Eating Disorders (Medical Stabilization) Care Guideline

CHOC Children's at Mission Hospital

Inclusion Criteria: Patients with known or suspected eating disorder requiring hospitalization due to any of the following:

- Unstable vital signs (pulse < 46/min or irregular, systolic BP < 90, diastolic BP < 45, pulse increase on standing > 20/min, systolic BP decrease on standing > 10mm Hg, T < 36 degrees
- Significant electrolyte abnormality
- Cardiac disturbance, syncope or other medical disorder
- Extremely low body weight (< 75% mean BMI - 50% for height and weight)
- Failure of outpatient treatment

Exclusion Criteria: PICU status

Initial Assessment: Thorough medical evaluation with attention to:

- Vital signs, weight, & height
- Electrolytes, magnesium, phosphorus, calcium, Vit D
- Cardiac status (ECG & Echo)
- Nutritional status
- Psychosocial/suicidality assessment/status
- Treatment goal weight

Initial Therapies:

- Activity Level 1 – strict bedrest
- Close monitoring of vital signs & weight
- Initiate diet as prescribed (< 70% of mBMI: 1400 kcals/day; >/= 70% mBMI: 1800 kcals/day)
- Strict I & O, including emesis & stool
- Daily CMP, Mg, Phos x 7 days. If labs remain stable after 7 days, transition to biweekly labs.
- Monitoring for refeeding syndrome, electrolyte disturbance, cardiac failure/ dysrhythmia, etc.
- Oral supplementation to include:
  - Nutraphos 1-2 packets/day
  - Thiamin 100 mg /daily (add reference)
  - Multivitamin 1 tab/daily
  - Miralax 17 gms/daily
  - Tums 2 tabs TID (elemental CA 200mg)
- Zofran 4mg q4-6 hrs prn
- 24/7 observation (sitter) x 24 hrs, transition to video monitoring once cleared by care team
- Consultations: Psychology, Adolescent Medicine, Nutrition, Social Work, Case Management, and Child Life. Rehab Therapies (PT/OT/ST) when clinically appropriate.
- Interdisciplinary meetings held bi-weekly.
- Family meeting to be scheduled within 2-3 days of admission

See Management Essentials beginning on page 2

Medical Discharge Criteria

- Improved vital signs, stable electrolytes, magnesium, phosphorus, calcium, & cardiac status
- Stable weight gain
- Able to tolerate activity at discharge goal
- Patient & family willing to comply with discharge/transfer plan

Recommendations/ Considerations

- The goal of hospitalization is medical stabilization, correcting and preventing complications, and transitioning to an eating disorder treatment program (outpatient or inpatient depending on individual circumstances).
- Consider obtaining lipid panel, celiac screen, and hormone levels on admission.
- The major manifestations of refeeding syndrome are: delirium, chest pain, heart failure often in association with hypo-phosphoremia and depletion of potassium and magnesium.
- Eating disorders are associated with significant mortality and morbidity. Prognosis is generally guarded.
- The mainstay of management is a team-centered approach to the patient and family
- EDO admissions should be directed to CHOC at Mission Hospital. If admission to CHOC Orange is required, the same practices should be utilized.

Patient/Parent Education

Admission Handouts:
What to Expect I & II
Meal Coaching
Visitation guidelines

Parent Classes/Modules:
Understanding EDO's
Nutrition
Meal Support
Behavior Management

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EBM Comm 2-18-15, revised 11-14-18, 5-19--21

Reassess the appropriateness of Care Guidelines as condition changes and 24 hrs after admission. This guideline is a tool to aid clinical decision making. It is not a standard of care. The physician should deviate from the guideline when clinical judgment so indicates.

