## **Clinical Pathways**

# Eating Disorder

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An evidence-based guideline that decreases unnecessary variation and helps promote safe, effective, and consistent patient care.

## **Objectives of the Eating Disorder Pathway**



- Restart nutrition in a safe manner to prevent refeeding syndrome
- Promote patient weight gain and gradual medical stability in a structured manner
- Provide appropriate treatment for the patient's medical needs and begin to address underlying psychiatric causes
- Some admissions for medical stabilization are entirely focused on giving the patient nutrition

 $\rightarrow$  Our pathway is focused on getting the patient to take the nutrition

 $\rightarrow$  medical and psychological focus

# Why is this pathway necessary?



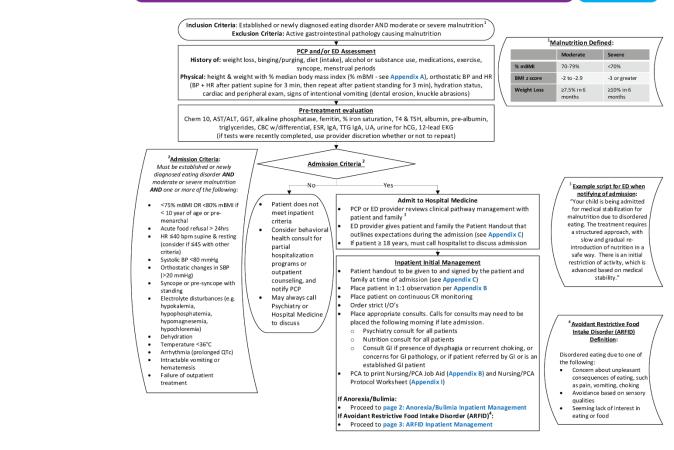
- To achieve the following goals:
  - Reinitiate nutrition in a safe environment
  - Prevent Refeeding Syndrome
  - $_{\odot}$  Establish the ability to maintain weight with activity
  - $_{\odot}$  Develop a discharge plan with appropriate referrals
  - $_{\odot}$  Streamline care between the ED and the inpatient floors

## **Refeeding Syndrome**



- A shift from fat to carbohydrate metabolism occurs, evoking insulin release → increasing cellular uptake of glucose, phosphate, potassium, magnesium, and water → further depletion
- Predominant features:
  - o Hypophosphatemia
  - o Hypokalemia
  - o Hypomagnesemia

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.



 The Eating Disorder pathway starts with a main first page, and then divides care for Anorexia/Bulimia (page 2), and Avoidant Restrictive Food Intake Disorder - ARFID (page 3).

 This is page 1 of 3 of the Eating Disorder Clinical Pathway.

 We will be reviewing each component in the following slides.

NEXT PAGE

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CLINICAL PATHWAY: Eating Disorder

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-3 or greate

≥10% in 6

months

Weight Loss

≥7.5% in 6

months

Inclusion Criteria: Established or newly diagnosed eating disorder AND moderate or severe malnutrition<sup>1</sup> Exclusion Criteria: Active gastrointestinal pathology causing malnutrition

Chem 10, AST/ALT, GGT, alkaline phosphatase, ferritin, % iron saturation, T4 & T5H, albumin, pre-albumin, triglycerides, CBC w/differential, ESR, IgA, TTG IgA, UA, urine for hCG, 12-lead EKG (if tests were recently completed, use provider discretion whether or not to repeat)

. . .

### **Inclusion Criteria:**

- Established or newly diagnosed eating disorder AND moderate or severe malnutrition
- Malnutrition severity is clearly defined

/	- <u>Ma</u>	alnutrition Def	fined:	<sup>3</sup> Example script for ED when
/		Moderate	Severe	"Your child is being admitted for medical stabilization for malnutrition due to disordered
	% mBMI	70-79%	<70%	eating. The treatment requires a structured approach, with slow and gradual re- introduction of nutrition in a safe way. There is an initial
	BMI z score	-2 to -2.9	-3 or greater	restriction of activity, which is advanced based on medical stability."
	Weight Loss	≥7.5% in 6 months	≥10% in 6 months	<sup>4</sup> Avoidant Restrictive Food Intake Disorder (ARFID) Definition:
	<ul> <li>Initiactable vormaling of hematemesis</li> <li>Failure of outpatient treatment</li> </ul>	If Anore • Pro • Pro • If Avoid	established GI patient t to print Nursing/PCA Job Aid (Appendix B) and Nursinj tocol Worksheet (Appendix I) exia/Bulimia: ceed to page 2: Anorexia/Bulimia Inpatient Management ant Restrictive Food Intake Disorder (ARFID) <sup>1</sup> : ceed to page 3: ARFID Inpatient Management	as pain, vomiting, choking Avoidance based on sensory qualities



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#### Inclusion Criteria: Established or newly diagnosed eating disorder AND moderate or severe malnutrition<sup>1</sup> Exclusion Criteria: Active gastrointestinal pathology causing malnutrition

### PCP and/or ED Assessment

**History of:** weight loss, binging/purging, diet (intake), alcohol or substance use, medications, exercise, syncope, menstrual periods

Physical: height & weight with % median body mass index (% mBMI - see Appendix A), orthostatic BP and HR (BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min), hydration status, cardiac and peripheral exam, signs of intentional vomiting (dental erosion, knuckle abrasions)

### **Prior to admission:**

- Complete a thorough history and physical with all of the elements outlined.
- Appendix A is a guide to help calculate the patient's median BMI (mBMI)

<ul> <li>C 10 year of age or pre- mearchal Acute food retuisal &gt; 24hrs Rt ≤40 borm supine &amp; resting (consider if ≤43 who then partial health consult for partial hospitalization programs or outpatient tanding lectrohyde faturbances (e.g. hypokalemia, hypochloremia)</li> <li>D may always call pospital Medicine try obspital Medicine tratable worning or herwatemesis relative of outpatient</li> <li>C Consider if ≤43 who then partial hospital Mainton partial hospital Mainton programs or outpatient counseling, and notify PCP</li> <li>May always call Psychiatry or Hospital Medicine to discuss</li> <li>D return to alway the safe safe safe partial hospital Mainton programs or outpatient counseling, and notify PCP</li> <li>May always call Psychiatry or Hospital Medicine to discuss</li> <li>P alce patient on consult for all patients or concerns for Gl patholgy, or if patient set entermesis relation to consult Gi patholgy, or if patients or concerns for Gl patholgy, or if patients</li> <li>PCA to print Nursing/PCA Job Aid (Appendix B) and Nursing/PCA</li> </ul>	<ul> <li>FCP or ED provider reviews clinical pathway management with patient criteria</li> <li>PCP or ED provider reviews clinical pathway management with patient and family 3</li> <li>ED provider gives patient and family 3</li> <li>ED provider gives patient and family 3</li> <li>ED provider gives patient and family 4</li> <li>ED provider gives patient family the fatient family at time of admission (see Appendix B)</li> <li>Place patient in 1:1 observation per Appendix B</li> <li>Place patient on continuous CR monitoring</li> <li>Order strict (O's</li> <li>Place patient for all patients</li></ul>				/
		<75% mBMI OR <80% mBMI if < 10 year of age or pre- menarchal Acute food refusal > 24hrs HR ≤40 bpm supine & resting (consider if ≤45 with other criteria) Systolic BP <80 mmHg Orthostatic changes in SBP (>20 mmHg) Syncope or pre-syncope with standing Electrolyte disturbances (e.g. hypokalemia, hypomagnesemia, hypocholoremia) Dehydration Temperature <36°C Arrhythmia (prolonged QTc) Intractable vomiting or hematemesis Failure of outpatient treatment	meet inpatient criteria Consider behavior health consult for partial hospitalization programs or outpatient counseling, and notify PCP May always call Psychiatry or Hospital Medicine	<ul> <li>patient and family <sup>3</sup></li> <li>ED provider gives patient and family the Patient Handout that outlines expectations during the admission (see Appendix C)</li> <li>If patient ≥ 18 years, must call hospitalist to discuss admission</li> <li>Impatient Initial Management</li> <li>Patient handout to be given to and signed by the patient and family at time of admission (see Appendix C)</li> <li>Place patient on continuous CR monitoring</li> <li>Order strict 1/O's</li> <li>Place patient on continuous CR monitoring</li> <li>Order strict 1/O's</li> <li>Place appropriate consults. Calls for consults may need to be placed the following morning if late admission.</li> <li>Psychiatry consult for all patients</li> <li>Nutrition consult for all patients</li> <li>Concerns for Gi pathology, or if patient referred by Gi or is ar established Gi patient</li> <li>Protocol Worksheet (Appendix I)</li> <li>If Anorexia/Bulimia:</li> <li>Proceed to page 2: Anorexia/Bulimia Inpatient Management</li> <li>If Avoidant Restrictive Food Intake Disorder (ARFID)<sup>1</sup>:</li> </ul>	mainutrition due to disordered eating. The treatment requires a structured approach, with slow and gradual re- introduction of nutrition in a safe way. There is an initial restriction of activity, which is advanced based on medical stability."         *Avoidant Restrictive Food Intake Disorder (ARFID) Definition:         Disordered eating due to one of the following:         • Concern about unpleasant consequences of eating, such as pain, vomiting, choking Avoidance based on sensory qualities         • Seeming lack of interest in



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CLINICAL PATHWAY:
Eating Disorder
Appendix A: Guide to Calculating % Median Ideal Body Weight

#### Steps:

- 1. Find patient's BMI using the following link (need patient's height & weight): <u>Calculate Your BMI - Metric BMI Calculator (nih.gov)</u>
- Using a CDC growth/BMI chart (or one of the links below): BOYS:
   2 to 20 years: Boys, Body mass index-for-age percentiles (cdc.gov)
  - GIRLS: 2 to 20 years: Girls, Body mass index-for-age percentiles (cdc.gov)

Find the BMI at the 50<sup>th</sup> percentile\* for the patient's age.

3. % Median BMI (mBMI) = Patient's BMI ÷ BMI at 50<sup>th</sup> %\* for age

Example:

15 year old girl has a BMI of 14 (based on entering her height & weight in Step #1) BMI at 50<sup>th</sup> percentile for age = 20 (based on BMI chart in Step #2)

% mBMI = 14 ÷ 20 = 70%

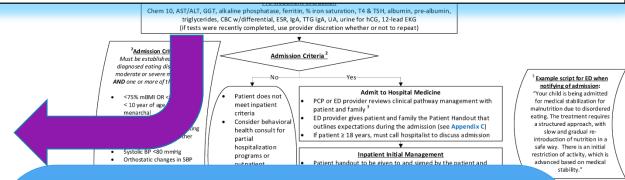
\* The dietitian and/or medical team may adjust the patient's % mBMI to a different BMI %ile (other than 50<sup>th</sup>%ile) based on the patient's previous growth history (e.g. if the patient has tracked at the 25<sup>th</sup> percentile prior to weight loss, use this for mBMI calculation).

