Eating Disorders: Assessment and Management - Adult/Pediatric - Inpatient Guideline Summary

Target Population: Pediatric patients (approximately 8 years or older) and adult patients (≥ 18 years) who are in a medically unstable condition secondary to an eating disorder.

Full Guideline: Eating Disorders: Assessment and Management - Adult/Pediatric - Inpatient

ADMISSION for an Eating Disorder

ADMITTING DIAGNOSIS	Patients may be admitted for medical stabilization of an eating disorder if they meet at least one indication below. Note that the patient is being admitted for an "acute exacerbation" of a "chronic disease". The admission diagnosis should be accompanied by a description of the acute symptoms/exacerbation (e.g., bradycardia, severe weight loss). Example: Admitting a CF patient for "CF *bronchopulmonary exacerbation" not just "Cystic Fibrosis".*
WHERE TO ADMIT	• If patient is ≤ 17 years- admit to Pediatric Hospitalist Service **(P5 unit)** • If patient is ≥ 18 years, admit to **D4/6** (for Family Medicine patients) or **F6/4** (for Hospital Medicine patients)

Medical Indications for Inpatient Treatment

Weight

- ≤ 75% IBW/EBW (Approximate BMI ≤ 15.99 in adults)
- Rapid Weight Loss (i.e., ≥ 10 lbs. in 2 wks.)
- Arrested growth and development

Temperature

- Hypothermia (< 96.0°F or 35.6°C)

Cardiovascular

- Heart rate < 50 bpm (daytime) or < 45 bpm (nighttime)
- Orthostatic blood pressure measurements that feature a decrease in systolic blood pressure of > 20 mmHg OR decrease in diastolic blood pressure of > 10 mmHg OR increase in heart rate of > 20 bpm.
- ECG abnormalities (e.g., arrhythmias)
- Chest Pain

Lab Values

Clinically significant abnormal lab values in the following:

Electrolytes	Anemia evaluation	Malnutrition indicators	For Females only (order serum labs only if in amenorrhea)
• Sodium • Potassium • Chloride • Magnesium • Calcium • Phosphorus	• Red Blood Cell count • Hemoglobin • Hematocrit	• Blood Urea Nitrogen • Creatinine • Glucose • Albumin	• Prolactin • Urine Beta- HCG

Additional symptoms

- Acute medical complications (e.g., syncope, seizures, cardiac failure, esophageal tears, etc.)
- Acute food refusal
- Uncontrollable bingeing and purging

Failure of ambulatory/outpatient therapy

ADMISSION COORDINATION	• MD should notify Nutrition of any eating disorder admissions planned for the day. • When patient arrives CTL is to email patient name and room number to CulinaryServicesKitchenSupervisor@uwhealth.org. • MD and RN/CTL to meet with patient/family as soon as possible to explain the admission and what it entails. If the assigned MD resident is not comfortable doing this the senior MD resident should assist. • Patient/family to receive "Disordered Eating: What to Expect in the Hospital" Health Facts for You. • An approved sign is to be hung on patient's door to remind culinary staff to deliver trays to Nurse's Station

DAILY ROUTINE ***Consistency is key for patients with an eating disorder as these patients often rely on a routine.****	
LABS	• Electrolytes daily for 7 days. Once the patient is at goal calories or electrolytes are normal, labs frequency may be decreased or discontinued. • Patient will be given the option of having a PIV. Explain that the PIV could stop drawing at any time, resulting in additional pokes. • Urine Specific Gravity is ordered as conditional if excessive water intake is suspected.
DAILY WEIGHTS	• Every morning by 0800. • Patient must void prior to measurement and only be wearing gown and underwear (no bra). • Patient cannot eat/drink anything prior to weight. Hair must be dry. Must use same standing scale. • Patient must face away from the scale. **DO NOT DISCUSS WEIGHT WITH PATIENT**.
ORTHOSTATIC VITAL SIGNS	• Every morning. • Measure heart rate and blood pressure after lying for 5 minutes, after standing for 1 minute, and after standing for 3 minutes. Patient may sit if unable to stand.
REGULAR VITAL SIGNS	• Every 4 hours while on continuous cardiac monitoring. May be increased to every 8 hours if patient is taken off continuous telemetry. • Will remain on continuous cardiac monitoring until all ECG and electrolyte abnormalities are resolved for 24 hours.

PATIENT COMMUNICATION AND EMERGENCT BEHAVIORIAL SITUATIONS *Patients with an eating disorder demonstrate impaired judgment in this area of their lives, even though they may demonstrate capacity in areas not influenced by obsession with food and/or body weight.*	
COMMUCATION APPROACH	• Avoid trigger words such as “food”, “calories” and “weight.” Instead, refer to the treatment in medical terms such as “medicine”, nourishment”, or “energy.”
DE-ESCALATION STRATEGIES	• Be as consistent as possible. • Have any people who are targets for the crisis behavior step out of the room. • Keep as few staff as possible in the room but keep enough to provide for safety. • Do not engage in bargaining or argument. • Most patients will respond to quiet, firm, and kind limit-setting. Present the treatment plan matter-of-factly. Use a take-it-or-leave-it approach. • If there is agitation, consider calling Security right away. They are unlikely to put hands on the patient but can be a calming "show of force" whose presence can remind the patient to be civil.
PEDIATRIC PATIENTS	Child Psychiatry can be paged at any time for consultation/advice; there is someone in the hospital about half of the time. If after hours, page the psychiatry resident on call. The Provider can contact the UW Main Hospital Adult Psychiatry Unit for other support or guidance as necessary.
ADULT PATIENTS	If patients are threatening to leave AMA, providers may call or page Psychiatry (Adult Psychiatry: pager 0079). Questions regarding whether to implement emergency detention may be directed to Psychiatry. Additional information on may be found in the UW Health Clinical Policy 1.2.1 Emergency Detention- State Mental Health Act. Security and the Behavioral Response Team may be able to assist with physically holding a patient sufficiently long to have the patient evaluated for their decisional capacity and medical condition.

HEALTHCARE TEAM AND COMMUNICATION	
MULTIDISCIPLINARY TEAM	Multidisciplinary team will include representation from: resident team, attending hospitalist, and supporting Eating Disorders team (NP or PA, Adolescent Medicine, staff RN, CNS, RN manager, Psychiatry/Child Psychiatry, Health Psychology, Case Management, Social Work, and Clinical Nutrition).

ROUNDING COORDINATION

Pediatric Patients	**Adult Patients**
• Daily rounding time to be determined in the morning. • Senior resident to send group text page to team. Pager #6481. • Any available member of the Eating Disorders support team will round with resident team	• Daily rounding should occur during Care Team Rounds • Group page sent to team members to coordinate rounds • Care Team Rounds should be held outside the patient room to discuss sensitive information (e.g., as weight changes) • Selected team members should still enter the patient room daily to talk with the patient

PATIENT ACTIVITY AND SUPERVISION	
SUPERVISION	• **Patients with eating disorders require continuous supervision for safety and compliance.** • **Family members or friends are NOT permitted to substitute for staff providing constant observation under ANY circumstance.** **Additional UW Health information on Constant Observation**
ACTIVITY	• Patients should be restricted to bed rest. Staff members should retrieve and put away patient belongings, as the patient is not allowed to walk back and forth in the room. • Patients may be allowed to sit up in bed, but not in a chair. If they sit up in bed, the head of bed needs to support their back to limit abdominal muscle use. They may not dangle legs off the side of the bed. • Watch for energy-burning behaviors such as tapping feet, shaking, muscle tensing etc. • MD permission is needed to attend hospital activities in a wheelchair. • Activity will be increased slowly by the MD team as conditions improve.
BATHROOM PRIVILEGES	• Bathroom use is restricted during meals and snack time. PATIENTS CANNOT USE THE BATHROOM FOR 1 HOUR after any meal/snack. • Bathroom use MUST be supervised by a staff member at ALL TIMES to prevent purging, extra water intake, and falls. • One 5-minute seated shower per day may be allowed when electrolytes and cardiovascular system are stable, and they are cleared by the MD team.
PURGING BEHAVIOR	Remove all loose trash cans from the room.

MEALS AND SNACK TIME	
MEALS PLANNING	• Clinical Nutrition (pager 5254) meet with patient **within 24 hours of admission** to discuss food preference, restrictions and limitations. (See Personal Food Preferences Worksheet) • All meal planning is done by Clinical Nutrition- patients CANNOT order their own meals.
IF CLINICAL NUTRITION UNAVAILABLE	If a patient is admitted in the evening when Clinical Nutrition is unavailable • The RN will make the patient an RS-2 room service class and call Culinary Services to place orders for the dinner and breakfast meals per the Admission Meals Menu for Evenings/Weekends. • The patient can choose to eat the pre-planned meal OR drink 1 can of 1.5 kcal/mL oral nutritional supplement.
MEALS and SNACK TIME	• Each patient will receive 3 meals and 2-3 snacks, depending on their calorie level. Most patients start at a minimum of 2000 kcal/day. (Refer to Bell Meal Replacement Guidelines) • Meals arrive between 0800-0830, 1200-1230, 1700-1730. Snacks arrive between 1000-1030, 1500-1530, and 2000-2030. All trays should arrive during designated time and be delivered to the Nurse's Station. • If tray is late, RN to page Clinical Nutrition. • RN should compare the tray ticket to the content of the tray before delivering the tray to the patient. If there is a discrepancy, RN should page Clinical Nutrition. • Cans of 1.5 kcal/mL oral nutritional supplement are sent to Nurse's Station daily at the 1000 snack time. • Patients are allotted 30 minutes for meals, 20 minutes for snacks and 15 minutes for nutritional supplement. • Patients must eat on bedside table (not in lap). Ensure tray is clear and no food is hidden. • Please do not interrupt snacks/meals with vital signs, assessments etc. • **ABSOLUTELY NO OUTSIDE FOOD IS PERMITTED**. • Family members may eat in the patient's room but CANNOT SHARE food with patient and must dispose of any food OUTSIDE the patient's room.
PATIENT FOOD PREFERENCES	• Patients will be allowed to specify 3 of their favorite foods and 3 foods to avoid. The personal food preferences document/worksheet cannot be updated or changed. • Lactose free, vegetarian diets and documented allergies will be honored- vegan diets will not. • Patients may not have caffeinated or diet beverages or diet foods. • Patients may have one packet of salt per meal.