Management Essentials for the Treatment & Medical Stabilization of Eating Disorders

Eating disorders in children and adolescents are serious conditions that can have life-threatening physical consequences. Early diagnosis and treatment is crucial to avoid permanent medical complications and to increase the likelihood of a positive prognosis. Family-based Treatment (FBT) is the most well-established evidence-based treatment for youth with eating disorders. The FBT approach works to engage families to help them understand and take charge of their child's eating behaviors. FBT is characterized by a non-judgmental stance regarding the origin of the eating disorder and a conceptualization of parents as the primary resource in restoring their child back to health. The focus of the treatment is orchestrating a parent-driven intervention to restore healthy eating patterns in the child and then gradually transitioning the child back to eating autonomy (Lock & Le Grange, 2013). At CHOC our interdisciplinary team has adapted FBT principles into a busy inpatient medical stabilization setting to empower parents and equip them with the education necessary to restore their child back to health. Our physicians, dietitians, and nurses oversee the medical recovery of the malnourished and medically unstable patient. Psychology, social work, case management, and child life help support the family by providing structure, behavioral plans, psychosocial support, and discharge planning. Parents are considered a vital part of the patient's care team. The FBT model helps guide our daily approach with our parents by encouraging typical family interactions (e.g., family meals) involving them in treatment interventions (meal planning, meal coaching, promoting positive coping strategies), and empowering them with the knowledge and skills to be able to continue their child's recovery following discharge.

COMMON EATING DISORDERS IN CHILDREN

Anorexia Nervosa is an eating disorder characterized by restrictive eating relative to energy requirements that leads to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. It is also characterized by an intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight. Other characteristics include disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Bulimia Nervosa is an eating disorder, which involves the consumption of excessively large amounts of food within a short period of time (binge eating), followed by compensatory behavior to prevent weight gain. Compensatory behavior may include purging behaviors such as self-induced vomiting, abuse of laxatives/enemas, diuretics or excessive exercise. Non-purging behaviors may include fasting.

Avoidant/Restrictive Food Intake Disorder (ARFID) is an eating or feeding disturbance that is characterized by a persistent failure to meet appropriate nutritional and/or energy needs. Symptoms of ARFID vary widely and may include:
-Accepting a limited diet due to sensory sensitivity, sensory aversion, or sensory over-stimulation
-Food refusal related to fear of aversive consequences of eating such as choking, nausea, vomiting, or pain
-Not eating enough due to low appetite, extreme pickiness, and/or lack of interest in food

As a result of the eating problem, the person is not able to take in adequate calories or nutrition through their diet. ARFID is not better explained by a lack of available food or a culturally sanctioned practice, does not occur exclusively during the course of another eating disorder, and there is no evidence of a disturbance in body weight or shape.

Other Specified Feeding or Eating Disorder (OSFED) is a feeding or eating disorder that causes significant distress or impairment but does not meet the criteria for another feeding or eating disorder. Atypical anorexia nervosa: All of the criteria for anorexia nervosa are met except that despite significant weight loss, the individual's weight is within or above the normal range

CHOC CARE GUIDELINE ADMISSION CRITERIA

Patients are admitted for vital sign instability, significant electrolyte abnormalities, cardiac disturbance, or being less than 75% median Body Mass Index (percent median BMI calculated as patient BMI/50th percentile BMI for age and sex in reference population x 100)) *or considered to be at a significantly lower weight than is expected.* Additionally, patients who are admitted may have failed to respond to or comply with outpatient management.

Once admitted, patients will be followed by the hospitalist service with nutrition, psychology, social work, physical therapy, and child life consultants. Other services may include Psychiatry and Music Therapy. The team's goal for admission is medical stabilization. Once achieved, patients will transition to an eating disorders treatment program or intensive outpatient services, depending on individual circumstances.

The most critical aspects of care are:

1. Monitoring and enforcing prescribed activity level.
2. Close monitoring of vital signs (VS) and weight.
3. Observing prescribed calories.
4. Strict intake and output.

All patients are on medical bed rest initially.
All patients' orthostatic vital signs are assessed throughout entire stay.
All patients' nutritional intake is closely monitored during hospitalization.

GENERAL RESTRICTIONS

Treatment will begin with these general restrictions, with plan to individualize motivators and incentives to the patient. Privileges will increase in accordance with increased patient compliance.

- 1:1 sitter for the first 24 hours. The patient's care team will evaluate the appropriateness of discharging the 1:1 sitter after 24 hours and switch to video monitoring.
- No outside food is to be provided to the patient unless approved by Nutrition Services and/or physician.
- No food to be left in room after meal completed.
- No bathroom use for at least one hour after meals and 30 minutes after snacks
- For the first 24 hours, only the immediate family will be allowed to visit.

