Canberra Health Services

Eating Disorders Residential Treatment Centre – Operational Procedure

Contents

Purpose

This document provides local operational procedures specific to the Eating Disorders Residential Treatment Centre (The Centre) operated by Canberra Health Services (CHS). Adherence to these procedures will ensure:

- Clinical practice supports the intended model of care
- Compliance with statutory responsibilities
- Adoption of evidence-based practice principles
- Practice which supports overarching CHS and Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS) policy, procedures, and frameworks.

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Scope

This document relates to all staff and students working within the Centre and should be adhered to in conjunction with all relevant Canberra Health Services (CHS), and MHJHADS policies, procedures, and frameworks.

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Section 1 Introduction

1.1 Eating Disorders Residential Treatment Centre

The Eating Disorders Residential Treatment Centre (the Centre) in Coombs is classified as a sub-acute inpatient health facility run by CHS. The building has been designed to have a homelike, residential feel where consumers receive intensive psychosocial support for their recovery. All participants at the Centre are referred to as 'consumers' in this document.

The Centre is a 24 hour, 7 days a week voluntary, specialist service for people with eating disorders. The Centre focuses on the psychological, physical and functional recovery of consumers. Specialist intensive nutritional and psychological treatment with medical monitoring and 24/7 nursing support is provided for up to three months. This provides an opportunity for consumers, carers, families, and supporters to envision their recovery journey. Consumers engage in education, therapy and activities which improve their relationship with food, eating and their bodies. This provides them with skills to maintain their physical and mental health when they return to their own homes.

The Centre has 7 bedrooms with 12 beds laid out in a combination of single and double bedrooms. Each room has an ensuite with a maximum of two people sharing bathroom

facilities. Room assignment is decided by the multi-disciplinary team, based on the consumer's medical and psychological needs with consideration of gender, trauma informed care, culture, and sexual safety.

1.2 Eating Disorders Residential Treatment Centre Model of Care

The Centre focuses on providing best practice, evidence-based treatment to all consumers, irrespective of their diverse clinical presentations. The Model of Care (MoC) outlines an evidence-based framework and guides the delivery of the right treatment at the right time, by the right person/team, in the right location across the continuum of stepped care. Development of the MoC was informed by the National Eating Disorder Collaboration (NEDC) National Strategy 2023-2033, the Australia and New Zealand Academy for Eating Disorders and RANZCP Clinical Practice Guideline, Guidance from the Commonwealth Government on the establishment of Residential Eating Disorder Treatment Centres and the National Safety and Quality Health Service Standards.

The principles for the Centre are:

- Person-centred informed decision making
- Supporting and involving carers, families, and supporters in shared decision making
- Recovery-orientated practice
- Least restrictive treatment context
- Multi-disciplinary approach
- Stepped care and seamless transitions
- A culturally affirming approach, including Aboriginal and Torres Strait Islander communities and people from culturally and linguistically diverse backgrounds
- Promotion of sensitive, respectful, and inclusive practice for Lesbian, Gay, Bisexual, Transgender, Intersex and Queer + People (LGBTIQ+) community, people who are neurodivergent, and people with disabilities.
- Trauma informed principles of treatment
- Strong integration with general practitioners (GPs) and other primary healthcare providers

1.3 Legislation

Centre staff are required to comply with overarching legislation to ensure that consumers admitted with mental health needs receive safe, appropriate and compassionate care.

The legislation governs the operation of mental health services, sets standards for assessment, treatment and detention while adhering to human rights principles and best practice in the mental health field.

The legislative foundation for the approach to care provision, recovery, treatment, security and a person's requirements for privacy and dignity are the guiding principles of the *Human Rights Act 2004*, and the *Mental Health Act 2015.*

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Section 2 – *Mental Health Act 2015* provisions

The Office of the Chief Psychiatrist website has resources for clinicians and delegates on the rights of people experiencing mental illness or mental disorder and advisory notes on disclosure of information to carers and substitute decisions makers.

2.1 Decision making capacity

A consumer must be assumed to have decision making capacity unless established that they do not. Article 12 of the Convention on the Rights of Persons with Disabilities recognises that people have the right to make decisions and be supported in their decision making.

All Centre staff will refer to and comply with the CHS *Assessment of decision making capacity and supported decision making for people being treated under the Mental Health Act 2015* Procedure.

Consumers 16-18 may be admitted to the centre. Competency will be assessed in these individuals and they may be considered mature minors.

2.2 Advance Agreement and Advance Consent Directions

An Advance Agreement is a document stating a consumer's preferences for future mental health treatment, care and support and any relevant information about practical support they may need.

An Advance Consent Direction is a document that records the consumer consent or non-consent to receiving treatment, care or support, or specific medications and procedures if they do not have decision making capacity in the future.

All Centre staff will refer to and comply with the CHS *Advance Agreements, Advance Consent Directions and Nominated Persons under the Mental Health Act 2015* Procedure.

2.3 Nominated person

A Nominated Person is someone appointed by a consumer with a mental illness or mental disorder under the *Mental Health Act 2015.* A Nominated person is to be informed and consulted about the consumer's treatment, care, and support to ensure that the consumer's interests and rights are respected.

A Nominated Person does not have the power to make treatment or other decisions on behalf of the consumer with a mental illness or mental disorder.

See CHS *Advance Agreement, Advance Consent Direction and Nominated Person* Procedure for further information.

Section 3 Referral and Pre-admission assessment

3.1 Eligibility criteria

The target population for the Centre are voluntary consumers with a primary diagnosis of an eating disorder. They require further nutritional, psychological and psychosocial support to achieve long term recovery. They must be medically stable to be admitted to the Centre as the focus is on psychosocial recovery and psychological therapy rather than physical/medical treatments.

The service is sex/gender inclusive.

Table 1 Eligibility Criteria for the Centre

ACT residents	Interstate residents
• Age ≥16 years (dependent on developmental maturity). People aged under 16 will be managed by the eating disorders team in consultation with the Division of Women, Youth and Children.	• Age ≥16 years (dependent on developmental maturity).
• Consumers are available for two weeks prior to potential admission to undertake pre assessment and day service engagement	• Are engaged with an Eating Disorders treatment team within their local area who are available for consultation, liaison and discharge care following the residential care admission. • Consumers are located within the ACT and are available for a minimum two weeks prior to potential admission to undertake pre assessment and day service engagement. • Engaged with adequate supports to enable safe travel to and from the ACT.
All consumers	

- Residential treatment is determined via the Eating Disorders Clinical Hub as the most appropriate and evidence-based mode of treatment at the time
- Active engagement with a GP for medical monitoring and continuity of health care
- Primary diagnosis of an Eating Disorder (DSM-5-TR) including Anorexia Nervosa, Bulimia Nervosa, Binge Eating, Other Specified or Unspecified Feeding or Eating Disorder (OSFED/USFED) which is causing significant psycho-social functional impairment.
- Commitment to not engage in non-suicidal self-injury (NSSI) or suicidal behaviours while participating in the program.
- Classified as a voluntary patient and willing and able to consent to treatment at the Centre and ready to make behavioural change with a high level of support.
- No active alcohol or illicit substance dependence
- Manageable dietary restrictions (e.g. religious and/or cultural dietary considerations, allergies, and sensory sensitivities will be accommodated following a dietitian assessment.)
- Medically stable as detailed in the Centre Operational Procedures and can be safely monitored and managed in the Centre

3.2 Exclusion criteria

Exclusion criteria:

- Primary diagnosis of feeding disorder such as Avoidant Restrictive Food Intake Disorder, Pica, Rumination Disorder. People who present with feeding disorders as their primary presentation will be referred to more appropriate services.
- Requiring a level of medical care that cannot be provided at the Centre (e.g. parenteral and enteral feeding, daily blood tests, observations multiple times per day, at risk of re-feeding syndrome)
- A lower level of care would be beneficial as determined in collaboration with the consumer and Eating Disorders Clinical Hub team.
- Consumer does not consent to the consumer agreement

3.3 Referral process

All referrals are directed to the Eating Disorders Clinical Hub (the Hub) Multi-Disciplinary Team (MDT) as the single point of access. The Hub referral process is outlined in Attachment A.

The Hub MDT assess the consumer's need and suitability for residential treatment. The Centre consultant psychiatrist attends the Hub MDT as the admitting officer for the Centre.

If the Hub MDT recommends residential treatment, a Digital Health Record (DHR) referral to the Centre is created. The Centre manage the next steps with consideration of bed flow management and pre-admission assessment.

If the Hub MDT decides the Centre is not the most appropriate treatment setting, a clinician from the Hub will contact the referrer and the person referred. They will explain the reasons for not accepting the referral, discuss alternate treatment recommendations and whether/ when it may be appropriate to re-refer.

Referral of current client of MHJHADS services:

- The consumer is discussed at the referring team's MDT
- Referring team's MDT makes a recommendation to the Centre, completes an ISBAR DHR referral to the Hub
- The Hub MDT considers the referral, makes a decision or requests additional information from the referrer
- The Hub adds accepted referrals to DHR and the outcome is communicated to the referrer, GP and consumer.

Referral of ACT consumers

- Referrals can be made by self, carer, GP, inpatient, private provider
- The referral is received by the Hub
- A clinician from the Hub contacts the consumer and conducts an Initial Presentation by phone.
- At the conclusion of the Initial Presentation, the person will be offered a Single Session Intervention with an Eating Disorders clinician.
- The Single Session will be discussed at the Hub MDT

Interstate referrals

- Interstate consumers referred to the Hub must be engaged with a treatment team for their eating disorder diagnosis in their local area. The Hub will liaise with the local team regarding suitability of the referral.
- An Initial Presentation is completed.
- Additional information and a current physical health update are requested from the consumer's GP via a Hub referral form.
- An SSI is conducted either in person or by telehealth to confirm suitability for residential treatment.

3.4 Referral assessment and outcomes

Consumers whose referral for residential treatment is accepted are invited to a 2-week pre-admission program to assess readiness for the full 12-week program.

- Pre-Admission Week 1: Assessment
- Pre-Admission Week 2: Engagement with day therapy program
- Week 3: Continued engagement with day therapy program, admission when bed available.