### PCP and/or ED Assessment

**History of:** weight loss, binging/purging, diet (intake), alcohol or substance use, medications, exercise, syncope, menstrual periods

**Physical:** height & weight with % median body mass index (% mBMI - see **Appendix A**), orthostatic BP and HR

- (BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min), hydration status,
  - cardiac and peripheral exam, signs of intentional vomiting (dental erosion, knuckle abrasions)



### **Appendix A: Guide to Calculating Median BMI**

- It may not be possible to get a nutrition consult in the ED. If unable to get a consult, provider should:
  - Obtain growth charts from PCP
     OR
  - Use growth chart in EPIC to determine mostly at the 25<sup>th</sup>, 50<sup>th</sup>, or 75<sup>th</sup> percentile prior to weight loss.

ctive Food (ARFID)

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unpleasant of eating, such g, choking

l on sensory

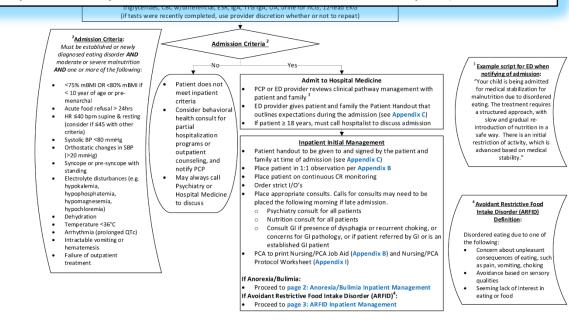
### Inclusion Criteria: Established or newly diagnosed eating disorder AND moderate or severe malnutrition

Pre-treatment evaluation

Chem 10, AST/ALT, GGT, alkaline phosphatase, ferritin, % iron saturation, T4 & TSH, albumin, pre-albumin, triglycerides, CBC w/differential, ESR, IgA, TTG IgA, UA, urine for hCG, 12-lead EKG (if tests were recently completed, use provider discretion whether or not to repeat)

### **Pre-treatment evaluation:**

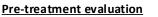
- Patients may come to the ED with some or all of this work-up done by their primary care physician. It is at the provider's discretion whether to repeat or not.
- Be sure to consider findings identified by the PCP
  - For example, a patient with bradycardia in the PCP's office may not be bradycardic in the ED due to anxiety





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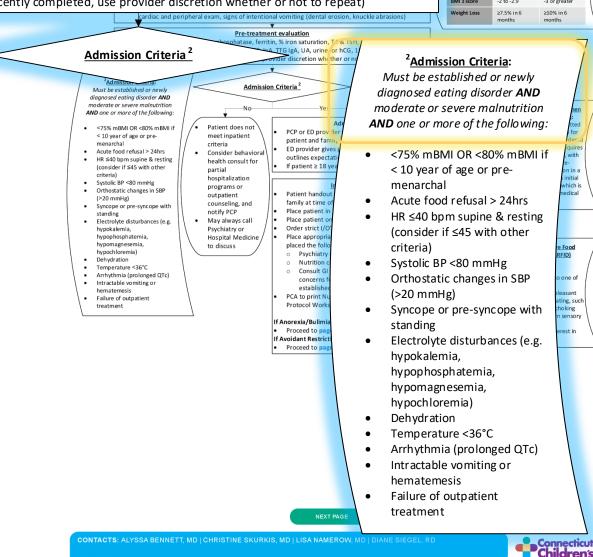
Chem 10, AST/ALT, GGT, alkaline phosphatase, ferritin, % iron saturation, T4 & TSH, albumin, pre-albumin, triglycerides, CBC w/differential, ESR, IgA, TTG IgA, UA, urine for hCG, 12-lead EKG (if tests were recently completed, use provider discretion whether or not to repeat)





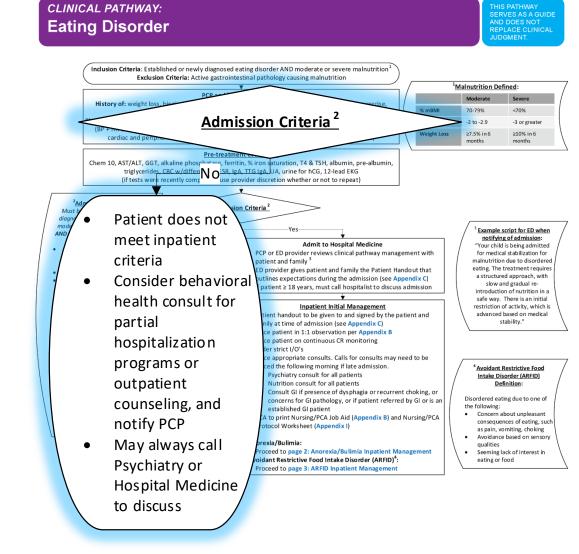
In addition to having a new or previous diagnosis of eating disorder **and** moderate or severe malnutrition, the patient must meet 1 or more criteria for admission.

Note: this was newly updated in 2023.



### Admission Criteria:

If the patient does **not** meet inpatient criteria, considering behavioral health support is critical.





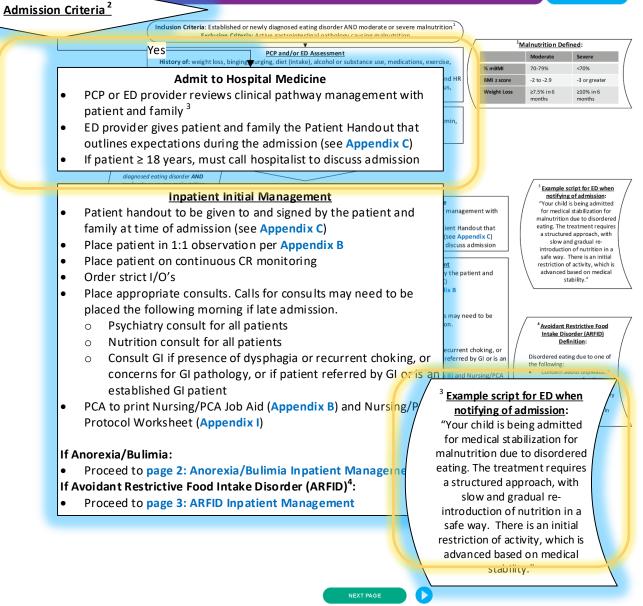
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### If patient admitted:

- Early communication and expectation setting is critical to success
- ED provider reviews clinical pathway management with patient and family
  - See example script
- ED provider gives patient and family the patient handout that outlines what to expect during the admission
  - See Appendix C
- If patient ≥18 years, ED must call hospitalist to discuss admission
- If any delays in obtaining inpatient bed, initiate pathway from the ED (patient should not miss meal, initiate 1:1 and privilege restrictions



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#### Visiting:

- Immediate family and clergy may visit at any time, except mealtime, unless otherwise ordered by the team.
- Visits with friends and extended family members will be considered once medical stability is achieved and in accordance with current hospital visitation guidelines.

### Activity:

1. All patients are admitted on bedrest.

- You will be placed on a cardiac monitor upon admission. This means stickers on your chest will measure your heart rate and breathing. The duration of cardiac monitoring depends on your medical condition.
- Vital signs (blood pressure, heart rate, breathing rate and temperature) will be taken at least every 4 hours, or more frequently, if your medical condition warrants.
- 4. Any transports for medical care off the unit must be via wheelchair or stretcher.
- 5. Activity level will be advanced as the medical status improves.
  - a. All patients are admitted on Activity 1 (bed rest) and activity is progressed as nutritional status stabilizes and will be identified by level 1, 2, and 3 with increasing ability to leave the room in a wheelchair and move about the room out of bed.
  - Medical stability requirements for each activity level can be described by the medical team in the sequence per protocol.
  - c. The patient and family will be updated daily regarding advancements in activity level.
  - d. If the family and/or patient need clarification of a privilege or activity level, they are encouraged to check with the medical team, nurse, or PCA.

#### Reinforcement

- All safe patients will be admitted to a standard room with access to usual comfort items and child life activities that are available to all patients
- 2. No personal mobile devices
- 3. A behavioral plan will be considered if it is needed to support nutritional stabilization
- All activities will be stored and/or turned off (e.g. television, video games, crafts) before meals and at bedtime.

Date Reviewed with Patient:

Patient Signature: \_\_\_\_\_\_\_ (signature indicates patient received a copy of this handout)

Dinner = 5:00pm - 5:30pm Snack = 8:30pm - 9:00pm





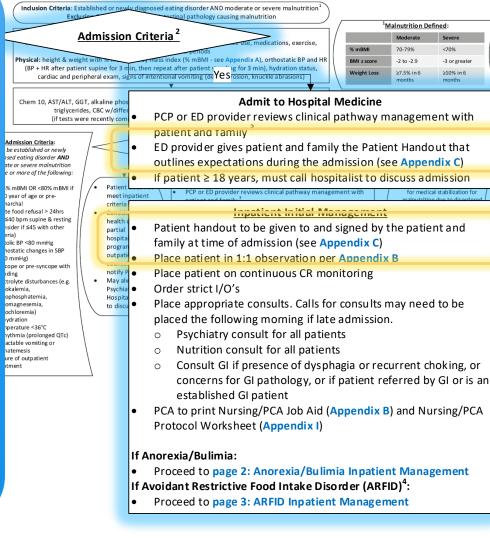
Appendix C: The Patient Handout

- This is a 3 page document given to the patient and family in the ED
- It must be signed by patient and family on admission
- Explains and reinforces reasons for admission, treatment goals, and patient expectations



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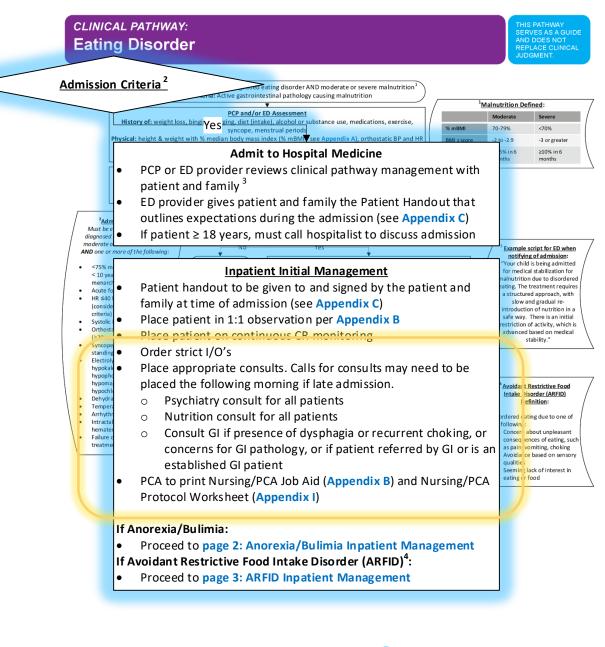
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### **Basic patient care:**

- Multidisciplinary approach involving patient and family, PCAs, RNs, Hospitalists, Psychiatry, Nutritionists, and other specialties as needed
- PCA job aid and the Nursing/PCA protocol worksheet are designed to help assist with workflow and pathway guidelines.
  - See Appendix B and I for these documents

NEXT PAGE

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#### 1:1 observation specifics:

- Recommend patient use bathroom before meals
- Make bed in preparation for meal. If patient is on activity level 1 and eating meals in bed, patient must lay/sit on blankets
- For activity level 2 and higher, patient must eat sitting in a chair without blankets
- Sitter remains in the room at the bedside during meals and for the observed time after completion of the nutrition. The 1:1 observing for an extended time beyond meals may then move to the doorway, unless an order is placed stating otherwise.
- The computer should remain outside of the room when the sitter is at the bedside
- Monitor for and document on Appendix I (Observation Worksheet) attempts at hiding or vomiting food
- Monitor for and document on Appendix I (Observation Worksheet) eating behaviors such as cutting food into tiny pieces, moving food around on the plate, excessive chewing, gagging, etc.
- Provide meal support by utilizing strategies such as supportive comments and distractions (refer to Appendix G: Meal Support Strategies)
- We ask that families and staff do not discuss meals, weight, or other eating-related topics, as these topics may raise anxiety.

#### Eating disorder secure room:

- Before admission:
  - Remove trash receptacles, bins, tissue boxes that could be used to hide food or purge into
  - o Remove excessive linens/blankets
  - Consider covering mirror in room
- Bedside curtains must be kept open, except when dressing
- Lights remain on during the day except brief naps
- Bathroom use is supervised by staff with door cracked open when on 1:1 observation
- · Staff will measure all urinary output and stool
- Any earned privileges materials will be stored at night after bedtime

#### Activity Status:

Patient will be admitted to Activity Level 1. Activity level is advanced based on increasing medical stability. Providers use the eating disorder order set to change activity level.