- Visitors can visit after 24 hours, per care team clearance.
- Parents are to review 'Visitor Guidelines' with visitors.
- Parent and visitors may only eat in room if patient is also eating
- No telephone, cell phone, or computer privileges unless deemed appropriate by the care team.
- May not leave unit, unless deemed appropriate by the care team.
- Belongings will be inventoried at admission and as needed during the hospitalization.
- New items (e.g., presents, reading material, etc.) will be inventoried and reviewed for appropriateness throughout hospitalization.

ORTHOSTATICE VITAL SIGNS

The patient must lie completely flat (no pillow) and still for at least 5 minutes in a supine position. A full one-minute radial pulse is taken. At the same time, blood pressure (BP) may be taken by machine. The patient then stands for two minutes, after which the pulse and BP are taken again using the same technique. However, if the patient's BP is less than 90/45 while lying down do not have them stand. It may be necessary to obtain an apical pulse when standing if radial is too rapid or weak. Document dizziness or lightheadedness if present upon standing. The patient's temperature may be taken while waiting the 2 minutes. Staff are not to retake VS at patient's request. Repeat VS should only be done when there is a suspicion of error or equipment malfunction. If patient is unstable, notify the physician.

Note: There is a potential risk that the patient may fall due to orthostatic changes and/or overall medical instability. The fall risk category should be documented during charting.

VITAL SIGN STABILITY CRITERIA

The patient is considered unstable if at least one of the following is met within 24 HRS (AM rounds to AM rounds):

1. Pulse < 46/min. or irregular (lying or standing)
2. Systolic blood pressure < 90 (lying or standing)
3. Diastolic blood pressure < 45 (lying or standing)
4. Pulse increase on standing > 35/min
5. Systolic blood pressure decreased on standing > 10mm/HG
6. Oral temperature < 36.3 – Days and Evenings
7. Oral temperature < 36 – Nights

ACTIVITY LEVELS

A. It is important to determine which activity level your patient is on and make sure they adhere to it. Too much activity is a strain on their compromised cardiovascular system and delays healing. Hypotension places them at risk for fainting and falling if they get up. Another extremely important aspect of protecting patients from too much activity is conserving energy to allow weight gain.

B. When considering advancing to **next activity level**:
   i. patient must be asymptomatic, have an echo/EKG with no major disturbances, and have resolving/improved orthostatics.

ii. Typical criteria for advancing levels is **no more than 3 to 5 VS instability during 24 HRS (AM rounds to AM rounds)**, however based on individual medical needs and progress.
iii. Sometimes the first morning orthostatic BP or pulse change will be disregarded in this evaluation.
iv. When known history of low BP or POTS is available, the medical team may consider using less strict criteria for BP increase or pulse increase on standing if patient is not symptomatic.
v. Normal labs
vi. Patient is at or near 75% of mBMI
vii. There is no concern of over-exercise behavior in hospital
viii. May consider decreasing activity level (return to Bedrest) if the patient has more than 5 unstable vital signs within a 24-hour period while on Bedrest and Wheelchair Activity Level

C. Patients may return to a previous activity level protocol if persistently unstable.

D. **If sitter is assigned, sitter is expected to monitor all activities inside the room and accompany patient on all activities outside the room.**

E. **Patients are not allowed off the medical floor if actively suicidal, aggressive, or a flight risk.**

I. Bedrest (Level I):

A. All patients should start at Bedrest, regardless of vital sign instability (e.g., Even patient with bulimia nervosa who only has lab abnormalities) to best assess level of stability. Minimum Bedrest for 24 hours (most patients will likely be at this stage for at least 1 week).

B. Activity at this level:
i. Bedrest with the exception of the following chair activities:
a. Linen changes
b. Group activities
c. Physical therapy
ii. Commode at bedside
iii. Stand only for weight in am and vitals (in gown, no underwear)
iv. No showers, unless approved by physician. May have hair washed in bed if not hypothermic or bradycardic
v. <u>shower (seated) weekly after 1 week if has not progressed</u>

C. Vitals:
i. Q4H temp resting pulse (lying flat), orthostatic pulse and BP
ii. No orthostatic blood pressures required at MN and 0400 after 24 hours (after EKG and ECHO complete and no major abnormalities found)
iii. If hypothermic – actively warm with blankets or patient may require Bear Hugger warming blanket at night

D. Cardiac Monitoring:

i. Continuous cardiac monitoring while at Level 1 to monitor for anticipated or existing bradycardia. Pulse oximetry for the first 24 hours only, unless otherwise indicated.

