their feet. Ensure that there are no neurological problems and plan care accordingly if they exist. Note in particular any change in conscious level if the child/young person is unstable and escalate this to a senior doctor.

11. Pain/comfort

This is a particularly stressful time for the child/young person, as they are away from home. They may also have to undergo the unpleasant procedure of having a nasogastric tube passed. The child/young person should be afforded a lot of reassurance and care throughout their stay, and any pain experience dealt with accordingly. The child/young person must be supervised at all times, unless otherwise stated by their Psychiatric Consultant. All patients should be nursed with the support of a Registered Mental Health Nurse. All due care should be given to their NG tube following policy. Close observation and documentation of all behaviour is essential. Any tests ordered by medical staff must be done in a timely fashion as the patient will be physiologically unwell. Staff must be aware of any treatment orders or mental health section orders. Staff should be aware that children and young people with Anorexia Nervosa often self harm, so all staff must be vigilant for this.

12. Consent

The first consideration must always be to act in the child/young person's best interests, and this applies to all children and young people up to their 18th birthday (i.e. 17 years and 364 days). ***Remember these children and young people are sick and are unlikely to be competent to make a decision for them selves around this issue. Remember if the situation is life threatening you MUST intervene to safeguard the their health.***Those with parental responsibility should always be consulted and consent sought **and documented.** The child/young person and parents/carers should **always** be kept informed of any action you are going to take immediately before this action is commenced. Due consideration should be given to involving them in earlier discussion if it is considered that the child/young person may abscond or refuse feeding.

The practitioner must remember that the child/young person may refuse care, and

before more formal measures are taken, a firm, clear and authoritative approach may resolve any refusal to treatment. *(For example, a child/young person may be told that a naso-gastric tube will be passed in order to supplement their nutrition and keep them safe. Do they wish to be held gently and firmly whilst this is done, or remain still throughout the procedure? The professional is then only giving the choice of how the procedure is done, rather than whether a procedure is done and giving the child/young person the option to refuse.)* However, if the child/young person does refuse, and for example, physically actively prevents a procedure, then further consideration must be given on how to take the issue forward.

Under the Mental Health Act (MHA) feeding is recognized as treatment for Anorexia Nervosa and can be done against the will of the patient as a life-saving measure.

Although a last resort, the decision to apply the MHA should be considered from the outset, for example, in a patient refusing treatment in A&E.

"Young people under 16 can be treated against their will if at least one parent (or those with parental responsibility) consents to treatment on their behalf. However, if the child/young person actively fights his/her parents' decision regarding the necessity of the treatment, treatment under the Mental Health Act needs to be considered. This applies to decisions within the zone of parental control i.e. ones which parents would normally make on behalf of children, and is in the best interests of the child.

If both the child and the parent refuse treatment, procedures in keeping with the Surrey Safeguarding Children Board or the Emergency Duty Team (out of hours), should be followed, and use of the Children Act might be necessary.

The underlying principles of using Mental Health Legislation in the management of this client group are broadly applicable i.e. Anorexia Nervosa is a serious mental disorder, inpatient re-feeding is at times an essential and a direct treatment for this and in rare situations, where there is life-threatening physical risk and an unwillingness or inability to agree to treatment, compulsory treatment can and should be instituted.

Note that Consultant Paediatrician can no longer be the responsible clinician for a patient detained under the Mental Health Act. Under the amended Act the Responsible Clinician must be an Approved Clinician, in this situation usually a psychiatrist. **Reference:** Report from the Junior MARSIPAN Group, Junior MARSIPAN: Management of Really Sick Patients Under 18 with Anorexia Nervosa, 2011).

16 – 18 year olds can be admitted under the MHA and treated against their will, although this should rarely be required. It is essential, however, that it is done when it is necessary.

"The refusal of a competent 16 or 17 year old to be medically treated can be overridden by their parents or other person who has parental responsibility for that 16 or 17 year old or by the court. Consideration should be given to whether the use of the Act, if applicable, would be appropriate. **Emergency treatment** 31.17: In an emergency situation a doctor may undertake treatment if delay would be dangerous (see para 15.25). It is good practice in that situation to attempt to obtain the consent of the parents or other person with parental responsibility." (Code of Practice, Mental Health Act 1983, Chapter 31. Children and young people under the age of 18.)

If paediatric staff suspect that formal measures are necessary then psychiatric services should be contacted, as they will be familiar with arranging a Mental Health Act assessment. **If the Paediatric Consultant is not satisfied with the opinion given, there should be direct contact between him/her and the Consultant Psychiatrist and the issue escalated until the patient's treatment is safe.**

13. Discharge

Ideally, patients should be discharged from the paediatric ward as soon as the reasons for admission have been addressed and physical health is robust enough for safe discharge. Discharge planning involves the multidisciplinary discussion at senior level including both the Paediatrician and Psychiatrist in charge and other relevant personnel. It is important that discharge planning is started as soon after admission as possible to avoid unnecessary delays.

Discharge may be to a specialist eating disorder unit or the community. This decision should be made after the following factors have been considered:

- The original rationale for admission; has this resolved?
- The current physical health and any continuing medical requirements
- Nutritional status, method of feeding and monitoring
- Mental health and specific requirements; is a specialist eating disorder bed required?
- Whether the young person is subject to compulsory treatment and admission
- The family and individual's needs, circumstances and preferences
- The capacity of the specialist eating disorder service to manage the physical risk

Guidelines for
a) behavioural management of eating
b) management of physical activity
c) engaging young people with anorexia nervosa

From: Anorexia nervosa within an inpatient paediatric setting – protocol for the nursing management (including dietetic guidelines). *Cheshire and Merseyside Adolescent Eating Disorder Service and Paediatric Services at Countess of Chester NHS Trust*

a) Guidelines for the behavioural management of mealtimes

Management of mealtimes can be a very difficult and emotionally exhausting experience for staff. The young person with anorexia may exhibit high levels of distress and animosity towards staff. Their anorexic thinking will drive them to attempt to engage staff in negotiations regarding food and also distract them in order to dispose of food. **This means that staff will need to be extra vigilant during meals, but also calm and firm in their refusal to engage in discussions regarding food.**

It is helpful if all staff could communicate a high expectation to the young person that they need to complete all meals and snacks plus drinks. Although this will meet with initial resistance and protestations, continuing to give this message can be very helpful in breaking down anorexic resistance. It can be difficult to know how to respond to the young person's resistance at mealtimes and staff can often feel very powerless in being able to get them to eat.

The following responses can be helpful. Although the phrases sound very mechanical, repeating them in as neutral a tone as possible gives the young person a clear message that you are in charge and will not become engaged in arguing about the meal.

- "You need to pick up your knife and fork/spoon and begin to eat "
- "You need to eat your food as it is part of your prescribed treatment here."
- "I know you do not want to eat it but you have no choice as I (the doctors/ eating disorders service) am saying that you have to eat

it."

- "I am not prepared to get into any discussion with you about the food – I am telling you to eat it."
- "I cannot get into discussion with you re how much you are to eat – you are expected to eat all of the food."
- "I am reminding you that you have …… minutes left to eat your food. You need to put the food in your mouth and eat it."

Outlined below are details of some of the behaviour you may have to deal with and tips on how to respond to this. **Consistency in approach within the staff team is crucial.**

Behaviour	Staff Response	Comment
Attempts to draw staff into negotiations or arguments regarding food choices and dislikes	Consistently and calmly remind the child/young person of the rules set out at admission and that this is not open to discussion Attempt to direct the conversation away from the argument.	Dislikes of food are not allowed during treatment unless there is an established medical reason for this. In the majority of cases the dislike can be directly linked to the onset of anorexia and allowing these continues the power of the anorexic thinking. Initially there may be resistance to this but if staff continue to be firm with this approach the young person does accept it.
Evidence of using mediums to avoid food/eating at mealtimes	Explain to the child/young person that you are concerned that the TV/music/conversation are being used to avoid eating and that they will not be available.	It is not unusual for patients with anorexia to use mediums such as watching TV, listening to music, engaging in conversation to avoid eating. If this is apparent then such mediums should not be available during mealtimes.
Parents engage in negotiations with staff re food choices and are on the ward prior to mealtimes	Staff to support parents in disengaging from the child/young person immediately before, and during mealtimes. Parents to be advised to return to the ward once mealtimes have finished.	Often by the time of admission parents have become entrenched in colluding with the anorexia and feel disempowered by the strength of resistance they are met with when attempting to get their child to eat. Consequently it is not unusual for parents to appear to support the young person in their attempts to negotiate their way out of eating certain foods. It is advisable that parents are not involved