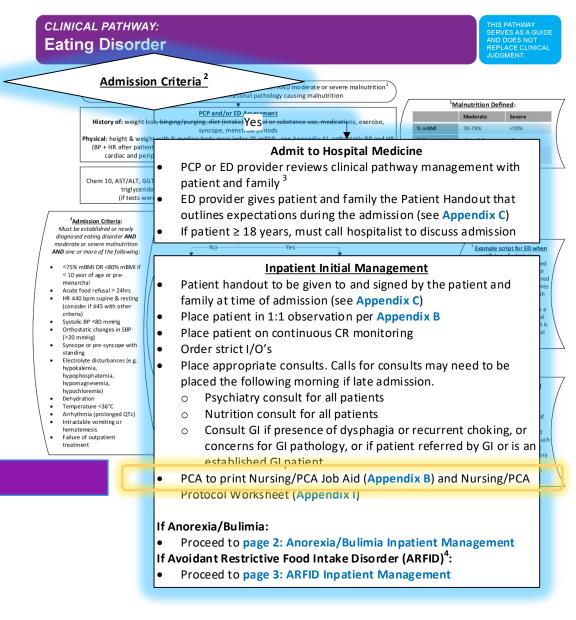
Level 1:

- Strict bed rest due to vital sign instability
- Out of Bed for bathroom use only

Level 2: Advance to this level once BP and orthostatic symptoms stabilize (may still be orthostatic by HR)

- Out of bed in room for meals
- Out of bed in wheelchair for scheduled floor activities as determined by medical team
- Shower based on medical and psychiatric team clearance
- Level 3: Advance to this level once oral intake promotes weight gain
  - First, ad lib activity in room
  - Then, advance to 1 to 3 five minute walks per day (advancement based on medical stability)







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tient Name:				Date:	Unit	
Date	Day	Meal Step Plan	100% Compliance	Activity Level (Assigned)	Distraction techniques that work for the patient	Comments Eating behaviors/exercise/oth
	Admit		Yes / No			
	1		Yes / No			
	2		Yes / No			
	3		Yes / No			
	4		Yes / No			
	5		Yes / No			
	6		Yes / No			
	7		Yes / No			
	8		Yes / No			

Connecticut Children's Admission Criteria<sup>2</sup> Yes Admit to Hospital Medicine PCP or ED provider reviews clinical pathway management with • patient and family<sup>3</sup> ED provider gives patient and family the Patient Handout that • outlines expectations during the admission (see Appendix C) If patient  $\geq$  18 years, must call hospitalist to discuss admission Inpatient Initial Management Patient handout to be given to and signed by the patient and • family at time of admission (see Appendix C) Place patient in 1:1 observation per Appendix B • Place patient on continuous CR monitoring • Order strict I/O's • •

- Place appropriate consults. Calls for consults may need to be placed the following morning if late admission.
- Psychiatry consult for all patients
- Nutrition consult for all patients
- Consult GI if presence of dysphagia or recurrent choking, or concerns for GI pathology, or if patient referred by GI or is an established GI patient
- PCA to print Nursing/PCA Job Aid (Appendix B) and Nursing/PCA Protocol Worksheet (Appendix I)

### If Anorexia/Bulimia:

- Proceed to page 2: Anorexia/Bulimia Inpatient Management If Avoidant Restrictive Food Intake Disorder (ARFID)<sup>4</sup>:
- Proceed to page 3: ARFID Inpatient Management

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RETURN TO THE BEGINNING 

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/		LABS & DIAGNOSTICS	NUTRITION & FLUIDS		MEDICATIONS	~	ACTIVITY & 1:1	<	Reinforcement and
1	Q4HR						OBSERVATION STATUS		Meal Support
	$\searrow$								$\searrow$
	Ť	Ť	Ť		Ť		Ť		Ť
	Orthostatics:	Day 1:	Nutrition:		Anorexia:		Activity		Reinforcement:
	Instructions for	<ul> <li>Consider</li> </ul>	See Appendix D for Anorexia and	•	Complete multivitamin 1	1	Advancement based on increasing	•	All safe patients will be
	obtaining	echocardiogram for	Bulimia diet plans		tablet daily		medical stability.		admitted to a standard
	orthostatics: BP + HR	any patient with a		•	Thiamine 100 mg/day x7 days				room with access to
	after patient supine	positive cardiac ROS or	<ul> <li>Initiate meal plan</li> </ul>		total	Lev	el 1 (start at admission):		usual comfort items
	for 3 min, then	at provider discretion	immediately after admission	•	Consider Turns for low	•	Strict bed rest due to VS instability		and child life activities
	repeat after patient	based upon severity of	lab results reviewed		calcium levels	•	OOB for bathroom use only		that are available to all
	standing for 3 min	malnutrition (in echo	<ul> <li>RD will ask patient for 3 food</li> </ul>	•	Consider oral phosphorus if				admitted patients
	Obtain 1 <sup>st</sup> set on	order, select "Eating	dislikes		serum phos < 3 mg/dL [Phos-	Lev	el 2: (usually by 24 hours)	•	No personal mobile
	admission	Disorder patients")	<ul> <li>Advance diet based on PO</li> </ul>		NaK contains 250mg Phos,	•	Advance to this level once BP and		devices
	If orthostatic for BP		compliance (includes water		160mg (7mEq) Na, 280mg		orthostatic symptoms stabilize	•	If an additional
	or HR, take daily	If not previously obtained in	intake) and medical necessity		(7.2mEq) K]		(may still be orthostatic by HR)		reinforcement plan is
	until normalized	the ED:	until weight gain is achieved	•	Consider IV phos supplement	•	OOB in room for meals		needed to support
	(positive if SBP drops	• UA	with advancement of activity		if phosphate level ≤ 2mg/dL	•	OOB in wheel chair for limited		compliance with
	by ≥ 20 mmHg or	<ul> <li>Urine hCG (female pts)</li> </ul>	<ul> <li>Place next day's diet order</li> </ul>				scheduled activities as		nutrition, then
	DBP by $\geq$ 10 mmHg,		after evening snack by		Bulimia:		determined by medical team		additional reinforcers
	HR increase by $\geq$ 20)	Days 2-5:	modifying existing diet order	•	Consider IV phos supplement	•	Shower based on medical & psych		will be used from Child
		<ul> <li>i-STAT Chem 10 daily</li> </ul>	<ul> <li>Start with 24oz of free water</li> </ul>		if phosphate level ≤ 2mg/dL		clearance		Life services, including
	Weight:	for 5 days, then PRN	and then adjust per RD	•	Consider sodium bicarbonate		1.0		but not limited to:
	Weigh patient QAM	based on risk of	recommendations     See Annendix E for Ensure		or oral Bicitra if bicarbonate	lev	<u>el 3:</u>		o iPad
	after 1 <sup>st</sup> void and	refeeding syndrome	- beeringsenannt for enbare		levels are low	•	Advance to this level once oral		o Kindle
	before breakfast		replacement guideline	•	Consider potassium		intake promotes weight gain or		<ul> <li>Nintendo Switch</li> <li>Xbox One</li> </ul>
	Weight to be done	* If patient is admitted in	<ul> <li>Place nasogastric tube (NGT) after snacks if not 100%</li> </ul>		supplement if low serum K		weight stability		<ul> <li>Xbox One</li> </ul>
	in hospital gown	the evenina/niaht and	compliant with caloric goals		and normal pH (indicates		First, ad lib activity in the room Then, advance to 1-3 five-minute		Meal Support
	only (no socks, underwear etc.)	admission chem 10 is	(Appendix D regarding NGT		dangerous reduction of total	•	walks per day (may advance more		See Appendix B:
		normal, do not need to	feedings)		body K)		slowly or rapidly based upon	•	Nursing/PCA Job Aid
	Neither patient nor family are to be told	repeat chem 10 on the 1st	reeungs				medical stability)		and Appendix G: Meal
	the weight	morning	IV Fluids:				medical scability)		Support Strategies
	Obtain growth	morning	Consider NS bolus and/or				Observation:		See Appendix I for
	charts from PCP		continuous IVFs if severe				Based on daily review of progress.	1-	nursing/PCA protocol
	chards in Officer		dehydration or patient			1	or at any time exclusion criteria	1	worksheet
			refusing PO fluids (consider				are identified, care team can	1	
			smaller bolus if signs of heart				escalate to a higher observation		
			failure)				level. For example, if the patient is	1	
							not gaining weight despite		
							adequate nutrition (Appendix B)		
			· · · · · · · · · · · · · · · · · · ·						

AND DOES NOT

#### Discharge Criteria/Medications:

- Medically cleared with stable labs and vital signs
- Patient adherent to prescribed nutrition plan with weight gain, especially with ad lib activity
- Appropriate placement arranged in inpatient, PHP or outpatient program with psychiatry team input
- Medications at discharge: complete multivitamin; thiamine (if 7 days not complete)

Proceed to page 2 to place patient on the Anorexia/Bulimia arm of the pathway. Admit to Hospital Medicine

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- PCP or ED provider reviews clinical pathway management with patient and family <sup>3</sup>
- ED provider gives patient and family the Patient Handout that outlines expectations during the admission (see Appendix C)
- If patient  $\geq$  18 years, must call hospitalist to discuss admission

#### Inpatient Initial Management

- Patient handout to be given to and signed by the patient and family at time of admission (see Appendix C)
- Place patient in 1:1 observation per Appendix B
- Place patient on continuous CR monitoring

Yes

Order strict I/O's

Admission Criteria<sup>2</sup>

- Place appropriate consults. Calls for consults may need to be placed the following morning if late admission.
- Psychiatry consult for all patients
- Nutrition consult for all patients
- Consult GI if presence of dysphagia or recurrent choking, or concerns for GI pathology, or if patient referred by GI or is an established GI patient
- PCA to print Nursing/PCA Job Aid (Appendix B) and Nursing/PCA Protocol Worksheet (Appendix I)

### If Anorexia/Bulimia:

 Proceed to page 2: Anorexia/Bulimia Inpatient Management If Avoidant Restrictive Feed Intake Disorder (ARFID)<sup>4</sup>:

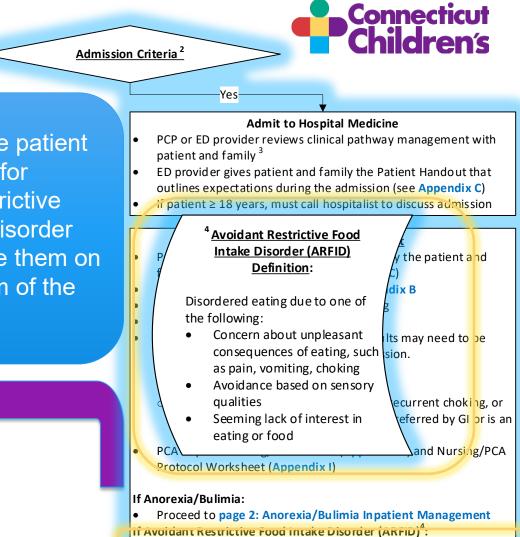
Proceed to page 3: ARFID Inpatient Management

