Title: EATING DISORDERS
Responsibility: Registered Nurse (RN) or any other trained personnel under the supervision of an RN at Kobacker

Procedure
1. Obtain a clear history and physical assessment by speaking with the patient, reading past histories and/or talking to the family.
   a. Include detailed information regarding eating patterns/habits, food likes and dislikes, fears around foods, and presence of any food allergies.
   b. Include recent changes in activity, behavior and mood.
   c. Include questions related to cultural and/or religious dietary habits.
   d. Include body image perception.
   e. Obtain history of purging or restricting calorie intake.

2. Inform patient of all relevant diagnostic work-ups that will be performed, i.e., blood work, dental and dietary consults, etc.

3. Check the patient's history for any validated GI disturbances that could effect appetite, absorption, weight.

4. Obtain a baseline weight upon admission then continue with regular weights according to physician's orders. Obtain baseline height upon admission as well.

Points of Emphasis
Verify information with reliable family members when possible. A family history of eating disorders or other psychiatric disorders including alcohol and other substance use disorders, a family history of obesity, family interactions in relation to the patient’s disorder; and family attitudes towards eating, exercise and appearance are all relevant to the assessment.

Verify special "diets" that are said to be cultural or religious.

Be skeptical if any are very low in calories.
1. Explore odd food habits- hoarding, hiding food, rituals
2. Extreme exercise patterns
3. Mood or sleep disturbances
4. Obsessive behavior while eating

Electrolyte imbalance, dental caries, enamel erosion can confirm suspicions of eating disorders. Physiologic requisites for diagnosis of anorexia- Weight less than 35% of expected. Most cases are female adolescents age 13 to 20. Other medical symptoms include cardiac changes such as Bradycardia, hypotension, cold intolerance, hair loss, presence of lazugo, amenorrhea and dehydration.

Obtain weight in the a.m. for accuracy. Respect privacy (many patients with eating disorders have been sexually abused).
5. Monitor patient's intake and output according to physician's orders.  
   a. It may be necessary to decrease H2O intake.  
   b. Implement ordered diet including high calorie supplement if ordered.  
   c. Provide nutritional counseling through a dietary consult.  
   d. Provide a combination of diet and psychosocial treatments.  

6. Monitor mealtime behavior and mood. Observe for unusual eating habits, overeating, pulverizing food, and binge/purge cycles.  
   a. Encourage discussion related to thoughts, feelings and fears.  
   b. Encourage positive coping skills.  
   c. Redirect and/or discourage patient's focus on weight, diet and food.  
   d. Monitor patient during meals to prevent patient from hiding or throwing food away. Observe patient for 1 hour after meals.  

7. Monitor physical behavior and mood after meals and note any nausea, vomiting, diarrhea, or constipation.  

8. Encourage food and juices high in fiber.  

9. Encourage socialization with staff and peers after meals.  
   a. Again, encourage discussion related to thoughts and feelings and discourage talk regarding weight and food.  
   b. Provide education, information about self-help groups to patients and caregivers.  

   Be discrete with monitoring I & O so not to bring attention to the patient.  
   Large amounts of water intake before meals may be used to decrease appetite and increase ease in purging.  
   Patients with eating disorders eat or restrict intake to cover up feelings or fill emotional voids.  

   This promotes adequate elimination and encourages peristalsis in flaccid bowels (related to chronic laxative use).  
   This will help decrease purging behaviors and decrease guilt related to consumption of food.  

   It is imperative to include family members in treatment. It is important to identify family stressors whose amelioration may facilitate recovery. It is essential to involve parents and whatever school personnel and health professional who routinely work with the patient.
10. Do not threaten or punish patient for meal time behavior.  
   a. Ignore negative behavior. Offer support and encouragement, especially as intake increases.  
   b. Encourage patient to follow evidenced based self help programs. Use cognitive behavioral therapy and exposure with response prevention. Also use interpersonal psychotherapy and establish healthy target weight.

11. Monitor patient and assess carefully for suicidal ideation—especially with weight gain.  
   As weight increases, patient may feel extremely out of control. Assessment for suicidality is of particular importance in patients with co-occurring alcohol and other substance use disorder.

12. Convey caring attitude and open communication.  
   Establishes relationship so patient may feel more comfortable discussing feelings. Refer to outpatient counseling upon discharge.

Documentation: In patient's medical record, document the following:  
1. Weight, I&O, dietary consumption  
2. Behavior before, during and after meals.  
3. Any behavior changes and when they occurred  
4. Changes in mood, socialization, activity level, sleep  
5. Interventions utilized and patient's response

Remember: Eating disorders are extremely individualized. The patient usually feels very out of control and complex. Issues around food are easier for them to control than their environmental issues. Give them as much control as safely possible.

Reviewed by: Tammy Cerrone, BSN, RN, Nursing Director Kobacker & Anne Mullins, MSW, LISW-S.

Approved: 7/05  
Reviewed: 4/08, 8/31/2010, 5/14, 8/14, 7/17  
Revised: 8/10, 8/14, 7/17

References: