CLINICAL PATHWAY:
Eating Disorder

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

Inclusion Criteria: Established or newly diagnosed/suspected eating disorder
Exclusion Criteria: Active gastrointestinal pathology causing malnutrition

PCP and/or ED Assessment

- **History of:** weight loss, binging/purging, diet, alcohol, substance use, meds, exercise, syncope, menstrual periods
- **Physical exam:** measure height & weight, calculate % Goal BMI (see Appendix A), perform orthostatic vitals (BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min), assess hydration status, cardiac and peripheral exam

Pre-Treatment Evaluation and Interventions

- Chem 10, AST/ALT, GGT, alkaline phosphatase, ferritin, % iron saturation, free T4 & TSH, albumin, pre-albumin, CBC w/diff, ESR, total IgA, celiac disease panel, zinc, Vitamin D, UA, urine for hCG, 12-lead EKG.
- If vegan, add vitamin B12.
- Always repeat Chem 10, otherwise if tests were recently completed, use provider discretion whether to repeat.
- Offer patient food. Replace electrolytes. NS/LR bolus only for significant dehydration (dextrose may cause refeeding).

Admission Criteria [1]

No

- Notify PCP
- Consider behavioral health consult for partial hospitalization programs or outpatient counseling
- May always call Psychiatry or Hospital Medicine to discuss

Yes

Admit to Hospital Medicine

- PCP or ED provider reviews clinical pathway management with patient and family [2]
- ED provider gives patient and family the Patient Handout that outlines expectations during the admission (see Appendix C)
- If patient ≥ 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
  - Consult OT + SLP (feeding team) for ARFID[3] patients
- Nurse or observer to print Nursing/observer Job Aid (Appendix B) and Nursing/observer Protocol Worksheet (Appendix I)

If Anorexia/Bulimia:

- Proceed to page 2: Anorexia/Bulimia Inpatient Management

If Avoidant Restrictive Food Intake Disorder (ARFID)[3]:

- Proceed to page 3: ARFID Inpatient Management

[1] Admission Criteria:

*Must meet inclusion criteria **AND** one or more of the following criteria secondary to the eating disorder:*

- % Goal BMI of < 75% OR % Goal BMI of < 80% if < 10 years old or pre-menarchal
- >25% weight loss
- Acute food refusal > 24hrs
- HR ≤40 bpm supine & resting
- Systolic BP <80 mmHg
- Orthostatic changes in SBP (>20 mmHg)
- Syncope or near syncope with standing
- Electrolyte disturbances
- Moderate or severe Dehydration
- Arrhythmia including prolonged QTc
- Intractable vomiting or hematemesis
- Failure of outpatient treatment

[2] Example script for ED when notifying of admission:

"Your child is being admitted for medical stabilization for malnutrition 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."

[3] 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 eating or food

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CLINICAL PATHWAY:
Eating Disorder
Anorexia/Bulimia Inpatient Management

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

VITAL SIGNS Q4HR

Orthostatics:

- Obtain on admission
- Instructions: BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min
- Positive if SBP drops by ≥ 20 mmHg or DBP by ≥ 10 mmHg, HR increase by ≥ 20
- If orthostatic by BP or HR: Check daily until BP normalizes and HR improves (HR may take weeks to normalize)

Monitoring:

- Place on cardiorespiratory monitor
- Discontinue monitor at Level 2 activity

Weight:

- Weigh patient QAM after 1st void and before breakfast
- Weight to be done in hospital gown only (no socks, underwear etc.)
- Do not share weight or BMI with patient or guardian (can share trend with guardian)
- Obtain growth charts from PCP

LABS & DIAGNOSTICS

- Consider echocardiogram for any patient with a positive cardiac ROS, murmur, unexpected EKG abnormality or at provider discretion based upon severity of malnutrition (in echo order, select "Eating Disorder patients")
- Consider first morning urine specific gravity to determine fluid goal or identify water loading

Refeeding Labs:

- Perform Chem 10 daily for 6 days, then PRN based on risk of refeeding syndrome & lab trends
- Use i-STAT when available
- Refeeding lab Day 1 = first morning of admission

** If patient has severe malnutrition or abnormal admission labs, consider labs Q12 hours initially*

NUTRITION & FLUIDS

Nutrition:

[See Appendix D for Anorexia and Bulimia diet plans]

- Initiate meal plan immediately after admission lab results reviewed
- RD will ask patient for 3 food dislikes
- Advance diet daily until patient achieves consistent weight gain and is at activity level 5
- Place next day's diet order after evening snack by modifying existing diet order
- Start with 24oz of water per day and adjust per RD recommendations
- See Appendix F for oral nutrition supplement replacement guideline
- Place nasogastric tube (NGT) after snacks if not 100% compliant with caloric goals (See Appendix D regarding NGT feedings)
- Do not share calories with patient or family

IV Fluids:

- Isotonic IV fluid bolus reserved for severe dehydration (Dextrose fluids may cause refeeding syndrome)
- Use smaller bolus if signs of heart failure)

MEDICATIONS

Anorexia and Bulimia:

- Complete multivitamin 1 tablet daily
- Thiamine 100 mg/day x7 days total
- Calcium carbonate for low calcium levels
- Replete phosphorus if low for age [Consider IV phos if severe]
- Replete potassium if low for age [Consider IV KCl if severe]
- If constipated, and not improving after initiating nutrition, consider Polyethylene Glycol 17g 1-2x/day

Bulimia:

- Consider sodium bicarbonate or oral Bicitra if bicarbonate levels are low
- Consider potassium supplement if normal serum K and signs of metabolic acidosis (may indicate dangerous reduction of total body potassium)

ACTIVITY & 1:1 OBSERVATION STATUS

Activity:

Advance activity daily if meeting medical stability criteria for each level

Level 0: ONLY for patients with SBP < 80 or cardiovascular or neurologic instability

- Strict bed rest
- OOB for bathroom use only

Level 1: MOST patients on admission

- OOB in chair for meals
- OOB in wheelchair for scheduled child life activities and wheelchair rides as determined by inpatient team
- Shower based on medical & psych clearance

Level 2: when gaining weight

- Ad lib activity in the room

Level 3: when above admit weight and gaining weight. Admit weight defined as weight from 1st morning on pathway

- Ad lib in room plus require 1 five-minute walk per day

Level 4: continued weight gain

- Ad lib in room plus require 2 five-minute walks per day

Level 5: continued weight gain

- Ad lib in room plus require 3 five-minute walks per day (= home ADLs)

Observation:

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 despite adequate nutrition (Appendix B)

REINFORCEMENT AND MEAL SUPPORT

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 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
  - Xbox One

Meal Support:

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

Discharge Criteria/Medications:

- Continued weight gain with maximum activity level and stable electrolytes
- Adherent to prescribed nutrition plan, received relevant discharge meal planning education, awake HR > 45, and SBP > 80
- Scheduled appointments made with outpatient multidisciplinary team including PCP/ Adolescent Med, nutrition, and therapy
- If being discharged to higher level of care, meets program's medical criteria with intake scheduled or bed confirmed
- Medications at discharge: complete multivitamin; thiamine (if 7 days not complete)

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CLINICAL PATHWAY:
Eating Disorder
ARFID Inpatient Management

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

VITAL SIGNS Q4HR

Orthostatics:

- Obtain on admission
- Instructions: BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min
- Positive if SBP drops by ≥ 20 mmHg or DBP by ≥ 10 mmHg, HR increase by ≥ 20
- If orthostatic for BP or HR, take daily until BP normalizes and HR improves (HR may take weeks to normalize)

Monitoring:

- Place on cardiorespiratory monitor
- Discontinue monitor at Level 2 activity

Weight:

- Weigh patient QAM after 1st void and before breakfast
- Weight to be done in hospital gown only (no socks, underwear etc.)
- Neither patient nor family are to be told the weight
- Obtain growth charts from PCP

LABS & DIAGNOSTICS

Day 1:

- Consider echocardiogram for any patient with a positive cardiac ROS, murmur, unexpected EKG abnormality or at provider discretion based upon severity of malnutrition (in echo order, select "Eating Disorder patients")
- Consider first morning urine specific gravity to determine fluid goal or identify water loading

Refeeding Labs:

- Perform Chem 10 daily for 6 days, then PRN based on risk of refeeding syndrome & lab trends
- Use i-STAT when available
- Refeeding lab Day 1 = first morning of admission

** If patient has severe malnutrition or abnormal admission labs, consider labs Q12 hours initially*

NUTRITION & FLUIDS

Nutrition:

[See Appendix E for ARFID plans]

- Initiate meal plan immediately after admission lab results reviewed
- RD will identify food likes, which will be prioritized
- Advance diet daily until patient achieves consistent weight gain and is at activity level 5
- 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 oral nutrition supplement replacement guideline
- The decision to begin nasogastric tube (NGT) feedings is based on medical necessity as determined by the multi-disciplinary team (See Appendix E regarding NGT feedings)
- Do not share calories with patient or family

IV Fluids:

- Isotonic bolus reserved for severe dehydration (Dextrose fluids may cause refeeding syndrome)
- Use smaller bolus if signs of heart failure)

MEDICATIONS

ARFID:

- Complete multivitamin 1 tablet daily
- Thiamine 100 mg/day x7 days total
- Calcium carbonate for low calcium levels
- Replete phosphorus if low for age [Consider IV phos if severe]
- Replete potassium if low for age [Consider IV KCl if severe]
- If constipated, consider Polyethylene Glycol 17g 1-2x/day

Severe Vomiting:

- Consider sodium bicarbonate or oral Bicitra if bicarbonate levels are low
- Consider potassium supplement if normal serum K and signs of metabolic acidosis (may indicate dangerous reduction of total body potassium)

ACTIVITY & 1:1 OBSERVATION STATUS

Activity

Advance activity daily if meeting medical stability criteria for each level

Level 0: ONLY for patients with SBP < 80 or cardiovascular or neurologic instability

- Strict bed rest
- OOB for bathroom use only

Level 1: MOST patients on admission

- OOB in chair for meals
- OOB in wheelchair for scheduled child life activities and wheelchair rides as determined by inpatient team
- Shower based on medical & psych clearance

Level 2: when gaining weight

- Ad lib activity in the room

Level 3: when above admit weight and gaining weight. Admit weight defined as weight from 1st morning on pathway

- Ad lib in room plus require 1 five-minute walk per day

Level 4: Continued weight gain

- Ad lib in room plus require 2 five-minute walks per day

Level 5: Continued weight gain

- Ad lib in room plus require 3 five-minute walks per day (= home ADLs)

Observation:

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 despite adequate nutrition (Appendix B)

CONSULTS, REINFORCEMENT, AND MEAL SUPPORT

Consult:

- Consult OT and SLP (feeding team)

Reinforcement:

See Appendix H ARFID Behavioral Plan

- Behavioral plan will be created with multidisciplinary input, identifying:
  - Patient motivators
  - 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
- See Appendix I for nursing/PCA protocol worksheet

Discharge Criteria/Medications:

- Continued weight gain with maximum activity level and stable electrolytes
- Adherent to prescribed nutrition plan, received relevant discharge meal planning education, awake HR > 45, and SBP > 80
- Scheduled appointments made with outpatient multidisciplinary team including PCP/ Adolescent Med, nutrition, and therapy
- If being discharged to higher level of care, meets program's medical criteria with intake scheduled or bed confirmed
- Medications at discharge: complete multivitamin; thiamine (if 7 days not complete)

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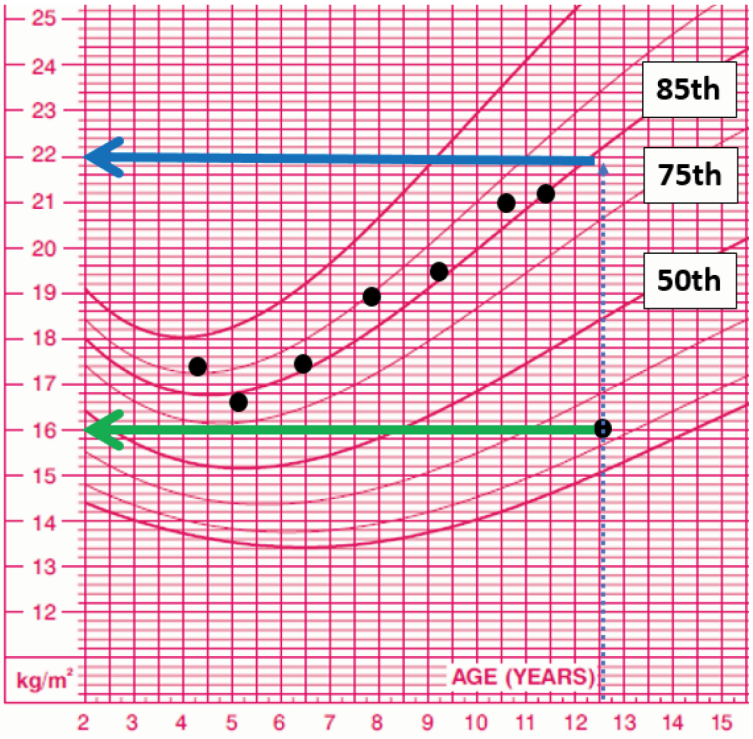
Steps:

1. Review patient's growth chart to determine approximate BMI percentile trajectory prior to onset of their eating disorder (*Goal BMI percentile*)
2. Using the BMI growth chart in Epic, find the BMI that corresponds to the goal BMI percentile (*Goal BMI*) for their current age
3. Calculate % of Goal BMI: current BMI ÷ Goal BMI

- **Step 1: Goal BMI percentile = 85th**
- **Step 2: Goal BMI: 22**
- **Step 3: % of Goal BMI = current BMI/Goal BMI = 16/22 = 73%**



*If no historical weights are available, calculate % of median BMI using the following method:

1. Visit www.peditools.org
2. Select "CDC Growth Calculator for 2 to 20 years"
3. Enter pt data (DOB, Measurement date, gender, height, weight) then Submit
4. Calculate % median BMI by taking current weight and dividing by "Weight for 50th percentile BMI"

You can substitute % median BMI for % Goal BMI for admission criteria.

