Connecticut Children's MEDICAL CENTER	**CCMC Corporation**		
	☑Connecticut Children's Medical Center **❑Connecticut Children's Specialty Group, Inc.**	**❑CCMC Affiliates Inc.** **❑Connecticut Children's Medical Center Foundation, Inc.**	
	Provision of Care, Treatment and Services	Date Effective:	November 29, 2013
	Protocol: Eating Disorder	Date of Origin:	February 01, 2003
	Approved By: Clinical Council	Date Approved:	November 28, 2013

I. Purpose

It is the purpose of this document to provide guidance in the medical stabilization and care of eating disorder patients at Connecticut Children's Medical Center (Connecticut Children's). Specifically, the aim is to achieve the following goals: reinitiate nutrition in a safe environment, prevent re-feeding syndrome, establish the ability to maintain weight with activity, and develop a discharge plan with appropriate referrals and patient disposition.

II. Background

Children with eating disorders can be acutely ill and in a state of malnutrition, dehydration, or starvation. They may engage in self-induced vomiting, use laxatives or diuretics, engage in strict dieting or fasting, or use vigorous exercise to prevent weight gain. They may experience related mental illness, including depression, anxiety, obsessive compulsive disorder (OCD), and suicidal ideation, Admission to Connecticut Children's usually occurs through the Emergency Department (ED), through a psychiatric referral, or through a primary care physician referral. Medical and nutritional stabilization in concert with psychiatric consultation remain the most important pillars of inpatient treatment at Connecticut Children's.

III. Determining Medical Necessity for Admission

The criteria below help to identify patients who require inpatient medical stabilization and are at significant risk of refeeding syndrome. They are based on guidelines and literature from the American Academy of Pediatrics, the Society of Adolescent Medicine, the American Dietetic Association and the American Psychiatric Association. They are meant as a guide only and are not binding or all-inclusive.

IV. Guidelines for Hospital Admission for Children & Adolescents with Eating Disorders:

In general terms, the typical patient in need of inpatient admission will have at least one Primary plus at least two Secondary criteria. However, individual patients will vary and clinical judgment is most important in making the admission decision.

A. Primary Criteria (weight based):
- <75% of Ideal Body Weight (IBW) (see "Guide to Calculating % IBW" Appendix A)
- Acute food refusal combined with 10% weight loss over a 3 month period

B. Secondary Criteria (vital sign and laboratory data based):
- Heart rate ≤ 49 beats per minute awake; ≤ 45 beats per minute with sleep
- Systolic blood pressure below 80 mmHg
- Orthostatic changes in blood pressure (> 10–mmHg) or pulse (>20 beats per minute)
- Electrolyte disturbances (e.g. hypokalemia, hypophosphatemia, hypomagnesemia)
- Dehydration

- Temperature <36C
- Arrhythmia, prolonged QTc
- Serum chloride concentration <88mmol/L
- Esophageal tear (e.g. Mallory-Weiss)
- Intractable vomiting or hematemesis

V. Key Procedural Steps

A. Thorough History and Physical including these elements:

1.Height and weight with calculation of % IBW
2. History of weight loss
3. History of binging/purging
4. Diet (intake) history
5. History of alcohol or substance use
6. Medications (including nutraceuticals, herbs, or non-prescription drugs)
7.Exercise history
8. History of syncope
9.Menstrual periods
10. Orthostatic Blood Pressure and Heart Rate
11.Hydration status
12. Cardiac and peripheral vascular exam
13.Bulimia specific signs (dental erosion, knuckle abrasions)

B. Pre-treatment Evaluation (studies which may help to determine medical stability, may occur in ED or in the outpatient setting)

1. History and Physical with specific elements as above
2. Limited serum chemistries (Chem 10 or (iStat Chem 8 + Magnesium, Phosphorous)) 3.12 lead EKG (to check for arrhythmias or prolonged QTc)

C. Orders:

1. Once it is determined that the patient requires admission for medical stabilization, all care is coordinated by the multidisciplinary team based on this protocol.
2. The Patient handout is to be given to the patient and family at the time of admission. The protocol must be signed by the patient and family to indicate receipt of the handout. Any questions should be referred to the Attending MD. If the Attending pediatrician has questions regarding the handout's guidelines, these should be directed to the psychiatrist on call.
3. Vital signs:
   a) Take first set in orthostatic positions on admission.
   b) If orthostatic blood pressure or heart rate is abnormal, take daily until normalized.
   c) Subsequently vital signs every 4 hours per unit standard.

D. Activity Status: Admit initially to Activity Level 1

a) There are three activity levels which are prescribed by the medical team as medical status allows. Orders need to be placed to direct and advance activity level. Activity level is advanced based on increasing medical stability and are entirely separate from privilege advancements.

b) Level 1: Strict bed rest due to vital sign instability (typically first 24 hours). May be out of bed for bathroom use only.
Level 2: Should advance to this level once vital signs and orthostatic symptoms stabilize (not orthostatic for BP, no symptoms when upright). Goal is to achieve this level within 24-36 hours. At Activity Level 2, patient will be off strict bed rest and can be out of bed in the room for meals. Patient may also be allowed to leave room in wheelchair for limited scheduled hospital activities as determined by the medical team.

Since taking a shower requires both medical and psychological stability, allowing the patient to shower is determined by the medical and psychiatric teams, based on both medical and psychological factors.

c) Level 3: Once patient's oral intake is at a level that promotes weight gain at Level 2 activity, patient should be advanced to Level 3. This level includes ad lib activity in the room as prescribed by the medical team, and a slow progression of daily walks starting with one five minute walk per day then advanced to two walks per day, up to three walks per day as long as weight gain continues with this increased activity. This allows patients to begin to self-regulate activity as they gain medical stability.

5. Observation: 1: 1 sitter on admission, with need for observation reduced as medical and psychiatric condition warrant, based on compliance with protocol and extent of interfering Eating Disorder behaviors. Consideration of reducing sitter to “meals and 1 hour after” will be made on day 3, in consultation with psychiatry.

6. Admission Labs/Procedures (day 1 of admission): a)12 lead EKG (if not already done)
b) Chem 10 (if not just done) (includes electrolytes, glucose, BUN, creatinine, calcium, magnesium, phosphorous)
c) AST, ALT, GGT, alkaline phosphatase
d) Ferritin, percent iron saturation
d) T4 & TSH
e) Albumin, Pre-albumin, Triglycerides
f) CBC with differential
h) Urinalysis
i) Urine for hCG (for female patients) 7.Daily labs:
a) Obtain daily i-Stat Chem 10 on days 2 through 5, then if labs have been stable can obtain i-Stat Chem 10 every other day.

Pay special attention to those electrolytes typically affected in refeeding syndrome, e.g.

potassium, phosphorous, magnesium, and calcium.

c) Once labs stable for two weeks total, can discontinue all scheduled labs unless otherwise indicated.

8. Pre-albumin every 3 days, if low on admission.
9. Medications to consider based on lab values (Patients with Anorexia): Registered Dietician (RD) to be paged on admission can help to guide the following:
   a)Tums
   b) Oral phosphorous supplement (Phos-NaK: one packet contains 250 mg Phosphorous, 160 mg (7 mEq) Sodium and 280 mg (7.2 mEq) of Potassium)
   c) Consider intravenous P04 replacement if phosphate levels are ≤ 2 mg/dL
10. Medications to consider based on lab values (Patients with Bulimia): RD to be paged on admission, can help to guide the following:
   a) Consider phosphorous supplement if patient has history of abusing non-phosphate laxatives:
      (1)Phos-NaK: one packet contains 250 mg Phosphorous, 160 mg (7 mEq) Sodium and 280 mg (7.2 mEq) of Potassium.
   b) Consider intravenous phosphate replacement if phosphate level is less than or equal to 2 mg/dL.
   b) Consider sodium bicarbonate or oral Bicitra if bicarbonate levels are low.
   c) Consider potassium supplementation with patients who have low serum potassium and normal pH (indicative of dangerous reduction in total body potassium).
   d) Start a complete vitamin-mineral supplementation on admission.
11. Weigh patient every morning after the first void, JUST prior to eating breakfast, in hospital gown ONLY (no socks, underwear, etc.), while standing with his/her back to the scale. Neither the patient nor the family is to be told the weight, but they may be told whether the weight is up, down, or the same.
12. Strict I's & O's with an accurate recording of foods consumed once admitted.

