NURSING SERVICES GUIDELINE
INPATIENT BEHAVIORAL HEALTH

Guideline: **Eating disorders**

Policy Number Superseded:

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

Purpose of Guideline:

Effective Date:
June 2023

Initial Effective Date:
July 2017

PROCEDURE	POINTS OF EMPHASIS
(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.	(1) 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. (a) Explore odd food habits - hoarding, hiding food, rituals. (b) Extreme exercise patterns. (c) Mood or sleep disturbances. (d) Obsessive behavior while eating.

(2) Inform patient of all relevant diagnostic workups that will be performed, i.e., blood work, dental and dietary consults, etc.	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 aged 13 to 20; other medical symptoms include cardiac changes such as Bradycardia, hypotension, cold intolerance, hair loss, presence of lazugo, amenorrhea and dehydration.
(3) Check the patient's history for any validated GI disturbances that could affect 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.	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 H_2O 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.	Be discrete with monitoring I & O so as 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.
(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.	Patients with eating disorders eat or restrict intake to cover up feelings or fill emotional voids.

(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.	This promotes adequate elimination and encourages peristalsis in flaccid bowels (related to chronic laxative use).
(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.	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 professionals who routinely work with the patient.
(10) Do not threaten or punish patient for mealtime 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 behavorial therapy and exposure with response prevention. Also use interpersonal psychotherapy and establish healthy target weight.	This will encourage negative behaviors to continue. Positive feedback and support is most effective. Encourage patient to monitor own care as possible to provide a sense of control.
(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 communication.	Establishes relationship so patient may feel more comfortable discussing feelings. Refer to outpatient counseling upon discharge.

(A) 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.

(B) References.

Allen, K. L., Byrne, S. M., & Crosby, R. D. (2015). Distinguishing between risk factors for bulimia nervosa, binge eating disorder, and purging disorder. *Journal of Youth and Adolescence, 44*(8), 1580-1591.

Roger, R. F., Paxton, S. J. & McLean, S. A. (2014). A biopsychosocial model of body image concerns and disordered eating in early adolescent girls. *Journal of Youth and Adolescence, 43*(5), 814-823.

Sibeoni, J., Orri, M., Valentin, M., Podlipski, M. A., Colin, S., Pradere, J., & Revah-Levy, A. (2017). Metasynthesis of the views about treatment of anorexia nervosa in adolescents: Perspectives of adolescents, parents, and professionals. *PloSone, 12*(1), e0169493

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Initial effective date:
July 2005

Review/Revision Completed by:
Tamara Cerrone, BSN, RN, Director Inpatient Behavioral Health
Reviewed by Policy & Standard Committee
August 2010, August 2014, July 2017, July 2020, June 2023

Review/Revision Date:
April 2008
August 31, 2010
May 2014
August 2014
July 2017
July 2020
June 2023

Next review date:
June 2026