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Vital Signs: q4hr

Orthostatic vital signs ("Orthostatics") HR and BP when supine and standing:

- Obtain 1st set on admission
- BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min
- If Orthostatic by BP or HR, take daily until normalized

Lowest heart rate per shift

- PCA document the lowest HR noted each shift in the vital signs flowsheet in Epic

Weight:

- Weigh patient every morning after 1st void and before breakfast
- Weigh patient in hospital gown only (no socks, underwear etc.)
- Do not share weight or BMI with patient or guardian (can share trend with guardian). Upon discharge, can share weight info with parent/guardian. Admission weight is defined as weight taken on first morning of pathway
- In general, goal weight gain is approximately 0.2 kg/day or 3 pounds per week

Nutrition and Fluids:

- See **Appendix C** (Patient Handout) for detailed Meal Guidelines. See **Appendix D** for Anorexia and Bulimia meal plan, & **Appendix E** for Avoidant Restrictive Food Intake Disorder (ARFID) meal plan
- Patients will be started on 1800 calories and advanced daily until they achieve consistent weight gain and are at activity level 5
- Each meal and snack will last 30 minutes
- Parents, guardians and visitors should not be present for meals and snacks until approved for meal support by the team
- Do not share calories with patient or family
- Staff must check tray for accuracy before each meal
- Staff remove meal ticket from tray, document meal completion on meal ticket, and save in the patient's thin chart for 48 hours
- Makeup oral nutrition supplement will be offered with/after snacks 3 times per day as needed if not 100% compliant with preceding meal and current snack
- NG tube will be placed after each snack if not 100% compliant with food + makeup and then removed
- NG tube exceptions
  - Consider not placing NG right away in patients <11 years
  - Consider not removing if NG tube is needed twice or more regardless of age

Nutrition Observation status: Nutrition observation is different than safety risk observation due to risk of harm to self or others. An eating disorder patient will have 2 observation orders, one for nutrition and one for safety risk.

- Definitions:
  - Nutrition observation is specific to patients with eating disorders and for observing meals to document intake, observing for eating disorder behaviors including hiding food or manipulating NG tube, and to provide support during and after meals and snacks.
  - Safety risk observation is for patients at risk of harm to self or others and is ordered using the safety risk order.

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- Patients with and without purging behaviors will be admitted with constant observation during meals and snacks and for 1 hour after each meal and snack is completed if no risk criteria are present (see below).
- Patients will have continuous constant observation during any time an NG or NJ tube is present.
- Patients can be placed on constant nutrition observation for 24 hours a day, if they meet any of the following risk criteria at any point during hospitalization.
    - concern for excessive exercise
    - concern for water loading
    - high fall risk
- Patients must be placed on increased safety risk observation using the safety risk order set if they have active suicidal ideation or safety risk behaviors that warrant increased observation due to risk of harm at any point during hospitalization.
- Based on daily review of progress, or at any time risk criteria are identified, care team can escalate to a higher observation level or de-escalate to a lower observation level. For example, they can increase observation level if the patient is not gaining weight despite adequate nutrition.
- Team will review daily whether family members are suitable to begin training for meal support and/or support following meals (refer to **Appendix G:** Meal Support Strategies)

Constant observation specifics:

- Recommend patient use bathroom before meals and snacks. If patients need to use the bathroom within 1 hour after meals when on constant observation, they must be observed per unit policy.
- If patient is on activity level 0 and eating meals in bed, patient must lay/sit on blankets
- For activity level 1 and higher, patient must eat sitting in a chair without blankets
- The observer remains in the room at the bedside during meals and for the 1 hour observation time after completion of the nutrition. If there is an order for constant observation for safety unrelated to meals, the observer may then move to the doorway, unless an order is placed stating otherwise.
- The computer should remain outside of the room when the observer is at the bedside to prevent patient from seeing their weight or BMI on the screen
- Do not share weight or BMI with the patient or family
- Do not share calories with the patient or family
- Monitor for and document on **Appendix I** (Observation Worksheet) attempts at hiding or vomiting food or exercising
- 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 room:

- Before admission:
    - Remove trash receptacles, bins, tissue boxes that could be used to hide food or purge into
    - Remove excessive linens/blankets
    - Consider covering mirror in room

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- Bedside curtains must be kept open, except when dressing
- Lights remain on during the day except brief naps
- Bathroom use is supervised by staff per unit policy when on constant observation
- Staff will measure all urinary output and stool
- All activities will be stored and/or turned off (e.g. television, video games, crafts) before meals, snacks and at bedtime.

