Nutritional Deficiency Clinical Pathway for Medical Stabilization . Aug 31 2020

Goal: To provide medical stabilization for patients with nutritional deficiencies secondary to primary eating disorders.

Criteria to Consider for Admission or Discharge: See Appendix A

1. When to institute guidelines:
    a. Once diagnosis has been made of nutritional deficiency due to anorexia nervosa.
        i. If diagnosis is unclear and sub-specialty consult is not available, consider partial institution of protocol, i.e., institute behavioral component but hold on instituting nutritional component until it is clear that diagnosis is due to anorexia nervosa.
2. Introduction: Inpatient care for medical stabilization of patients with nutritional deficiencies secondary to primary eating disorders is a family-centered interdisciplinary team effort between the pediatric hospitalist team, medical home, adolescent medicine, psychology/psychiatry, child life, nutrition, nursing, and social work and other health care providers as needed. While admitted the hospitalist team will be the primary team with the others consulting. All members of the team should be notified within 24 hours of admission.
    a. Admission baseline medical assessment by hospitalist team, nutrition, and child psychology/psychiatry.
    b. Patient will be seen at least 3 times weekly by psychology.
    c. Social work evaluation: insurance status, coverage, discharge planning, transfer options, etc. Discharge planning to be initiated on admission.
    d. Medical home should be updated on admission and at least weekly by phone.
    e. Family centered rounds not recommended; please round in the Wainer room and have a small group update the patient/family separately. Limit number of evaluations and conversations with the family as much as possible. If pre-rounds are necessary for the safety of the patient, please limit number of providers to those necessary for the patient's care. Updates to be provided by resident/AI/attending team following rounds. If a medical student is involved, they should see the patient with the rest of the care team.
    f. Arrange team care conference with family within 2-3 days of admission (and weekly thereafter) to discuss plan for treatment. Include primary care provider as able.
3. Admission Discussion: Newly admitted patients should begin the **Nutritional Deficiency Clinical Pathway** once the diagnosis of nutritional deficiency due to anorexia nervosa has been made and after initial discussion with the patient and family reviewing the information contained in the **Patient and Family Information Booklet**. Primary medical team should discuss: reasons for admission/medical concerns; need to optimize nutritional status and concept of food as medicine; expectations of standardized meal plan including use of NGT if needed; need for continuous

monitoring; and need for 1:1 observation as well as any other concerns specific to the patient and family.

a. Please provide family with **Patient and Family Information Booklet** regarding expectations for this hospitalization upon admission. Nursing staff to review this material with family.

b. If patient/family refuse to follow pathway, consider the following:

   i. If patient is at high risk for decompensation (evidence of re-feeding on initial labs, history of syncope, severe bradycardia, etc.):

      1. Consider ethics consultation/DCF involvement

   ii. If patient is medically stable (no evidence of re-feeding, stable heart rate, no other evidence of medical compromise):

      1. Consider discussion with case management/PCP/psychology/adolescent medicine to set up for close intensified outpatient management by PCP and outpatient team. Discuss with outpatient team (PCP) and/or family that if patient fails to follow up and/or progress is not made over a set period, outpatient providers should consider re-admission and possible DCF referral.

   iii. Patient should not be admitted on "modified" pathway.

4. Medical Evaluation

   a. HPI, PE including Tanner staging and safety assessment (please see appendix B for specific rec regarding history and physical)

   b. Required Initial lab evaluation

      i. Labs/studies within last 24 hours: CBC, CMP, Mg, Phos, UA, LFTs, EKG, urine HCG

      ii. Labs within past month: fT4, TSH

      iii. If abnormal GI symptoms: Celiac Panel (if hasn't been done before)

   c. Additional labs to consider after admission:

      i. Nutrition labs if malnourished: Pre-albumin, Zinc, Vit D, Vit B12, Zinc, Ferritin, Lipids

      ii. Amylase if concern for purging

iii. If amenorrhea or otherwise indicated in females: Prolactin, LH/FSH, Estradiol, fT4, TSH

iv. Males: Testosterone, LH/FSH, Prolactin

v. T3 to check for sick euthyroid syndrome

vi. ESR, CRP (if any doubt about etiology of weight loss)

d. If at high risk for refeeding syndrome (extremely low BMI or percent of IBW, or rapid weight loss even if normal/high BMI):

i. Check BMP, Ca, Mg, Phos on admission and at minimum once per day for 5 days. Consider more frequent labs if abnormalities or at team discretion.

ii. If stable after 5 days may check PRN

e. Admission Nutrition/Medication Orders:

i. First 24 hours:

1. If admission before 2 PM: Nutrition to meet patient upon admission, determine initial calorie order, and make plan for 24 hours of meals.