3.4.1 Pre-Admission Week 1 Assessment

A Centre clinician contacts the consumer to arrange the pre admission assessment. This allows time for the consumer to make necessary arrangements. Assessment appointments are conducted at the Centre and include:

- Psychiatric and psycho-social assessment with the Centre psychiatrist and a clinician to confirm psychiatric diagnosis, current psychiatric medications and assess psychosocial functioning, mental state and risk and ensure suitability for admission.
- Medical or advanced health assessment with the Centre GP or Nurse Practitioner to review the person's physical health, treatment of any co-morbid conditions and ensure adequate medical stability for admission.
- Dietitian assessment
- Orientation

3.4.2 Psychiatric Suitability for Admission:

The psychiatric/mental health assessment is conducted by the Centre psychiatrist and a mental health clinician to determine suitability and identify any social considerations.

Psychiatric assessment includes:

- Comprehensive Mental Health assessment
- Risk assessment
- Suicide Vulnerability Assessment Tool (SVAT)
- Initial Clinical Risk Assessment (CRA) will be completed and assigned and At Risk Category Level (ARC)

Consumers with current Non-Suicidal Self Injurious (NSSI) or suicidal behaviours on risk assessment will be referred to an appropriate service for ongoing management prior to acceptance for admission.

3.4.3 Medical Stability for Admission

The physical health assessment is conducted by the Centre GP or Nurse Practitioner to determine medical stability and risk of re-feeding syndrome.

The physical health assessment includes:

- Physical examination
- Vital observations and anthropometry
- Collation and/or ordering of recent pathology and diagnostic test results
- Review of communication from the consumers GP

The *CHS Guideline: Adults with Eating Disorders – Medical Management of Inpatients* provides guidance for when a medical admission should be considered for people who are assessed as high or extreme risk of refeeding syndrome, as indicated in the table below.

The medical admitting officer and MDT will use clinical discretion to decide whether a consumer with some borderline indicators in the higher risk category can be safely medically managed in the Centre.

A consumer who is at extreme risk of re-feeding syndrome cannot safely be medically managed at the Centre. They will require further medical assessment and management prior to an admission to the Centre.

Table 2 Refeeding risk matrix

RE-FEEDING RISK	High	Extreme
Weight	Body Mass Index (BMI) <16kg/m^2	BMI <14kg/m^2
Weight loss	>10% body weight loss within the last 3-6 months or ≥1kg/week over several weeks	
Oral intake	None or negligible oral intake for >7 days (<500 kcal, or 50g carbohydrate/d) & BMI <18.5kg/m^2	
Systolic BP	<90mmHg	<80mmHG
Postural BP	>10mmHg drop when standing	>20mmHg drop when standing
Heart Rate	<50bpm	<40bpm or >110bpm or significant postural tachycardia (>10 bpm when standing)
Temperature	<35.5°C	<35°C or extremities are cold and blue
ECG findings		Any arrhythmia including QTc prolongation or non-specific ST or T

		wave changes including inversion or biphasic waves
Blood sugar	<3.5mmol/L	<2.5mmol/L
Sodium	<130mmol/L	<125mmol/L
Potassium	<3.5mmol/L	<3.0mmol/L
Magnesium	0.7 - 1.0 mmol/L	<0.7mmol/L
Phosphate	0.8mmol/L	<0.8mmol/L
Albumin	<35g/L	<30g/L
Liver enzymes	Mildly elevated	Markedly elevated (aspartate transaminase (AST) or alanine transaminase (ALT) >500
Neutrophils	<2.0 x 10^9/L	<1.0 x 10^9/L
Severity of eating disorder symptoms	- Severe and Enduring Eating Disorder - Bulimia Nervosa (BN) without control of vomiting - Vomiting more than 4 times per day - BN with hypokalaemia - Excessive daily laxative use	
Other	- Not responding to outpatient treatment - Adverse family relationships or severe family stress	

A consumer is who is medically stable and can be safely monitored and managed in the Centre is indicated by a MEWS <2 on admission, and no indicators for extreme refeeding syndrome risk. The GP or NP will determine if further assessment, ECG, pathology tests, or medical collaboration are required to establish medical stability.

The admitting officer and MDT decide if the psychiatric and medical assessments indicate the consumer is suitable to continue the preadmission process. A key worker is allocated to the consumer by the Allied Health Manager or CNC.

If the psychiatric and medical assessments indicate the consumer is not suitable to continue with preadmission, alternate options are discussed with the consumer and the referrer.

3.4.4 Dietitian assessment

The Centre dietitian:

- Assesses the consumer's nutritional status
- Assesses the dietetic needs of the consumer
- Develops a meal plan with the consumer.

3.4.5 Orientation

The allocated Key worker will:

- Take the consumer (and family, carers and supports as appropriate) on a tour of the Centre
- Discuss and answer questions about the program
- Provide the consumer (and family, carers and supports as appropriate) with the welcome booklet
- Facilitate signing of the consumer agreement.
- Co-ordinate Preadmission week 2 and next steps with the consumer

3.4.5 Week 2: Preadmission day service

The consumer participates in the therapeutic day service at the Centre on Monday, Wednesday and Friday.

This provides further opportunity for the consumer to be fully informed regarding the program and confirm that the Centre is an appropriate treatment setting before committing to the full program. If a consumer has difficulty engaging in group meal support and day service sessions, they may consider whether alternative treatment settings are more appropriate.

3.4.6 Pre admission assessment outcome

The MDT will review the 2-week preadmission assessment and determine the Care Plan. The allocated key worker is responsible for communicating the outcome of the pre-admission assessment to the consumer, the referrer, interstate team and the Hub.

Outcomes following the 2-week preadmission assessment will be:

- Suitable to progress to admission to the full program. Scheduling is managed through the wait list.
- Not suitable for admission to the full program at this stage. A care plan and alternative services are discussed with the consumer and referrer, and referrals made as indicated.
- If there is a change in circumstances and the Centre is later assessed as the most appropriate treatment setting, the person may be re-referred.
- Consumers are entitled to usual processes to provide feedback, make a complaint, or request a review or second opinion of clinical advice and decisions.

3.4.7 Wait list management

Accepted referrals are managed by the CNC/Allied Health Team Manager.

- Consumers on the waiting list are offered a bed based on their need and current dynamics of the Centre e.g. gender mix, vulnerabilities, or risk issues

- The waiting list is reviewed by CNC/ Allied Health Team Manager and Consultant psychiatrist in response to new referrals and before an expected discharge.
- The CNC/ Allied Health Manager allocate staff to conduct check in phone calls to consumers on the wait list and update the referrer.
- Consumers waiting for admission may continue attending the day service three days per week dependent on Centre capacity (maximum 4 people)

Table 3 Preadmission timeline.

Appointments are scheduled according to clinician availability.

	Monday	Tuesday	Wednesday	Thursday	Friday
Week 1					
	Psychiatric and Psycho-Social Assessment Medical/Health Assessment	MDT discussion, key worker assigned if suitable	Dietitian Assessment Tour and orientation by key worker	Commence admission planning and details	Finalise admission planning and details
Week 2					
Engagement with therapy program	Day session and therapeutic program	Rest day	Day session and therapeutic program	MDT discussion	Day session and therapeutic program
Week 3 Program commencement					
	Admission blood tests and ECG Continue Day Program if bed not available	Admission to the Centre if bed available			

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Section 4 Admission

All admissions to the Centre are planned and will occur on a Tuesday where possible.

4.1 Role of staff during admission

4.1.1 Key Worker

The Key Worker is the primary point of contact for the consumer, their family, and carers. The key worker may be a member of the allied health or nursing team and are assigned prior admission by the CNC or Allied Health Manager

On admission the key worker will:

- Greet and orientate the consumer and their carers, family, and/or supports to the Centre facilities and staff
- Introduce the consumer to the admitting nurse
- Provide information on therapeutic groups and individual supports
- Review the welcome booklet
- Complete and record outcome measures on DHR.

4.1.2 Nursing

- An admitting nurse is allocated by the CNC or RN2 shift team leader.
- The admitting nurse and the shift team leader are responsible for completing the admission process in the electronic clinical record.

4.1.3 The Medical team

Review ECG results from the week prior to admission and blood test results from within 24 hours prior to admission.

The admitting medical officer will complete the medical admission including CRA, ARC and leave requirements in DHR.

4.1.4 Allied Health

Some of the individual responsibilities of the allied health team on admission are outlined below:

- Dietitian – identify a suitable time to review and update the meal plan
- Social Worker - contact guardian, family, carer, nominated person or any other significant support person to introduce themselves and organise a family/carer meeting if appropriate
- Occupational Therapist - identify a suitable time(s) to undertake a functional assessment to inform functional needs of the therapy program

- Psychologist - identify a suitable time to conduct appropriate psychological assessments to inform psychological needs of therapy program.

4.1.5 Administration team

The Centre administrative staff will comply with the *CHS Admission to Discharge Procedure (Adults and Children).*

4.2 Belongings

On admission, the admitting nurse will assist a consumer to unpack their belongings and remove any prohibited items.

Consumers are discouraged from bringing valuable items to the Centre. Valuable items are to be put into the medication safe, labelled, sealed and signed by the CNC and documented in DHR. Where possible, the person will be encouraged to return valuables to a family member or carer.

The admitting nurse is to ensure that the person signs the admission checklist accepting responsibility for their items whilst at the Centre, and on discharge that they have all property and valuables. This form is then placed in the person's DHR.

Note: Ensure the person is aware that the Centre cannot accept full responsibility for loss or damage to personal effects unless property was taken into safe keeping.

The searching of a consumer's person or their property may be necessary to protect the person, visitors and Canberra Health Services (CHS) staff and to provide a safe care environment. Searching of a consumer's person or their property should only occur in specific circumstances. For guiding principles relating to consent and safeguards regarding a search of a person, please refer to the CHS *Searching of a Consumer's Person or Property* Policy.

For the removal of suspected prohibited substances from the person, please refer to the *CHS Responding to Consumer Use of Alcohol and/other Drugs (AOD) Procedure.*

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Section 5 Treatment Program

During their stay, consumers receive intensive biopsychosocial support for their recovery. Consistent with the principles of evidence-based eating disorder treatment, the program is designed to support regular and adequate eating of 3 meals and 3 snacks each day. Care is trauma informed, recovery focused and provided in partnership with carers, loved ones and other service providers.