RÉTURN TO THE BEGINNING



<	VITAL SIGNS Q4HR	LABS & DIAGNOSTICS		NUTRITION & FLUIDS	<	MEDICATIONS		ACTIVITY & 1:1 OBSERVATION STATUS	<	Reinforcement and Meal Support
	Orthostatics:	Day 1:		Nutrition:	•	Complete multivitamin 1		Activity		Reinforcement:
•	Instructions for	<ul> <li>Consider</li> </ul>		Appendix E for ARFID plans		tablet daily		Advancement based on increasing		See Appendix H ARFID
	obtaining orthostatics:	echocardiogram for			•	Thiamine 100 mg/day x7		medical stability.		Behavioral Plan
	BP + HR after patient	any patient with a	•	Initiate meal plan		days total				
	supine for 3 min, then	positive cardiac ROS or		immediately after admission lab results reviewed	•	Consider Tums for low calcium levels	Sto	If hypotension or symptomatic	•	Behavioral plan will be created with
	repeat after patient standing for 3 min	at provider discretion based upon severity of		RD will identify food likes,		Consider oral phosphorus	•	othostasis, start at Level 1:		multidisciplinary input,
	1 <sup>st</sup> set on admission	malnutrition (in echo		which will make up a large		if serum phos < 3 mg/dL		bedrest until stabilizes (may still		identifying:
	If orthostatic for BP or	order, select "Eating		portion of meals		[Phos-NaK contains		be orthostatic by HR)		<ul> <li>Patient</li> </ul>
	HR, take daily until	Disorder patients")		Advance diet based on PO		250mg Phos, 160mg		OOB in room for meals		motivators
	normalized (positive if			compliance (includes water		(7mEq) Na, 280mg		OOB in wheel chair for limited		<ul> <li>Reinforcers for</li> </ul>
	SBP drops by ≥ 20	If not previously obtained in		intake) and medical necessity		(7.2mEq) K]		scheduled activities as		small goals
	mmHg or DBP by ≥ 10	the ED:		until weight gain is achieved	•	Consider IV phos		determined by medical team		<ul> <li>Reinforcers for</li> </ul>
	mmHg, HR increase by	• UA		with advancement of activity		supplement if phosphate	•	Shower based on medical & psych		large goals
	≥ 20)	<ul> <li>Urine hCG (female pts)</li> </ul>	•	Place next day's diet order		level ≤ 2mg/dL		clearance		<ul> <li>Less desirable</li> </ul>
				after evening snack by						activities when
	Monitoring:	Days 2-5:		modifying existing diet order			Lei	<u>vel 3:</u>		goals are not met
•	Place on	i-STAT Chem 10 daily	•	Start with 24oz of free water			•	Advance to this level once oral		Mar of Community
	cardiorespiratory	for 5 days, then PRN based on risk of		and then adjust per RD recommendations				intake promotes weight gain or weight stability		Meal Support See Appendix B:
	monitor Discontinue	refeeding syndrome		See Appendix F for Ensure				First, ad lib activity in the room		Nursing/PCA Job Aid
•	continuous monitor at	rereeding syndrome		replacement guideline				Then, advance to 1-3 five-minute		and Appendix G: Meal
	Level 3 activity			The decision to begin			1	walks per day (may advance more		Support Strategies
	Level 5 activity	* If patient is admitted in	-	nasogastric tube (NGT)				slowly or rapidly based upon		See Appendix I for
	Weight:	the evening/night and		feedings is based on medical				medical stability)		nursing/PCA protocol
•	Weigh patient QAM	admission chem 10 is	1	necessity as determined by					1	worksheet
	after 1 <sup>st</sup> void and	normal, do not need to		the multi-disciplinary team				Observation:		
	before breakfast	repeat chem 10 on the 1 <sup>st</sup>		(Appendix E regarding NGT			•	Based on daily review of progress,		
•	Weight to be done in	morning	1	feedings)				or at any time exclusion criteria	1	
	hospital gown only (no							are identified, care team can		
	socks, underwear etc.)			IV Fluids:				escalate to a higher observation		
•	Neither patient nor		•	Consider NS bolus and/or				level. For example, if the patient is	1	
	family are to be told		1	continuous IVFs if severe				not gaining weight despite	1	
	the weight			dehydration or patient refusing PO fluids (consider				adequate nutrition (Appendix B)		
•	Obtain growth charts from PCP			smaller bolus if signs of heart						
	nometer			failure)						
			<u> </u>						<u> </u>	

However, if the patient meets criteria for Avoidant Restrictive Food Intake Disorder (ARFID), place them on the ARFID arm of the pathway.



Proceed to page 3: ARFID Inpatient Management

Discharge Criteria/Medications:

- Medically cleared with stable labs and vital signs
- Patient adherent to prescribed nutrition plan with weight gain, especially with ad lib activity
   Appropriate placement arranged in inpatient. PHP or outpatient program with psychiatry team input
- Medications at discharge: complete multivitamin: thiamine (if 7 days not complete)
- · Medications at discharge, complete manifentini, channine (in 7 days not complete)

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AND DOES NOT

CLINICAL PATHWAY: Eating Disorder Anorexia/Bulimia Inpatient Management

Connecticut Children's

	$\land$					
<		LABS & DIAGNOSTICS	NUTRITION & FLUIDS		OBSERVATION STATUS	Meal Support
					OBSERVATION STATUS	inear suppor
	$\searrow$					$\sim$
	Ť	Ť	Ţ	Ť	Ť	Ť
	Orthostatics:	Day 1:	Nutrition:	Anorexia:	Activity	Reinforcemer
•	Instructions for	Consider	See Appendix D for Anorexia and	Complete multivitamin 1	Advancement based on increasing	<ul> <li>All safe patient</li> </ul>
	obtaining	echocardiogram for	Bulimia diet plans	tablet daily	medical stability.	admitted to a s
	orthostatics: BP + HR	any patient with a		<ul> <li>Thiamine 100 mg/day x7 days</li> </ul>		room with acce
	after patient supine	positive cardiac ROS or	<ul> <li>Initiate meal plan</li> </ul>	total	Level 1 (start at admission):	usual comfort i
	for 3 min, then	at provider discretion	immediately after admission	<ul> <li>Consider Tums for low</li> </ul>	<ul> <li>Strict bed rest due to VS instability</li> </ul>	and child life ad
	repeat after patient	based upon severity of	lab results reviewed	calcium levels	OOB for bathroom use only	that are availab
	standing for 3 min	malnutrition (in echo	<ul> <li>RD will ask patient for 3 food</li> </ul>	<ul> <li>Consider oral phosphorus if</li> </ul>		admitted patier
•	Obtain 1 <sup>st</sup> set on	order, select "Eating	dislikes	serum phos < 3 mg/dL [Phos-	Level 2: (usually by 24 hours)	No personal mo
	admission	Disorder patients")	<ul> <li>Advance diet based on PO</li> </ul>	NaK contains 250mg Phos,	Advance to this level once BP and	devices
•	If orthostatic for BP		compliance (includes water	160mg (7mEq) Na, 280mg	or thostatic symptoms stabilize	If an additional
	or HR, take daily	If not previously obtained in	intake) and medical necessity	(7.2mEq) K]	(may still be orthostatic by HR)	reinforcement p
	until normalized	the ED:	until weight gain is achieved	<ul> <li>Consider IV phos supplement</li> </ul>	<ul> <li>OOB in room for meals</li> </ul>	needed to supp
	(positive if SBP drops	• UA	with advancement of activity	if phosphate level ≤ 2mg/dL	<ul> <li>OOB in wheel chair for limited</li> </ul>	compliance wit
	by ≥ 20 mmHg or	<ul> <li>Urine hCG (female pts)</li> </ul>	<ul> <li>Place next day's diet order</li> </ul>		scheduled activities as	nutrition, then
	DBP by ≥ 10 mmHg,		after evening snack by	Bulimia:	determined by medical team	additional reinf
	HR increase by $\geq 20$ )	Days 2-5:	modifying existing diet order	<ul> <li>Consider IV phos supplement</li> </ul>	<ul> <li>Shower based on medical &amp; psych</li> </ul>	will be used fro
		<ul> <li>i-STAT Chem 10 daily</li> </ul>	<ul> <li>Start with 24oz of free water</li> </ul>	if phosphate level ≤ 2mg/dL	clearance	Life services, in
	Weight:	for 5 days, then PRN	and then adjust per RD	<ul> <li>Consider sodium bicarbonate</li> </ul>		but not limited
•	Weigh patient QAM	based on risk of	recommendations	or oral Bicitra if bicarbonate	Level 3:	o iPad
	after 1 <sup>st</sup> void and	refeeding syndrome	<ul> <li>See Appendix F for Ensure</li> </ul>	levels are low	<ul> <li>Advance to this level once oral</li> </ul>	<ul> <li>Kindle</li> </ul>
	before breakfast		replacement guideline	<ul> <li>Consider potassium</li> </ul>	intake promotes weight gain or	<ul> <li>Nintendo S</li> </ul>
•	Weight to be done		<ul> <li>Place nasogastric tube (NGT)</li> </ul>	supplement if low serum K	weight stability	<ul> <li>Xbox One</li> </ul>
	in hospital gown	* If patient is admitted in	after snacks if not 100%	and normal pH (indicates	<ul> <li>First, ad lib activity in the room</li> </ul>	
	only (no socks,	the evening/night and	compliant with caloric goals	dangerous reduction of total	<ul> <li>Then, advance to 1-3 five-minute</li> </ul>	Meal Suppor
	underwear etc.)	admission chem 10 is	(Appendix D regarding NGT	body K)	walks per day (may advance more	
•	Neither patient nor	normal, do not need to	feedings)		slowly or rapidly based upon	Nursing/PCA Jo
	family are to be told	repeat chem 10 on the 1 <sup>st</sup>	number 1		medical stability)	and Appendix G
	the weight	morning	IV Fluids: Consider NS holus and/or			Support Strateg
•	Obtain growth		<ul> <li>consider no boltas alta/or</li> </ul>		Observation:	See Appendix I
	charts from PCP		continuous IVFs if severe		<ul> <li>Based on daily review of progress,</li> </ul>	nursing/PCA pr
		1	dehydration or patient		or at any time exclusion criteria	worksheet
		1	refusing PO fluids (consider smaller bolus if signs of heart		are identified, care team can	
		1	smaller bolus if signs of heart failure)		escalate to a higher observation	
			ranure)		level. For example, if the patient is	
					not gaining weight despite adequate nutrition (Appendix B)	
			1	1	adequate nutrition (Appendix B)	11

Discharge Criteria/Medications:

- Medically cleared with stable labs and vital signs
- Patient adherent to prescribed nutrition plan with weight gain, especially with ad lib activity
- Appropriate placement arranged in inpatient, PHP or outpatient program with psychiatry team input
   Medications at discharge: complete multivitamin; thiamine (if 7 days not complete)



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We will start with reviewing the Anorexia and Bulimia arm of the pathway.

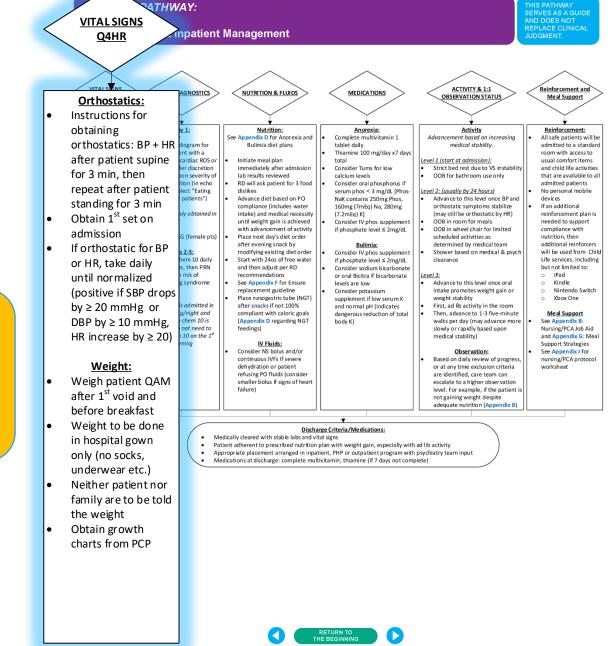
### **Orthostatics**

 Instructions for how to obtain orthostatics are given

### **Daily weights:**

- Done in the morning and in hospital gown only
- Patient and family are NOT told the exact weight/BMI or the amount gained/lost
  - They can be told if the weight is up, down, or the same.

It is critical that weight, BMI, and calories of the diet are **not** shared with the patient and family.

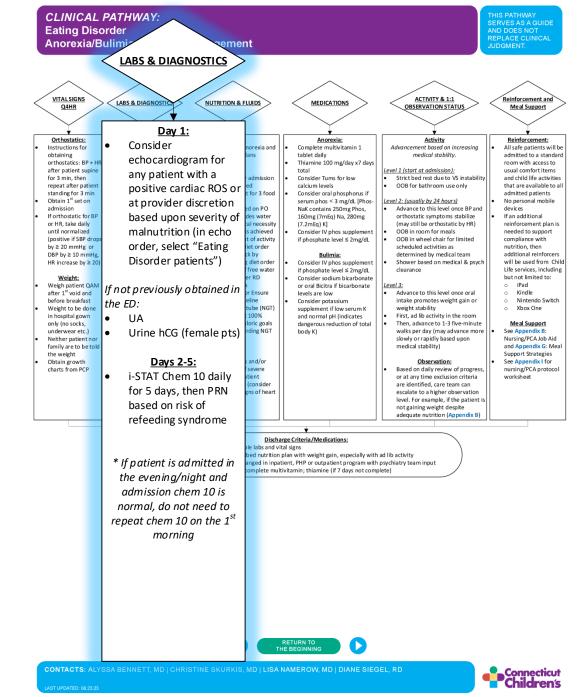


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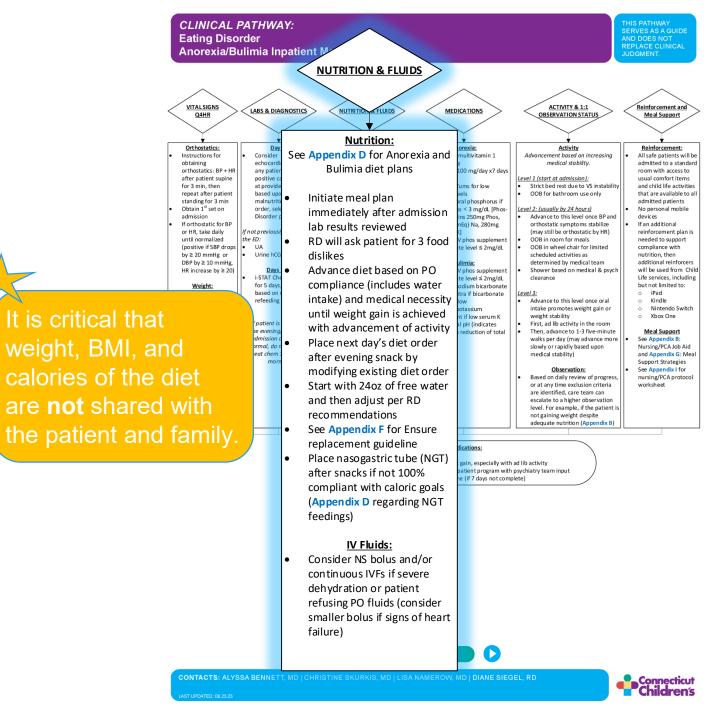
### Labs and Diagnostics:

- Consider (not automatic) echocardiogram on any patient with a positive cardiac ROS or at provider discretion based upon severity of malnutrition
- Consider daily urinalysis if concerns of dehydration or water loading
- Daily chemistry panels to monitor for refeeding syndrome
  - Daily for at least 5 days then PRN



### **Nutrition and Fluids:**

- Diet advancement usually occurs daily but should consider PO compliance and medical necessity
- If patient is medically stable and requires NG for large portion of nutrition, consider not advancing
- The next day's diet order is placed after evening snack and review of daily intake (modify diet order)
- Water is included in daily meal compliance
- IV fluids are rarely needed and be aware that dextrose can contribute to refeeding syndrome



The goal of the meal plan for the first 4 days is to prevent further weight loss and to encourage the patient to eat by mouth. The patient may not gain weight initially.

Do not share calorie levels with patient.

- The meal plan consists of 3 meals and 3 snacks
- The Registered Dietician (RD) will choose the meal plan to meet the patient's nutritional needs
- Minimum of 24oz of water per 24-hour period
- No additional coffee, tea, diet soda, or juice ٠
- If initial diet order is placed after 1800, each meal that first night will be 230 ml of Ensure + 1 packet of saltine crackers or food chosen by the parent or guardian. These can be initiated and provided in the ED or upon arrival to the floor. PCA will document everything consumed the EPIC flowsheet.
- The patient will be allowed to choose 3 food dislikes, and will be told that the dislikes will be started on the following day
- Step One: (1500 total calories per day) Begins the first meal after admission through a minimum of 1 calendar day Advance to next step based on severity of malnutrition and/or 100% PO completion
- Step Two: (1800 total calories per day) Advance to next step based on severity of malnutrition and/or 100% PO completion
- Step Three: (2100 total calories per day) Advance to next step based on severity of malnutrition and/or 100% PO completion
- Step Four: (2400 total calories per day) Advance to next step based on severity of malnutrition and/or 100% PO completion
- Increase intake by 20% or 200-300 kcal/day to initial goal set by Clinical Nutrition. Step numbers continue to advance until reach adequate intake, as determined by weight stability or weight gain with advancing activity based on patient need

If a patient does not finish an entire meal (breakfast, lunch, dinner), he/she will have the opportunity to take in the missed calories at the next snack by drinking a liquid nutrition supplement (Refer to

Appendix F; consult with Diet Tech if needed). An NGT will be placed at the end of each snack time if the patient does not consume the goal calories for that snack and the prior meal. The remainder of the calories will be provided via the NGT. The NGT will then be removed when the feeding is completed. The patient will then be given a "fresh start" to be able to achieve 100% compliance with the next meal.

The decision to place an NGT in a patient < 11 years old will be determined by the multi-disciplinary team.

If a patient has needed an NGT more than twice, in consultation with psychiatry, consideration should be made to keep the NGT in place, particularly if there has been no progress in PO feeds after the NGT is pulled.



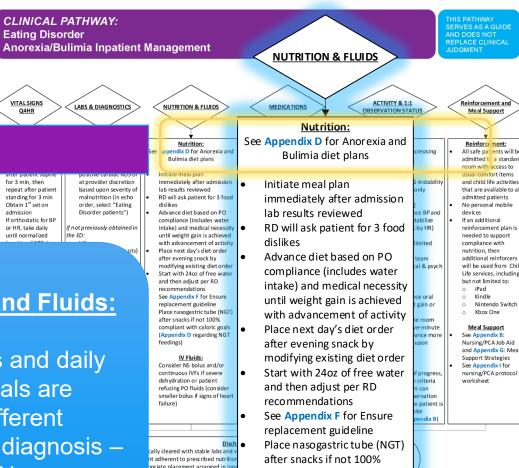
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ND DOES NOT REPLACE CLINICA



**ARFID** 



compliant with caloric goals (Appendix D regarding NGT feedings)

### IV Fluids:

Consider NS bolus and/or continuous IVFs if severe dehydration or patient refusing PO fluids (consider smaller bolus if signs of heart failure)

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CLINICAL PATHWAY:

LABS & DIAGNOSTICS

at provider discretion

based upon severity of

malnutrition (in echo

order, select "Eating

Disorder patients")

f not previously obtained in

the ED

dislikes

feedings)

failure)

ations at discharge: complete m

Eating Disorder

VITALSIGNS

Q4HR

for 3 min. then

repeat after patient

standing for 3 min

If orthostatic for BI

or HR, take daily

until normalized

Obtain 1<sup>st</sup> set on

admission

**Nutrition and Fluids:** 

Diet plans and daily

based on diagnosis -

Bulimia Nervosa, and

Anorexia Nervosa,

calorie goals are

slightly different



THIS PATHWAY SERVES AS A GUID AND DOES NOT REPLACE CLINICA

• Refer to CBORD meal ticket for total and individual food calories for each meal and snack

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- · For all food and beverage not consumed, calculate number of calories remaining on tray
- Give patient 1 ml Ensure (30 kcal/oz) per calorie remaining on tray
- Please save all meal and snack tickets in patient's thin chart

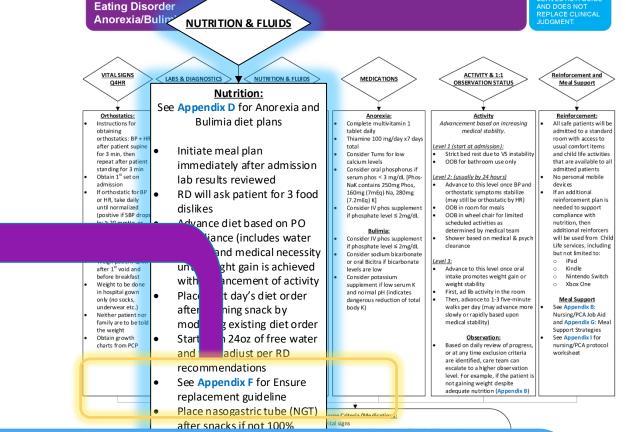
#### Example:

Patient ate all her chicken noodle soup, turkey, and carrots, but she only eats ½ her portion of strawberries and does not eat her bread or mayonnaise. How much Ensure will she need to replace the food she did not eat?

- Step 1: Use the ticket to calculate number of calories patient did not eat.
  - ½ strawberries = 12 kcal
  - Bread = 67 kcal
  - Mayonnaise = 70 kcal
- Total = 12 + 67 + 70 = 149 kcal
- Step 2: Convert to ml Ensure (1 kcal = 1 ml Ensure)
  - Patient needs to drink 149 ml Ensure

Connecticut Children's	
Lunch Delivery For. Thursday	
Requested Delivery Time	
Hot Food Prep:	
1 Chicken Noodle Soup 6oz (CHOgrams 9GRAM) IKCAL 91KCAL)	
1 Deli Turkey, Nature's Promise 1 ( IGHOprams 1GRAM) [KCAL 25KCAL)	oz
1 Carrots 1/2 cup (CHOgrams 7GRAM) (KCAL 28KCAL)	
1 Carrots 1/2 cup ICHOgrams 7GRAMI (KCAL 28KCAL)	
Cold Food Prep	
1 Sliced Fresh Strawberry Cup 1/2 (CHOgrams SGRAM) (KCAL 24KCAL)	2 c
Expeditor:	
1 Whole Wheat Bread ea (CHOgrams 12GRAM) (KCAL 67KCAL)	
1 Mayonnaise Hellman's Regular IKCAL 70KCAL)	ea
	ea
1 Mayonnaise Heliman's Regular IKCAL 70KCAL Service Instructions:	ea
	ea
	ea
	ea
	ea
Service Instructions:	
Service Instructions: EatingDisorderStep1	
Service Instructions: EatingDisorderStep1 Text Test1	
Service Instructions: EatingDisorderStep1	
Service Instructions: EatingDisorderStep1 Text Test1	
Service Instructions: EatingDisorderStep1 Treat Test1	
Service Instructions: EatingDisorderStep1 Totel Test1 Diet: Eating Disorder Step 1	
Service Instructions: EatingDisorderStep1 Text Test1	
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Service Instructions: EatingDisorderStep1 Out12 Teet Test1 Diet: Eating Disorder Step 1 Allergy: CHOgrams 41(GRAM)	
Service Instructions: EatingDisorderStep1 Totel Test1 Diet: Eating Disorder Step 1	
Service Instructions: EatingDisorderStep1 Out12 Test Test1 Diet: Eating Disorder Step 1 Allergy:	000

3 Entered by \_\_\_\_\_\_



Meal Replacement:

- If patient does not finish an entire meal, missed calories should be offered at the next snack in the form of liquid nutrition supplement (offer up to 3 times per day)
  - See appendix F for how to calculate the amount of Ensure replacement based on food not eaten

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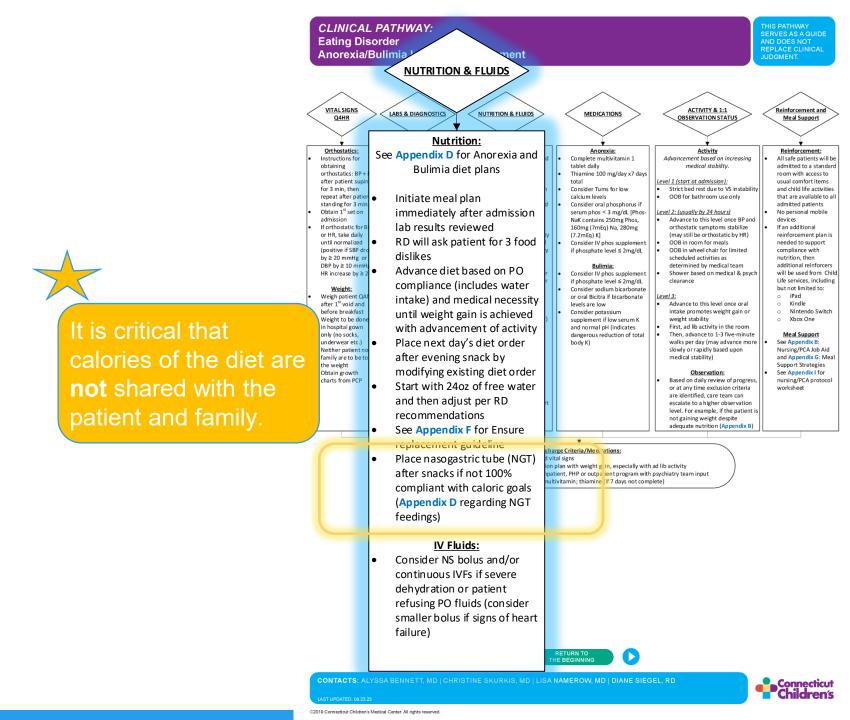
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CLINICAL PATHWAY

### Nasogastric Tube (NGT) Placement:

- If medically necessary, place NGT after snacks if not 100% compliant with caloric goals for the previous meal (assess 3 times per day)
- For patients <11 years, the decision to place an NGT should include discussion with the multidisciplinary team
  - Refer to appendix D

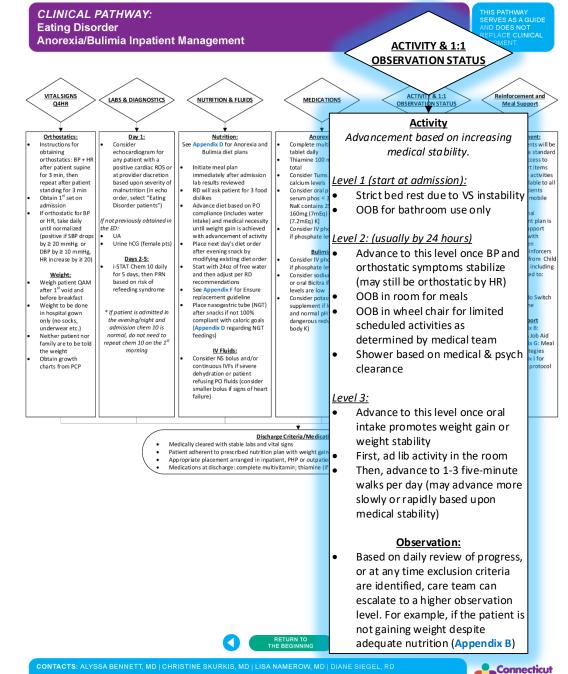


	CLINICAL PATHWAY: Eating Disorder Anorexia/Bulimia Inpatient Management	MEDICATIONS	THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.
s: exia : amin o results and deficiencies.	<section-header><section-header><section-header><section-header><section-header><section-header><section-header><section-header><section-header><section-header><section-header><section-header><section-header><section-header><section-header><section-header><section-header><section-header><section-header><section-header><section-header><section-header><section-header><section-header><section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header></section-header>	MEDICATION       Activity & 1:1         Depression       Anorexia         Complete multivitamin 1       tablet daily         Thiamine 100 mg/day x7 data'       Anorexia         Consider Tums for low calcium levels       Consider oral phosphorus ifserum phos < 3 mg/dL [Phos, NaK contains 250mg Phos, 160mg (7mEq) Na, 280mg (7.2mEq) K]       Worder of all the stabilize and the stabilize anotand the stabilize and the stabilize and the	admitted to a standard room with access to usual comfort items and child life activities that are available to all admitted patients • No personal mobile devices • If an additional reinforcement plan is needed to support compliance with nutrition, then additional reinforcers will be used from Child Life services, including but not limited to: • iPad • Kindle • Nintendo Switch • See Appendix 8: Nursing/PCA Job Aid and Appendix 6: Meal Support Strategies • See Appenda II for nursing/PCA protocol worksheet

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### **Medications:**

- All patients with Anorexia Nervosa/Bulimia need:
  - Complete multivitamin
  - Thiamine
- May vary based on lab results and underlying nutritional deficiencies.



### **Activity Status:**

- Initially all patients are on bedrest with continuous monitoring
- Activity level is advanced in a stepwise fashion
- Advancement is made based on medical stability
  - Of note, may advance once BP and orthostatics stabilize (still might be orthostatic by HR which can take much longer to resolve)



#### Strategies and Games that can help during meals

Get the patient's and family's input

- What strategies have worked in the past?
- Would you like to talk about something while you're eating?
- Would you like to listen to me while eating?
- Get to know the patient's interests

Distraction - Engage in conversation about topics unrelated to food

- <u>Categories</u> pick a topic (animals, items found at the mall, places...) take turns coming
  out with items in chosen category beginning with the letters of the alphabet in order
- <u>Going to the beach, on a picnic, or going shopping</u> Starting in alphabetical order take turns saying something that you would find or take with you. (A- ant, B-ball...)
- <u>20 questions</u> one person thinks of something (person, place, or object) the other person has to correctly identify and name it by asking "yes" or "no" questions. Then switch rolls (thinker becomes the question asker)
- Mad libs

#### For Young Children with ARFID

#### Be a food scientist

- What do you see? (shape, color, size)
- What does it feel like? (hard, soft, bumpy, smooth, fuzzy, wet, slippery, dry)
- What does it smell like? (sweet, sour, spicy, mild, strong)
- What does it taste like? (sweet, salty, tart, fruity, spicy)
- What does it sound like? (loud, quiet, crunchy, no sound)

Hokey Pokey: (you put the broccoli in, you take the broccoli out, you put the broccoli in and you move it all about)

Eat around the plate – use at least 3 foods (1. something always eaten, 2. something occasional eaten 3. something USED TO eat or something never eaten)

- · First, use all preferred foods to teach protocol and reduce anxiety
- Use a divided plate or small bowls have child place 2-3 preferred foods into each section
- Teach rules of even rotation (1 bite from each section of plate/bowl) Alternate difficult foods and easy foods - begin with reinforcing each bite of new food, progress to reinforcing following full sequence completion
  - Difficult food may first be an occasionally eaten food or a food with a slight change to taste, texture or brand
  - o Gradually progress to a never eaten food
  - If unable to actually eat food, reward any attempts to move up food hierarchy (touch, kiss, lick bite)
- \*\*\* You can play a game while following the above "eat around the plate" progression such as candy land, chutes and ladders, trouble, UNO \*\*\*
  - Assign a food to each color OR assign a food to each number
  - Take turns playing the game, taking bites of the assigned foods



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CLINICAL PATHWAY: Eating Disorder Anorexia/Bulimia Inpatient Management

### **Reinforcement and Meal Support:**

- Usual comfort items from home and standard child life activities are universally allowed.
- Personal mobile devices (such as cell phones) are never allowed.
   Laptops for school work may be allowed on a case-by-case basis.
- Meal Support strategies as outlined in Appendices B and G may be helpful to encourage nutritional compliance.
- Some children may benefit from additional tangible reinforcement items offered by Child Life.

>	<	ACTIVITY & 1:1 OBSERVATION STATUS	
		Reinfor cement:	
_	_	All safe patients will be	
		admitted to a standard	<u>t:</u> s will t
days		room with access to	ss to
	•	usual comfort items	ems tivitie
if	•	and child life activities	le to a its
nos-	<u>Lev</u>		bile
		that are available to all	olan is
ent dL	:	admitted patients	ort
ur		<ul> <li>No personal mobile</li> </ul>	orcor
ent	•	devices	m Chi cludin
dL ate		<ul> <li>If an additional</li> </ul>	to:
te	•	reinforcement plan is	
ĸ		needed to support	witch
tal	•	compliance with	t
		nutrition, then	: b Aid
		additional reinforcers	i: Mea ies
		will be used from Child	for ptoco
		Life services, including	
		but not limited to:	
		o iPad	
		o Kindle	
_		<ul> <li>Nintendo Switch</li> </ul>	
with	n ad lib	<ul> <li>Xbox One</li> </ul>	
	n psych plete)		
		Meal Support	

Reinforcement and Meal Support

See Appendix B: Nursing/PCA Job Aid and Appendix G: Meal Support Strategies See Appendix I for nursing/PCA protocol

worksheet

MEDICATIONS

orexia: multivitamin 1

100 mg/day x7 d

oral phosphorus

< 3 mg/dL [P]

ns 250mg Phos

nEq) Na, 280mg

/phossupplem televel≤2mg/

te level ≤ 2mg/

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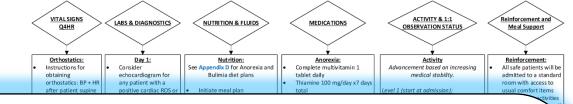


*CLINICAL PATHWAY:* Eating Disorder Anorexia/Bulimia Inpatient Management

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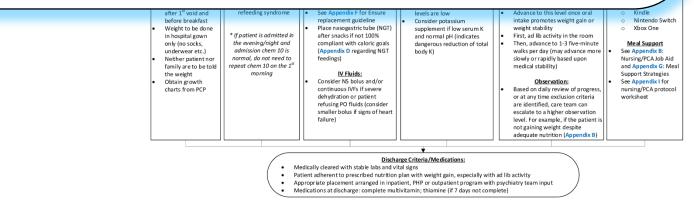
### Discharge Criteria/Medications:

Discharge criteria and home medications are outlined



### Discharge Criteria/Medications:

- Medically cleared with stable labs and vital signs
- Patient adherent to prescribed nutrition plan with weight gain, especially with ad lib activity
- Appropriate placement arranged in inpatient, PHP or outpatient program with psychiatry team input
- Medications at discharge: complete multivitamin; thiamine (if 7 days not complete)





