Eating Disorders (Medical Stabilization) Care Guideline

CHOC Children's

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

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

Exclusion Criteria: PICU status

Assessment: Thorough medical evaluation with attention to:

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

Observation/Treatment:

- Monitoring & enforcing prescribed activity level
- Close monitoring of vital signs & weight
- Observing & enforcing prescribed calories (< 70% of mBMI: 1400 kcals/day; >/= 70% mBMI: 1800 kcals/day)
- Strict I & O, including emesis & stool
- Monitoring for refeeding syndrome, electrolyte disturbance, cardiac failure/dysrhythmia, etc.
- Phosphorus supplementation (sodium phosphate 1.3 mEq/kg/dose daily oral to reduce risk of refeeding syndrome
- 24/7 observation (sitter) x 24 hrs, transition to video monitoring once cleared by care team
- Consultations: Psychology, Nutrition, Social Work, Case Management, and Child Life (others as clinically appropriate)
- Interdisciplinary weekly team meetings (1st meeting within 3- 5 days of admission)

Medical Discharge Criteria

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

See Management Essentials beginning on page 3

Recommendations/ Considerations

- The goal of hospitalization is medical stabilization, correcting and preventing complications, and transitioning to an eating disorder treatment program (outpatient or inpatient depending on individual circumstances).
- The major manifestations of refeeding syndrome are: delirium, chest pain, heart failure often in association with hypo-phosphatemia and depletion of potassium and magnesium.
- Eating disorders are associated with significant mortality and morbidity. Prognosis is generally guarded.
- The mainstay of management is a team-centered approach to the patient and family

Patient Education

Parent/Patient handout:
"What to Expect – Medical Stabilization for Eating Disorder"
KidsHealth handout (as appropriate) Eating Disorders (parent version)
Eating Disorders Resource list

Approved Care Guidelines Committee 6-18-08
Reviewed 1-25-11, 9-17-14, 11-16-16

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

Classification of Degree of Malnutrition for adolescents with eating disorders

	Mild	Moderate	Severe
%mBMI	80%–90%	70%–79%	<70%
BMI *z* score	−1 to −1.9	−2 to −2.9	−3 or Greater
Weight loss	>10% Body mass loss	>15% Body mass loss	>20% Body mass loss in 1 year or >10% body mass loss in 6 months

(Golden, J Adolesc Health 2015)

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Eating Disorders Care Guideline

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9-27-16

Management Essentials for the Treatment & Medical Stabilization of Eating Disorders

Eating disorders are debilitating disorders that can result in disturbance of eating behaviors, body image distortions, and considerable and anxiety and obsessional thoughts. Early recognition and treatment is crucial to avoid permanent medical complications and to increase the likelihood of a timely recovery. For child and teens, research has shown that Family Based Treatment (FBT) (aka Maudsley model) has the best outcome. The FBT approach engages families to help them understand and take charge of their child's eating disorder behaviors. FBT is characterized by a non-judgmental stance regarding the origin of the eating disorder and a conceptualization of parents as the primary resource in restoring their child back to health. The focus of the treatment is orchestrating a parent-driven intervention to restore healthy eating patterns in the child and then gradually transitioning the child back to eating autonomy (Lock & Le Grange, 2013). At CHOC, our multidisciplinary team uses an FBT approach adapted to an inpatient setting. Our physicians, dieticians, and nurses oversee the medical recovery of the malnourished and medically unstable patient. Psychology, social work, case management, and child life help support the family by providing structure, behavioral plans, psychosocial support, and discharge planning. The parents are considered a vital part of the patient's care team. The FBT model helps guide our daily approach with our parents by encouraging typical family interactions (e.g., visits from family and friends for emotional support, meals with the patient), involving them in treatment interventions (meal planning, meal coaching, promoting positive coping strategies), and empowering them the knowledge and skills to be able to continue their child's recovery following inpatient discharge.