Activity Status:

Most patients will be admitted to Activity Level 1. Activity level is advanced daily based on improving medical stability when criteria are met for vitals and weight. Providers use the eating disorder order set to change activity level.

Level 0: (ONLY for patients with hypotension, neurologic or cardiovascular instability)
- Strict bedrest due to vital sign instability
- Out of Bed for bathroom use only
- Eat sitting on blankets on bed

Level 1: (Start on this level for MOST patients on admission)
- Out of bed in chair for meals (this is required)
- Out of bed in wheelchair for scheduled floor activities as determined by medical team
- Shower based on medical and psychiatric team clearance

Level 2: (must have SBP > 80 mmHg and gaining weight gain)
- Ad lib activity in room

Level 3: (Must be above admit weight and gaining weight)
- Ad lib in room plus require 1 five-minute walk per day (May advance more rapidly if large weight gain)

Level 4: (Continued weight gain)
- Ad lib in room plus require 2 five-minute walk per day (May advance more rapidly if large weight gain)

Level 5: (Continued weight gain)
- Ad lib in room plus require 3 five-minute walk per day (May advance more rapidly if large weight gain)
- Outpatient eating disorder activity recommendations are for completion of ADLs only without walks. 3 five-minute walks is estimated to equal the activity to complete ADLs.

Other: Under rare circumstances, such as for a patient with a long length of stay, the team may decide to allow additional advancement such as additional walks or longer walks.

Allowances and Reinforcement:
- No personal mobile devices are allowed
- All patients will be admitted to a standard room with access to usual comfort items and child life activities that are available to all patients, except for patients determined to be at risk of harm to self or others who require secure room
- For patients with anorexia and bulimia: If an additional reinforcement plan is needed to support compliance with nutrition, then additional reinforcers will be used from the child life service including, but not limited to iPad, Kindle, Nintendo Switch, Xbox One.
- For patients with ARFID: A behavioral plan will be created with multidisciplinary input identifying behavioral expectations and reinforcement for meeting nutritional expectations. See **Appendix H** for ARFID behavior plan
- Do not start homework. Will be considered per psych team.

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You have been admitted to the hospital because your physician determined that it was medically necessary to hospitalize you to ensure your safety and restore your physical health. This protocol was developed to assure that your hospitalization achieves these goals. If you have any questions about this protocol, please discuss with your nurse or doctor. Your team will keep you up to date with your progress during your hospital stay. Medical stabilization includes getting adequate nutrition and obtaining labs to monitor electrolytes (salts) in the blood. This process generally takes about a week to ensure safety.

Patient Protocol

Allowances and Reinforcement:

1. You will be admitted to a standard, private room with access to the usual comfort items and child life activities that are available to all patients. If there are safety concerns, there may need to be restrictions placed.
2. Personal mobile devices are not allowed
3. A behavioral plan will be considered if it is needed to support nutritional stabilization.
4. All activities will be stored and/or turned off (e.g. television, video games, crafts) before meals, snacks and at bedtime.

Wake Up/Dress Guidelines:

1. At the time of admission, you will be asked to dress in a hospital gown.
2. You need to wake up, get weighed and be dressed prior to breakfast.
3. Wearing personal clothing will be based on medical team determination.

Weight Guidelines:

1. You will need to be weighed daily before breakfast, after the first morning urination, in a hospital gown only. No other clothing (i.e. underwear, socks, slippers, or shoes) will be worn.
2. You will use the bathroom to urinate prior to being weighed.
3. You may not eat, drink, bathe, or brush your teeth before getting weighed.
4. You must stand on the scale with your back toward the weight.
5. You and your family will not be told your weight, BMI or caloric intake.

Labs:

1. Blood labs will be obtained every morning, typically for 6 days. This is to monitor for refeeding syndrome which can cause sudden, serious drops in blood electrolytes (salts) like potassium and phosphorus when patients begin to take in adequate nutrition after a period of malnutrition.
2. If levels are dropping, supplements will be given.

Meal Guidelines:

1. There will be 6 meal times per day, 3 meals and 3 snacks. Each day your meals will be advanced by step, as directed by your Registered Dietician (RD), who will create balanced meal plans that meet your nutritional needs. Water goals are also determined. All meals will be supervised by staff.
2. There will be no visitors and no activities allowed during mealtime, except for meal support from a family member or the Patient Care Assistant (PCA). The readiness of a family member to provide meal support will be determined by the psychiatry team after initial evaluation, observation and education with the family.

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3. Staff will check your tray for accuracy prior to each meal. No food substitutions are allowed.
4. You will have 30 minutes to complete each meal or snack. After that time, the tray will be removed from your room.
5. Approximate meal times are:
   Breakfast = 8:00am – 8:30am
   Snack = 10:00am – 10:30am
   Lunch = 12:00pm – 12:30pm
   Snack = 2:30pm – 3:00pm
   Dinner = 5:00pm – 5:30pm
   Snack = 8:30pm – 9:00pm
6. Staff will record food intake on a meal ticket.
7. No other food, beverages, cups, or dishes are allowed in your room, including the food/beverage of family members.
8. 100% compliance with daily nutrition (food & water) is expected.
9. If you are unable to eat/drink all of the food and liquids presented, you will have the opportunity to take in the missed nutrition from a meal at the next snack by drinking a nutrition supplement.
10. If you are unable to make up the nutrition from the liquid nutrition supplement, a feeding tube, also called a Nasogastric Tube (NGT) will be placed. The feeding tube will be placed at the end of each snack time if you do not consume the goal nutrition for that snack and the prior meal. The remainder of the nutrition will be provided with a nutrition supplement via feeding tube. The feeding tube will be taken out when it is completed. You will then have a "fresh start" to be able to eat and drink all of the next meal and snack.
11. If you are on bedrest, you will eat meals in bed and must lay/sit on blankets. Otherwise you must eat sitting in a chair without blankets.

<u>Unit Environment:</u>

1. On admission, you will be placed on constant observation during and for one hour after meals/snacks, and if/when you have a feeding tube. *This means there will be a staff member with you to provide safety and support, and to monitor for any disordered eating behaviors.*
2. Bathroom use is supervised by staff with door open when on constant observation.
3. You will not have access to the family kitchen.
4. Lights must remain on during the day and bedside curtains must be kept open, except when dressing.
5. Staff will measure urine and stool output after each bathroom use.
6. You will be placed on constant observation for 24 hours a day, if you meet any of the following risk criteria during hospitalization:
   i. active suicidal ideation or safety risk behaviors that warrant constant observation
   ii. concern for excessive exercise in treatment setting or home
   iii. concern for water loading in treatment setting or home
   iv. high fall risk
7. Inappropriate language or threatening behavior is not acceptable.
8. All medications brought from home must be given to your nurse upon admission.
9. We ask that families do not discuss meals, weight, or other eating-related topics, as these topics may increase anxiety. The treatment team will help guide your family as to appropriate discussions and meal support.

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Visitors:

1. Immediate family and clergy may visit at any time, except mealtime, unless otherwise ordered by the team.
2. 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 activity restriction and will be advanced as nutrition and medical status improves.
    a. Medical stability requirements for each activity level can be described by the medical team in the sequence per pathway.
    b. You and your family will be updated daily regarding advancements in activity level and are encouraged to ask if you have questions.
2. 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.
3. 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.

The Patient Handout was reviewed with me and I understand the recommended treatment plan

Date : _____

Patient Signature: _____

Guardian Signature: _____
(for patients under 18 years)

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LAST UPDATED: 04.16.26

Supplemental Eating Disorder Patient Handout for Patients 18 and Older:

1. For your treatment plan to be successful, it is important for you to have the support and involvement from another person (such as a parent). We request that you sign a HIPAA release to authorize us to discuss your care with a parent or other trusted person.
2. We request that you sign release forms to allow the inpatient team to communicate with your outpatient providers (ie therapist, nutritionist, psychiatrist) and eating disorder programs (if applicable).
3. Your providers cannot safely care for you without your cooperation with the protocol and treatment plan. Failure to follow the protocol above may result in the inpatient team recommending discharge or transfer to another program.

Date : _____

Patient Signature: _____

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- Increase nutrition daily until patient has consistent weight gain and is at activity level 5. The patient may not gain weight initially as starting calories are less than goal calories.
- Do not share calorie levels with patient or family.
- The meal plan consists of 3 meals and 3 snacks per day.
- The Registered Dietician (RD) will choose the meal plan to meet the patient's nutritional needs.
- Start with 24oz of water per day and adjust per RD recommendations.
- No additional coffee, tea, diet soda, artificial sweeteners or juice.
- If initial diet order is placed after 18:00, pathway nutrition to start the following day. Patient food from floor stock, a boxed lunch, or guardian chosen foods are acceptable options for evening meal and snack on the first day. These can be initiated and provided in the ED or upon arrival to the floor. PCA will document everything consumed in 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:** 1800 total calories per day
  Begins the first meal after admission through a minimum of 1 calendar day

- **Step Two:** 2100 total calories per day

- **Step Three:** 2400 total calories per day

- **Step Four:** 2700 total calories per day

- Additional steps increase by 300 calories per day

If a patient does not finish an entire meal or snack, they will have the opportunity to take in the missed calories at the snack by drinking the equivalent oral 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 all the food and oral replacement 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 infusion 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 multidisciplinary 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 oral feeds after the NGT is pulled.