13. Monitoring:
    a) Place patient on cardio-respiratory monitor and pulse oximeter on admission, and for first 24 hours of stay. Continue monitoring based on MD order.
14. Nutrition and Fluids:
    a) Start feeding immediately after admission lab results have been reviewed and orders have been written.
    b) Vitamin/mineral supplements per RD recommendation
    c) Initiate Meal Plan (separate meal plans for Anorexia and Bulimia).
    d) Advance diet per RD recommendation.
    e) Intravenous fluids: Order only if necessary based on assessment of fluid balance. Goal is that total fluid intake (PO and IV) achieves 75% maintenance. Therefore, during Steps 1-3, IV supplementation may be necessary if PO portion does not achieve 75% maintenance,
    f) IV fluids should be discontinued when the patient reaches Step 3 of the dietary guidelines, or when full maintenance is achieved.
    g) Free water per RD recommendation only to help achieve fluid goals.
    h) Automatic Consults (within 24 hours):
    i) Nutrition (page Registered Dietician at admission)
    j) Psychiatry (only available on site Monday-Friday [enter consult and also call x58604] but accessible by phone consultation on weekends and holidays [call x57200])
    k) Cardiology “echocardiogram only” consult
    l) Others as appropriate, e.g., OT/PT.
    m) For patients with Bulimia, consider Dental consult post-discharge if oral exam indicates as well as GI consult if long-term esophagitis is suspected.

E. Documentation:
1. Document Medical indication for admission in medical record (e.g. bradycardia, hypophosphatemia, severe malnutrition as defined by % IBW, etc.)
2. Document all vital signs and assessments per protocol on the patient's flow sheet and include vital signs and daily BMI in the daily progress note.
3. Document patient/family teaching regarding this protocol in the medical record.
4. Describe the patient/family's response to care in the medical record.
5. MD or practitioner note should document patient progress in terms of exam, lab data, nutritional stage, activity level, privilege level and expected discharge/ transfer criteria.

F. Managing Daily Care

1. Diet Advancement: Occurs in consultation with the Registered Dietician, via stages called "Steps." The goal is to increase calories gradually to prevent re-feeding syndrome, while still moving towards medical stability. After each day of 100% compliance with the diet, the meal plan needs to be advanced to the next Step. This advancement is done via an order placed in the evening after the 8:30 pm snack, to take effect the following morning. If patient is to stay at the same Step, that decision will be documented in the progress note and will be based on a multidisciplinary determination.
2. Activity Advancement:
   a) The activity advancement is based on the patient's medical stability. This assessment should occur daily. See IV.C.4 above for guidance in how to advance patients from one activity level to the next.
   b) Any changes in activity level need to be put in as a new order, typically following discussion of all data on morning rounds.
3. Privilege Advancement:
   a) The privilege advancement is based on the patient's compliance with the diet plan.
   b) Each evening, a discussion should occur between the RN and ordering practitioner after the patient's 8:30 pm snack, to discuss the patient's compliance for that day.
   c) Following a day of 100% compliance with both solids and liquids, the patient is directed to identify the next day's privilege (using the privilege list).
   d) The order for the next day's privilege advancement is then put in as an order to begin the following day at 9 am. Previously obtained privileges cannot be lost.
   e) Each morning on rounds, the patient and family should be updated regarding the patient's activity level, privileges to date and advancement plans for the day. Providers should not discuss with the child the specific calories, weight or meal increases (as these may increase patient anxiety).
   f) No homework to start. Will consider starting a separate privilege per psychiatry team.

