Nutrition Restoration Plan for Eating Disorder Patients

ON ADMISSION
▪ Search patient's belongings for items such as diet pills, laxatives, diuretics, chewing gum, mints, weights etc. Repeat after any leave off ward. Please check after gifts have been received
▪ Provide patient with information regarding what to expect during admission i.e. activity level, observations, bathroom access, meal support, ward leave etc. Explain to patient and significant family members/carers that Nurse Special 24/24 is required
▪ 1:1 nurse special where possible
▪ Obtain height and weight on admission to ward, recheck height on G74
▪ Dietitian referral and review
▪ Ensure psych e-referral has been completed

DURING ADMISSION: *Medical Monitoring*
▪ 4/24 vital signs, small cuff
▪ TDS postural HR and BP: 0600, 1000 & 1800 (manual)
▪ BGLs: 2 hours post prandial (meals) and at 0200 and 0600. If continuous feeds, BGL monitoring QID and 0200hrs
▪ Daily ECG at 0600
▪ Daily urinalysis at 0600 with PVBS (document on weight chart)
▪ Daily bloods, including phosphate and calcium
▪ Daily weight: early morning POST first void, in white gown and knickers/jocks only
▪ Fully supervised daily shower, seated no longer than 10 minutes
▪ Cleaning of teeth, once daily seated at basin
▪ Fully supervised toileting, can be relaxed at the discretion of Medical Consultant only

DURING ADMISSION: *Behaviour Monitoring*
▪ Monitor and document any compensatory behaviours i.e. pacing, exercising, hiding food, purging, tampering with enteral feeds, hanging legs over side of bed
▪ Document mood, presentation, and/or any conversations of concerns.
▪ Outside privileges determined by medical team, to be documented
▪ Walking privileges determined by medical team, to be documented by medical team and usually if patient compliant and medically stable. Usually towards end of admission
▪ Be firm in requirements for compliancy, do not negotiate and if there are issues liaise with CNS/CNC
▪ Be consistent with responses as Eating Disorder patients are often manipulative
▪ Do not mention patient's weight or BMI

DURING ADMISSION: *Nutrition Monitoring*
▪ Oral nutrition meal plan provided by the Dietitian. Patient to consume meals within 30 minute time frame. If 100% of meal not consumed, oral nutritional supplement to be consumed. Snacks and oral nutrition supplements to be consumed within 15 minute timeframe.
▪ Record all oral intake and maintain accurate food intake and fluid balance chart
▪ No food or drinks allowed to be consumed outside of Dietitian meal plan, no food to be allowed from outside sources.
▪ No artificial or diet food / drinks allowed.
▪ Maximum 2 cups/tea/coffee/milo/herbal tea/hot water per day.
▪ No lukewarm water.
▪ Patient to go to the toilet before meals / snacks / nutritional supplements.
▪ Strict bed rest 60 minutes post meals and 30 minutes post snacks / nutritional supplements.
▪ Oral nutrition supplements (Fresubin Energy / Fresubin 2kcal Fibre) o *Do not freeze or heat and ensure patient does not over shake bottle*
▪ 2L fluid restriction, excluding enteral feeds and nutritional supplements. Restriction may be altered according to medical requirements.
▪ Avoid co phenylcaine spray as can worsen tachycardia and has a weight loss effect.
▪ Xylocaine Viscous Gel can be used 48hrs post NG insertion
▪ **No** lozenges as they contain artificial sweeteners and can cause diarrhoea
▪ If nasogastric feeding is required, size 12 NG tube to be inserted only, **no** paediatric tubes.
▪ Continuous enteral feeding regime determined by the Dietitian, with 4 hourly aspirations, flushes and measurements o Aspirate at least 20mls to ensure stomach contents and ph test o Measure NGT to very end of attachment
▪ Hypoglycaemia Management: o BGL 3.5 – 4.0 mmol 100mls fresubin energy o BGL below 3.5 mmol for glucose drink 60mls, then fresubin energy 100mls