II. Bedrest and Wheelchair Activity (Level II)

A. The patient will use a wheelchair pushed by staff to take laps on the floor and be wheeled to the playroom for seated activities to promote physical activity, as ordered by the medical team. The patient must be on their bed at all other times.

B. Activity at this level:
   i. Laps in wheelchair
      a. Start laps around the medical floor for a total of 3X per day.
      b. Laps may be increased every day or other day, depending on continued vital sign and lab stability
   ii. Visits to patio/playroom/family room
      a. Start with 1 hour of patio/playroom/family room access per day.
   iii. Chair activity expected for these tasks:
      a. Meals
      b. Homework
      c. Group activities

C. Vitals:
   i. Q4H temp resting pulse (lying flat), orthostatic pulse and BP
   ii. No orthostatic blood pressures required at MN and 0400.

D. Cardiac Monitoring: Continuous cardiac monitoring at night only

III. Bedrest and Ambulation Activity: Level III

A. Physical activity will include walking laps and walking to the playroom, as ordered by the medical team. The patient must be in a chair or on their bed at all other times.

B. Activity at this level:
   i. Walking laps
      a. Start laps around the medical floor 3X after each meal.
      b. Walking laps may be increased every day or other day, depending on continued vital sign stability.
   ii. Visits to Patio/Playroom/family room
      a. Patient is expected to access the playroom (or family room) for 3 hours a day to simulate discharge activities.
      b. Additional hours can be earned as privileges.
   iii. Chair activity expected for these tasks:
      a. Meals
      b. Homework
      c. Group activities
      d. Should lay in bed to watch movies or TV or read a book, etc.
   iv. May have purposeful ambulation within room within reason (ie. may use the bathroom for brief periods of time)
   v. Stand for weight in am and vitals (in gown, no underwear)

vi. May stand for linen changes
vii. May stand to use sink/brush teeth
viii. May stand for showers (≤ 15 min).

C. Vitals:
   i. Q4H temp resting pulse (lying flat), orthostatic pulse and BP
   ii. No orthostatic blood pressures required at MN and 0400.

D. Cardiac Monitoring: Not required

SUPERVISION

Patients will always receive supervision of activity, including meals and snacks and bathroom privileges for the duration of their stay either by a 1:1 sitter and/or video monitoring. For the first 24 hours, the care team will evaluate the patient for risk of self-harm, purging behaviors, excessive exercises, and other psychosocial stressors that may potentially impact the hospitalization. The patient's care team will evaluate the appropriateness of discharging the 1:1 sitter after 24 hours and switch to video monitoring. The parents are encouraged to provided observation, monitoring, and support throughout the hospitalization.

NIGHT CARE

The primary concern for patients with eating disorders during the night is a sustained drop in pulse. Temperature and pulse are closely related. When the body temperature drops, so does the pulse. Keeping the patient warm, without sweating, is the goal. Sweating tends to lead to cooling and requires a linen change, which is then very disruptive to sleep.

Using warm blankets to warm the patient is preferable to a Bear Hugger, yet if two attempts to warm in that manner are unsuccessful, a Bear Hugger warming blanket may be used. If a patient is without a cardiac monitor, pulse and temperature may be taken Q4H during the night, unless the initial VS are unstable or borderline. With a monitor, Q4H pulse and temperature are necessary. Currently, protocol dictates that patients remain on a monitor at night until pulse is 50 or greater for two nights in a row. Yet, if at midnight a patient without a monitor is found to have a pulse close to 46, a monitor would be placed. Warm blankets would be started at midnight if temperature is ≤ 36 because one may anticipate a further drop. A warm bath with a blanket around the head is very effective. Remember that warm blankets must go directly next to the skin. If pulse ≤ 40 notify the resident.