		in managing the mealtimes whilst the young person is on the Ward. Parents should be made aware of this at admission and encouraged to leave the ward at meal and snack times
Reluctance to begin the meal.	The child/young person is to be firmly told that they need to pick up their cutlery and start eating. This may need to be firmly and calmly repeated.	This reluctance is driven by extreme anxiety and the longer the child/young person sits in front of the meal without eating then the risk of the anxiety being reinforced increases.
Wearing of baggy clothes and long sleeves. Constantly wiping their hands on bedcovers, clothes during meals. Dropping food on to the floor. Crumbling food up or letting it drop off the side of the plate.	Trained staff to supervise all meals. This is to ensure that the child/young person is not able to get rid of food. A member of staff should be sat with the patient for the duration of their meal or snack. The child/young person needs to be firmly told that if they attempt to get rid of food during the meal then it will be replaced by staff. Long sleeves need to be rolled up if staff are concerned that food is being hidden inside them. All crumbs on the plate need to be gathered together and eaten at the end of the meal.	A child/young person with anorexia may exhibit all or some of the above behaviours. They are not always aware that they are doing them, although they may also be very skilled at using every opportunity to get rid of food. Consequently staff needs to be extra vigilant during mealtimes for any signs of attempts to get rid of food.
Screaming, shouting, throwing of food and/or objects.	Continue to be firm and persistent, telling the child/young person that you understand their distress, but they need to eat their food. Any thrown food is to be replaced either by other food or a food supplement as per dietetic food plan. Staff to seek support if the level of distress is overwhelming and difficult to manage.	A child/young person's level of distress at mealtimes can be very high and the above behaviour is often driven by the sheer terror of having to eat, but can often leave staff feeling powerless and distressed themselves.

b) **Guidelines for the management of physical activity**

It is important to remember that any energy that the child/young person takes in through eating is reserved for restoring tissue in order to stabilise their medical health. Consequently a child/young person being treated for anorexia on a paediatric unit should engage in minimal physical activity.

Patients with anorexia will be driven to exercise at any opportunity in order to reduce their weight. This can often be done through quite subtle behaviours such as:

Behaviour	Staff Response
Constantly standing up Constant leg and arm movement Walking up and down the ward Offering to help staff give out meals, deliver post Circulating around the ward under the premise that they are seeing how other children are	Remind the child/young person that they are currently on bed-rest due to the level of concern about their physical state. Remind the child/young person of the severity of their illness and firmly insist that they return to sitting down on their bed or a chair.
Going to the canteen/coffee shop with visitors Being desperate for the need for fresh air and a walk outside in the cold. Wanting to sit outside in the cold with very little on or in the heat with large jumpers on (this is a way of expending energy)	If the child/young person wishes to get some fresh air then they must go in a wheelchair with a clear instruction to whoever takes them out that they are not to walk anywhere. Trips out should be time-limited and only allowed if the child/young person is co-operating with their treatment.
An eagerness to be very helpful	Acknowledge the child/young person's wish to be helpful but remind them that because of their physical health they are not able to help in a physical way. They could be offered opportunities to engage in alternative activities such as make a card, play a game (sitting down), read, listen to music, and watch TV.

c) Guidelines for engaging with a child/young person with Anorexia Nervosa.

A child/young person with anorexia can evoke quite powerful responses within staff from extreme anger to a sense of wanting to befriend them and make them better. Anorexia is quite powerful in 'sucking' staff in to unhelpful alliances with the

child/young person. Although at the time this feels like it may be helping the child/young person it is quite destructive to the management as it becomes harder to set firm boundaries and enforce the food prescription.
This can at times lead to staff becoming involved in unhelpful relationships with the child/young person. The following are behaviours that may indicate that this is happening.