5.1 Individual Care Plan

Consumers take part in a multidisciplinary assessment which informs the development of a care plan with their clinician and/or the MDT. Family and carers may be included if appropriate. The plan is informed by a consumer's stage of care, clinical presentation and support requirements. Stages of care have been developed to facilitate consistency and accountability across care plans for consumers and staff. Guidelines regarding Stage of Care are detailed in Attachment B.

The care plan includes:

- Risk assessment
- Treatment goals
- Stage of care
- Distress tolerance plan
- Medication
- Meal plan
- Movement plan
- Use of electronic devices
- Agreed leave
- Sexual safety

The care plan is reviewed and updated at each MDT and the updated plan is added to DHR.

5.2 Multi-disciplinary Team (MDT) Meeting

An MDT meeting will be held at least twice weekly. The consumer and their carers, family, and supporters are included as appropriate. Case discussion may include diagnostic clarification, progress toward treatment goals and changes to the care plan, including stage of care. This will be documented by the key worker or delegate within the consumer's DHR.

All Centre staff are a part of the MDT. Minimum staffing for the MDT is the Centre psychiatrist, CNC/Allied Health manager and key worker or delegate.

5.3 Therapeutic Program

The therapeutic program is delivered through evidence-based individual and group treatments and therapy.

Individual therapy sessions with the key worker, psychologist, dietitian, psychiatrist, other Allied Health clinicians, nurses may include:

- Enhanced Cognitive Behaviour Therapy for Eating Disorders (CBT-E)

- Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA)
- Specialist Supportive Clinical Management (SSCM)
- Motivational Enhancement.
- Dialectical Behaviour Therapy (DBT)
- Interpersonal Psychotherapy (IPT)

Dietetics

- All consumers meet with the Dietician for indivisualised assessment and meal plan recommendations

Group therapy may be conducted in small or multiple group formats, informed by the social milieu and includes:

- Evidence-based talking therapies for eating disorders and their comorbidities
- Non-verbal therapies like creative art therapy, music therapy, movement groups and others
- Psychosocial interventions such as permaculture, animal therapy and others
- Off-site excursions to develop flexibility and normalise social eating

All treatment modalities are trauma informed. They aim to identify factors that maintain the eating disorder and develop skills to address these factors. This includes the development of emotional regulation, interpersonal skills, self-worth and identity outside of the eating disorder.

In addition to treatment, consumers will undertake household chores as agreed in their care plan. This is to simulate the home-like environment and foster a cohesive 'community' feel between consumers at the Centre.

Development of a therapeutic community within the Centre is supported by:

- Meal preparation including portioning and self-preparation of meals
- Social eating
- Engaging carers and supporters with mealtime activities

Depending on their stage of care, consumers are provided opportunities to shop for food items and go on excursions to cafés. Exposure activities replicate the consumer's regular life and helps to address any anxiety and concern during their admission.

A sample weekly therapy schedule is at Attachment D.

5.4 Meal support

Nutritional rehabilitation and exposure are core components of residential eating disorder treatment. The Centre includes a consumer kitchen and commercial kitchen. These are designed to enable consumers, carers, families, and supporters, and health professionals to prepare and eat meals together – replicating regular mealtimes when consumers are in their usual environments.

Most meals will be provided by CHS Food Services team in close consultation with the Centre dietitian. The Centre dietitian will design the meal plans and order the appropriate quantity from food services. The meal plans will consider consumers' nutritional requirements, therapeutic goals, and dietary restrictions. The CHS Food Services team will deliver meals, food service assistants will complete final preparations in the commercial kitchen and transfer to the consumer kitchen for portioning and serving.

The Centre dietitian will regularly review a consumer's nutritional requirements and meal plan throughout the admission. Recommendations are based on the consumer's treatment goals, allergies and sensory sensitivities, medical conditions, and available meal options.

The dietitian provides individual nutrition sessions as well as facilitating group sessions. Sessions may include psychoeducation, food appreciation and preparation and outings such as to grocery stores.

To reduce the risk of an adverse incident occurring because of handling/working with food in a therapeutic setting, all staff must comply with the:

- CHS Procedure *Occupational Therapy Food Safety* which was developed by the Division of Rehabilitation, Aged and Community Care
- Australia New Zealand Food Authority, August 2015 Safe Food Australia, A Guide to the Food Safety Standards

5.4.1 Serving of meals.

Consumers will either be provided with a meal portioned by staff or will portion and serve their own food under supervision in the consumer kitchen. This is dependent on their stage of care.

Supervision and management of concerns during mealtimes is the responsibility of allied health and nursing staff.

5.4.2 Supervision during and post mealtimes

Meal support and modelling of normal eating behaviours is an important part of the therapeutic program. All staff will be trained and will provide meal support. At a minimum, the Centre will have one staff member provide meal support for a maximum six consumers. This ratio may need to be higher dependent on the level of support required by the consumers. Other staff will be available to provide individual assistance where needed.

Consumers will not be able to go to the bathroom for 30 minutes post meal and will need to stay in communal areas within this time - this is scheduled into the therapy program.

5.4.3 Self-catered meals

The meal plan may include self-catered meals where ingredients are purchased by the consumer and prepared in the consumer kitchen under the supervision of staff. This is dependent on their stage of care. All practices are in line with safe food handling and storage requirements as outlined in the CHS Procedure - *Bringing Food into Canberra Health Services (Adults and Children).*

Consumers may purchase items from a café or shop to consume at the Centre as part of a therapeutic food challenge. This will comply with to the CHS Procedure – *Bringing food into the Canberra Hospital (Adults and children).*

5.5 Leave

Consumers will be granted access to leave consistent with their stage of care. Access to leave arrangements will be discussed and agreed upon at the MDT with the consumer and included in the consumer's care plan. The psychiatrist will communicate the MDT leave approval within DHR by updating the CRA. When clinically indicated, consumers may also take authorised leave to visit their General Practitioner for routine primary healthcare care as per section 5.8 (Physical health support).

Every episode of leave is documented within DHR and includes:

- Time of leave starting, and expected duration of leave
- Updated contact details for consumer while on leave
- Return from leave time

If a consumer is absent without leave (AWOL) all Centre staff will comply with the CHS *Missing Patient Procedure.*

5.6 Visitors

The Centre team recognise the important role that carers, families, and other service providers have in supporting consumers and being actively involved in treatment and discharge planning.

Visitors are welcome at the Centre as per the therapy schedule and consumer's stage of treatment. A phone call prior to visiting is recommended.

Visitors that do not have a legitimate cause to be at the Centre will be asked to leave. If they do not comply with this request, they will be informed that they are trespassing, and Security or the police will be contacted.

In the event of violence or aggression by a visitor, staff will comply with the CHS *Occupational Violence Operational Procedure.*

Other service providers from Government and non-Governmental organisations (NGOs) may attend the Centre to support discharge planning and transition to the community. They will also be provided the Welcome Booklet. If the Community Worker wishes to take the person off site for leave the Consumer Leave Agreement needs to be completed. The Consumer may take authorised leave to meet with other service providers off-site.

5.7 Communication and care planning pathways

5.7.1 Safety huddle

A huddle will occur each morning to discuss new admissions, deteriorations, discharges and the schedule for the day. The meeting is attended by the senior nursing, medical and allied health staff. The CNC, allied health manager or shift team leader will construct the consumer list for the morning and lead the discussion.

5.7.2 Handover

All Centre staff will comply with the *CHS Clinical Handover Procedure.*

5.7.3 Progress concerns - Flag system

The Centre recognises that recovery from an eating disorder can be challenging. Consumers may have difficulty progressing toward their care plan goals, engaging with aspects of the treatment or require a higher level of support at times. A Flag System is used by Centre staff to communicate ("flag") with the consumer and MDT that a review of barriers to the consumer's progress and level of support provided by the Centre is required. A "flag" is raised for discussion at the MDT when a consumer is observed to have difficulty progressing toward their care plan goals or is not following the Consumer Agreement. Family/carers are involved as appropriate. Concerns may include (but not limited to):

- Not attending therapy sessions
- Not adhering with their nutritional meal plan
- Not adhering with their medication treatment plan
- Weight interfering behaviour
- Non suicidal self-injury
- Inappropriate personal device use
- Inappropriate conduct with others.

Discussions and plans at all stages are documented on the consumer's electronic clinical record.

<u>Initial concern</u>

A staff member who has concerns regarding a consumer's adherence to the program will raise them with the consumer. They will provide support and encouragement for them to use the

skills they have learnt during treatment. They will advise the consumer that the MDT will be informed of the concern, the additional support required and the consumer's response to that support. The MDT will decide whether a flag is raised with the consumer.

First Flag

The first flag is raised by the key worker following discussion with the MDT. The key worker will help the consumer to problem solve what is happening for them, what support they need to progress toward their recovery goals, and whether a different stage of care will provide a more appropriate level of support.

Second flag

The second flag is raised by the key worker or the MDT**.** The consumer has a formal review with the MDT and if appropriate a family/carer meeting about why the program supports and consumer are not in concordance. The MDT work with the consumer to identify how the Centre can support them in their stage of treatment or whether a different stage of treatment is more appropriate.

Third flag

The third flag is raised by the MDT and indicates that the support provided by the Centre is not currently matching the consumer's needs. The MDT includes the person and their family, carers and supporters where possible to collaboratively discuss barriers to adherence to the program and needed supports. The consumer's participation in the Centre program will be suspended to consider their readiness to engage in the program. If they would like to resume their participation, a plan and evidence for addressing challenges needs to be demonstrated.

Readmission to the Centre

If a consumer returns to the Centre within three months, one "flag" is removed from their file. However, there will still be two "flags" pending. Early discharge from the Centre occurs if:

- another "flag" is raised due to difficulty adhering to their recovery goals (again totalling three flags), and
- all previous attempts to identify and resolve difficulties in committing to and persevering with their recovery goals have been exhausted. They may require alternate treatment services at that time.

It may be possible for a consumer to re-commence participation at a later stage.

Immediate discharge from the Centre

If the consumer engages in behaviours that mean they cannot safely be managed at the Centre, they will be discharged or transferred to an appropriate care setting. These behaviours may include:

- Engaging in weight control behaviour that results in a deterioration in physical stability

- Serious self-injury
- Alcohol/drug/medication misuse
- Violent or aggressive behaviours toward others
- Criminal activity whilst on the Centre premises.