COMMON EATING DISORDERS IN CHILDREN

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

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

Avoidant and Restrictive Food Intake Disorder (ARFID) is an eating or feeding disturbance as manifested by persistent failure to meet appropriate nutritional and/or energy needs. As a result of the eating problem, the person is not able to take in adequate calories or nutrition through his/her diet. There are many types of eating problems that might warrant an ARFID diagnosis, including perception of difficulty digesting certain foods, avoiding certain colors and textures of food, eating only very small portions, having no appetite, or being afraid to eat due to fear of choking or vomiting. ARFID is not better explained by a lack of available food or a culturally sanctioned practice does not occur exclusively during the course of another eating disorder, and there is no evidence of a disturbance in body weight or shape.

Other Specified Feeding or Eating Disorder (OSFED) is a feeding or eating disorder that causes significant distress or impairment, but does not meet the criteria for another feeding or eating disorder.

Atypical anorexia nervosa: All of the criteria for anorexia nervosa are met except that

CHOC Care Guideline Admission Criteria

Patients are admitted for vital sign instability, significant electrolyte abnormalities, cardiac disturbance, or being less than 75% mean Body Mass Index (50% for height and weght) *or considered to be at a significantly lower weight than is expected.* Additionally, patients who are admitted may have failed to respond to or comply with outpatient management.

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

The most critical aspects of care are:

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

All patients are on strict medical bed rest initially.
All patients' orthostatic vital signs are assessed throughout entire stay.
All patients are on very closely observed calories.

General Restrictions

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

- 1:1 sitter for the first 24 hours. The patient's care team will evaluate the appropriateness of discharging the 1:1 sitter after 24 hours and switch to video monitoring.
- No outside food is to be provided to the patient unless approved by Nutrition Services.
- No food to be left in room after meal completed.
- No cafeteria privileges for meals or snacks.
- No bathroom use for at least one hour after meals.
- For the first 24 hours, only the immediate family will be allowed to visit.
- Visitors can visit after 24 hours, per care team clearance.
- Parents are to review 'Visitor Guidelines' with visitors.
- Parent and visitors may only eat in room if patient is also eating
- No telephone, cell phone, or computer privileges unless deemed appropriate by the care team.
- May not leave unit, unless deemed appropriate by the care team.
- Belongings will be inventoried at admission and as needed during the hospitalization.
- New items (e.g., presents, reading material, etc.) will be inventoried and reviewed for appropriateness throughout hospitalization.

Orthostatic Vital Signs

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

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

Vital Sign Stability Criteria

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

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

The three activity levels that patients typically progress through prior to discharge are:

1. **Strict Medical Bedrest** (Level 1) – orthostatic VS Q4H unless unstable, in which case they are repeated Q2H until stable
   - The criteria for moving from "Strict Medical Bedrest" to "Bedrest and Wheelchair Activity" are **no more 3 to 5 VS instabilities during 24 HRS (AM rounds to AM rounds),** asymptomatic, normal labs, consuming at least 50% of solid nutrition, and is at least 75% of ideal body weight.
   - Sometimes the first morning orthostatic BP or pulse change will be disregarded in this evaluation.
   - Night notify parameters: Nursing to discuss night notify parameters of vital signs after 5 day with MD
2. **Bedrest and Wheelchair Activity** (Level 2) – orthostatic VS Q4H
   - The criteria for moving from "Bedrest and Wheelchair Activity" to "Bedrest and Ambulation Activity" are no more 3 to 5 VS instabilities for 24 HRS, asymptomatic, normal labs, consuming at least 75% of solid nutrition, and is at least 75% of ideal body weight.
   - Again the first morning orthostatic change may be disregarded.
3. **Bedrest and Ambulation Activity** (Level 3) – orthostatic VS Q4H unless unstable

*** Please refer to the Activity Level Progression Schedule document for a more comprehensive review and considerations for moving through the activity levels.