Behaviour	Response
The child/young person begins to request specific staff to look after them.	Ensure that changes in staffing are not made to respond to this. The child/young person to be made aware that they cannot request this and that all staff is able to care for him/her.
Drawing staff into discussions (splitting behaviour) re other staff and their likeability.	Make them aware that this is not an appropriate discussion and you cannot discuss other staff with them. Encourage them to discuss their concerns with the staff concerned or their key-worker.
Bringing gifts in for certain staff Indicating that only certain staff understand them	Adhere to Trust policy re the receiving of gifts. Reinforce to the child/young person that all the staff is there to support and understand them.

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Appendix 1 Information sheet for child/young person and family

(*From:* Anorexia nervosa within an inpatient paediatric setting – protocol for the nursing management (including dietetic guidelines). *Cheshire and Merseyside Adolescent Eating Disorder Service and Paediatric Services at Countess of Chester NHS Trust)*

Information for Children/Young People and their Family/Carer - Admission Process and Care Management Plan

You have been admitted to the paediatric ward for treatment due to medical concerns relating to Anorexia Nervosa. This is aimed at stabilising your medical condition, and an important aspect of your treatment will involve ensuring that you have adequate daily amounts of food and drink.
We know that this can be a very distressing time both for yourself and your family/carers and we are aware that you may not be happy about coming into hospital. We believe that it is most helpful if you are fully informed of your treatment plan on admission as the nature of your illness will mean that you may feel a strong need to resist treatment.
Although the following plan may appear very strict and rigid, the aim of this is to reduce any confusion and to ensure that you, your family and the staff all know what will happen during your admission.

Care Management Plan:

1) You will only be allowed food dislikes that you had prior to your illness. This will be discussed with you and your parents/carers. Staff will not enter into any discussion or negotiation regarding this.

2) All food choices will be decided by the staff team based on the dietetic plan devised to ensure adequate nutrition. Staff will not engage in any negotiation regarding choices as they are aware that because of your anorexia you will wish to reduce food intake whenever possible.

3) On the morning after your admission you will be weighed and in the following weeks you will be weighed twice a week prior to breakfast in your nightwear (without a dressing gown). You can discuss with the team whether you want to know your weight.

4) It is helpful to think about the eating regime you are being expected to follow as being your prescribed medicine or treatment. The reason why the staff need to adhere rigidly to this eating regime is because your low weight is having such a serious impact on your physical health.

5) All meals and snacks will be supervised by staff and the following time limits will be followed:
- ♉ 30 minutes per main meal
- ♉ 20 minutes per dessert
- ♉ 30 minutes for breakfast,
- ♉ 20 minutes for snacks

At the end of these times any left over food will be removed and if the meal has not been completely eaten you will be given a supplement drink. This is a meal replacement drink.

Staff understands that eating can be a very distressing experience for a patient with anorexia. In our experience we have found that the most effective approach to this is to be supportive but very firm in our expectation that you will eat all of the food. The aim of this approach is for us to take responsibility for your eating.

6) You will be on **strict** bed rest and will be expected to go to the toilet in a commode at your bed side. You will wash at your bedside and at the beginning will have one shower per week. As you progress more frequent showers and use of the ward toilet with nursing observation will be introduced. This is to ensure that you are supported in resisting the urge to exercise or purge following a meal.

7) It is likely that in the weeks leading up to your admission that your parents have been extremely worried about you. You may also have shown high levels of distress and anger at mealtimes and parents will have often found themselves backing down for fear of making you worse. Consequently whilst you are being treated on the ward parents and carers are asked to visit during the evening or between the main mealtimes of the day. If they are visiting at a meal or snack time then they will be asked to leave the ward until the meal/snack is completed.

8) You have been admitted to a medical ward because of serious concerns about your physical state. Consequently you will initially be on bed rest (resting either on the bed or in a chair, and to use a commode. This is **non-negotiable**. Minimal physical activity (e.g.; walking short distances around the ward) is planned into your treatment once you have made some progress.

9) Decisions will be made by the whole team (paediatrician, psychiatrist, nurses, and dietician) at a weekly review meeting. These decisions will not be changed unless there is an urgent need to do so.
It is understandable that the above plan may seem unreasonable to you and staff are there to support you with this. It is important to remember that the aim of this plan is to ensure your recovery so that you can be discharged as soon as you are well enough.

A copy of this information has also been given to your parents/carers so that they are fully aware of your treatment.
If you have any questions or concerns about your treatment you should speak to the Paediatric Consultant looking after you or your Psychiatrist.