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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 the patient to eat by mouth. The meals will include many likes and familiar foods. There will be less of a focus on nutritional balance.

Increase nutrition until patient has consistent weight gain and is at activity level 5.

Patients with ARFID will likely be on a behavioral plan using 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.
- Start with 24oz of water per day and adjust per RD recommendations.
- If initial diet order is placed after 1800, pathway nutrition to start the following day. Patient food from floor stock, a boxed lunch, or guardian chosen foods are acceptable options for evening meals. These can be initiated and provided in the ED or upon arrival to the floor. PCA will document everything consumed in the EPIC flowsheet.
- A feeding team (OT and SLP) evaluation will be ordered on the first day.

- **Step One:** 1800 total calories per day

- **Step Two:** 2100 total calories per day

- **Step Three:** 2400 total calories per day

- **Step Four:** 2700 total calories per day

- Additional steps increase by 300 calories per day

If a patient does not finish an entire meal or snack, they will have the opportunity to take in the missed calories at the snack by drinking the equivalent oral 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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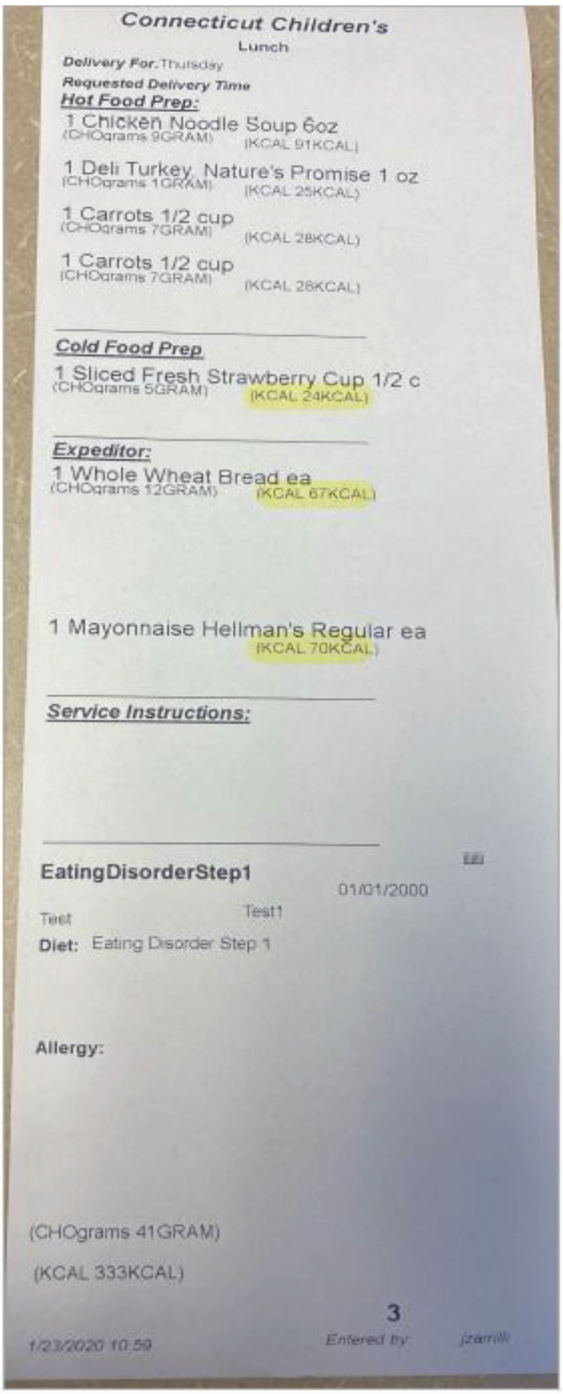
- Refer to CBORD meal ticket for total and individual food calories for each meal and snack.
- For all food and beverage not consumed, calculate number of calories remaining on tray.
- For 30 kcal/oz supplement, give patient 1 ml per 1 calorie remaining on tray.
- For 45 kcal/oz supplement, give patient 1 ml per 1.5 calories remaining on tray.
- Please save all meal and snack tickets in patient's thin chart.