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

It is important to determine which activity level *your patient is on and make sure he/she adheres to it. Too much activity is a strain on his/her compromised cardiovascular system and delays healing. Hypotension places him/her at risk for fainting and falling if he/she gets up. Another extremely important aspect of protecting patients from too much activity is conserving energy to allow weight gain.*

Activity Levels

Strict Medical Bedrest (Level 1)

Activity: Complete bedrest with commode at bedside. Stand only for weight in AM, and for vitals; sit in chair for linen change; bedbath only - no shower. May have hair washed in bed only if not hypothermic or bradycardic at the time (may check with charge nurse if uncertain).
May shower (seated) weekly after one week if has not progressed.

Vitals:

- Q4H temp and orthostatic pulse and BP – days and evenings after stable
- Q4H temp and resting pulse (lying flat) – nights
- If hypothermic – actively warm with blankets or patient may require Bear Hugger warming blanket at night

Cardiac Monitoring: Generally a patient is placed on continuous cardiac monitoring when admitted to strict bedrest. This is to monitor anticipated or existing bradycardia. If there is no order for this at time of admission, it is important to clarify with MD. The monitor is usually discontinued during the day first, once the pulse is 50 or greater for several days. It remains on during the night until the pulse is 50 or greater for 2 nights in a row.

Bedrest and Wheelchair Activity (Level 2)

Activity: The patient will use a wheelchair pushed by staff to take laps on the floor and be wheeled to the playroom for seated activities to promote physical activity, as ordered by the medical team. The patient can walk to and use of toilet in bathroom, and briefly stand at sink to brush teeth or use sink with a caregiver/staff within arm's reach due to potential fall risk. Patient should use chair for meals, crafts, homework, or other purposeful seated activities. The patient must be on his/her bed at all other times.

Vitals:

- Q4H temp and orthostatic pulse & BP – days and evenings after stable
- Q4H temp & resting pulse (flat) – nights
- If hypothermic actively warm and recheck temp in 30 min.

Bedrest and Ambulation Activity (Level 3)

Activity: Physical activity will include walking laps and walking to the playroom, as ordered by the medical team. The patient may ambulate purposefully in his/her room within reason. He/she may use the bathroom for brief periods of time including use of standing shower ($\leq$ 15 min). The patient must be in a chair or on his/her bed at all other times.

Vitals:

Q4H temp and orthostatic pulse & BP – days and evenings after stable
Q4H temp & resting pulse (flat) – nights
If hypothermic actively warm and recheck temp in 30 min.

Supervision

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

Night Care

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

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

NUTRITION

Orders specify number of cans of Boost. Each can of Boost equals 240 calories.
Boost with fiber may be ordered if a patient complains of constipation. Unfortunately, some patients do not like the taste of fiber. Ice may be given if patient is not hypothermic or bradycardic (pulse < 46) at the time. Ice is equivalent to ½ the amount in water. It must be put on intake and goes toward fluid max/min along with their liquid nutrition.

The patient must consume meals within 30 minutes. Snacks must be consumed within 15 minutes. Boost is used to supplement meal calories not eaten within 30 minutes (Example: 300 kcal/meal, 50% eaten, substitute 150 ml of Boost), and snack calories not eaten within 15 minutes. Boost (or equivalent product) must be consumed within 15 minutes. Food tray to be removed immediately after meal. If patient refuses to complete meals, treatment team will discuss NGT placement. NGT will likely remain until patient consumes desired oral intake or until transfer. The team will determine the goal of desired oral intake as well as when to remove the NGT. While it may be tempting to threaten

placement NGT, it is more effective to state, *"It is your choice to eat or not to eat. If you choose not to eat, then we will need to place the NG tube to make sure your body gets the nutrition it needs."*

As a 1:1 sister, remove food or Boost from room if you discover you need something or need to take a call, etc. You may chart if you can keep a close eye on the patient, but remember all it takes is a glance away to dump Boost or food into a wastebasket, linen, etc. For both 1:1 sitters and video monitoring sitters, giving firm limits are frequently necessary, with the explanation that we understand this isn't easy for them. Document and specify the percentage of each food item the patient has consumed. If patients are unable to complete meal by end of allotted time, the resident is notified to determine if more time should be given or if the remainder should be given NGT.