G. Discharge-Transfer Readiness:

1. Based on assessment of multiple factors which include, but are not limited to:
   - Physiologic and Cardiovascular stability
   - Achievement of a diet plan which will lead to ongoing medical stability
   - Weight gain or weight stabilization with activity (amount of activity may vary)
   - Acceptable ranges for electrolytes and other laboratory data
   - Appropriate plan for placement, disposition and follow up

VI. References

American Dietetic Association Position of the American Dietetic Association: nutrition intervention in the treatment of anorexia nervosa, bulimia nervosa, and other eating disorders. JADA 2006; 106:2073-2082.

American Psychiatric Association Practice guideline for treatment of patients with eating disorders Am J Psychiatry. 2000; 157(suppl 1): SI-S39.

American Psychiatric Association Treatment of Patients With Eating Disorders, Third Edition. Am. J Psychiatry 163:7, July 2006 Supplement.

Committee on Adolescence Identifying and treating eating disorders Pediatrics. 2003; 11 I: 204-211

Rome ES, Ammerman S, Rosen DS, Keller RJ, Lock J, Mammel KA, O'Toole J, Rees JM, Sanders MJ, Sawyer SM, Cneider M, Sigel E, Silber TJ. Children and adolescents with eating disorders: the state of the art. Pediatrics 2003; 111:98-108.

VII. Related Documents

Assessment and Reassessment of Patients
Nutraceutical Use at Connecticut Children's
Observation for Non-behavioral Management
Restraint and Seclusion

VIII. Appendices

Appendix A: Guide to Calculating % Ideal Body Weight

Appendix B: Meal Plan for a Child with Anorexia Nervosa

Appendix C: Meal Plan for a Child with Bulimia Nervosa

Appendix D: Patient Handout

Appendix E: Protocol Worksheet

Appendix F: Privilege Men

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Appendix A:

Guide to Calculating % Ideal Body Weight

Steps:

1. Find Patient's BMI using the following link (need patient's weight & height)
   http://www.nhlbisupport.com/bmi/bminojs.htm

2. Using a CDC growth/BMI chart (or one of the links below):
   BOYS:
   http://www.cdc.gov/growthcharts/data/set1clinical/cj41c023.pdf
   GIRLS:
   http://www.cdc.gov/growthcharts/data/se1clinical/cj41c024.pdf
   Find the BMI at the 50th %'tile for the patient's age.

3. % Ideal Body Weight (% IBW) = $\frac{\text{Patient's BMI}}{\text{BMI at 50}^{th}\text{ %'ile for age}}$

   Example:

   15 y/o girl has a BMI of 14 (based on entering her height and weight via link above)
   BMI at 50th %'ile for her age = 20 (from BMI chart)

   % IBW= $\frac{14}{20}$ = 70%

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Appendix B:

Meal Plan for a Child with Anorexia Nervosa

☐ No additional coffee, tea, diet soda, soda, or juice. Free water as below.

☐ **Step One**: First meal after admission; 6 mini meals consisting of: 185 mls of Ensure 1 packet crackers at each meal (1200 total calories), with minimum of 24 oz of water per 24 hour period.
Continue until patient complies with Step One.

☐ **Step Two**: 6 meals consisting of: 220 of Ensure + 1 packet crackers with each meal (1500 total calories). Continue until patient complies with Step Two, with minimum of 24oz. of water per 24 hour period
During step 2, the patient will be allowed to choose 3 food dislikes but will be told that the Registered Dietician (RD) will choose the meal plan to meet the patient's nutritional needs.

☐ **Step Three**: 6 meals--Limited food choices.
Meal plans provided by Clinical Nutrition (1800 total calories).

☐ **Step Four through discharge**: Increase intake by 20% or 100-200 kcal/day to goal set by Clinical Nutrition. Step number continues to advance until reaching adequate intake, as determined by Clinical Nutrition.

The goal of the meal plan for the first four days is to prevent further weight loss, and to encourage patient compliance. The patient may not gain weight initially.