MEALS AND SNACK TIME	
MEAL/SNACK PROCEDURE	• Maintenance fluids will be brought with meal/snack trays. Patients can have up to 1.5x maintenance. MD/Nutrition should enter an order of how much water the patient can get from the unit. • Water bottles that come with meals may be kept on the patient's bedside table for > 30 minutes but must be consumed prior to the arrival of the next meal tray/bedtime for dinner tray water. • If patient eats < 100% of a meal or snack, offer specified volume of 1.5 kcal/mL oral nutritional supplement. The appropriate portion should be poured into a separate cup for administration. • The amount of nutritional supplement to be given is in the diet orders and based off percentage eaten/drank. 50% is 50% of the calories on the tray, not just 50% of the items. Take the caloric density of items into consideration when figuring out the percentage eaten/drank. • If patient is unwilling or unable to take the 1.5 kcal/mL oral nutritional supplement orally within 15 minutes, an NG tube should be placed for administration. • If patient refuses NG tube, remind them that it's a valuable part of a safe treatment plan for the condition since it may be challenging to eat the full amount of nourishment that the heart and body needs. Emphasize that the NG will allow the patient to relax and receive the nourishment safely, without worry or pressure. Do not negotiate or use the NG as punishment. • Patients will be required to eat 100% of their provided meals and snacks before requesting extra food. This request for additional food should be discussed with Clinical Nutrition
RN DOCUMENTATION	• RN will record percentage of food intake in Tray Monitor and Health Link. • Nutritional supplements count towards fluid goals and should be documented in the supplement column found in the I&O flowsheet. This information will be calculated by Clinical Nutrition and entered in Health Link flowsheet the next morning. • *For Adult patients*: Food on trays should be documented in Mobile Intake.

KEY POINTS – PATIENT DISCHARGE	
DISCHARGE CRITERIA	• Weight is never used as sole criterion for discharge. • Patients should NOT be discharged until they meet at least one criteria for discharge.
Medical Indications for Discharge	
Weight: > 75% IBW **OR** weight stabilization	
Temperature: Normothermia for 24 hours	
Cardiovascular	
• Heart rate > 40 bpm **OR** stable heart rate per attending physician discretion • Resolution of EKG abnormalities • Resolution of orthostatic symptoms (e.g., dizziness, light-headedness, etc.)	
Normal lab values	
Discharge Preparation	
DISCHARGE TO HOME	• Discharge meal plan should be coordinated between the patient and the dietitian • Exercise parameters should be provided by provider
DISCHARGE TO REFERRAL FACILITY	• Social Worker/Nurse Case Management will contact a referral facility on hospital day 1-2 to arrange possible transfer • Social Worker/Nurse Case Management and Psychiatry will assist parents in setting up a phone interview with the designated referral facility • Social Worker/Nurse Case Management or Nursing will fax admission H&P, discharge summary, and most recent Clinical Nutrition progress note to referral facility upon patient discharge • Psychiatry will make the decision whether the patient will transfer by ambulance or family vehicle. ***NOTE**: The following tests **MAY BE REQUIRED 72 hours prior to discharge if transferring to certain inpatient facilities (e.g., Rogers Memorial)**: EKG; CBC with differential, CMP (Sodium, Potassium, Chloride, Total Carbon Dioxide, Anion Gap, Glucose, BUN, Creatinine, Calcium, Albumin, Total Protein, Total Bilirubin, AST, ALT, Alkaline Phosphatase), Magnesium, Phosphate, Urine Pregnancy, Urinalysis with Microscopy, TSH, Free T4, Urine Drug Screen Labs*