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

Weigh-In

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

Random Weigh-In

This is ordered when numbers don't make sense, in order to rule out possibility of patients using weights, not voiding prior to weigh-in, or drinking water just prior to weigh-in, etc. DO NOT TELL PATIENT ABOUT RANDOM WEIGH-IN UNTIL JUST PRIOR TO WEIGH-IN AND STAY WITH THEM AT ALL TIMES UNTIL WEIGH-IN IS COMPLETED. As in AM weigh-ins, patients are asked to void and change into gown (no bra, socks or underwear). Staff needs to be present during voiding and gown change, and may stand just outside bathroom door provided that door is ajar and patient is in direct line of sight. Be as tactful as possible commenting that numbers don't match and doctor is confused.

Intake and Output

Strict I & O are very important. When patients first arrive they tend to be either dehydrated from restricting all intake or over-hydrated in an attempt to increase their weight to avoid admission. Once hospitalized, all intake, including water, is to be observed. Patients may still try to drink when unobserved. Specific gravity along with urine dip with first AM void must be performed before weigh-in. A urine specific gravity of 1.010-1.020 is optimal. Fluid overload is potentially hazardous with peripheral edema, seizures, or congestive heart failure. There are frequently orders for a fluid minimum and maximum. It is important to determine amount of free water or ice allowed at the start of the day once calories are prescribed. PH is also monitored. It is one indication of possible purging. A PH of ≤ 7 is desirable. Other indicators of purging may be decreased output, weight loss, or lack of

weight gain despite increased calories, as well as routine trips to bathroom after meals. If purging is suspected, access to the bathroom may be limited after meals.

Physical Assessment and Medications

Patients are given usual head-to-toe nursing assessment with emphasis on several areas. Any arrhythmia in heart rate should be reported. Watch for peripheral edema, seen most often in ankles, as well as circulation problems with delay cap refill, mottled skin, and cool extremities. Observe for skin breakdown in particularly emaciated patients. Routinely, eating disorder patients are given egg crate mattresses to protect their skin, as well as for comfort. GI complications are frequent and occur as a result of starvation, binging, or vomiting. Starvation may result in constipation and delayed gastric emptying with bloating. Dietary strategies like increased fiber are recommended. A laxative may be ordered if necessary, keeping in mind patient history and laxative abuse potential. Warm packs to abdomen after meals may sometimes alleviate discomfort. It is recognized that discomfort may not be able to fully go away, as such discomfort is normal in the initial stages of the re-nourishment process.

Patients are routinely prescribed zinc, multivitamin, phosphorus and Tums that are given along with breakfast. This is helpful if patients have no free water. Tums is given for calcium and zinc for hair loss and dry skin associated with malnutrition.

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

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

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

Activity Levels Progression Schedule

*** If sitter is assigned, sitter is expected to monitor all activities inside the room and accompany patient on all activities outside the room.**
**** Patients are not allowed off the medical floor if actively suicidal, aggressive, or a flight risk.**

I. Strict Medical Bedrest: Level I:

A. All patients should start at Strict Medical Bedrest, regardless of vital sign instability (e.g., Even patient with bulimia nervosa who only has lab abnormalities) to best assess level of stability.
B. Minimum Strict Medical Bedrest for 24 hrs (most patients will likely be at this stage for at least 1 week).
C. Activity at this level:
    a. Complete bed rest
    b. Commode at bedside
    c. Stand only for weight in am and vitals (in gown, no underwear)
    d. Sit in chair for linen changes
    e. No showers. May have hair washed in bed if not hypothermic or bradycardic
D. When considering advancing to **next activity level**:
    a. No more than 3 to 5 unstable vital signs in the last 24 hours, and is asymptomatic
    b. Improved labs
    c. Patient consuming at least 50% of solid nutrition
    d. Patient is at least 75% mean BMI
    e. There is no concern of over-exercise behavior in hospital