Any clinical decision in response to the flag system will consider the most up to date MHJHADS triage scale assessment of risk in the context of a mental illness. Responding to deterioration and discharge planning will occur as outlined below.

5.8 Physical health care

5.8.1 Physical health support

Physical health support is provided by nurses, the Nurse Practitioner and the Centre GP as clinically indicated and documented in the care plan. Physical health support may include:

- Vital Observations
- Pathology (blood tests, urinalysis, blood glucose) and ECG

A GP is available part time to provide medical assessments and monitor complex medical co-morbidities during the admission. Nursing and medical staff liaise with a consumer's usual GP and co-ordinate care with the GP, CHS and other health care providers throughout the admission as clinically indicated.

A Nurse Practitioner is usually available during business hours and works collaboratively with the GP, consultant psychiatrist and other nursing and allied health staff members. The Nurse Practitioner can conduct advanced health assessments, order diagnostic tests, and prescribe medications if required. See *CHS Providing Physical Health Care across Mental Health, Justice Health and Alcohol and Drug Services Operational Guideline* for more information.

Consumers also have access to an accredited exercise physiologist, who can develop and review an individualised movement plan. The exercise physiologist facilitates group sessions including gentle movement/stretching and psychoeducation.

5.8.2 Diagnostic interventions

- Pathology ordered at the Centre will be collected by appropriately trained nursing staff, and processed by ACT Pathology
- ACT Pathology Courier to be contacted by shift leader or CNC for collection of specimens within recommended timeframes (i.e. 4 hours for blood specimens)
- Routine Electrocardiogram (ECG) performed at the Centre will be immediately available in DHR and consult request sent to Cardiology for inpatient consult/ review

- Non-urgent medical imaging ordered during admission will require transport of consumer to the nearest medical imaging facility
- Any urgent pathology or medical imaging will require consideration of the medical stability of the consumer and need for assessment and monitoring in an acute facility.

5.9 Deterioration of mental health or physical health

If a consumer's mental or physical health deteriorates and they can no longer be safely managed at the Centre, staff will follow the Centre escalation pathway (table 4 and table 7).

If a consumer requires admission to an acute ward for medical or psychiatric stabilisation, the consumer will be discharged from the Centre as per the CHS *Admission to Discharge Procedure (Adults and Children)* to enable admission to the appropriate ward.

5.9.1 Mental health deterioration

The Centre admitting psychiatrist will utilise the Clinical Risk Assessment (CRA) form to determine the At Risk Category (ARC), frequency of observations, leave authorisation, access to electronic devices and further needs of the consumer. Consumers with an ARC score > ARC 1 will require review as per the escalation pathway for mental health deterioration (Section 6: Table 7).

Consumers or their carers may advise staff of a deterioration in their mental health or staff may notice a change in consumer's behaviour or evidence of distress or agitation. Information disclosed to Centre staff that would impact a consumer's mental or physical health will be relayed to the Team Leader (TL) and documented in DHR.

The RN2 Team Leader should be notified immediately of any changes to the CRA form by the psychiatrist.

See section 6 on Risk assessment for further detail.

5.9.2 Physical health deterioration

All Centre staff will comply with the *CHS Vital Signs and Early Warning Scores Procedure* and the Centre escalation strategy. The Centre will use the following MEWS escalation pathway.

Table 4 Escalation pathway for physical health deterioration

08:30hrs – 17:00hrs Monday – Friday – Medical review available				
MEWS	**NOTIFY**	**ESCALATE**	**OBSERVATIONS**	**TRANSFERS**
MEWS 2-3	Inform Shift Lead and NP, CNC or medical staff	To senior staff member or medical staff.	Increase observations to 4 hourly until Observations < 2. If	Remains on ward with increased

			further deterioration, then action as per the MEWS.	frequency of observations.
MEWS 4 – 5	Consultant psychiatrist, GP or NP to review within **30** minutes.	If after **60** minutes nil review or improvement escalate per MEWS **≥6**	**Vital Signs:** **Consider BGL** 1/2 hourly until MEWS <4 **Consider BGL** If MEWS below 4 Continue follow up Hourly for 4 hours. 4 hourly for 24 hours	Notify Bed Access Coordinator of all transfers
MEWS ≥6	Activate Duress, consultant psychiatrist, GP or NP to review immediately and call an Ambulance	**Transfer consumer to ED via ambulance**		Notify Bed Access Coordinator of all transfers
Afterhours and Weekends / Public Holidays or when medical review unavailable				
MEWS 2-3	Inform Shift Lead, MHJHADS After-hours CNC	Increase observations and review care plan.	Increase observations to 4 hourly until Observations < 2. If further deterioration, then action as per the MEWS score.	Remains on ward with increased frequency of observations.
MEWS 4 – 5	Repeat vital observations, Follow local business rule	If after **60** minutes and MEWS remains **≥4**, escalate per MEWS **≥6**	**Vital Signs:** 1/2 hourly until MEWS <4 **Consider BGL** If MEWS below 4 Continue follow up Hourly for 4 hours. 4 hourly for 24 hours	Notify Bed Access Coordinator of all transfers
MEWS ≥6	**Transfer consumer to ED via Ambulance.**			Notify Bed Access Coordinator of all transfers

5.9.3 Readmission to the Centre following deterioration of physical health.

If a consumer returns from an acute facility or Emergency Department, they may be re-admitted to the Centre with handover to the RN2 TL. An MDT will occur the next business day to discuss factors that contributed to the deterioration in physical health and adjustments made to the care plan.

5.9.4 Medical Emergencies (Code Blue):

Code Blue relates to a medical condition that has the potential to be life threatening and/or cannot be managed with the available resources at hand.

Any staff member may activate a Code Blue if they have concerns for any person's health and wellbeing at the Centre.

Code Blue Emergency Criteria are used for immediate Ambulance Call and transfer to the Emergency Department

All **Cardiac** and **Respiratory Arrests** and all conditions listed below

Dial 0-000

Table 5 Medical emergency (Code Blue) criteria

ACUTE CHANGES IN:	PHYSIOLOGY
AIRWAY	Threatened
BREATHING	**ALL RESPIRATORY ARRESTS** Respiratory Rate <5 Respiratory Rate >36
CIRCULATION	**ALL CARDIAC ARRESTS** Pulse Rate <40 Pulse Rate >140 Systolic Blood Pressure <80
NEUROLOGY	Sudden fall in level of consciousness (Fall in GCS of >2 points) Repeated or prolonged seizures
Other	**Any patient who you are seriously worried about that does not fit the above criteria**

5.10 Medication

All medication supplied to consumers of the Centre will be sourced from CHS Pharmacy stock unless otherwise agreed by the treating team.

The Centre supports a medication management model that allows a person to continue to manage their medication as they would in the community. The model includes self-administration of medication (SAM) whenever it is appropriate and safe for the person to do so.

It is the responsibility of the treating team to assess that consumers are willing and competent to participate in SAM. Where someone is assessed as competent and willing to self-administer their medications, nursing staff will support this process.

Medication that is commenced by the treating team, undergoing titration and evaluation, or is subject to change will be dispensed from Imprest stock. All medication will be documented in the Medication Administration Record (MAR) in DHR.

Regular ongoing medication will be dispensed by CHS pharmacy in a Dose Administration Aid (DAA) to facilitate self-administration. The DAA and Imprest stock is kept in the locked medication room and provided to consumers to self-administer on request or as scheduled. Nursing staff will record the self-administration in DHR.

Medications prescribed by the medical team are done so with the expectation that they will be taken by the consumer. When a consumer does not follow the agreed medication treatment plan (including refusing medication or attempting to hide medication) the treating team must be informed as soon as possible and documented in DHR. This will be raised as a concern under the flag system.

For a consumer who is voluntarily admitted to the Centre, who is also on a treatment order under the *Mental Health Act, 2015*, and taking medication is a part of the treatment order, non-adherence will result in the commencement of a breach process in line with CHS *procedure Care of Persons subject to Psychiatric Treatment Orders (PTOs) with or without a Restriction Order (RO).*

See CHS Policy *Medication Handling* for more information about prescribing, administering, or managing consumer medications.

5.10.1 Medications not prescribed by the Centre medical team

Consumers should not be taking any medications without the knowledge and approval of the treating medical team.

All medications (including for example, supplements, vitamins, nutraceuticals or nootropics) recommended by external providers (e.g. from community GP, or Specialist) will need to be discussed with the treating team. Consumers will be responsible for the purchase of supplements not on the hospital formulary.

5.10.2 Medication Safety and Accountability

- Pharmacy will supply all regular medications in a DAA which will be packed once a week. If there is a change in the consumer's regular medications or supplements that is not able to be accommodated in a newly packed DAA, Imprest stock will be dispensed.
- If there is a short-term change in medication recommended by a medical doctor external to the Centre, it should be discussed with the medical team (psychiatrist, Centre GP or Nurse Practitioner) and if appropriate have it charted in DHR.
- Schedule 4 and Schedule 8 medications will remain in the locked safe in the medication room, and the consumer must request these to be administered by the RN. These will be handled in accordance with the Medication Handling Policy.

5.10.3 Nicotine Replacement Therapy

The entire Centre campus is a nonsmoking/vaping environment. Consumers will be offered support and Nicotine Replacement Therapy as indicated as per the *CHS Procedure Managing Nicotine Dependence.*

Staff training on how to implement the procedure is available through e-learning. Staff are also able to access support for nicotine dependence as per the procedure.

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Section 6 Risk assessment

6.1 Suicide Vulnerability Assessment Tool (SVAT)

SVAT is used to document the assessment of a consumer's suicide vulnerability and to formulate management strategies to mitigate that risk.

SVAT will be completed on admission and if there is a change in clinical presentation.

All staff must be familiar with the MHJHADS *Initial Management, Assessment, and Intervention for People Vulnerable to Suicide Procedure and the Suicide Vulnerability Assessment Tool (SVAT)* to assess a consumer's suicide vulnerability.

6.2 Clinical Risk Assessment (CRA)

An CRA will be completed on admission by the admitting psychiatrist using the initial CRA form in DHR. This will determine the level of observation required for each person admitted to the Centre. CRA is reviewed throughout the consumer's stay as clinically indicated by the psychiatrist.