Example:

Patient ate all their chicken noodle soup, turkey, and carrots, but they only ate ½ their portion of strawberries and did not eat their bread or mayonnaise. How much oral nutrition supplement will they need to replace the food they 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:
  - If patient is getting 30 cal/oz supplement (1 kcal = 1 ml supplement) Convert to ml of supplement
    - 149 calories = 149 ml of supplement
  - If patient is getting 45 cal/oz supplement (1.5 kcal = 1ml of supplement)
    Convert to ml of supplement
    - $\frac{149 \text{ kcal}}{1.5 \text{ kcal/ml}} = 99.3 \text{ ml}$


Connecticut Children's
Lunch
Delivery For: Thursday
Requested Delivery Time
Hot Food Prep:
1 Chicken Noodle Soup 6oz
(CHOgrams 9GRAM) (KCAL 91KCAL)
1 Deli Turkey, Nature's Promise 1 oz
(CHOgrams 1GRAM) (KCAL 25KCAL)
1 Carrots 1/2 cup
(CHOgrams 7GRAM) (KCAL 28KCAL)
1 Carrots 1/2 cup
(CHOgrams 7GRAM) (KCAL 28KCAL)
Cold Food Prep
1 Sliced Fresh Strawberry Cup 1/2 c
(CHOgrams 5GRAM) (KCAL 24KCAL)
Expeditor:
1 Whole Wheat Bread ea
(CHOgrams 12GRAM) (KCAL 67KCAL)
1 Mayonnaise Hellman's Regular ea
(KCAL 70KCAL)
Service Instructions:
EatingDisorderStep1
01/01/2000
Test
Test1
Diet: Eating Disorder Step 1
Allergy:
(CHOgrams 41GRAM)
(KCAL 333KCAL)
3
1/23/2020 10:59
Entered by: jzarrilli

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Anorexia nervosa patients have restricted caloric intake relative to energy expenditure that leads to weight loss, plus either an intense fear of gaining weight, or behaviors that consistently interfere with weight gain like over-exercising. Also, there is an altered perception of body weight or shape, or lack of acknowledgment of the seriousness of one's low body weight.

Individuals with ARFID usually do not have altered body image perceptions. They limit/restrict food intake for one of the following reasons:

1. Concern about unpleasant consequences of eating, such as pain, vomiting or choking
2. Based on sensory qualities of the food
3. Seeming lack of interest in eating or food

During this hospitalization, meal time support will be developed by the medical team and then provided by sitter. Meal support strategies will be taught to the family, and meal support may be transitioned to family members to practice before discharge from the hospital.

The goal of meal time support is to help with extinction of the learned avoidance behaviors, increase comfort during meal time, and increase the amount of food consumed during meal.

Learned "safety or avoidance behaviors"

- Eating the same limited foods - can increase sensitivities to new tastes, textures or smells.
- Eating the same foods over and over - can become boring and further limit options.
- Nibbling at food, taking very small bites, or excessive chewing.
- Avoiding eating – can increase the worry and anxiety associated with eating.

Establish routines - Keep TRYING! This takes practice and consistent exposure

- Structured meal place: sit in chair at table. Activities should be put away during meals.
- Structured meal time and duration: Keep to schedule and remove meal after 30 minutes.

Social Modeling

- Eat together – observer is required to sit in the room, consider sitting at the table based on patient comfort. If family is providing meal support, they can sit at the table.
- Watch your own body language and facial expressions- try to convey positive feelings about food, model expected feeding behavior.
- Do not over focus on the child's behavior - offer praise for interactions with food. Otherwise remain neutral about the patient's eating. Do not punish the patient.
- Validate the patient's feelings– Let them know all emotions/feelings are acceptable.

Think about your words

- Try to use "you can" versus "can you?"
- Offer choices: "Which would you like to start with? The apples or the crackers?"
- Acknowledge: "WOW, you worked hard, that wasn't easy, and you were able to take a nice sized bite of that sandwich" AVOID: "I knew you'd like it" OR "See, it was easy"
- It is generally best to avoid talking about food

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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

- Categories – pick a topic (animals, items found at the mall, places…) take turns coming up with items in chosen category beginning with the letters of the alphabet in order.
- Going to the beach, on a hike, or going shopping – Starting in alphabetical order take turns saying something that you would find or take with you. (A- ant, B-ball…).
- 20 questions – 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 around)

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
    - 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 food

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Patient Name: _____ Date: _____

Reinforcers:

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 Eat _____% of a new food

Taste a new food Eat _____% of a familiar food Drink _____ medicine cups of a drink

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)

_____

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Patient Name: Date: Unit:

Date	Day	Meal Step Plan	100% Compliance	Activity Level (Assigned)	Distraction techniques that work for the patient	Comments Eating behaviors/exercise/other
	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			

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