II. Bedrest and Wheelchair Activity: Level II

A. Typical criteria for advancing from "Strict Medical Bedrest" to "Bedrest and Wheelchair Activity" is **no more than 3 to 5 unstable vital signs during 24 HRS (AM rounds to AM rounds)**, however based on individual medical needs and progress.
B. Sometimes the first morning orthostatic BP or pulse change will be disregarded in this evaluation.
C. When known history of low BP or POTS is available, the medical team may consider using less strict criteria for BP increase or pulse increase on standing (e.g., < 35/min), as long as patient is not symptomatic.
D. Activity at this level:
    a. Laps in wheelchair
        i. Start laps around the medical floor 1X after each meal for a total of 3X per day.
        ii. Laps may be increased every day or other day, depending on continued vital sign an lab stability
    b. Visits to playroom
        i. Start with 1 hour of playroom access per day.
        ii. Playroom hours may be increased along with number of laps. For a maximum of 3 hours per day.

c. Chair activity expect for these tasks:
    i. Meals
    ii. Homework
    iii. Arts/Crafts
d. Pt should lie in bed to watch movies or TV or read a book, or other leisure activities
e. Purposeful ambulation within room (e.g., walk to bathroom, etc) for brief periods
f. Stand for weight in am and vitals (in gown, no underwear)
g. Sit in chair for linen changes
h. May briefly stand to brush teeth and/or use sink
i. Seated showers (≤ 15 min).

E. When considering advancing to **next activity level**:
    a. No more than 3 to 5 vital sign instabilities in the last 24 hours, and is asymptomatic
    b. Normal labs
    c. Patient is consuming at least 75% of solid nutrition
    d. Patient is at least 75% of mean BMI
    e. There is no concern of over-exercise behavior in hospital
    f. May consider decreasing activity level (return to Strict Medical Bedrest) if the patient has more than 5 unstable vital signs within a 24 hour period while on Bedrest and Wheelchair Activity Level

III. Bedrest and Ambulation Activity: Level III

A. Typical criteria for advancing from Level II to Level II is **no more than 3 to 5 VS instability during 24 HRS (AM rounds to AM rounds)**, however based on individual medical needs and progress.
B. Sometimes the first morning orthostatic BP or pulse change will be disregarded in this evaluation.
C. When known history of low BP or POTS is available, the medical team may consider using less strict criteria for BP increase or pulse increase on standing (e.g., < 35/min), as long as patient is not symptomatic.
D. Activity at this level:
    a. Walking laps
        i. Start laps around the medical floor 1X after each meal for a total of 3X per day. If patient wants extra laps, may use wheelchair, but total laps not to exceed 3X around floor after each meal.
        ii. Walking laps may be increased every day or other day, depending on continued vital sign stability.
    b. Playroom access:
        i. Patient is expected to access the playroom (or family room) for 3 hours a day to simulate discharge activities.
        ii. Additional hours can be earned as privileges.
    c. Chair activity expect for these tasks:
        i. Meals
        ii. Homework
        iii. Arts/Crafts

iv. Should lay in bed to watch movies or TV or read a book, etc.

d. May have purposeful ambulation within room
e. Stand for weight in am and vitals (in gown, no underwear)
f. May stand for linen changes
g. May stand to use sink/brush teeth
h. May stand for showers (≤ 15 min).