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LAST UPDATED: 08.23.2

CLINICAL PATHWAY: Eating Disorder ARFID Inpatient Management	THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.
--------------------------------------------------------------------	------------------------------------------------------------------------------------

failure)	VITAL SIGNS Q4HB           VITAL SIGNS Q4HB           Orthostatics:           Instructions for obtaining orthostatiks:           BP + HR After patient supine for 3 min, then repeat after patient standing for 3 min           1 <sup>II</sup> set on admission           If orthostatic for BP or HR, take daily until normalized (positive iff SBP drops by ≥ 20 mmHg, HR increase by ≥ 20)           Monitoring:           Place on cardiorespiratory monitor           Discontinue continuous monitor at Level 3 activity           Weight to be done in bofore breakfast           Weight to be done in socks, underwarertc.)           Nekher patient nor family are to be told the weight obtain growth charts from PCP	ABS & DIAGNOSTICS Day 1: Consider echocardiogram for any patient with a positive cardiac ROS or a torovider discretion based upon severity of malnutrition (in echo order, select. "Eating Disorder patients") If not previously obtained in the ED: URINE the CG (female pts) Days 2-5: I-ISTAT Chem 10 daily for 5 days, then PRN based on risk of refeeding syndrome * If patient is admitted in the evening/night and admission chem 10 is normal, do not need to repeat chem 10 on the 1 <sup>st</sup> morming	NUTRITION & FLUDS NUTRITION & FLUDS Nutrition: Appendix E for ARFID plans Inimediately after admission lab results reviewed RD will identify food likes, which will make up a large portion of meals Advance diet based on PO compliance (includes water intake) and medical necessity until weight gain is achieved with advancement of activity Place net day's diet or der after evening snack by modifying existing diet order Start with 24oz of free water and then adjust per RD recommendations See Appendix F for Ensure replacement guideline The decision to begin nasogastric tube (NGT) feedings is based on medical necessity as determined by the mult-disciplinary team (Appendix E regarding NGT feedings) <u>VEHids:</u> Constiteurs VIS biolss and/or continuous VIS if severe dehydration or patient refusing PO fluds (consider smaller bolus if signs of heart	<ul> <li>MEDICATIONS</li> <li>Complete multivitamin 1 tablet daily</li> <li>Thiamine 100 mg/day x7 days total</li> <li>Consider Tums for low calclum levels</li> <li>Gonsider oral phosphorus if serum phos &lt; 3 mg/d. [Phos-Nak contains 250mg Phos, 160mg (7/mEq) KJ</li> <li>Consider IV phos supplement if phosphate level ≤ 2mg/d.</li> </ul>	Activity Advancement based on increasing medical stability. Advancement based on increasing medical stability. Start at Level 1: bedrest until stabilizes (may still be orthostatic by HR) • OOB in noom for meals • OOB in noom for inited scheduled activities as determined by medical team • Shower based on medical & psych clearance • Advance to this level once or al intake promotes weight gain or weight stability • First, ad lib activity in the room • Then, advance to 1-3 five-minute walks per day (may advance more slowly or rapidly based upon medical stability) • Based on daily review of progress, or at any time exclusion criteria are identified, care team can escalate to a higher observation level. For example, if the patient is not gaining weight despervation level. For example, if the patient is not gaining weight despervation level. For example, if the patient is not gaining weight despervation level. For example, if the patient is not gaining weight despress, or at any time exclusion the patient is not gaining weight despervation level. For example, if the patient is not gaining weight despress.	Reinforcement and Meal Support See Appendix H ARFID Behavioral Plan Behavioral Plan will be created with multidisciplinary input, identifying: Patient motivators Reinforcers for small goals Reinforcers for arge goals Reinforcers for arge goals Beat Bendix B: Mursing/PCA Job Aid and Appendix G: Meal Support Strategies See Appendix G: Meal Support Strategies
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Discharge Criteria/Medications: Medically cleared with stable labs and vital signs

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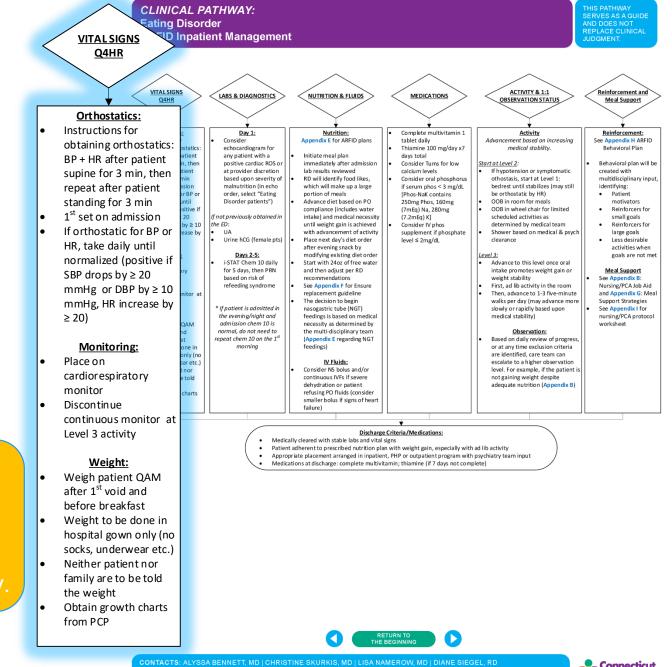
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Page 3 of the pathway describes specific treatment goals for patients with ARFID

Daily weights and BP are performed according to the same standards as for patients with anorexia or bulimia

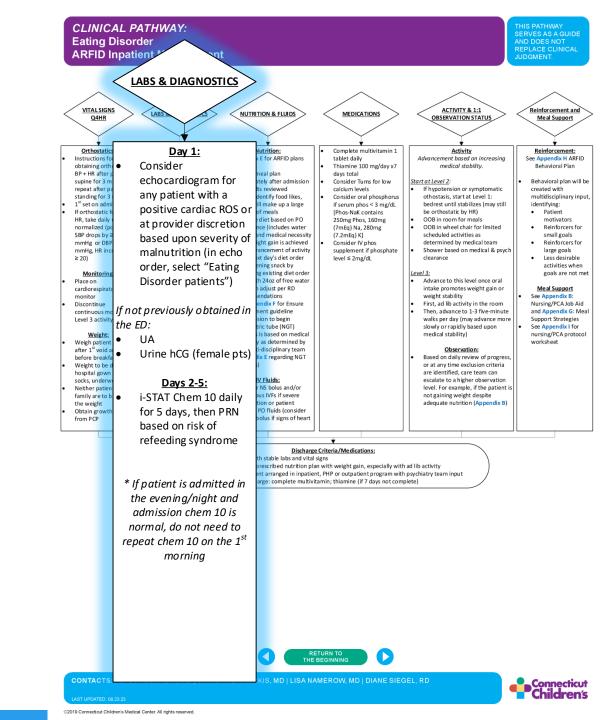
Patients with ARFID are also placed on a continuous cardiorespiratory monitor until reaching level 3 activity.

> It is critical that weight, BMI, and calories of the diet are **not** shared with the patient and family.



### Labs and Diagnostics:

 Same as for patients with anorexia or bulimia



The goal of the meal plan for the first day is to learn about the patient's food history, current and recent food likes, as well as reinforcers that will help engage the patient to eat

The goal of the meal plan for the next 4 days is to prevent further weight loss and to encourage patient to eat by mouth. The meals will include many likes and familiar foods. There will be less of a focus on nutritional balance.

Patients with ARFID will likely be on a behavioral plan using more frequent reinforcers for goals such as smelling, touching, tasting and/or eating small bites or a percentage of the meal.

- The meal plan consists of 3 meals + 3 snacks
- The Registered Dietician (RD) will choose the meal plan with a focus on likes and familiar foods
- Minimum of 24oz of liquid per 24-hour period.
- If initial diet order is placed after 1800, each meal that first night will be 230 ml of Ensure + 1 packet of saltine crackers or food chosen by the parent or quardian. These can be initiated and provided in ED or upon arrival to the floor. PCA will document everything consumed.
- A feeding team evaluation will occur on the first day
- Step One: (1500 total calories per day) Advance to next step based on severity of malnutrition and/or 100% PO completion
- Step Two: (1800 total calories per day) Advance to next step based on severity of malnutrition and/or 100% PO completion
- Step Three: (2100 total calories per day) Advance to next step based on severity of malnutrition and/or 100% PO completion
- Step Four:

Increase intake by 20% or 200-300 kcal/day to a goal set by Clinical Nutrition. Step number continues to advance until reaching adequate intake, as determined by Clinical Nutrition.

If a patient does not finish an entire meal (breakfast, lunch, dinner), he/she will have the opportunity to take in the missed calories at the next snack by drinking a liquid nutrition supplement (Refer to

Appendix F; consult with Diet Tech if needed)

Patients with ARFID are more likely to require nasogastric tube (NGT) feedings. The decision to begin nasogastric tube (NGT) feedings is based on medical necessity as determined by the multi-disciplinary team. Once an NGT is placed, the medical team will determine if the tube should be removed or left in place.

The decision to place an NGT in a patient < 11 years old will be determined by the multi-disciplinary team.



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CLINICAL PATHWAY: Eating Disorder **ARFID** Inpatient Management

VITAL SIGNS

Q4HR

repeat after patient

**Nutrition and Fluids:** 

Appendix E details nutritional plans for

Focus on familiar foods and likes

Goals of nutritional compliance

before encouraging non-preferred

may include smelling, touching, or

tasting foods; or completing only

NGT feedings may be more readily

standing for 3 min

The main differences from the

nutritional plan for patients with

anorexia and bulimia include:

portions of a meal

medical need

patients with ARFID

food

**NUTRITION & FLUIDS** 

LABS & DIAGNOSTICS

at provider discretion

based upon severity of

NUTRITION & FLUIDS

lab results reviewed

RD will identify food likes,

MEDICATIONS

calcium levels

serum phos < 3 mg/dL

K contains

160mg

nin 1

v x7

OBSERVATION STATUS

Nutrition: Appendix E for ARFID plans

Meal Support

Initiate meal plan Consider oral phosphorus

- immediately after admission lab results reviewed RD will identify food likes, which will make up a large portion of meals
- Advance diet based on PO compliance (includes water intake) and medical necessity until weight gain is achieved with advancement of activity Place next day's diet order after evening snack by
- modifying existing diet order Start with 24oz of free water and then adjust per RD recommendations
- See Appendix F for Ensure replacement guideline The decision to begin nasogastric tube (NGT) feedings is based on medical necessity as determined by the multi-disciplinary team (Appendix E regarding NGT feedings)

### IV Fluids:

Consider NS bolus and/or continuous IVFs if severe dehvdration or patient refusing PO fluids (consider smaller bolus if signs of heart failure)

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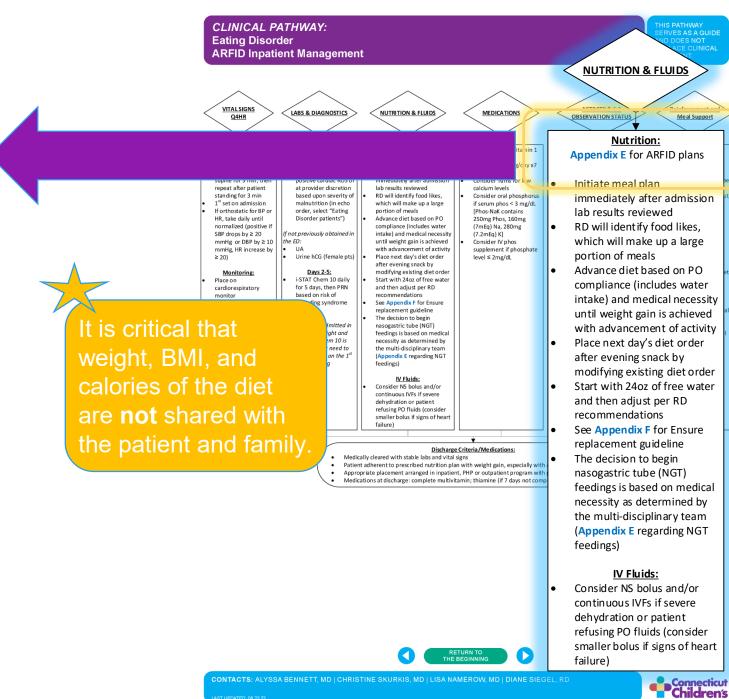
Appendix F; consult with Diet Tech if needed).