6.3 Observation

Observation through engagement is the purposeful gathering of information from consumers to inform clinical decision making and the formal and objective assessment of a consumer's physical, mental, and social condition.

The purpose of observation is to provide optimum care, to escalate and manage deterioration in a timely way and ensure safety of the environment where care is provided.

Observations are not passive but require nurses to be person centred and engage therapeutically with consumers. Observation through engagement is for safety, protection from harm and maintenance of wellbeing. It provides opportunity to develop rapport and contribute to ongoing assessment and recovery.

Observations enable engagement with consumers which actively contributes to comprehensive care. There are several principles that underlie the practice of observation:

- It is multifaceted
- Observation and assessment are interrelated
- Observation is grounded in therapeutic engagement with the consumer
- Appreciation of how a consumer's illness influences behaviour
- Are communicated between staff
- There is a clear process of documentation that is timely and descriptive.

The TL or allocated nurse should know the location of the consumer. Observation should be established as part of the Centre routine and performed regularly by the consumer's allocated nurse as part of their everyday practice to maintain the safety of consumers.

The frequency of clinical documentation in a consumer's clinical record is based on their ARC level. There are 5 levels of ARC observation:

Table 6 At Risk Category (ARC) levels

ARC Level	Level of Risk	Description	Observations AM and PM shifts	Observations Night shift
Level 1	Low risk	Less distracted by psychiatric symptoms, no inappropriate behaviour, not troubled by thoughts of self-harm, engaging with treatment and Centre program.	General engagement and observations while at the Centre every 2 hours.	2 hourly

Level 2	Low to Medium risk	Distracted by psychiatric symptoms but can manage in the Centre, potential risk to harm self or others but no immediate risk. Compliant with the Centre program	Intermittent engagement and observations every 50-60 minutes	Every 50-60minutes
Level 3	Medium risk	Distracted by psychiatric symptoms and potential risk to harm self or others but no immediate risk. Non-adherent with the Centre program.	Frequent engagement and observation. Review by treating team Action as per escalation pathway for mental health deterioration	Every 20-30 minutes. Action as per escalation pathway for mental health deterioration
Level 4	Medium to High risk	Expressing suicidal ideation with plan and intent, or active self-harm, overt psychotic phenomena, mania. Risk of aggression and possible violence	Close engagement and observation every 10-15minutes. Action as per escalation pathway for mental health deterioration	Every 10-15 minutes. Action as per escalation pathway for mental health deterioration
Level 5	High risk	High suicidal risk, aggressive, overt psychotic phenomena, manic, high risk of harm to self and/ or others.	Continuous visual observations. Action as per escalation pathway for mental health deterioration	Continuous. Action as per escalation pathway for mental health deterioration

ARC 1 - General Observation – 2 hourly

Minimum level of observation for a consumer at the Centre

ARC 2 (Intermittent engagement and observations) – 50-60 Minutes

Consumer risk requiring observation higher than ARC 1.

ARC 3 (Frequent observations) – 20-30 Minutes

Consumer risk requiring observation higher than ARC 2, as assessed as posing a significant risk of:

- Suicide /Self harm
- Overt psychotic symptoms
- Harm to others
- Falls
- Severe self-neglect
- Violence, aggression, or physical harm

ARC 4 (Close observations) – 10-15 Minutes

Consumer risk requiring observation higher than ARC3 as assessed as posing a more severe risk than for ARC 3.

ARC 5 1:1 Engagement and observations or at arm's length

Consumer risk requiring constant observation at arm's length distance, as specified by the clinical risk assessment as posing a serious, significant, and immediate risk as outlined for ARC 3 and 4. Staff must not leave the consumer unsupervised under any circumstances or for any period. The consumer must be managed in a highly visible area. Staff providing continuous observation during normal sleeping hours will sit outside the consumer's bedroom, with the bedroom door open.

The following escalation pathway is to be followed for all consumers admitted to the Centre.

Table 7 Escalation pathway for mental health deterioration

08:30hrs – 17:00hrs Monday – Friday – Psychiatric review available				
ARC	**NOTIFY**	**ESCALATE**	**OBSERVATIONS**	**TRANSFERS**
ARC 2	Available medical practitioner- consultant psychiatrist, GP or NP to review that day	If increasing concerns	**ARC Observations as per level descriptors**	Notify Bed Access Coordinator of all transfers
ARC3	Inform TL, Consultant psychiatrist, GP pr NP to review within 2 hours	**Transfer consumer to ED via ambulance if no assessment available**		Notify Bed Access Coordinator of all transfers

ARC 4-5	Inform TL or activate duress, consultant psychiatrist, GP or NP to review immediately	**Call ambulance for transfer**	**Constant observation until able to transfer**	Notify Bed Access Coordinator of all transfers
Afterhours and Weekends / Public Holidays or when review unavailable				
ARC 2	Notify team leader and ensure medical review next business day	Escalate to next ARC level if increased concerns or ward environment unable to sustain increased observation	**ARC Observations as per level descriptors**	Notify Bed Access Coordinator of all transfers
ARC 3	Psychiatric registrar or consultant psychiatrist on call	**Transfer consumer to ED via ambulance**		Notify Bed Access Coordinator of all transfers
ARC 4-5	**Activate duress for team response** **Organise transfer to Emergency for psychiatric assessment**		**Constant observation until able to transfer**	Notify Bed Access Coordinator of all transfers

Note: A Registered Nurse, in consultation with the shift team leader can increase the ARC score if clinically indicated. If an ARC score has been increased by a registered nurse, the treating team must complete a revised CRA as soon as practicable.

Only the Medical team or the Nurse Practitioner can revise the CRA or decrease the ARC after a mental health review.

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Section 7 – Safety and security

The Centre aims to ensure safety for consumers, visitors and staff.

The Centre will utilise the Safewards model and interventions. The Safewards model is designed to reduce conflict and containment or restrictive practices within in-patient units by identifying and addressing the causes of behaviours in staff and patients that may result in harm (conflict)

and reduce the likelihood of this occurring. Staff are trained to use a range of methods to manage patient behaviours in a concerted effort to reduce restrictive or coercive interventions. This also requires staff to review their own behaviours and responses to conflict and the strategies used to manage challenging behaviours. Safewards strategies are included in the orientation and induction for new Centre staff.

7.1 Duress Alarms

Personal duress alarms – ASCOM, are security devices to help ensure safety and communication around safety for consumers, staff and visitors.

All members of staff are required to wear a personal duress alarm registered to them. A personal duress alarm should be collected from the storage/charging racks immediately on arrival for duty. Staff must then enter their name and duress number on the handset to register their details on the computer terminal.

The Centre also has fixed duress alarms in the Nurses Station, interview rooms, meeting rooms and therapy rooms.

Operation of the ASCOM device:

1. Single press and/or 'man-down' activation will be a local response
2. A double press will escalate via a C-cure notification to CHS Security operations who will request an off-site security response

Annunciation of an alarm will be via the handsets and fixed annunciators in the staff workspace and in the main therapy wing.

7.2 Environment safety check

All Centre staff will comply with Section 13 of the CHS *Ligature Use, Response and Risk Management MHJHADS Procedure* which details the requirement for Environmental Safety Checks (ESC) on each nursing shift handover.

Random environmental checks will be conducted as required or at the discretion of the CNC or Team Leader.

7.3 Consumer Identification

The Centre will utilise photographs for positive consumer identification as described in the CHS Procedure – *Patient Identification and Procedure Matching.*

7.4 Access Control

The Centre will be access controlled with some sections for staff only. Building access is via pass key or intercom communication with staff. The intercom connects to both the staff administration area and the nurse's station. If not answered within 30 seconds, the intercom is then transferred to the Shift Team Leader's ASCOM handset.

7.4.1 Security bracelets

- Consumers will be issued with an access bracelet with a programmable RFID chip (like an access card) on admission. This allows a consumer access to controlled doors within the facility including their bedroom door.
- Programmed bracelets open a lock when placed close to the door's proxy-controlled unit.
- The bracelets are purchased and programmed by an external security contractor, arranged though CHS Security Operations.
- Each bracelet has a unique number visible on the interior of each bracelet.
- The clinical team will hold 36 pre-programmed bracelets on site. One programmed for each of the 12 rooms and 6 spare bracelets in the event of loss or fault.
- These bracelets will be kept in a locked cabinet in the staff office.
- When a new participant is to be admitted to the facility the admitting nurse will:
    - provide the participant with the bracelet programmed to their bedroom door
    - explain the operation of the bracelet
    - record the participants name against the bracelet number within the electronic register
- The bracelet must always be worn by participants while in the facility.
- When a participant is being discharged, staff will ensure the bracelet is returned and reconciled against the electronic register.
- Staff must notify CHS Security Operations of lost or broken bracelets. Staff can request CHS Security to program a spare bracelet to the appropriate room and a replacement bracelet.
- Lost bracelets must also be reported on Riskman.

7.5 Security services

The Centre is supported by security procedures and CHS Security. There are three tiers of response:

1. Local response by clinical staff
2. Escalate to off-site security
3. If c-cure alarm is activated (see ASCOM)- CHS Security operations will contact the CHS Security contractor to attend. This service consists of a single person patrol with 20-minute response time KPI.

More serious incidents escalate to AFP based on threat level determined by the Centre staff. Two welfare checks/patrols will be conducted overnight by the CHS security contractor.

CCTV is located on the external aspect of the building, within the communications room, within the medication room focused on the drug safe and within communal social areas. CCTV is used in accordance with the CHS *Protective Security – Closed Circuit Television* procedure.

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Section 8 – Codes

8.1 Emergency codes

All staff will comply with the Eating disorder Residential Centre Emergency Plan, a sub plan of the CHS Emergency Plan. This is available at the Centre in hardcopy and on the CHS Health Hub SharePoint. Staff are orientated to the Centre Emergency Plan and its location on induction.

8.2 Code Black

The Centre adheres to CHS *Occupational Policies and Procedures for Occupational Violence*. Occupational Violence is unacceptable and includes any situation where a staff member is abused, threatened, or assaulted by a consumer or visitor in circumstances relating to their work.

All Centre staff will comply with the *CHS Emergency Management Plans – Code Black Procedure*.

