Eating Disorders - Refeeding Pathway v8.0: **Table of Contents**

Stop and **Review**

Inclusion Criteria

- 5-17 years (if ≥18, call Psych re: consent issues that may preclude admission)
- Concern for eating disorder (Anorexia nervosa, avoidant restrictive food intake disorder, eating disorder unspecified, Bulimia nervosa)

Exclusion Criteria

- Other diagnosis resulting in severe malnutrition that is NOT an eating disorder (e.g. cystic fibrosis, IBD)
- ≥18 years with refusal to consent to refeeding & NG tube or ≥ 21 years old

Eating Disorders - Refeeding Care

Appendix

Last Updated: April 2024
Next Expected Review: April 2022

For questions concerning this pathway, contact:
EatingDisorderRefeedingPathway@seattlechildrens.org

If you are a patient with questions contact your medical provider, Medical Disclaimer

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Eating Disorder - Refeeding Pathway v8.0: **Emergency Department**

Stop and **Review**

Inclusion Criteria

- 5-17 years (if ≥18, call Psych re: consent issues that may preclude admission)
- Concern for eating disorder (Anorexia nervosa, avoidant restrictive food intake disorder, eating disorder unspecified, Bulimia nervosa)

Exclusion Criteria

- Other diagnosis resulting in severe malnutrition that is NOT an eating disorder (e.g. cystic fibrosis, IBD)
- ≥18 years with refusal to consent to refeeding & NG tube or ≥ 21 years old

Evaluation/initial therapies

- Vital signs, orthostatics, weight (after void), height, cardiorespiratory monitor
- Enter weight & height in EHR to obtain BMI and z-score
- Labs: Electrolytes, BUN, Creatinine, Phos, Mg, Ca, ALT, CBC, TSH, UA, urine preg
- IVF bolus if needed (start with 10mL/kg and then re-evaluate if 2nd bolus is needed)
- Correct electrolytes at same time/prior to refeeding
- EKG (if not done already)

Meets admit criteria?

Admission criteria

Admit if one or more of the following:

- Electrolyte disturbance (e.g. hypokalemia, hyponatremia, hypophosphatemia)
- EKG abnormalities (e.g. prolonged QTc males>450ms/females>470ms or severe bradycardia)
- Physiologic instability unresolved after management in ED
  - Severe bradycardia (HR<45 BPM)
  - Hypotension MAP ≤57
  - Hypothermia (Temp <96F or 35.6C)
  - Symptomatic orthostasis (systolic BP decrease >20mmHg systolic, or diastolic BP decrease >10mmHg), despite adequate fluid resuscitation
- Acute medical complications of malnutrition (e.g. syncope, seizures, cardiac failure, pancreatitis)

After work-up complete:

- Consider consulting Adolescent Medicine for clinical concerns not addressed by the pathway
- Provide meal or oral supplement (Boost Plus if ≥ 11yr, or BKE 1.5 if <11yr)

Yes, meets admission criteria.

Prior to leaving ED

- Admit to Inpatient- Abnormal EKG or HR <30 BPM requires telemetry
- Add Blind Weight Flag in EPIC (*for SCH only*)

No

Psychiatry admission

- Consider PBMU admit if patient does not meet criteria for med admit AND patient is not safe to receive treatment at an eating disorder residential center (suicidality, elopement, eating disorder behaviors that may require restraint).
- Contact MHE as indicated.

Discharge Instructions

- Provide family with Return to Activity Guidelines.

If new patient:

- Recommend referral to psychiatry's Brief Transition Services (BTS) for Eating Disorders via Referral Process (*for SCH only*).
- Refer for one time Urgent Telemedicine Evaluation with Adolescent Medicine.

If followed by SCH ADO Med:

- Recommend patient follow up with their team (medical and nutrition) within one week.
- If unable to schedule visit within one week, then see PCP for blind weight and vital signs.

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Eating Disorder - Refeeding Pathway v8.0: **Inpatient**

Stop and **Review**

Inclusion Criteria

- 5-17 years (if ≥18, call Psych re: consent issues that may preclude admission)
- Concern for eating disorder (Anorexia nervosa, avoidant restrictive food intake disorder, eating disorder unspecified, Bulimia nervosa)

Exclusion Criteria

- Other diagnosis resulting in severe malnutrition that is NOT an eating disorder (e.g. cystic fibrosis, IBD)
- ≥18 years with refusal to consent to refeeding & NG tube or ≥ 21 years old

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Consistent Messaging is critical. Confer before you set treatment plans with family. Refer to Restoring Nutrition-Refeeding.

Inpatient Admission

Admit

- Medical Team
- Initiate Medical Stabilization Eating Disorder orders
- Add Blind Weight Flag in EPIC (*for SCH only*)
- Provide caregiver(s) with instructions for Inside Out Medicine registration (*for SCH only*) and instruct them to complete the initial tasks.
- Provide caregiver(s) with Restoring Nutrition-Refeeding (PE 643) and describe feeding protocol

Vitals

- Continuous cardiorespiratory monitoring; vitals q 4 hours
- Abnormal EKG or HR<30 BPM requires telemetry

Activity

- Bedrest with bathroom privileges; avoid excess movement
- Wear long sleeves/long pants/socks/under covers
- Recommend bathroom restriction 60 minutes after all meals/snacks
- Showers 5 minutes; use shower stool due to fall risk
- Please refer to schoolwork guidelines prior to patient doing school work

Refeeding

- Monitor for refeeding syndrome
- Initiate refeeding protocol at 1800 kcal/day for children ≤12 or 2000 kcal/day for children >12 until assessed by Dietitian
- Correct electrolytes at same time/prior to refeeding
- Proceed with NG tube placement with FIRST incomplete meal, snack, or water AND incomplete oral supplement
- Call Support Nurse if needed

Nursing

- Follow GOC: Eating Disorders and Refeeding (*for SCH only*)

Labs

- On admit check electrolytes/BUN/creatine/Phos/Mg/Ca/ALT/CBC/TSH/UA/urine preg / EKG (if not already done)
- Check electrolytes, Ca, Mg, Phos daily for *refeeding day #1-5 then Mon/Thurs

*Refeeding day #1 = 24 hours after completion of 100% prescribed nutrition

Consults (to facilitate consistent messaging)

- Consult Adolescent Medicine, Dietitian, Psychiatry C&L within 24 hours

Family Education

- Provide family with info about Meal Support Classes
- Total length of hospital stay averages 7-10 days for safe refeeding, to be determined by interdisciplinary team

Dietitian

- Dietitian to calculate Estimated Treatment Goal Weight (eTGW) during first consultation
- It is expected that there will be a range for the patient's weight. However for inpatient care, a specific number is chosen to make initial calorie calculations

Discharge Criteria

- Resolution of physiologic instability (awake HR ≥ 50 and sleeping HR ≥40 for 48 hours, normal EKG, no longer a fall risk due to orthostasis)
- All electrolyte abnormalities corrected (no longer on supplements)
- Low risk for refeeding syndrome (highest risk in first 2 weeks of refeeding)
- Eating all prescribed nutrition in the form of solid food (recommended). Goal is < 10% nutritional supplement

Discharge Instructions

- Provide family with Return to Activity Guidelines
- Ongoing care:
  - If patient is NOT transitioning to residential or PHP within three days from discharge, or outpatient within the following week, then follow up with psychiatry's Brief Transition Service (BTS) and Adolescent Medicine Clinic's Hospital Transition Service (HTS) within one week of discharge. Note: BTS and HTS are not discharge plans, though can support bridging to discharge plans if there is an access delay
  - See PCP within one week of discharge
  - If previously followed by a mental health provider, then schedule appointment as soon as possible
  - If followed by SCH ADO Med OPED Program, then recommend appointments with medical provider and RD in 2-3 weeks. See PCP or HTS weekly until ADO provider available

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Hypotension MAP

Age	Hypotension Threshold MAP ≤ 5% for age
6-7 Years	54
7-9 Years	55
9-16 Years	56
16-18 Years	57

Return to ED

To Table of Contents

Refeeding Syndrome

Who is high risk for refeeding syndrome? (adapted from NICE guidelines)

1. Patient has **at least one of the following**:
   - BMI z-score < -2
   - Weight loss ≥ 10% usual body weight in last 3-6 months
   - Little or no nutritional intake for >10 days
   - Low levels of potassium, phosphate, magnesium before re-feeding
2. Patient has **two or more of the following**:
   - BMI z-score = -1 to -1.9
   - Weight loss ≥ 7.5% usual body weight in last 3-6 months
   - Little or no nutritional intake for >5 days
3. BMI < 70% mBMI (mBMI = BMI at 50% percentile for age & gender)
4. Abnormal EKG or HR<30 BPM requires telemetry bed
5. Acute medical complications of malnutrition (e.g. syncope, seizures, cardiac failure, pancreatitis, severe electrolyte disturbance)
6. Clinical concern for medical acuity that requires higher level of medical monitoring

What is Refeeding Syndrome?

- A potentially life-threatening complication in the first 2-3 weeks of refeeding; patients may appear deceptively well.
- Body cannot tolerate the amount of nutrition consumed
- Hallmark is hypophosphatemia: occurs when carbohydrates trigger release of insulin; insulin drives phosphate and other electrolytes into depleted cells
- Risk of RFS present in most patients with severe malnutrition.
- Highest risk if very low body weight, rapid weight loss, minimal intake over past 5-10 days regardless of body weight, and electrolyte abnormality prior to refeeding (replete electrolytes at same time or prior to refeeding).

Additional reading: O'Connor 2013, Junior MARSIPAN 2012

Return to Inpatient

To Table of Contents

Estimated Treatment Goal Weight

Nutrition: Registered dietitian (RD) is consulted within 24 hours of admission. RD will determine estimated Treatment Goal Weight (eTGW) which determines inpatient meal plan calories for weight restoration. RD follows a standardized process to determine eTGW based on a subjective and objective assessment with consideration of a variety of factors including, but not limited to:

- Growth history and pre-morbid BMI
- Developmental stage and menstrual status (if applicable)
- Parental height
- Presence of linear stunting
- History of artificial weight suppression

Questions about eTGW should be directed to program RD.

Return to Inpatient

To Table of Contents

Guidelines for medical providers: Recommendations for school work during medical stabilization

- Families often ask for recommendations as to whether their child can/should do schoolwork as they medically stabilize in the hospital.
- As hospital stays may be 2-3 weeks in duration, schoolwork / on-line classes may be a welcome distraction.
- However, treatment including meals/ visits by staff and healthcare providers must take priority and on-line course work must be interrupted for care provision.
- If school is especially stressful for the child, we recommend taking a break during nutritional rehabilitation in the hospital.
- In our experience, schools are very understanding about the need for treatment and recovery and willingly accommodate these patients, many of whom excel in academics.
- Consider ordering a School Consult and the hospital teachers can help with facilitating discussions with school and getting assignments if needed.

Return to Inpatient

To Table of Contents

Inpatient Discharge

Inpatient Discharge Criteria
No single criteria demonstrates readiness, but should be considered as part of the overall assessment of readiness for discharge.

Physiologic Criteria

- Resolution of physiologic instability (awake HR≥ 50 and sleeping HR≥ 40 for 48 hours, normal EKG, no longer a fall risk due to orthostasis)
- All electrolyte abnormalities corrected (no longer on supplements)
- Low risk for refeeding syndrome (highest risk in first 2 weeks of refeeding)
- Eating all prescribed nutrition in the form of solid foods (recommended). Goal is < 10% nutritional supplement.

Psychosocial Criteria (includes education and continued care info)

Education

- Nutrition Education Session 1 and 2 (Dietician)
- Psychiatric Education (Psych team)
- Medical Complications Education and provide Return to Activity Guidelines (Adolescent Medicine team)
- Parents must attend Meal Support Class (Psych team) and provide meal support for at least 2 meals/ snacks

Continued Care /Next phase of treatment appointments

- Has plan for continued care after discharge from the hospital which may be residential care, PHP, IOP, or outpatient care
- Outpatient care should include providers with expertise in eating disorders for:
  - Mental health treatment
  - Medical monitoring
  - Nutritional guidance
- Recommend all appointments scheduled.

Return to Inpatient

Admits from Residential Eating Disorder Programs

Patients admitting from Eating Recovery Center (ERC) or other residential eating disorder program:

Note: these patients may be referred for admission due to suicidal ideation and are assessed for admission by the Mental Health Evaluator in the Emergency Department. If admitted to PBMU, they need elements of the ED-Refeeding pathway but they are generally weight-restored and do not require refeeding. In general they require clear behavioral support to maintain nutrition, and as such receive all nursing interventions pre-checked in the Nursing and PBMU orders section of the plan as well as the following:

a. **EKG:** Order EKG if not done in the ED
b. **Labs:** Order AM admission labs and refeeding labs if not already done in ED
c. **Diet:** Modified diet at the kcal level provided by ERC RD; this information will be emailed to the PBMU LOC and the Child Psychiatry Consultation Case Manager

