### EATING DISORDER/IMBALANCED NUTRITION

**Problem:**
To provide help with nutritional rehabilitation, weight restoration, cessation of weight reduction behaviours, improvement in eating behaviours and improvement in psychological and emotional state.

### NURSING INTERVENTION

#### 1 NUTRITION MANAGEMENT

- Offer meals as per dietician’s plan.
- Administer Enteral feed as per dieticians plan
- Note: All meals/snacks are pre-planned. They are non-negotiable at time of mea/snack.
- Meals to be supervised by nursing staff □ [Name] or Parent/Carer □ [Name]

  *This is subject to change based how this process works*

- 30-45 minutes rest period following meals. Patient to use toilet prior to meal if needed.
- Accurately record all food offered, eaten & refused on record sheets.
- Record fluid intake on separate daily fluid balance sheet.
- Observe patient’s eating behaviours & reaction to food & mealtimes

#### 2 WEIGHT MANAGEMENT

- Record weight and height on admission.
- Record weight: ___________ weekly on ______________________________________
- (no. of times) ______________ (Specify days)

  *maintaining standard conditions i.e., on same scale (sitting scales), prior to*  

- Breakfast, patient in night attire, barefoot, empty bladder.)
- Don’t disclose weight at time of weigh in. This will be discussed during psychiatry reviews.

#### 3 PHYSICAL ACTIVITY

- Level of activity – Total bed rest □
- Reduced activity □
- Normal activity □

**Details:** (description of activities allowed as per medical/psychiatry teams)

**Date changes:**

- Monitor activities. Observe for behaviours used to increase energy output or to lose weight
- Example:
  - Be aware of frequency of trips to the toilet and time spent in toilet/shower where patient may be exercising or purging
  - *Exercising- pacing in room or on corridors, repeatedly in/out of bed, over-use of toilet facilities, long periods in toilet/shower*
  - *Micro-exercising- constant small movements while lying in bed, sitting or standing (repeated flexing/extending muscles, kicking/tapping legs)*
## Nursing Care Plan 36

### Eating disorder

#### Care of a child presenting with an eating disorder or imbalanced nutrition (less than body requirements)

**Version No. 1**

**Patient Name: **

Created Nov 2016

**Hospital No.: **

**Edel McCarra- CNS**

### Nursing Intervention

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<thead>
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<th>No.</th>
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<th>NURSING INTERVENTION</th>
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<tr>
<td>CONT'D 4</td>
<td>MONITOR PHYSICAL STATUS</td>
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- Medical investigations as per medical team

**Vital signs as prescribed** Details: ..............................................................

**Bloods required** □ Details: ..............................................................

**ECG required** □ Details: ..............................................................

**Other investigation** □ Details: ..............................................................

- Monitor for effects of re-feeding syndrome (at early stages of admission or at times of significant increase in nutrition)

*Note vulnerability to Hypotension, Hypoglycemia, Bradycardia, Low core temp, Electrolyte imbalances, Vitamin deficiency, Gastric discomfort.*

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<tr>
<th>5</th>
<th>MONITOR MENTAL STATE</th>
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<tbody>
<tr>
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<td>Establish a therapeutic relationship with patient.</td>
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<td>Observe &amp; record patient’s mood &amp; behaviours.</td>
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<td>Monitor &amp; record patient’s sleep patterns.</td>
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<td>Monitor interactions with staff, family and visitors.</td>
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<td>Offer child the opportunity to verbalise his/her thoughts, feelings &amp; concerns re. increased dietary intake, weight gain, body image. Report to psychiatry team.</td>
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<td>Offer patient encouragement around issues relating to his/her dietary intake in particular at meal times if patient is struggling to complete meals. (A firm but supportive approach by the nurse/carer is needed)</td>
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<th>ANY ADDITIONAL ASPECTS OF CARE</th>
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<td>Above aspects of care must be explained on a daily basis to nurse’s and HCA’s providing special observations to patient especially if patient is not known to them.</td>
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