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Section 9 – electronic devices for consumers

9.1 Centre rules regarding personal electronic items

Consumers:

- May have their laptop, tablet or mobile phone whilst they are staying at the Centre
- Are responsible for their items at all times
- Agree not to use their personal electronic items during therapeutic activities/groups unless previously agreed as being a part of a therapeutic activity.
- Are requested not to use electronic items after 9pm to help develop sleep hygiene and sleep routines

For further information refer to CHS *Patient Mobile and Recording Devices: Management and Use Procedure* on the CHS Policy and Guidance Register.

9.2 Responding to inappropriate use of electronic devices

If there are concerns about inappropriate use of an item or content, this should be referred to the CNC or shift TL. The consumer will be asked to put away the device, and the matter referred to the MDT for further discussion where the item is:

- Used to access/view inappropriate sexual, violent, or "pro eating disorder" content,
- Used to take photographs or record staff or other people without their consent
- Used to make calls of a threatening or harassing nature.
- Contributing to the deterioration of a consumer's mental state or others in the Centre.

The CNC is responsible for documenting the discussion and action taken. The next MDT will include discussion and documentation in DHR of actions and plans for further use.

9.3 Taking Photographs

Consumers, staff and visitors should respect consumers and their privacy when taking, using, storing and disposing of images and audio. This includes gaining consent.

Please refer to *CHS Procedure Photo, Video and Audio: Capture, Storage Disposal and Use*

9.4 Televisions

Televisions are in the lounge area of the Centre and may be watched during free time as per the therapy schedule. Personal televisions are not permitted in the Centre.

The volume of televisions and other audio devices should be kept low such that it does not interfere with the sleep or wellbeing of others.

9.5 Electrical cords and appliances

Electrical cords must be tested and tagged if older than 12 months. Admin staff can arrange this on admission by contacting BGIS on x47000. The consumer will not be able to use these items until tagging and testing has been completed.

Electrical appliances brought onto the unit should be small and for personal use, for instance electric toothbrushes, shaver or hairdryers. Medium or large appliances such as personal televisions, coffee machines are not permitted in the Centre. Individual risk assessment informs whether a person may have charging cords in their room (section 6).

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Section 10 – Discharge

All Centre staff should comply with the CHS *Admission to Discharge Procedure (Adults and Children)* and the CHS *Discharge Summary Completion Inpatients Procedure*.

Graduation and discharge planning begins at commencement of the program. It is the responsibility of the Key Worker to invite the relevant people to discharge planning meetings.

Discharge may occur:

- When the consumer has completed the program
- If the consumer chooses to withdraw from the program,
- If the program is not meeting the consumer's needs (as indicated from three flags being raised)
- The consumer's condition requires transfer to a more acute setting.

As part of discharge planning, an expected discharge timeframe will be discussed with the consumer, families and carers and any other support services or networks. It will be noted if additional community supports need to be arranged.

External stakeholders involved in discharge planning may include:

- Community mental health services
- Carers, families, and supporters,
- General Practitioners (GP)and other primary health providers
- Private psychiatrists and other treating specialists,
- Private counsellors and psychologists
- Other community services

A care plan will be developed for post discharge treatment and services including an option to continue day sessions at the Centre. This will be dependent on clinical need and Centre capacity (maximum capacity 4 consumers).

A discharge summary is completed by the consumer's key worker and sent to the person's GP within 48 hours of discharge. This is a divisional Key Performance Indicator (KPI).

Guidance on the collection of discharge medications can be found in the *CHS Medication Handling Policy.*

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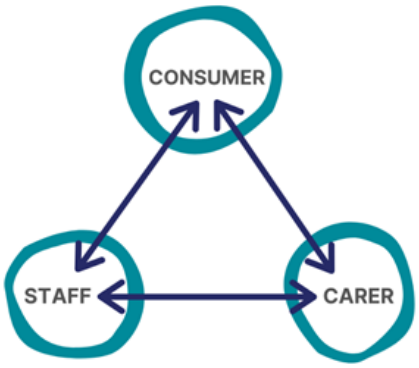
Section 11 – Partnering with consumers, carers, family, and other supports

11.1 Carers and Family inclusion

Centre staff are committed to partnering with consumers and carers as a foundation for exceptional care. Partnering with consumers supports a person centred approach to individual care.



The Triangle of Care, adapted from Worthington, Rooney and Hannan, 2013

Partnering with consumers and carers is supported by open communication between the consumer, carer and all Centre staff, with consent from the consumer. The triangle of care reflects this interaction. Communication enables active engagement of carers and families in the consumer journey and recovery.

The Centre staff will provide education and training to carers, families, and supporters so they feel equipped and skilled to assist their loved one in their recovery journey during admission and post discharge.

The Centre offers carers, families and supporters:

- The welcome booklet
- Information sessions
- Opportunities to be involved in meal support
- Workshops on practical skills to support a loved one
- Opportunities to connect and share their experience

Carers, families, and supporters may be invited to attend MDTs, consumer individual therapy sessions, family meetings, and carer skills and support groups.

Consumers and family and carers can also access advocacy and support through consumer and carer organisations.

See *CHS Partnering with Consumers Framework and CHS Partnering with Consumer policy* for further information.

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Section 12 – Documentation

Doc Number	*Version*	*Issued*	*Review Date*	*Area Responsible*	*Page*
<xxxxx/xxx>	**X**	**<XX/XX/XXXX>**	**<XX/XX/XXXX>**	**XXXX**	38 of 57

The purpose of a clinical record is to:

- Communicate clinical information between members of the treating team
- Provide accurate reflections of the assessment made, changes in clinical state, the care provided and pertinent information to support the ongoing clinical care provided to the consumer.

Clinical records are multidisciplinary and should contain sequential entries from all health professionals on the treating team. Engagement with the consumer should be documented in the clinical record at the time it occurs or as soon as practicable after.

The CHS centralised clinical record system (DHR) is used to record all interactions, assessments, and clinical tools between a consumer and CHS. All risk assessment forms and templates are built into the clinical record.

See *CHS Clinical Records Procedure* for further information.

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Section 13 – Centre governance and meeting structure

The Centre governance is embedded within the existing MHJHADS and CHS corporate, clinical, and operational governance systems. These provide a framework that draws together initiatives, process, systems, and ways of working. All eating disorders program areas sit in the CAMHS stream of MHJAHDS Governance.

The Clinical and Operational Directors provide overarching leadership to ensure service delivery is in line with the strategic direction, organisational accountability and corporate governance processes. The clinical governance structure sits within a tiered hierarchy of organisational governances regarding decision making and endorsement of service activities

The governance structure of the eating disorder services is in Attachment C.

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Section 14 Evaluation

The Centre is committed to ongoing service improvement and contributing to the evidence base for the role of Residential Centres in the stepped care model of treatment for eating disorders. The workforce profile includes a part time research position responsible for planning and implementing research and evaluation activities and data management.

The Centre will report on qualitative and quantitative benefits.

Qualitative benefits:

- Consumer experience surveys (YES Survey)
- Evaluation feedback from carers, families, and supporters (CES to be introduced)
- Staff experience and satisfaction surveys, and
- Compliments or complaints received as feedback.
- Audit of the use of CCTV will be conducted a year after the Centre commences operating

Quantitative benefits:

CHS has an obligation to report both locally and nationally on its performance. Additional measures will be administered consistent with the *Use of Mandatory National Outcome Measures – MHJHADS* policy and updated clinical guidelines, research, and CHS policy.

Other indicators may include adverse clinical events resulting in significant harm, morbidity or mortality.

Table 8 Key Performance Indicators

Key Performance Indicators	Description
Admissions	Total number of admissions. Admission source: • MHJHADS teams • Interstate • Other Age Gender Diagnosis Cultural background
Discharges	Total number of consumers discharged Discharge reason: • Completion of program • Required higher level of care • Withdrew from the program Discharge follow up: • MHJHADS team • Private provider • Interstate • Other
Centre occupancy	Percentage of inpatient beds occupied
Average length of stay	Calculated for discharged consumers
Care plan	Percentage of consumers with a care plan - completed
Readmission rate	Readmission to inpatient care within 28 days

Admission assessment	Percentage of consumers who have undergone physical examination within 24 hours of admission – conducted by a medical officer
Consumer experience	Your Experience of Service (YES) survey results on discharge
Consumer and carer feedback response.	Percentage of Feedback responded to within 35 days (National Standard response time)

The Commonwealth Technical Advisory Group developed a minimum data set for collection by all residential eating disorders programs across Australia. Research and evaluation may be undertaken by Centre staff and/or in partnership with universities with relevant ethics approvals obtained.

Table 9 Minimum data set measures

Measure	Frequency
Body Mass Index (BMI)	Weekly
Health Questionnaire EQ-5D-3L or EQ-5D-5L (EuroQol)	Admission and follow-up as per the National evaluation strategy under development
World Health Organisation Disability Assessment Scale (WHO-DAS)	Admission and follow-up as per the National evaluation strategy under development
Eating Disorder-15 (ED15)	Weekly
Eating Disorder Examination Questionnaire (EDED-Q)	Start of treatment, every 4 weeks during admission, every 3 months post-discharge over 12 months
Body Image Acceptance and Action Questionnaire (BIAA-Q)	
Patient Health Questionnaire (PHQ-9)	
General Anxiety Disorder Screener (GAD-7)	
Clinical Impairment Assessment (CIA)	
Your Experience of Service Survey (YES)	On discharge or end of treatment
Carer Experience Survey (TBC)	On discharge or end of treatment

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Section 15 Related Policies, Procedures, Guidelines and Legislation

Policies

- Informed Consent (Clinical)
- Medication Handling
- Occupational Violence
- Smoke Free Environment
- Work Health and Safety & Work Health and Safety Management System
- Partnering with Consumers

Procedures

- Incident Management
- Advance Agreements, Advance Consent Directions and Nominated Persons under the *Mental Health Act 2015*
- Assessment of Decision-making Capacity and Supported Decision-making for people being treated under the *Mental Health Act 2015*
- Care of Persons Subject to Psychiatric Treatment Orders (PTOs) with or without a Restriction Order (RO)
- Ligature Use, Response and Risk Management in MHJHADS
- Clinical Handover
- Sharing Information with Carers – Mental Health Inpatient Units
- Infection Prevention and Control - Healthcare Associated Infections
- Information and Communication Technology Resources: Acceptable Use
- Initial Management, Assessment and Intervention for People Vulnerable to Suicide Managing
- Occupational Violence
- Patient Identification and Procedure Matching
- Providing Physical Health Care across MHJHADS
- Discharge Summary Completion – Inpatient

- Protective Security – Closed Circuit Television
- CHS Missing Patient Procedure
- Bringing Food into Canberra Health Services (Adults and Children)
- Animal visits

Standards

- National Standards for Mental Health Services 2010
- National Safety and Quality Health Service Standards - Second edition (updated May 2021)
- Standards of Practice for ACT Health Allied Health Professionals 2016

Legislation

- *Mental Health Act 2015*
- *Human Rights Act 2004*
- *Health Records (Privacy and Access) Act 1997*
- *Information Privacy Act 2014*
- *Carers Recognition Act 2021*
- *Work Health and Safety Act 2011*

Other

- Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders
- Australian Charter of Healthcare Rights
- ACT Charter of rights for people who experience mental health illness
- CHS Partnering with Consumers Framework

Section 16 References

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Heruc, G., Hurst, K., Casey, A. *et al.* ANZAED eating disorder treatment principles and general clinical practice and training standards. *J Eat Disord* **8,** 63 (2020). https://doi.org/10.1186/s40337-020-00341-0.