2. If admission after 2 PM/nutrition unavailable: With input from patient and family, nurse should order the patient healthy meals and two snacks off of the menu until nutrition able to meet with patient and family and official meal plan can begin.

ii. Strict I/O's.

iii. IV fluids:

1. If patient requires IV fluids for hemodynamic stabilization, hypoglycemia, AKI, or other medical indication, be cautious and monitor cardiovascular response to fluid boluses and maintenance fluids. Consider partial fluid boluses. D/c fluids as soon as able given patients may have underlying cardiac output abnormalities.

2. Avoid adding dextrose to fluids if able due to concerns for re-feeding.

iv. PO fluid restriction: 8 oz of non-caloric fluid a day initially. Caloric drinks preferred. May liberalize water if meeting nutrition goals and no concern for fluid loading.

v. Neutra-phos 250mg BID (unless phos > 4.5 on admission), Thiamine 100 mg bid, and MVI with folate for nutritional stabilization

vi. Miralax 1 17g capful once daily

f. Activity restrictions:

i. After first 24 hours of admission Pt will take up to three walks per day, minimum of 5 minutes, maximum of 10 laps around B5 floor, unless they are:

1. Behaviorally unsafe (following team discussion)

2. Concern for fall risk – consider if symptomatic orthostasis

ii. If not walking three times a day needs SCDs while sleeping

g. Nursing orders:

i. Bedrest with access to bathroom as needed after first 24 hours. For first 24 hours, patient will use the bedside commode. After first 24 hours, patient will continue to use bedside commode if symptomatically orthostatic, otherwise may use bathroom with door ajar.

ii. Order one-to-one patient attendant (mental health tech preferable).

iii. Blind daily morning weights after emptying bladder AND before breakfast in 2 gowns and underwear on same scale. Patient and family should not be told weight or be able to see weights on computer.

1. Can space to every other daily weights once at goal caloric intake and weight stable or increasing from admission.

iv. Daily morning orthostatic vital signs with morning weights (upon waking, goal is first time out of bed).

1. Lie flat in bed x 5 minutes, measure blood pressure and pulse.

2. Stand – measure blood pressure and pulse after standing for one minute. Assess symptoms (light-headedness, dizziness, etc.). Support forearm at heart level when taking the blood pressure.

3. Nursing communication – "Inform HO if patient is symptomatic, has blood pressure (SBP or DBP) decline ≥ 10mmHg or heart rate increase of ≥ 20bpm after 1 minute of standing."

v. Continuous cardiac monitor. Ok to hold for walks.

1. Once HR > 50 during the day, may d/c daytime leads.

2. Once HR > 40 overnight, may d/c nighttime leads.
3. OK to d/c overnight vitals and transition to q8 vitals once hemodynamically stable.
4. House staff to determine at what rate nursing should inform of low HR.

h. Consults:

i. Adolescent Medicine, Nutrition, Psychology/Psychiatry, Social Work, Child Life.

5. Daily monitoring:

a. Limitations: Upon admission patient must be on bed rest for at least 24 hours.

i. Bathroom privileges: If orthostatic by symptoms, bedside commode should replace bathroom privileges. Otherwise, patient may use bathroom with door ajar after first 24 hours with CPSA observing.

ii. Showers: If orthostatic by symptoms, a seated shower is allowed once daily for 5 minutes. Once no longer symptomatically orthostatic, the patient can take standing shower once daily for up to 10 minutes.

b. One-to-One Observation: Observer within visual distance at all times unless team decides to discontinue. Patient Attendant/LNA will report any concerning behaviors to nurse; unless patient is an acute risk to themselves or someone else they should not intervene with patient.

c. Nutrition Plan: Adjust diet following nutrition consult to reflect official meal plan.

i. Advance 200-400 calories/day per discussion with nutrition services.

ii. Majority of patients should be on a standardized menu plan.