NUTRITION

Initiate diet as prescribed (< 70% of mBMI: 1400 kcals/day; >/= 70% mBMI: 1800 kcals/day). Patients will be advanced by 200-400kcal q 1-2 days or per dietitian/MD.

Patients should be placed on a set meal and snack schedule. Meals must be consumed within 30 minutes and snacks within 15 minutes. Food tray should be removed immediately after the meal.

Boost Kid Essentials 1.0 (BKE) is provided as the standard supplement if patient does not complete the meal/snack. BKE is a 1.0cal/ml formula. Orders specify the amount of supplement to provide. CA/RN will calculate the number of calories not consumed during the meal using information provided by the Nutrition team. Supplementation is usually given as a 1:1 ratio (1 ml of formula is supplemented per 1 kcal not consumed). If a patient is struggling to complete the volume of Boost, a more calorically dense formula may be utilized. Keep in mind, the ideal goal is for patients to be consuming regular foods and beverages. Therefore, if a patient is complaining or struggling with the volume but still able to meet goals & expectations, it may be worthwhile continuing the 1.0cal/ml formula with the hope to reinforce intake of the meal. Boost (or equivalent product) must be consumed within 15 minutes.

If patient refuses to complete meals &/or BKE, the CA/RN should notify the medical/nutrition team to determine if more time should be given or if the remainder should be given NGT. The team will determine the goal of desired oral intake as well as when to remove the NGT. We do not threaten the patient with placement of NGT; it is more effective to state, "*It is your choice to eat or not to eat. If you choose not to eat, then we will need to place the NG tube to make sure your body gets the nutrition it needs."*

The CA/RN will document and specify the percentage of each food item the patient has consumed using the meal sheet/ticket provided by Nutrition. Percentage of meals consumed will be documented in the EMR along with intake of BKE.

As a 1:1 sitter, remove food or Boost from room if you discover you need something or need to take a call, etc. You may chart if you can keep a close eye on the patient, but remember all it takes is a glance away to dump Boost or food into a wastebasket, linen, etc. For both 1:1 sitters and video monitoring sitters, giving firm limits are frequently necessary, with the explanation that we understand this isn't easy for them.

There is no trading or sharing food with patient. Upon treatment team recommendations, parents are encouraged to have meals with patient and are asked to bring their own food. Any outside food for patient must be cleared by treatment team first as well as cleared by dietitian as meeting nutritional requirements.

WEIGH-IN

Patients are weighed first thing in AM. Use the same scale daily with hospital gown only (no bra, socks, or underwear, as patients with eating disorders may hide weights in their underwear). Patient must void completely prior to weigh-in. Staff needs to be present during voiding and gown change and may stand just outside bathroom door provided that door is ajar, and patient is in direct line of sight. Do not re-weigh at patient's request. Patients are not permitted on scale at other times. <u>Patients are not to be told weight, except by Physician/Nutrition or Psychology in certain circumstances.</u>

RANDOM WEIGH-IN

This is ordered when numbers do not make sense, in order to rule out possibility of patients using weights, not voiding prior to weigh-in, or drinking water just prior to weigh-in, etc. DO NOT TELL PATIENT ABOUT RANDOM WEIGH-IN UNTIL JUST PRIOR TO WEIGH-IN AND STAY WITH THEM AT ALL TIMES UNTIL WEIGH-IN IS COMPLETED. As in AM weigh-ins, patients are asked to void and change into gown (no bra, socks or underwear). Staff needs to be present during

voiding and gown change and may stand just outside bathroom door provided that door is ajar, and patient is in direct line of sight. Be as tactful as possible commenting that numbers do not match, and doctor is confused.

Intake and Output

Strict I & O are very important. When patients first arrive, they tend to be either dehydrated from restricting all intake or over-hydrated in an attempt to increase their weight to avoid admission. Once hospitalized, all intake, including water, is to be observed. Patients may still try to drink when unobserved. Specific gravity along with urine dip with first AM void must be performed before weigh-in. A urine specific gravity of 1.010-1.020 is optimal. Fluid overload is potentially hazardous with peripheral edema, seizures, or congestive heart failure. There are frequently orders for a fluid minimum and maximum. It is important to determine amount of free water or ice allowed at the start of the day once calories are prescribed. Ice may be given if patient is not hypothermic or bradycardic (pulse < 46) at the time. Ice is equivalent to ½ the amount in water and should be documented in the I&Os. PH is also monitored. It is one indication of possible purging. A PH of ≤ 7 is desirable. Other indicators of purging may be decreased output, weight loss, or lack of weight gain despite increased calories, as well as routine trips to bathroom after meals. If purging is suspected, access to the bathroom may be limited after meals.