Hay, P. et al (2014). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. Australian and New Zealand Journal of

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Waller, G., Turner, H., Tatham, M., Mountford, V., & Wade, T. (2019). Brief Cognitive Behavioural Therapy for Non-Underweight Patients: CBT-T for Eating Disorders (1st ed.). Routledge. https://doi.org/10.4324/9780367192280

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Definition of Terms (if applicable)

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Search Terms

List the search terms to be used to assist in locating this document in the register.

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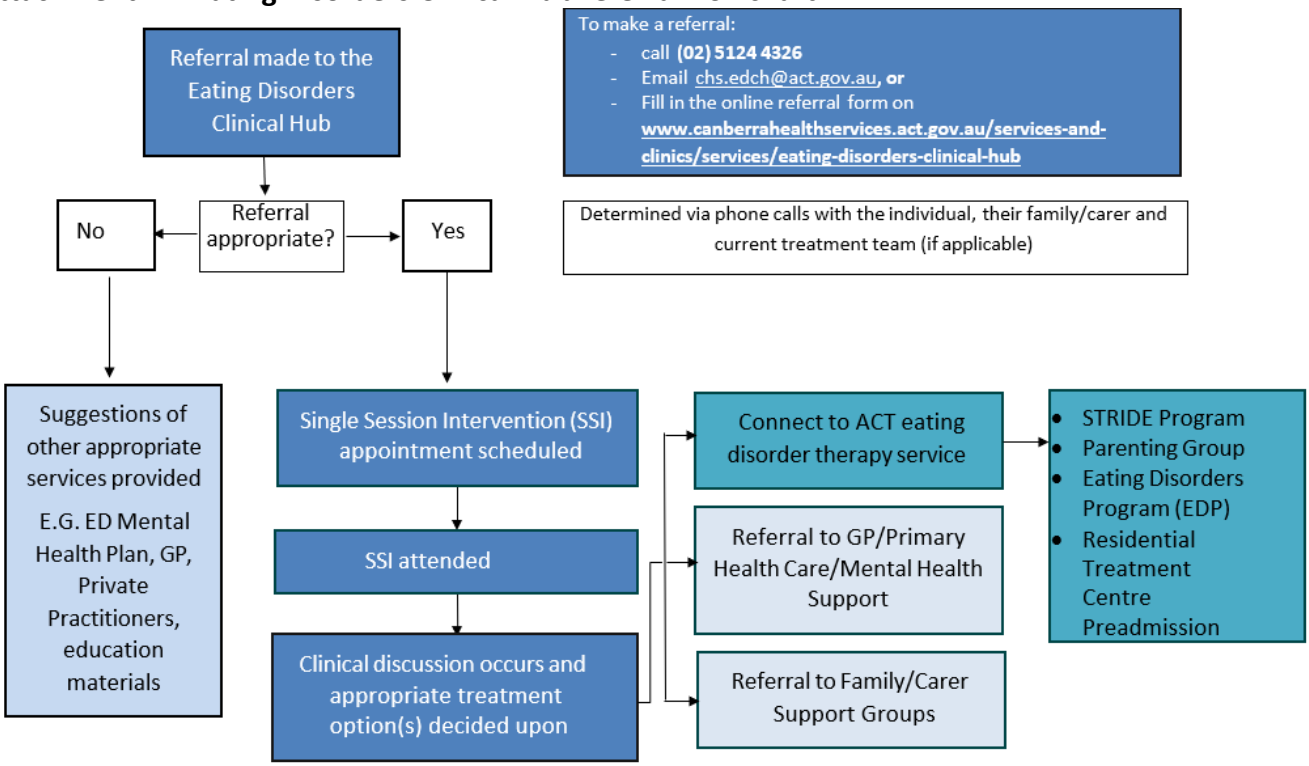
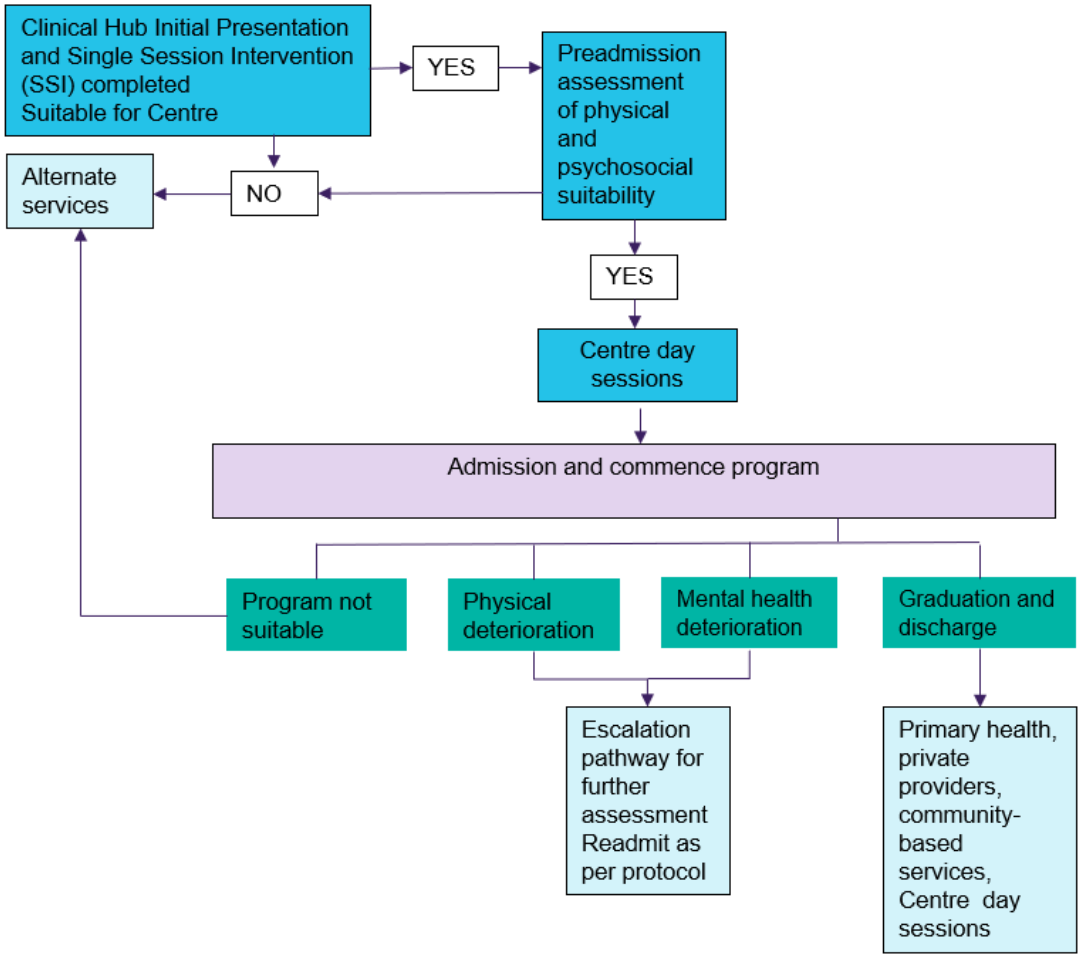
Section 17 Attachments

Attachment A – Eating Disorders Clinical Hub referral flowchart



Participant journey through the Centre program



Attachment B – Stages of Care

Stage of care	Philosophy	Indicators that ready for this stage	Meals	Role in household	Challenges/ skills building	Exercise	Leave / unstructured time	Group therapy	Individual therapy
Pre-admission stage. **Week 1 Assessment** **Week 2 – Engagement in day therapy program** Attend day therapy and meal sessions Monday, Wednesday and Friday	Orientation to the Centre and provide consumers with an opportunity to experience group meal support and therapy sessions to enable them to make an informed decision before consenting to participate in the full program.	Assessed by clinical hub as meeting admission criteria and consumer consents to participate.	As developed with dietitian at commencement of program 1.0 hrs observation post meal (n.b. post meal observation includes participation in group therapy sessions and household activities)	Not expected to participate in chores	Participate in group sessions	Participation in movement groups dependent on medical stability	Full observation while attending the Centre	Attend all day sessions	Continue outpatient therapy

Welcome Admission week (Tuesday to Friday)	Orient consumer to the full treatment program.	Assessed by clinical hub as meeting admission criteria and consumer consents to participate	As developed with dietitian 1.0 hrs observation post meal	Not expected to participate in chores	Introductory sessions with MDT Develop formulation and treatment plan	Exercise and participation in movement groups dependent on medical stability	Full observation	Attend all day sessions	Introductory sessions with MDT, including family/carers as appropriate.
1	Provide realistic challenges and high level of support	Developed and agreed to care plan and wish to continue after the welcome stage. Nil weight loss in welcome stage.	Meals portioned by staff. Can self-select breakfast and snacks, certain items on lunch and dinner menu Supplements as much as necessary as per the meal plan 1.0 observation post meal	Maintains own room and personal belongings	Establish regular and adequate eating. Reduce ritualistic eating behaviours Reduce compensatory behaviours Reduce frequency of weight and mirror checking	Assessment with exercise physiologist Exercise dependent on medical stability	Full observation No leave for non-medical appointments, accompanied by a staff member	Attend all sessions Family/Carers/ supports invited to attend CCSW	Attend all sessions Clinician: 1/wk. Key worker: 1/wk. Dietitian: 1/wk. Psychiatrist: as required Engagement with outpatient team: invited to MDT