1. Nutrition team will provide menu, patient/family will circle foods they will eat.
2. Family may not bring in own food for patient.
3. All nutrition information (i.e. packaging) should be removed from food before providing it to patient.
4. Patient observer will be only person to sit with patient during meals until the initial team care conference. At that point, care team may decide to expand options for who can be present with patient for meals.

5. Meals should be completed in 30 mins. Snacks should be completed in 15 mins.

6. Snacks should be between breakfast and lunch and lunch and dinner.

7. Food should remain on tray in front of patient for the full allotted meal/snack time. Uneaten food will be replaced by nutritional supplements (Boost) after the meal. Pt will have 15 mins to drink Boost. Meals should never be automatically replaced by Boost.

8. Patient should be monitored for any abnormal food behaviors during the meal. Patient observer should report to nursing if any abnormal behaviors are observed.

9. Meals should be followed by 60 min rest periods with no access to bathroom.

10. Once the official meal plan is in place: If patient is unable to complete a meal/snack and the Boost supplementation for that meal/snack, an NGT will be placed and will remain in place until the patient is able to complete 24 hours of meals or boost by mouth. If the patient has been compliant with all meals for 5 days, before placing an NGT, there should be a team discussion regarding need for placement.

    a. If team believes that NG tube is de-motivating for patient to transition to PO after an appropriate period of observation, NG tube should be removed after team discussion.

d. Weight: Staff should not document weight in any location that is accessible to patient or family.

    i. The goal of hospitalization for medical stabilization does not include a specific weight gain goal so weight should not be a primary focus of medical monitoring.

    ii. Interdisciplinary team will discuss weights with family and patient at admission and periodically as needed.

    iii. Medical staff and visitors should avoid discussing the patient's current weight, goal weight, current calories, and goal calories with the patient.

e. Media: No personal computers, tablets, or cell phones are permitted for the duration of the hospitalization.

i. Ok to watch the in-room TV - specifically non-food channels and NOT during mealtimes.

ii. Ok to use hospital phone to make calls up to 30 minutes 3 times a day.

iii. Additional access to child-life internet-enabled devices to be provided following discussion with pediatric psychology, and not until patient is at yellow level as measured by the SEND tool (see below).

f. Child Life activities: should only be restricted when they involve food (e.g., baking) or physical activity (e.g., scavenger hunt). If patient is on bedrest, activities should be offered for participation in the patient's room.

g. Family presence: One caregiver is permitted to stay with the patient overnight. During daytime hours, up to 2 primary caregivers are permitted at a time.

h. Safety Evaluation for Nutritional Deficiency (SEND) tool: 24 hour completion of the *SEND Tool* that is completed conjointly by inpatient care team to identify patient's color level for the day

6. Behavioral monitoring:

a. Managing strong emotions

i. Patients will have worked with Psychological Services to identify appropriate ways to express strong feelings. These methods should be shared with the care team and patient should be reminded of these methods if they are having difficulty appropriately expressing their emotions.

b. Resolving conflict

i. Patients and family members have been asked to address concerns about specific staff members or providers with that individual directly or to ask for help in accomplishing this goal.

ii. Nursing leadership, Pediatric Psychology, and Patient Advocacy are good resources to assist patients and families in having communication directly with staff members or providers with whom they are having a difficult time, if needed.

c. Opportunity Knocks Algorithm

i. Initiating the program

1. Following the initial care conference, if patient falls in the green, yellow, or orange range, patient completes an Opportunity Knocks sheet of their assigned color to initiate an opportunity on the following day.

2. If patient falls into the red range, the first day the Intake or Safety score decreases at least one point, patient completes red Opportunity Knocks sheet to initiate an opportunity on the following day.

ii. Daily assessment

1. Nighttime nurse (with input from daytime nurse going off shift) will determine whether patient has been successful with opportunities during the day and will keep those opportunities or switch out for the next day and will pass that information on at shift change.