E. Additional ambulation ***privileges*** that can be earned per behavioral plan (Psychology)
   a. Patio access
      i. When earned pt may walk directly to patio and then sit on a chair with a back support.
   b. Seacrest Studios:
      i. When earned p may walk to event, but will need to sit for activity at the studio.
   c. Gift Shop/Meditation/Family Resource Center:
      i. When earned pt may walk to event, but will need to sit for activity at the studio

III. DISCHARGE

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

Mealtime Coaching

CHOC encourages parents and caregivers to support their child during meals and snacks, both throughout his/her hospital stay and after he/she is discharged. Completing all necessary nutrition is a crucial part of your child's hospital stay, as your child is currently admitted for nutritional rehabilitation for medical stabilization. Since meals and snacks can be very challenging for individuals with eating disorders, there are important considerations we would like to share with you. In order to help your child be as successful as possible in completing all nutritional requirements during meals and snacks, please review the follow recommendations:

- Provide positive encouragement to your child during meals and snacks.
    - For example, if your child stops eating his/her food, encourage your child to "take another bite". Offer praise for your child's effort in completing his/her nutrition.
    - A compassionate approach is recommended. Be both firm and supportive.
- As we mentioned, we encourage you to eat with your child during meals and snacks. If you choose to do so, please make sure your meals are balanced and well-portioned. Your dietitian can provide guidance on this as well.
- Limit comments related to your child's eating, calories consumed, or portion sizes.
    - For example, avoid remaking on how small or large the food portion appears.
- Monitor for signs of your child hiding or disposing of food during meals and snacks, and minimize opportunities for your child to hide or dispose of food. For example:
    - Your child should not use the bathroom during meals or snacks
    - Supervise your child's bathroom use. You may also ask your child to count or sing while in the bathroom, to minimize risk for excessive activity or purging behavior.
- The period after a meal or snack is often difficult for individuals with eating disorders. The following can help your child feel better and again minimize opportunities for your child to "get rid of" calories consumed
    - Engage your child in a distracting activity after meals and snacks
    - Engage your child in conversation unrelated to eating
    - Provide praise and encouragement for your child's efforts in completing all nutrition
- Your child may want to know about the amount of calories that he/she is consuming. However, focusing on calories or weight can cause distress in your child and hinder progress in recovery.
    - Remind your child that he/she is receiving all of the nutrition needed to be healthy, and encourage your child to focus on improving health rather than on a number.
- Limit negotiations or arguments with your child during meals and snacks. The following phrases can be helpful to redirect conversation and return your child's focus to the meal or snack:
    - "I know this is hard for you, and I am proud of you for trying your best"
    - "Remember that food is your medicine right now, and is necessary to help you be healthy"
    - "What is on your tray is exactly what your body needs to be healthy"
- If you notice yourself becoming upset during a meal or snack, consider taking a break for yourself before returning calmly to your child's meal or snack

Revised: 11/18/16

What to Expect…
Medical Stabilization Program for Eating Disorders

CHOC has developed a multidisciplinary approach in the treatment of acute medical instability related to eating disorders guided by patient and family care principals to ensure you, as the parent, are part of the treatment process.

Our physicians, dieticians, and nurses oversee the medical recovery of the malnourished and medically unstable child/adolescent. Psychology, social work, case management, and child life help support the family by providing structure, behavioral plans, psychosocial support, and discharge planning. You are considered a vital part of your child's care team. You are encouraged to participate in typical family interactions while in the hospital (e.g., visits from family and friends for emotional support, meals in the room). We will also involve you in treatment interventions (e.g., meal planning, meal coaching, promoting positive coping strategies). Our hope is that we can empower you with the knowledge and skills to be able to continue their child's recovery following discharge from CHOC.

Admission is designed to:

- Assess and treat medical disorders resulting from abnormal eating.
- Provide nutritional rehabilitation
- Prevent long-term and life threatening complications

The patient's stay depends on the level of medical instability. Once medically stable, we will help facilitate treatment arrangements to continue treatment for the eating disorder following discharge.