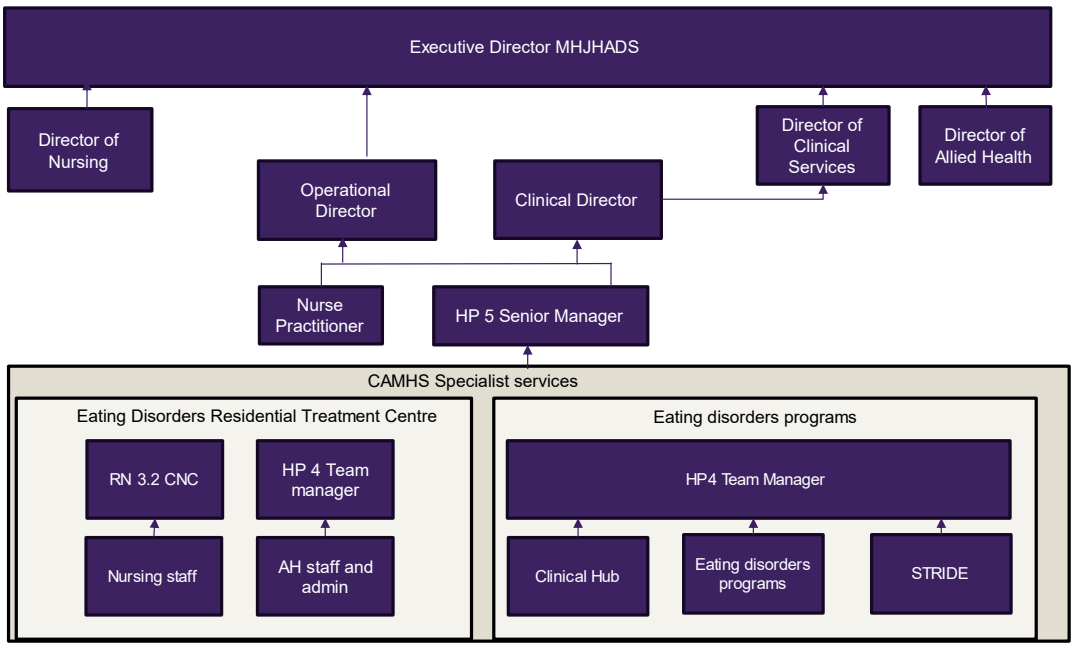
2	Increase independence with moderate to high level of support Exploring and developing skills to reduce the impact of factors that maintain the eating disorder	Completed all P1 assignments Increased motivation Decreased use of supplements Less ritualistic table behaviours	Portion some food (breakfast, snacks) under supervision of staff. Lunch and dinner portioned by staff 1.0-hour post meal support following main meals and 30 minutes post snack Self-select all food choices with options provided Incorporate family / carers into meal times	Maintains own room and personal belongings Complete indoor chores and light outdoor chores with later stage consumer	Maintain regular and adequate eating Increase variety in intake Nil compensatory behaviours Minimal ritualistic behaviours Increased participation in groups	Nature walks and exercise as appropriate	Go on non-medical and non-feed outings with staff and potentially family/carers	Attend all sessions Family/Carers/ supports invited to attend CCSW	Clinician: 1/wk. Key worker: 1/wk. Dietitian: 1/wk. Psychiatrist: As required
3	Increase independence with low to moderate level of support	Mastery of challenges in stage 2	Self-select all food and portion all meals and snacks within options available	Maintains own room and personal belongings	Maintain regular and adequate eating Increase social eating	All program exercise	Go on non-medical outings with staff, family/carers and friends. This can include	Attend most sessions. May be able to take leave with family and friends during	Clinician: 1/wk. Key worker: 1/wk. Dietitian: 1/wk.

	Increase Social eating	Increased motivation for recovery Can show recovery leadership (role modelling – increased participation in groups, healthy food behaviours, recovery-oriented discussion) No supplements Reach out from and support others	under supervision of staff. Go grocery shopping and prepare snacks 30 minutes supervision and bathroom restrictions post main meal	Complete indoor chores and light outdoor chores with earlier stage consumer	Nil compensatory behaviours Nil ritualistic eating behaviours Role modelling recovery orientated behaviours and leadership in groups		meals out with family and friends.	group session times as agreed with MDT.	Psychiatrist: Aa required Engagement with outpatient team: face to face or telehealth appointments as agreed at MDT review with consumer
4	Instil independence and prepare for step down from residential.	Mastery over challenges presented Role models Recovery focused in actions and	Responsible for food including portion all meals and snacks Prepare some meals on own	Maintains own room and personal belongings Complete indoor chores and light	Maintain regular and adequate eating Increase spontaneous eating	Independent exercise	Go on non-medical outings with family/carers, friends, alone Use their car	Attend 50% of group sessions as agreed with MDT.	Clinician: As required Key worker: 1/wk. Attend final session to discuss relapse prevention. Dietitian: As required. Attend final session to

		conversations, including plans for returning home.	Select foods not on the menu Nil post meal supervision	outdoor chores with earlier stage consumer	Nil compensatory behaviours Nil ritualistic eating behaviours Role modelling recovery orientated behaviours and leadership in groups		Engage in extracurricular activities that mirror what they do post-graduation		discuss guidance for meals at home Psychiatrist: As required Engagement with outpatient team: As required
Graduation	Prepare to step down to a lower level of care	Discharge when in P 1, 2, 3	To be determined with MDT dependent on current stage of care and treatment goals	To be determined with MDT dependent on current stage of care and treatment goals	To be determined with MDT dependent on current stage of care and treatment goals	To be determined with MDT dependent on current stage of care and treatment goals	To be determined with MDT dependent on current stage of care and treatment goals	To be determined with MDT dependent on current stage of care and treatment goals	Clinician: As required Key worker: 1/wk. Attend final session to discuss relapse prevention. Dietitian: As required. Attend final session to discuss guidance for meals at home Psychiatrist: As required

									Engagement with outpatient team: As required

Attachment C – Governance Structure of the Eating Disorder Services



Attachment D Weekly therapy schedule example.

	Monday	Tuesday (e.g. psychiatrist day)		Wednesday	Thursday	Friday	Saturday	Sunday
6.30 7.00 7.30	Wake up/self-care Vitals Quiet time	Wake up/self-care Vitals Quiet time		Wake up/self-care Vitals Quiet time	Wake up/self-care Vitals Quiet time	Wake up/self-care Vitals Quiet time	Wake up/self-care Vitals Quiet time	Wake up/self-care Vitals Quiet time
8.00	Breakfast (RN)	Breakfast (RN)		Breakfast (RN)	Breakfast (RN)	Snack (RN)	Breakfast (RN)	Breakfast (RN)
8.30	Mindfulness (RN)	Mindfulness (RN)		Mindfulness (RN)	Mindfulness (RN)	Mindfulness (RN)	Mindfulness (RN)	Mindfulness (RN)
9.00 9.30	Goal (intention) Setting / reflect (RN/AH)	Art therapy	MDT	Pet therapy (incl morning tea) (RN/AH)	OT session (OT)	Breakfast out (3 staff – RN/AH)	Family/friends Incl lunch	Excursion - incl snack (social exposure) (2 staff – RN/AH)
10.00	Morning tea (RN/AH)	Morning tea			Morning tea			

11.00	Psych skills (psychologist)	Peer led recovery			(prepare snack For Excursion) (dietitian)	Healthy self Reflection (RN/AH)		
11.30								
12.00				Lunch out (3 staff – RN/AH)		Movement (EP)		
12.30	portioning	Portioning			Portioning	portioning		Family / friends (incl lunch)
13.00	Lunch (RN/AH)	Lunch			Lunch	lunch		
13.30	Nutrition (dietitian)	Individual/family Consult / Free time/permaculture			Psych skills (psychologist)	Music therapy	House meeting (RN)	
14.00				Healthy self Reflection (RN/ AH)				
14.30								
15.00	Afternoon tea	Afternoon tea		Afternoon tea	Afternoon tea	Afternoon tea	Afternoon tea	
15.30	Indiv/family Sessions (AH) / 1 group help prepare dinner (dietitian/chef)	Individual/family Consult (MED) / Free time / permaculture (RN)		Psych skills (Psych)	Indiv/family Sessions (AH) / 1 group help prepare dinner (dietitian/OT)	Indiv/family Sessions (AH) / Permaculture / Free time (RN)	Goal setting / Reflection (RN)	
16.00								
16.30				Movement (EP)			Free time	
17.00								
17.30	portioning	Portioning		Portioning	Portioning	Portioning	Portioning	portioning

18.00	Dinner (RN)	Dinner (RN)	Dinner (RN)	Dinner (RN)	Dinner (RN)	Dinner (RN)	Dinner (RN)
18.30	Mindfulness (RN)	Mindfulness (RN)	Mindfulness (RN)	Mindfulness (RN)	Mindfulness (RN)	Mindfulness (RN)	Mindfulness (RN)
19.00	Milieu therapy (games/tv/ clean up) (RN)	Goal setting/ Reflection (RN)	Milieu therapy (games/tv/ clean up) (RN)	Goal setting / Reflection (RN)	Movie night (incl snack) (RN)	Milieu therapy (games/tv/ clean up) (RN)	Milieu therapy (games/tv/ clean up) (RN)
19.30							
20.00							
20.30	Supper (RN)	Supper (RN)	Supper (RN)	Supper (RN)		Supper (RN)	Supper (RN)
21.00	Reflect/free (RN)	Reflect/free (RN)	Reflect/free (RN)	Reflect/free (RN)		Reflect/free (RN)	Reflect/free (RN)
21.30	Self-care	Self-care	Self-care	Self-care	Self-care	Self-care	Self-care
22.00	Bed time	Bed time	Bed time	Bed time	Bed time	Bed time	Bed time

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Policy Team ONLY to complete the following:

Date Amended	*Section Amended*	*Divisional Approval*	*Final Approval*

This document supersedes the following:

Document Number	*Document Name*