The decision to begin nasogastric tube (NG Tube) feedings is based on medical necessity as determined by the multi-disciplinary team. It will be considered if the patient is unable to take in 100% of nutritional requirements AND is continuing to lose weight to the point of compromising medical stability. The protocol for placement is that the patient will be notified during the day that his/her medical status is threatened and that a nasogastric tube is being considered. The patient will also be told that he/she will be given the opportunity to take in the missed calories at the 8:30 pm snack by drinking a liquid nutrition supplement. (Refer to caloric amounts on menus to determine amount consumed during day; consult with Diet Technician if needed). If the patient is unable to make up the missing calories for the day at that 8:30 pm snack, an NG Tube will be placed for overnight feeds. The NG Tube will then be taken out when the feeding is completed, at least 2 hours prior to the next day's breakfast. The patient will then be allowed a "fresh start" to be able to achieve 100% compliance with the diet for the coming day.

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Appendix C:

Meal Plan for a Child with Bulimia Nervosa

All meals/snacks should contain adequate fat and fiber to prevent excessive feelings of hunger.

The goal of the meal plan for the first 4 days is to prevent weight loss and to encourage patient compliance. Actual weight gain may not be a goal during the admission.

Allow additional fluids after eating the meal as planned. Restrictions on patients who are meeting meal goals are not recommended.

- **Step One**: Starts with first meal after admission (1500 total calories per day).
  - Three meals/three snacks
  - Patient selects foods from modified menu
  - Continue until patient is compliant with Step One for 24 hours.
  - Minimum of 24oz. of water.

- **Step Two**: (1750 total calories per day)
  - Three meals/three snacks
  - Patient selects foods from modified menu
  - Continue until patient is compliant with Step Two for 24 hours
  - Minimum of 24oz. of water.

- **Step Three**: (2000 total calories per day)
  - Three meals/three snacks
  - Patient selects foods from modified menu

- **Step Four through discharge**:
  Increase intake by 20 % or 100-200 kcal/day to achieve goal established by Clinical Nutrition.

The decision to begin nasogastric tube (NG Tube) feedings is based on medical necessity as determined by the multi-disciplinary team. It will be considered if the patient is unable to take in 100% of nutritional requirements AND is continuing to lose weight to the point of compromising medical stability. The protocol for placement is that the patient will be notified during the day that his/her medical status is threatened and that a nasogastric tube is being considered. The patient will also be told that he/she will be given the opportunity to take in the missed calories at the 8:30 pm snack by drinking a liquid nutrition supplement. (Refer to caloric amounts on menus to determine amount consumed during day; consult with Diet Technician if needed). If the patient is unable to make up the missing calories for the day at that 8:30 pm snack, an NG Tube will be placed for overnight feeds. The NG Tube will then be taken out when the feeding is completed, at least 2 hours prior to the next day's breakfast. The patient will then be allowed a "fresh start" to be able to achieve 100% compliance with the diet for the coming day.

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Appendix D:

PATIENT HANDOUT

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. Your team will keep you up to date with your progress during your hospital stay.

Patient Protocol

Wake Up/Dress Guidelines:

1. At time of admission, you will be asked to dress in long pajama pants, a long-sleeved shirt, and socks.
2. You need to wake up, get weighed, and be dressed prior to breakfast.
3. Clothing per activity level.

Weight Guidelines:

1. You will need to be weighed dally, before breakfast, after 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. No jewelry is to be worn.
4. You may not eat, drink, bathe, or brush your teeth before getting weighed.
5. You must stand on the scale with your back toward the weight.
6. Neither you nor your family will be told your actual weight, but you will be told the general trend of up, down, or the same.

Meal Guidelines:

1. There will be 6 mini-meals per day. Each day, if you are 100% compliant, your meals will be advanced through a system as directed by your Registered Dietician. For the first 2 days nutrition is provided through Ensure and crackers. Once you achieve Step 2, you will be allowed to choose 3 food dislikes. The RD will then be in charge of creating a balanced meal plan that meets nutritional and caloric needs. All meals will be supervised by staff.
2. There will be no visitors and no activities allowed during mealtime, unless receiving 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.
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 mini-meal. After that time, the tray will be removed from your room.
5. Approximate meal times are:

	8:00		8:30
B =	a.m.	-	a.m.

	10:00 a.m.		10:30
S =	-		a.m.
	12:00 p.m.		12:30
L =	-		p.m.
	2:30		3:00
S =	p.m.	-	p.m.
	5:00		5:30
D =	p.m.	-	p.m.
	8:30		9:00
S =	p.m.	-	p.m.