PHYSICAL ASSESSMENTS & MEDICATION

Patients are given usual head-to-toe nursing assessment with emphasis on several areas. Any arrhythmia in heart rate should be reported. Watch for peripheral edema, seen most often in ankles, as well as circulation problems with delay cap refill, mottled skin, and cool extremities. Observe for skin breakdown in particularly emaciated patients. Routinely, patients with eating disorders are given egg crate mattresses to protect their skin, as well as for comfort. GI complications are frequent and occur as a result of starvation, binging, or vomiting. Starvation may result in constipation and delayed gastric emptying with bloating. A stool softener &/or laxative may be ordered if necessary, keeping in mind patient history and laxative abuse potential. Warm packs to abdomen after meals may sometimes alleviate discomfort. It is recognized that discomfort may not be able to fully go away, as such discomfort is normal in the initial stages of the re-nourishment process. Physical Therapy will evaluate the patient to address pain and immobility, assist with safe return to functional activity, and provide structured physical activity during admission and for transition home.

Patients are routinely prescribed zinc, thiamine, multivitamin, phosphorus, and Tums. Zinc is given for hair loss and dry skin associated with malnutrition, thiamine and phosphorus to protect against refeeding syndrome, and Tums for calcium supplementation.

Report any concerns of symptoms related to depression, anxiety, and/or obsessive-compulsive disorder to Psychology as there is an increase comorbidity of these disorders with eating disorders. Psychology may additionally request a Psychiatry medication evaluation, as appropriate. It is recommended that a search of the patient's belongings for sharps (e.g., razor, scissors) and contraband (e.g., diet pills, laxatives) be done with the patient at time of admission. Observe for any scarring or cuts on patient's body as this may be indicative of cutting or self-harm behavior and report any concerns of these behaviors to Psychology.

Observe for the following disordered eating behaviors and relay concerns to team to address concerns:

a) Fluid overloading (drinking a lot of water)
b) Purging (vomiting)
c) Exercising, walking in hallways, exercising in bed, using stress ball
d) Increased irritability around meals and/or snacks
e) Eating very slowly, cutting food into tiny pieces, picking at food, wiping food into napkin or hiding food
f) Excessive use of condiments
g) Bingeing

DISCHARGE

Medical team should consider the following when **discharging home**:

A. Vital signs:
    a. 24 hours of stable vital signs and asymptomatic
    b. When known history of low BP or POTS, may consider discharge when patient is still unstable on 1-2 vital signs within a 24-hour period.
B. Nutrition
    a. Has reached nutritional goals
    b. Shown consistent weight gain for three days while on Bedrest and Ambulation Activity
    c. Is consuming between 80 -100% of solid nutrition
    d. Nutrition education with parents completed
C. Weight:
    a. Is at least 85% of mBMI (exact percentage is set by treatment team)
D. Normal labs
E. Psychology
    a. Parenting training/education has been completed
    b. Discharge plan reviewed
F. Case Management
    a. Appropriate referrals provided (i.e., PMD, Nutrition, Psychology/Mental Health)
    b. Outpatient referral appointments confirmed
G. School Plan
    a. Mealtimes & Supervision
    b. PE/Activity

Classification of Degree of Malnutrition for adolescents with eating disorders

	Mild	Moderate	Severe
%mBMI	80%–90%	70%–79%	<70%
BMI *z* score	−1 to −1.9	−2 to −2.9	−3 or Greater
Weight loss	>10% Body mass loss	>15% Body mass loss	>20% Body mass loss in 1 year or >10% body mass loss in 6 months
Inadequate Nutrient Intake	51% to 75% estimated energy/protein needs	26% to 50% estimated energy/protein needs	≤ 25% estimated energy/protein needs

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