Return to ED Return to Inpatient

To Table of Contents

Summary of Version Changes

- **Version 1.0 (4/12/2017)**: Go live.
- **Version 2.0 (5/24/2017)**: Clarified Admit Criteria and High Risk Criteria; added Refeeding Syndrome definition; added Family Care Conference description; added instruction on how to view %mBMI.
- **Version 2.1 (9/20/2017)**: Added action for PMHS2/ED2 to provide Restoring Nutrition (PE643) handout to patient and answer questions prior to leaving the ED. Contact information and backup resources also provided.
- **Version 2.2 (5/30/2018)**: Refined Admit Criteria.
- **Version 2.3 (7/29/2019)**: Changed email address and added email disclaimer to page footers.
- **Version 3.0 (1/28/2021)**: Modified the algorithm to reflect current workflow and patient placement on the Medical Unit due to COVID-19. In addition to, migrating the content to the new CSW algorithm template.
- **Version 4.0 (4/12/2022)**: Modified the algorithm to have higher starting kcal/day, added links to wheelchair use guidelines, added guidance around school work during medical stabilization, updated MAP hypotension table, and corrected typo for HR criteria from > to ≥. Corrected bibliography pages.
- **Version 4.1 (2/23/2023)**: Added information and a link to the referral process for the new Psychiatry Brief Transition Service (BTS) for eating disorders.
- **Version 4.2 (3/2/2023)**: Removed the link to the retired Job Aid: Wheelchair and Room Chair Privileges for Eating Disorder Refeeding Patients.
- **Version 5.0 (8/9/2023)**: Revised the Inpatient Discharge Criteria supporting slide along with the corresponding phases: Inpatient, PBMU - Medical Service MBB, and PBMU – Psychiatry Service. Removed retired Provider Job Aid for Difficult Conversations 12835.
- **Version 6.0 (12/13/2023)**: Revised the ED & Inpatient discharge instructions to include referrals to the BST and HTS. Deleted PBMU and MBB pages from the algorithm. Added content about how RDs calculate the estimated treatment goal weight.
- **Version 7.0 (2/29/2024)**: Removed the reference to family care conference on the inpatient phase and the supporting slide.
- **Version 8.0 (4/15/2024):** Removed routine Adolescent Medicine Consults and added a link for the Inside Out Medicine Registration instructions.

Approval & Citation

Approved by the CSW Eating Disorder - Refeeding Pathway team for April 12, 2017, go-live

CSW Eating Disorder - Refeeding Pathway Team:

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Retrieval Website: https://www.seattlechildrens.org/pdf/eating-disorder-refeeding-pathway.pdf

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Evidence Ratings

This pathway was developed through local consensus based on published evidence and expert opinion as part of Clinical Standard Work at Seattle Children's. Pathway teams include representatives from Medical, Subspecialty, and/or Surgical Services, Nursing, Pharmacy, Clinical Effectiveness, and other services as appropriate.

When possible, we used the GRADE method of rating evidence quality. Evidence is first assessed as to whether it is from randomized trial or cohort studies. The rating is then adjusted in the following manner (from: Guyatt G et al. J Clin Epidemiol. 2011;4:383-94, Hultcrantz M et al. J Clin Epidemiol. 2017;87:4-13.):

Quality ratings are *downgraded* if studies:

- Have serious limitations
- Have inconsistent results
- If evidence does not directly address clinical questions
- If estimates are imprecise OR
- If it is felt that there is substantial publication bias

Quality ratings are *upgraded* if it is felt that:

- The effect size is large
- If studies are designed in a way that confounding would likely underreport the magnitude of the effect OR
- If a dose-response gradient is evident

Certainty of Evidence

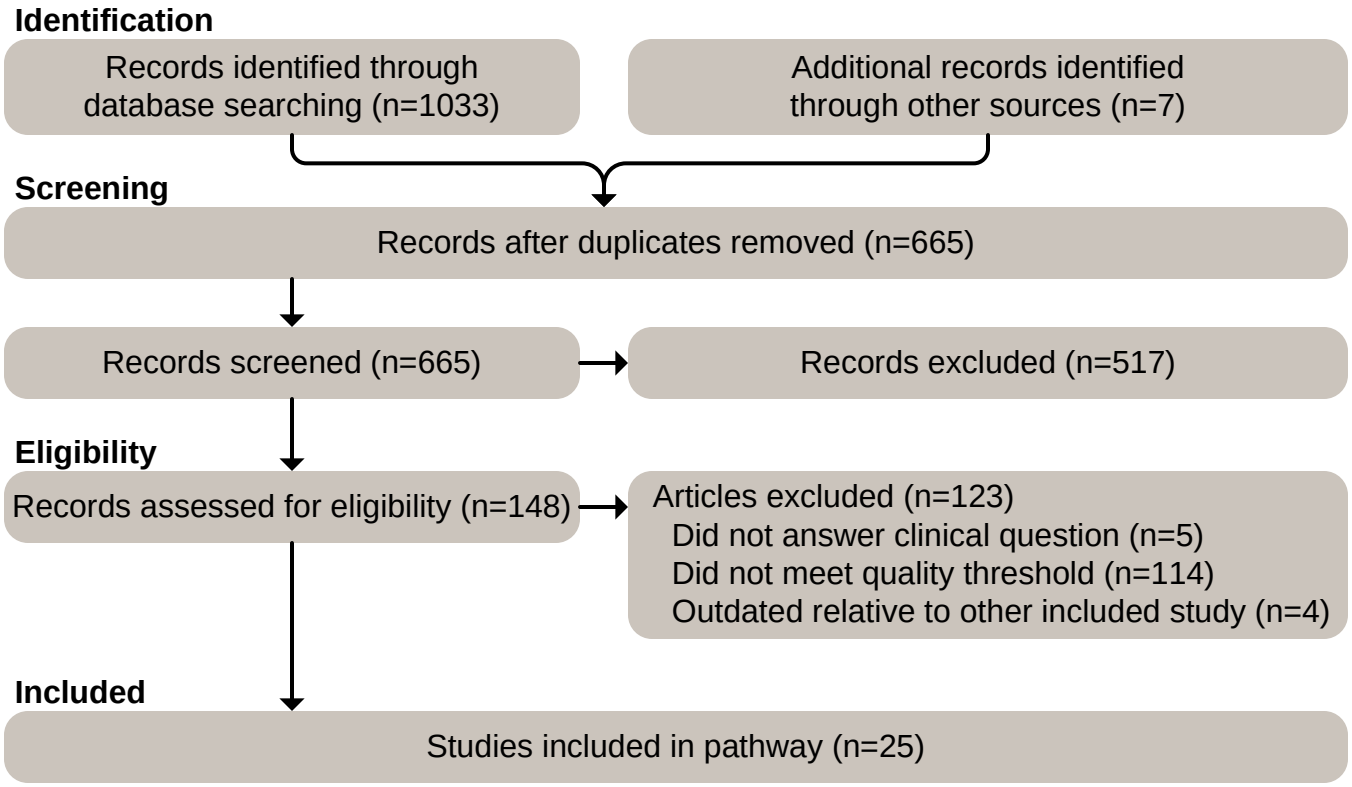
✪✪✪✪ High: The authors have a lot of confidence that the true effect is similar to the estimated effect
✪✪✪○ Moderate: The authors believe that the true effect is probably close to the estimated effect
✪✪○○ Low: The true effect might be markedly different from the estimated effect
✪○○○ Very low: The true effect is probably markedly different from the estimated effect
Guideline: Recommendation is from a published guideline that used methodology deemed acceptable by the team
Expert Opinion: Based on available evidence that does not meet GRADE criteria (for example, case-control studies)

Bibliography

Literature Search Methods

Studies were identified by searching electronic databases using search strategies developed and executed by a medical librarian, Susan Groshong. An initial search was performed in March and April, 2015. The following databases were searched—on the Ovid platform: Medline, PsycINFO and Cochrane Database of Systematic Reviews; elsewhere: Embase, CINAHL, Clinical Evidence, National Guideline Clearinghouse, TRIP and Cincinnati Children's Evidence-Based Recommendations. In Medline, Embase, CINAHL and PsycINFO, appropriate subject headings were used along with text words and the search strategy was adapted for other databases using text words. Concepts searched were eating disorders, anorexia nervosa and female athlete triad syndrome. An additional search was conducted in June, 2016, using the same databases listed above except Clinical Evidence and with the addition of Nursing+ and Registered Nurses' Association of Ontario Best Practice Guidelines. Previously searched concepts were limited to March, 2015 to current. Newly selected concepts, bulimia nervosa, feeding and eating disorders of childhood and avoidant/restrictive food intake disorder (ARFID), were searched from 2006 to current. Retrieval from all searches was limited to humans, English language and certain evidence categories, such as relevant publication types, index terms for study types and other similar limits. Additional articles were identified by team members and added to the results.

Susan Groshong, MLIS
March 29, 2017



Flow diagram adapted from Moher D et al. BMJ 2009;339:bmj.b2535

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Medical Disclaimer

Medicine is an ever-changing science. As new research and clinical experience broaden our knowledge, changes in treatment and drug therapy are required.

The authors have checked with sources believed to be reliable in their efforts to provide information that is complete and generally in accord with the standards accepted at the time of publication.

However, in view of the possibility of human error or changes in medical sciences, neither the authors nor Seattle Children's Healthcare System nor any other party who has been involved in the preparation or publication of this work warrants that the information contained herein is in every respect accurate or complete, and they are not responsible for any errors or omissions or for the results obtained from the use of such information.

Readers should confirm the information contained herein with other sources and are encouraged to consult with their health care provider before making any health care decision.