Treatment includes:

- Complete physical examination and laboratory testing
- Individualized medical treatment plan including vitamin and mineral supplements
- Cardio-respiratory monitoring
- Nutritional assessment and management
- Growth and development evaluation
- Psychological evaluation and monitoring
- Psychiatric medication evaluation and monitoring as needed

<u>We provided a structured behavioral and incentive based program for the treatment of eating disorders per evidence-based guidelines. Treatment will begin with these general guidelines, with plans to individualize motivators and incentives for your child/adolescent within 24-48 hours.</u>

- You child/adolescent will receive supervision of activity at all times, including meals and snacks and bathroom privileges (e.g., 1:1 sitter (minimum of 24 hours) or video monitoring).
- Supervision needs will be reassessed throughout hospitalization.

- Parents are strongly encouraged to participate in care, throughout the hospitalization, and especially as we transition the monitoring to a home-like environment.
- Visitors are permitted after the 24 hours. The parents will review appropriate visitor guidelines with visitors.
- Telephone, cell phone and computer privileges will be earned as part of the structured behavioral plan, but initially restricted for the first 24-48 hours as our team conducts our initial assessment.
- Your child/adolescent may earn the access to other parts of the hospital once more stable (Level 2, 3).
- Your child/adolscent's belongings will be inventoried at admission and as needed during hospitalization.
- New items (e.g., presents, reading material, etc.) will be inventoried and reviewed for appropriateness throughout the hospitalization.
- Meals are to be completed within 30 minutes and snacks are to be completed in 15 minutes, or will be supplemented with Boost (or nutritional substitute).
- Feeding therapies may include NG Tube feedings, if meals are not completed per instruction.
- Your child/adolescent is not allowed outside foods unless approved by Nutrition, as we are carefully monitoring input, weight, and medical instability.
- Your child/adolescent will be asked to refrain from bathroom privileges for at least one hour after meals to discourage maladaptive behaviors.
- Parents are encouraged to eat with the patient and to provide support during meal times. Parents and visitors can only eat in room when patient is also eating; otherwise additional food is not to be left in the room. The family room and cafeteria are available for the parent use.

- Based on your child/adolescent's medical instability (i.e., vital and orthostatics), your child/adolescent will be placed on the appropriate activity level:
  - Strict Medical Bedrest (Level 1): Complete bedrest with commode at bedside. May stand only for daily weight and vitals; sit in chair for linen change; bed bath only, no shower.
  - Bedrest and Wheelchair Activity (Level 2): Pushed in a wheelchair by staff/parent on the floor and access playroom, per medical orders; may take seated shower (≤ 15 min); walk to toilet in bathroom and briefly stand to brush teeth or use sink; sit in chair for activities (e.g., meals, crafts, games, etc.); Otherwise on bedrest.
  - Bedrest and Ambulation Activity Level 3): Take walks around the floor and to the playroom accompanied by staff/parent, per medical orders; may use toilet in bathroom and take standing showers(≤ 15 min); may be up in room for short periods. Otherwise on bedrest.

American Dietetic Association. Position of the American Dietetic Association: Nutrition Intervention in the Treatment of Eating Disorders. Journal of the American Dietetic Association. 2011; 111, 1236-1241. http://www.eatright.org/position

American Psychiatric Association Work Group on Eating Disorders. Practice Guideline for the Treatment of Patients with Eating Disorders. Third Edition; June 2006. http://www.psychiatryonline.com/pracGuide/loadGuidelinePdf.aspx?file=EatingDisorders3ePG_04-28-06

Guideline Watch (August 2012): Practice Guideline for the Treatment of Patients With Eating Disorders, 3rd Edition.
Published online: January 01, 2014. http://dx.doi.org/10.1176/appi.focus.120404

Resources for Families

Book recommendations:
Help Your Teenager Beat an Eating Disorder by James Lock & Daniel le Grange
Decoding Anorexia by Carrie Arnold
Eating with Your Anorexic by Laura Collins
Goodbye ED, Hello Me by Jenni Schaefer

Websites:
http://eatingwithyouranorexic.com
http://www.feast-ed.org/
http://www.maudsleyparents.org/
http://www.parents-to-parents.org
http://thefamilydinnerproject.org/