6. Staff will record food intake on the graphic sheet.
7. No food, beverages, cups, or dishes are allowed in your room, including the food/beverage of family members.
8. Meal plans are advanced in the evening based on compliance and will begin at breakfast the next morning.

   100% compliance with daily nutrition (food and water) is expected. If you are unable to meet 100% compliance and medical status warrants, a feeding tube may be required. If this feeding tube, called a Nasogastric Tube (NG Tube) is required, it will be placed at night after the 8:30 pm snack, during which you have an opportunity to take the remaining calories by mouth. In the am, the NG Tube is removed to allow for a fresh start at taking meals by mouth. The patient and family will be notified if the patient's medical condition warrants this level of intervention.

<u>Unit Environment:</u>

1. The family kitchen is off limits.
2. Bedside curtains must be kept open except when dressing.
3. Bathroom use is supervised by staff.
4. There is no bathroom use for 1 hour after all meals.
5. Staff will measure urinary output after each void.
6. You will be placed on constant observation on admission. *This means there will be a Patient Care Assistant (PCA) who sits outside your door to provide safety & support and monitor for any disordered eating behaviors.*
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 raise anxiety. The treatment team will help guide the family as to appropriate discussions and meal support.

Visiting:

1. Immediate family and clergy may visit, at any time except mealtime, unless ordered otherwise by the team.
2. Friends and extended family members may only visit after the privilege has been obtained per this protocol.

Activity:

1. All patients are admitted on bed rest.
2. You will be placed on a cardiac monitor upon admission. Length of need for cardiac monitoring depends on your medical condition.
3. Vital signs 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 stretcher.
5. The patient and family will be updated daily regarding advancements in activity level. Activity level will be advanced as medical status improves. All patients are admitted on Activity 1 (bed rest) and activity is then progressed as nutritional status stabilizes and will be identified by level 1, 2, and 3 with increasing ability to leave room in wheelchair and move about in room out of bed. Medical stability requirements for each activity level can be described by the medical team in the sequence per protocol. If the family and/or patient need clarification of privilege or activity level, they are encouraged to check with the medical team, RN, or PCA.

Privileges:

1. You will be admitted to a room without TV, phone, or other in-room activities. Throughout your hospital stay, you may earn these "privileges" based upon 100% compliance with your daily meal plan. If you have been 100% compliant with all food and drink for the entire day, you will be able to earn a privilege (listed on the Privilege Menu) for the following day.
2. On any given day, if you are not 100% compliant then you will not obtain an additional privilege. Previously obtained privileges will not be lost.
3. Privileges for the next day must be selected and communicated to the staff by 10 PM and the staff will document the choice on the care plan.
4. Privileges advance at 9 AM the following day.

Date Reviewed with Patient: _____

Patient Signature: _____

Signature indicates patient received a copy of this handout.

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Appendix E:

Protocol Worksheet

Patient Name: Date: Unit:

Date	Day	Wt (kg)	Meal Plan Calories	100% Compliance	Privileges (*Patient Choice)	Activity Level (Assigned)	Comments
	Admit			Yes No	Begin on Day 2 at 9 AM, if compliant	Advancement requires physiologic stability + weight gain w/ no IV fluids	
	1			Yes No	Not applicable	All patients start at Activity Level One	
	2			Yes No			
	3			Yes No			
	4			Yes No			
	5			Yes No			
	6			Yes No			
	7			Yes No			

***PRIVILEGES are chosen by the patient. See protocol for guidance in granting of privileges.**

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APPENDIX F:

PRIVILEGE MENU

Name: _____ Date: _____

PRIVILEGES: One privilege may be added for each day of 100% compliance with all 6 mini-meals. Please circle your choice by 10 PM today. Your privilege will begin at 9 AM tomorrow.

Arts & Crafts | Phone in Room | Writing

Reading | Visitors | TV & Movies

Games &Video Games
(No wireless devices)
No “Wii” or “Wii-like” devices

Music
(CD player, Keyboard, Other)
(No wireless devices)

Wheelchair rides (once medically stable)
(Three 5-minute rides)