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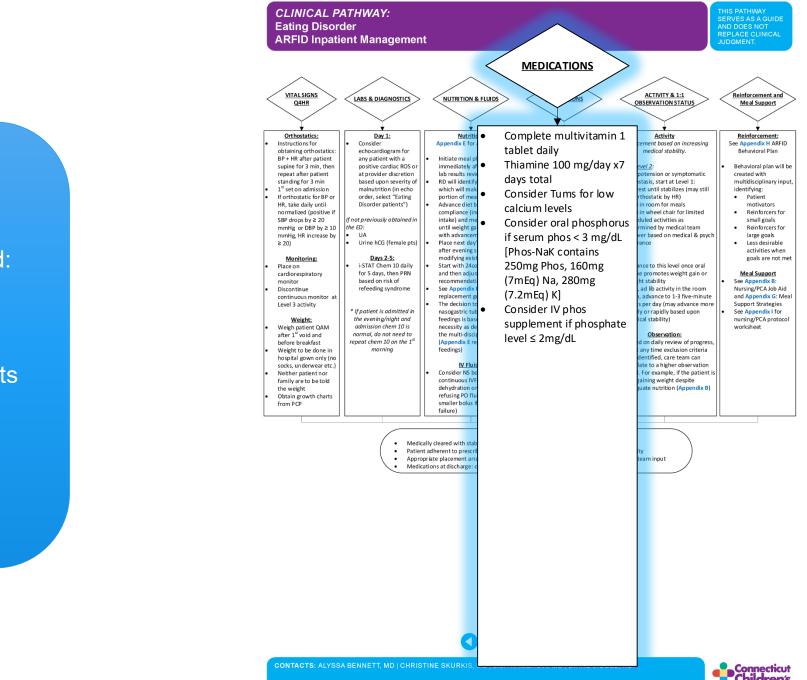
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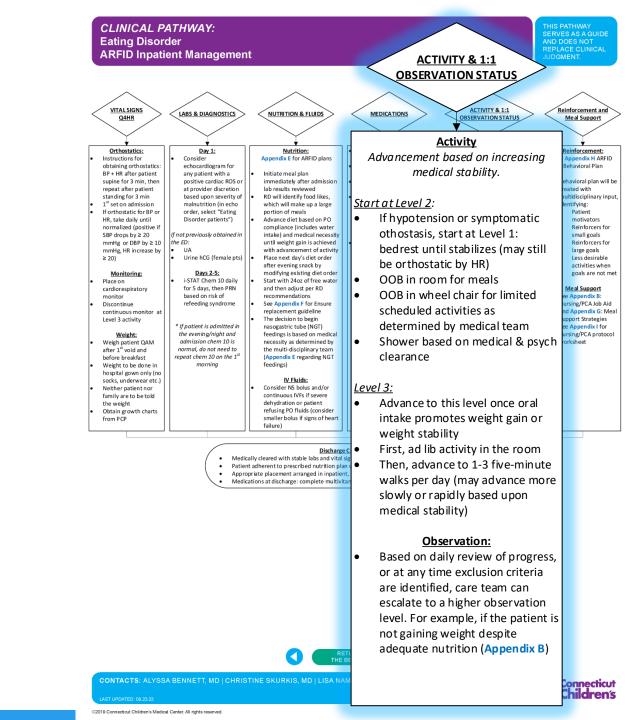
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### **Medications:**

- All patients with ARFID also need:
  - Complete multivitamin
  - Thiamine
- May also vary based on lab results and underlying nutritional deficiencies.



### **Activity Status:**

- Initially all patients are on Level 2 activity (as opposed to level one activity for those with anorexia or bulimia) unless medically unstable.
- Activity level is advanced in a stepwise fashion based on medical stability
  - Of note, may advance once BP and orthostatics stabilize (still might be orthostatic by HR which can take much longer to resolve)





\_\_\_\_\_ Date:

#### Reinforcers:

Patient Name:

Tablet	Coloring pages	Arts/Crafts	Games
TV/Movies	Wheelchair rides	Visits with friends	Visits with family
Other:			

#### Small Goals:

Touch a new food	Take _	bite(s) of a new food	l	Eat	% of a new food
Taste a new food	Eat	_% of a familiar food	Drink _		medicine cups of a drir
Other:					

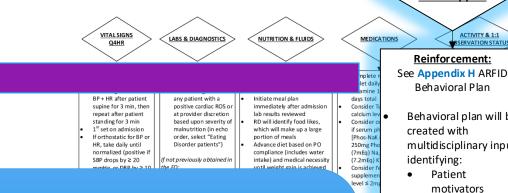
Reinforcer for small goal (ex. 15 minutes of tablet)

#### Large Goals:

Eat \_\_\_\_% of the meal Eat 100% of a familiar food Drink a cup of a drink

Other:

Reinforcer for Large Goal (ex. 2 hours arts/crafts with sister)



### **Behavior Plan**

 An individualized behavioral plan will be created to enhance nutritional compliance for children with ARFID

ACTIVITY & 1:1 Reinforcement and SSERVATION STATUS Meal Support Reinforcement: See Appendix H ARFID Behavioral Plan Behavioral plan will b Behavioral plan will be created with multidisciplinary input identifying: Patient multidisciplinary input, motivators Reinforcers for • small goals Reinforcers for large goals Less desirable activities when goals are not me

REPLACE CLINICAL JUDGMENT.

Meal Support

and Appendix G: Mea Support Strategies

See Appendix I for

worksheet

nursing/PCA protocol

See Appendix B: Nursing/PCA Job Aid

- Reinforcers for small goals
- Reinforcers for large goals
- Less desirable activities when goals are not met

### Meal Support

- See Appendix B: Nursing/PCA Job Aid and Appendix G: Meal
- Support Strategies

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RETURN TO

- See Appendix I for
- nursing/PCA protocol worksheet

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SERVES AS A GUIDE

REPLACE CLINICAL JUDGMENT.

#### Strategies and Games that can help during meals

#### Get the patient's and family's input

- What strategies have worked in the past?
- Would you like to talk about something while you're eating?
- Would you like to listen to me while eating?
- Get to know the patient's interests

Distraction - Engage in conversation about topics unrelated to food

- <u>Categories</u> pick a topic (animals, items found at the mall, places...) take turns coming out with items in chosen category beginning with the letters of the alphabet in order
- Going to the beach, on a picnic, or going shopping Starting in alphabetical order take turns saying something that you would find or take with you. (A- ant, B-ball...)
- 20 guestions one person thinks of something (person, place, or object) the other person has to correctly identify and name it by asking "yes" or "no" questions. Then switch rolls (thinker becomes the question asker)
- Mad libs

#### For Young Children with ARFID

#### Be a food scientist

- What do you see? (shape, color, size)
- What does it feel like? (hard, soft, bumpy, smooth, fuzzy, wet, slippery, dry)
- What does it smell like? (sweet, sour, spicy, mild, strong)
- What does it taste like? (sweet, salty, tart, fruity, spicy) •
- What does it sound like? (loud, quiet, crunchy, no sound)

Hokey Pokey: (you put the broccoli in, you take the broccoli out, you put the broccoli in and you move it all about)

Eat around the plate - use at least 3 foods (1. something always eaten, 2. something occasional eaten 3. something USED TO eat or something never eaten)

- · First, use all preferred foods to teach protocol and reduce anxiety
- Use a divided plate or small bowls have child place 2-3 preferred foods into each section
- Teach rules of even rotation (1 bite from each section of plate/bowl) Alternate difficult foods and easy foods - begin with reinforcing each bite of new food. progress to reinforcing following full sequence completion
  - Difficult food may first be an occasionally eaten food or a food with a slight change to taste, texture or brand
  - o Gradually progress to a never eaten food
  - o If unable to actually eat food, reward any attempts to move up food hierarchy (touch, kiss, lick bite)
- \*\*\* You can play a game while following the above "eat around the plate" progression such as candy land, chutes and ladders, trouble, UNO \*\*\*
  - Assign a food to each color OR assign a food to each number
  - Take turns playing the game, taking bites of the assigned foods





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CLINICAL PATHWAY: Eating Disorder **ARFID Inpatient Management** 

REPLACE CLINICAL Reinforcement and

### **Reinforcement and Meal** Support:

Meal Support strategies as outlined in Appendices B and G may also be helpful to encourage nutritional compliance.

the weight

from PCP

Obtain growth charts

refusing PO fluids (consider smaller bolus if signs of heart

MEDICATIONS

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See Appendix I for

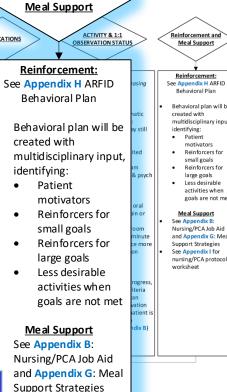
worksheet

nursing/PCA protocol

Appropriate placement arranged in inpatient, PHP or o Medications at discharge: complete multivitamin; th

dehydration or patient

failure)

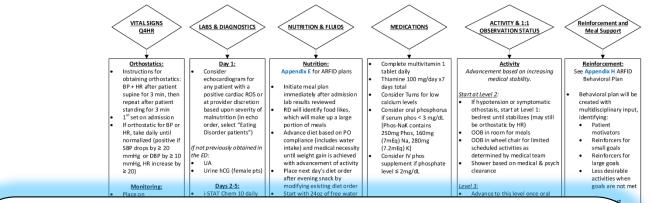


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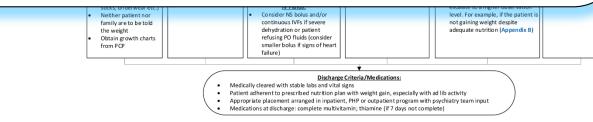


### Discharge Criteria/Medications:

• Medically cleared with stable labs and vital signs

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- Patient adherent to prescribed nutrition plan with weight gain, especially with ad lib activity
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### **Discharge Criteria/Medications**

 Discharge criteria and medications for ARFID are the same as Anorexia/Bulimia

# **Quality Metrics**



- % Patients with pathway order set (ARFID/NON-ARFID)
- AVG time (minutes) from hospital admission to pathway order set (ARFID/NON-ARFID)
- % Patients who require NG placement (ARFID/NON-ARFID)
- % Patients with 1 NG tube placement (ARFID/NON-ARFID)
- % Patients with 2 NG tube placements (ARFID/NON-ARFID)
- % Patients with > 2 NG tube placements (ARFID/NON-ARFID)
- % Patients with Hypophosphatemia who receive phosphorus supplement (ARFID/NON-ARFID)
- AVG time (days) from hospital admission to Order Activity 3 (ARFID/NON-ARFID)
- # Patients readmitted (ARFID/NON-ARFID)
- ALOS (Days) (ARFID/NON-ARFID)

## **Pathway Contacts**



- Christine Skurkis, MD • Pediatric Hospital Medicine
- Lisa Namerow, MD • Pediatric Psychiatry
- Alyssa Bennett, MD • Adolescent Medicine
- Diane Siegel, RD • Department of Clinical Nutrition





- Golden NH, Katzman DK, Rome ES, Gaete V, Nagata JM, Ornestein RM, Garber AK, Starr T, Kohn M, Sawyer SM. Position Paper from The Society for Adolescent Health and Medicine. Medical Management of Restrictive Eating Disorders in Adolescents and Young Adults. Journal of Adolescent Health. 2022 71:648-654
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## **About Connecticut Children's Pathways Program**

Clinical pathways guide the management of patients to optimize consistent use of evidence-based practice. Clinical pathways have been shown to improve guideline adherence and quality outcomes, while decreasing length of stay and cost. Here at Connecticut Children's, our Clinical Pathways Program aims to deliver evidence-based, high value care to the greatest number of children in a diversity of patient settings. These pathways serve as a guide for providers and do not replace clinical judgment.