2. Per Opportunity Knocks Algorithm (see Appendix D) and patient's SEND color for that day (green, yellow, orange, or red) determined in huddle/rounds, daytime nurse determines whether patient completes an Opportunity Knocks sheet for the day.

3. If sheet is completed, daytime nurse works with patient to make a plan to incorporate opportunities into the day. Laminated Daily Reflections sheets color-coded to coincide with the patient's SEND color can be used to guide plan-making for the day. Child Life and Psychological Services are available to assist nursing staff, if needed.

7. Discharge Planning:

a. If plan for inpatient or residential transfer:

i. Social work should begin working on options at time of admission and coordinate plans for discharge planning with family, medical home, social workers, and care coordinators.

ii. Family should speak with insurance company and request insurance care coordinator if possible.

b. If plan for discharge to medical home or adolescent medicine outpatient care please coordinate with medical home. Patient will need follow up with:

i. Medical home.

ii. Adolescent medicine (if needed).

iii. Nutrition: patient should discharge with specific nutrition plan and follow up with outpatient nutrition should be scheduled prior to discharge.

iv. Psychotherapy: individual therapist, follow up with family therapist if indicated.

APPENDIX A: CRITERIA TO CONSIDER FOR ADMISSION AND DISCHARGE

Primary criteria: < 75% ideal body weight and/or acute food refusal with 10% weight loss over 3 month period.

Secondary criteria to consider for Admission	Criteria to consider for Discharge
HR <50bpm while awake	HR >50bpm while awake
HR<40bpm while asleep	HR >40bpm while asleep
SBP <80mmHg	SBP >80mmHg
Temp<96F	Temp>96F
Prolonged QTc or other arrhythmia	Resolution of arrhythmia
Electrolyte abnormalities	Resolution of electrolyte abnormalities
Esophageal tears or hematemesis	Resolution of tears and hematemesis
Intractable vomiting	Resolution of vomiting

APPENDIX B: Key aspects of eating disorder history:

Criteria for diagnosis:***

Current Vital Signs: ***

Weight History: ***

Current Body Weight: ***

LMP/PMP: ***

Menstrual History: ***

Pubertal History: ***

Fear of Gaining Weight interfering with healthy weight: ***

Disturbance in way weight is experienced, Undo influence of weight on self eval, Persistent lack of recognition of seriousness of low weight: ***

Diet Current/History: ***

24 Hour Diet Recall: ***

Specific Restrictions - Types of food/ Amount of food: ***

Binge Eating in last 3 months: ***

Purging in last 3 months:

Exercise: ***

Medications: ***

Other: ***

Exercise: ***

Uses any tools for weight management?: ***

FamHx: Eating Disorders/Mental Health Disorders?: ***

Previous Evaluations/Interventions:***

Expected Weight per growth curve: ***

Ideal Body Weight: ***RESOURCES: (All original articles available in shared drive)

Key exam findings:***

Appendix C: 24- Hour Safety Evaluation for Nutritional Deficiency (SEND) Tool - Review and discuss at each nursing handoff communication; scored in AM huddle/rounds

	0	1	2	3
Cardiovascular	Awake: HR > 50 Asleep: HR > 40	Awake: HR > 50 Intermittent bradycardia: Asleep < 40	Intermittent bradycardia: Awake < 50 Asleep < 40	Persistent bradycardia: Awake < 50 Asleep < 40 -OR- Intermittent bradycardia: Awake < 40 Asleep < 30
Orthostasis	Asymptomatic No BP orthostasis*	Asymptomatic BP orthostasis*	Symptomatic No BP orthostasis*	Symptomatic BP orthostasis*
Intake	Taking in 100% of calories orally **without** boost supplement.	Taking in 100% of calories orally **with** boost supplementation.	Any calories come from NG.	More than 50% of calories come from NG.
Safety	Compliant with all safety measures without reminders.	Needing reminders for Nutritional Safety: • Calorie tracking • Weight Focus	Needing reminders for Physical Safety: • Over-exercising • Purging • Water Overloading	• Not compliant with one or more safety measures. • Physically aggressive behaviors toward self or others.

Green=Score ≤ 3; must be <1 in Safety and no area greater than 1

Yellow=Score ≤ 7; must be ≤1 in Safety and can't be greater than 1 on Intake

Orange= Score ≤ 11; must be ≤ 2 in Safety and ***not*** considered a fall risk

Red= Score ≥ 3; if >2 in Safety OR >2 in Orthostasis + considered fall risk

*BP changes: blood pressure decline ≥ 10mmHg in systolic or diastolic blood pressure or heart rate increase of ≥ 20bpm

Appendix D: OPPORTUNITY KNOCKS ALGORITHM

Initiating opportunities:

- Following the care conference
  - If patient's score falls in the GREEN, YELLOW, or ORANGE range, the patient may complete an OPPORTUNITY KNOCKS sheet to initiate an opportunity on the following day.
  - If the patient's score falls in the RED range, the first day either the *intake OR safety* number improves (lower) at least one point, the patient may complete an OPPORTUNITY KNOCKS sheet to initiate an opportunity on the following day.

After successful engagement with an opportunity:

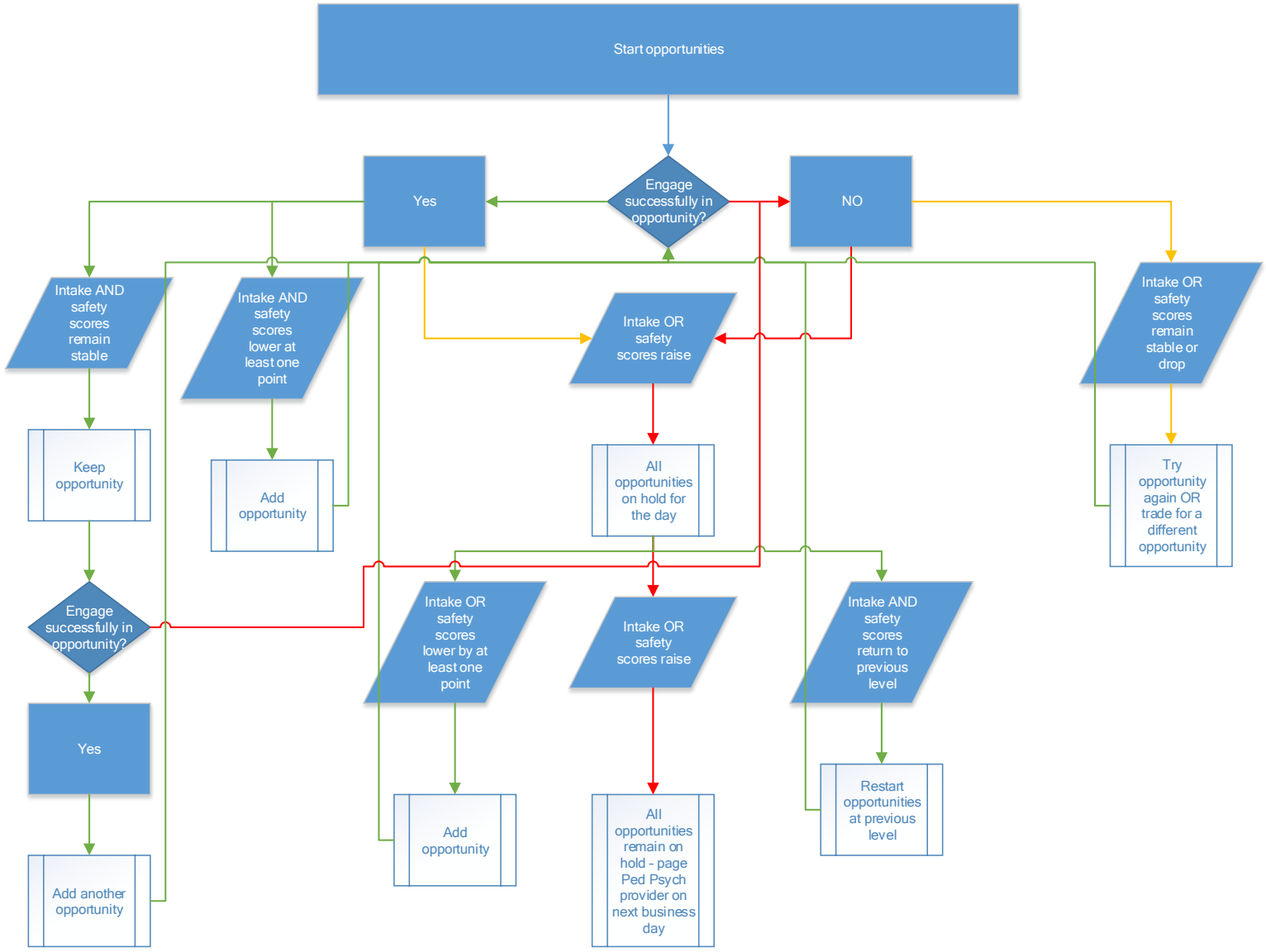
- If the *safety* OR *intake* numbers improve (lower) at least one point, the patient keeps that opportunity and can complete an OPPORTUNITY KNOCKS sheet to add another opportunity.
- If the *safety* AND *intake* numbers remain stable, the patient keeps that opportunity.
- If the *safety* AND *intake* numbers remain stable for two days in a row AND the patient maintains their current COLOR level, the patient may complete an OPPORTUNITY KNOCKS sheet to add another opportunity.

After *un*successful engagement with an opportunity:

- If the *safety* OR *intake* numbers remain stable or improve (lower) at least one point, the patient can try that opportunity again or swap it out for a different opportunity.

If at any point the *safety* OR *intake* numbers worsen (raise), all opportunities will be placed on hold for the remainder of that day.

- The next day, if *safety* OR *intake* numbers:
  - Improve (lower), but not to the previous level, the patient may begin to regain opportunities as if they are initiating the OPPORTUNITY KNOCKS process.
  - Improve (lower) AND the patient has at least returned to the *safety* AND *intake* number at which they were at before those numbers worsened (raise), the opportunities the patient had at that time will be reinstated.
  - Worsen again, continue to pause opportunities and PEDIATRIC PSYCHOLOGY SERVICES PROVIDER SHOULD BE PAGED (IF AFTER HOURS OR ON WEEKEND OR HOLIDAY, PLEASE PAGE BEFORE 8 AM ON THE NEXT WEEKDAY OR WORKDAY.


Start opportunities
Engage successfully in opportunity?
Yes
NO
Intake AND safety scores remain stable
Intake AND safety scores lower at least one point
Intake OR safety scores raise
Intake OR safety scores remain stable or drop
Keep opportunity
Add opportunity
All opportunities on hold for the day
Try opportunity again OR trade for a different opportunity
Engage successfully in opportunity?
Intake OR safety scores lower by at least one point
Intake OR safety scores raise
Intake AND safety scores return to previous level
Yes
Add opportunity
All opportunities remain on hold - page Ped Psych provider on next business day
Restart opportunities at previous level
Add another opportunity

THE University of Vermont Children's Hospital

CONGRATULATIONS

OPPORTUNITY KNOCKS

You did a great job getting your nutrition in today!

You did a great job being safe today!

You may try one/another of the following opportunities. Please circle the opportunity you would like to try by breakfast time and return it to your nurse. Your team will work with you to schedule your opportunity or opportunities today. We look forward to helping you be successful with your opportunity!

One hour use of the hospital phone to call someone on your contacts list

One (extra) hour of visitation from someone on your contact list outside of key caretakers

One hour of access to school work

Today's Date: _____ Collected by: _____

THE University of Vermont Children's Hospital

CONGRATULATIONS

Your heart is getting healthier!

You did a great job being safe today!

Your blood pressure is responding better to nutrition!

You did a great job getting your nutrition in today!

You may try one/another of the following opportunities. Please circle the opportunity you would like to try by breakfast time and return it to your nurse. Your team will work with you to schedule your opportunity or opportunities today. We look forward to helping you be successful with your opportunity!

One hour use of the hospital phone to call someone on your contacts list

One (extra) hour of visitation from someone on your contact list outside of key caretakers

One hour of access to school work

30-minute trip to the playroom

30-minute trip to gaming room

30-minute wheelchair ride on the unit

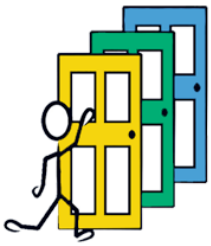
Today's Date: _____ Collected by: _____

THE University of Vermont Children's Hospital

CONGRATULATIONS

Your heart is getting healthier!

You did a great job being safe today!



Your blood pressure is responding better to nutrition!

You did a great job getting your nutrition in today!

You may try one another of the following opportunities. Please circle the opportunity you would like to try by breakfast time and return it to your nurse. Your team will work with you to schedule your opportunity or opportunities today. We look forward to helping you be successful with your opportunity!

One hour use of the hospital phone to call someone on your contacts list

One (extra) hour of visitation from someone on your contact list outside of key caretakers

One hour of monitored internet access

One hour of access to school work

One hour of video gaming in your room

30-minute trip to the playroom

30-minute trip to gaming room

30-minute wheelchair ride on the unit

Today's Date: _____ Collected by: _____

THE University of Vermont Children's Hospital

CONGRATULATIONS

Your heart is getting healthier!

You did a great job being safe today!

Your blood pressure is responding better to nutrition!

You did a great job getting your nutrition in today!

You may try one/another of the following opportunities. Please circle the opportunity you would like to try by breakfast time and return it to your nurse. Your team will work with you to schedule your opportunity or opportunities today. We look forward to helping you be successful with your opportunity!

One hour use of the hospital phone to call someone on your contacts list

One (extra) hour of visitation from someone on your contact list outside of key caretakers

One hour of monitored internet access

One hour of access to school work

One hour of video gaming in your room

30-minute trip to the playroom

30-minute trip to gaming room

Trip to the gift shop

Trip to the garden

Today's Date: _____ Collected by: _____

Daily Reflections

Today I made phone calls (up to 30 minutes each):

☐ ☐ ☐

To help distract myself, I:

played a game watched a movie colored/did drawings

made arts and crafts did a puzzle wrote letters/wrote in my journal

Special things Child Life has going on today that I plan to participate in are:

VT Teddy Bears seasonal crafts visit with a therapy dog massage

music therapy make Art from the Heart meet a special hospital visitor

Other: _____

"Trusted adults" with me today are:

_____

_____

Here with me overnight is: _____

OPPORTUNITIES I have KNOCKing today include:

_____ _____

_____ _____

_____ _____

Daily Reflections

Today I made phone calls (up to 30 minutes each):

☐ ☐ ☐

I got up and around the floor today (10 laps each time):

☐ ☐ ☐

To help distract myself, I:

played a game watched a movie colored/did drawings

made arts and crafts did a puzzle wrote letters/wrote in my journal

Special things Child Life has going on today that I plan to participate in are:

VT Teddy Bears seasonal crafts visit with a therapy dog massage

music therapy make Art from the Heart meet a special hospital visitor

Other: _____

"Trusted adults" with me today are:

_____

_____

Here with me overnight is: _____

OPPORTUNITIES I have KNOCKing today include:

_____ _____

_____ _____

_____ _____

Daily Reflections

Today I made phone calls (up to 30 minutes each):

☐ ☐ ☐

I got up and around the floor today (10 laps each time):

☐ ☐ ☐

To help distract myself, I:

played a game watched a movie colored/did drawings

made arts and crafts did a puzzle wrote letters/wrote in my journal

Special things Child Life has going on today that I plan to participate in are:

VT Teddy Bears seasonal crafts visit with a therapy dog massage

music therapy make Art from the Heart meet a special hospital visitor

Other: _____

My trusted adults with me today are:

_____

_____

_____

Here with me overnight is: _____

OPPORTUNITIES I have KNOCKing today include:

_____ _____

_____ _____

_____ _____

Daily Reflections

Today I made phone calls (up to 30 minutes each):

☐ ☐ ☐

I got up and around the floor today (10 laps each time):

☐ ☐ ☐

I decided to use one of my OPPORTUNITIES to go off the floor today ☐ YES ☐ NO

To help distract myself, I:

played a game watched a movie colored/did drawings

made arts and crafts did a puzzle wrote letters/wrote in my journal

Special things Child Life has going on today that I plan to participate in are:

VT Teddy Bears seasonal crafts visit with a therapy dog massage

music therapy make Art from the Heart meet a special hospital visitor

Other: _____

"Trusted adults" with me today are:

_____

_____

Here with me overnight is: _____

OPPORTUNITIES I have KNOCKing today include:

_____ _____

_____ _____

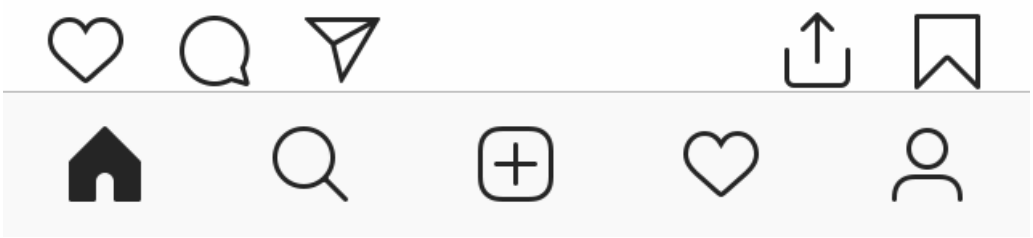
_____ _____

Resource borrowed from the Association of Child Life Professionals

Activity Guidelines for Psychiatric Patients

Typically Always Safe	Sometimes Safe (Use Clinical Judgement)	Typically Never Safe
Games	**Games**	**Games**
• Playing Cards	• Candy Land	• Jenga
• Shuffling Cards	• Trouble	• Dominoes
• Uno	• Sorry	• Clue
• Skip Bo	• Chutes and Ladders	**Art Projects**
• Apples to Apples	• Connect 4	• String longer than 9"
• Phase 10	• Headbandz	• Scissors
• Word Searches*	• Checkers/Chess	• Glue Bottles
• Sudoku*	• Scrabble	• Paint Brushes
• Puzzles	• Guess Who	• Pipe Cleaners
• Matching/Memory	• Pictionary	• Pens
Art Projects	**Art Projects**	• Colored Pencils
• Magic Nuudles	• Sticky Sand Art	• Regular Pencils
• Mandalas	• Bead Bracelets	**Busy Tasks**
• Adult Coloring*	• Markers	• Magazines/Books with Staples
• Play Doh (No Can)	• Fuse Beads	**Other**
• Modeling Clay/Model Magic	**Busy Tasks**	• Access to Internet
• Crayons	• Hard Back Books	• Cell Phones
• Sticker Scenes	• Rubiks Cube	• Social Media
• Oil Pastels	• Fidget Items	
• Origami	**Other**	
• Sponges/Cotton Balls with Paint	• Action Figures	
• Finger Paint	• Baby Dolls	
• Kinetic Sand	• Dinosaurs	
• Washi Tape	• Small amounts of Legos	
• Foam Shapes	• Larger Cars	
Busy Tasks		
• Tearing up Magazines/Paper*		
• Peeling Glue on Hand		
• Stress Balls/Bricks		
Other		
• Paperback Books		
• Music on Staff Computer		
• Stuffed Animals w/o Hard Eyes		
***Inspect these items for staples**		

For items in "Sometimes Safe" box patient must be able to contract for safety. Also remember to utilize "1 in: 1 out" approach to limit the number of items a patient has access to at any given time; as well as the amount of preferred item. Limiting the number of available items will assist with safety for patients and staff.



1. "Medical Stabilization of adolescents with nutritional insufficiency: a clinical care path" Rome et al 2015
2. "Eating Disorders in Adolescents", Position Paper of the Society for Adolescent Health and Medicine, 2003
3. DSM V Diagnostic Manual
4. "Refeeding Hypophosphatemia in Hospitalized Adolescents With Anorexia Nervosa: A Position Statement of the Society for Adolescent Health and Medicine" Katzman et al. Journal of Adolescent Health. June 2014.
5. "Managing Patients with Eating Disorders" Childrens Hospital of Philadelphia inpatient guidelines. Peebles, Chuang, Lantzouni et al. June 2015
6. "Eating Disorders in Children and Adolescents: State of the Art Review" Campbell & Peebles. Pediatrics. Aug 2014.
7. "Variations in Admission Practices for Adolescents with Anorexia Nervosa: A North American Sample" Schwartz et al. Journal of Adolescent Health. April 2008.