

Eating Disorders – An Interdisciplinary Model of Care

The medical and psychiatric management of eating disorder patients in the acute setting

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Disclaimers

- No disclaimers to declare

Learning Objectives

- To review the delivery of tertiary eating disorder services at St. Paul's Hospital in Vancouver
- To review an interdisciplinary model of care for eating disorder patients admitted to acute care and analyze data related to quantitative and quality measures of their admission
- To review the benefits of an interdisciplinary model of care for complex medical and psychiatric patients.

Learning Objective 1

To review the delivery of tertiary eating disorder services at St. Paul's Hospital in Vancouver

Adult Eating Disorder Program St. Paul's Hospital, Vancouver, BC

- Started in 1991
- Dedicated Unit in 2001
- Longstanding close relationship between Internal Medicine and Psychiatry
- Multidisciplinary Program
- Research

Adult Eating Disorder Program St. Paul's Hospital, Vancouver, BC

- 4NW Inpatient unit: 7 beds with emphasis on re-nutrition and stabilization, admission criteria based on APA and BC Clinical Practice Guidelines
- OCP bed: specific policy to address patients on medicine
- Discovery Day Program: 8 bed, recovery oriented program, structured 12-15 weeks (with Residential component, Vista House, in partnership with VCHA)

St. Paul's Eating Disorder Program

- Assessment, Consultation & Triage –Nursing, Psychiatry, Internal Medicine
- Outpatient Groups: Patient Education, Family and Friends, Coping Skills, Contemplation, Meal Support and Leisure Group
- Outpatient Follow Up in Collaborative Team Clinic Model
- Psychology Clinic
- Community Outreach
- Research

St. Paul's Eating Disorder Program

- Tertiary Specialized Program for treatment of adults with eating disorders
- Emphasis on providing the highest level of care for those with the most severe illness
- **Goal to work in collaboration with secondary programs and regional hospitals**
- Provincial Consultation

Acutely unwell ED patients on CTU

- Admitted to Medicine
- Psychiatry Consult Liaison Service
- ED Dietician
- ED Nursing Consult
- Standardized Care Plan for all patients (started in 2010)

Learning Objective 2

To review an interdisciplinary model of care for eating disorder patients admitted to acute care and analyze data related to quantitative and quality measures of their admission

Medical Indications for Acute Admission in Eating Disorder Patient

- Low Weight
- ECG Changes / Cardiac Abnormalities
- Low blood sugar - fasting < 2.5
- Renal Function Changes
- Neurologic Disorders

Care Plan for Acute ED Admissions

- Goals : (medical and psychiatric)
 - Stop weight loss
 - Prevent re-feeding syndrome
 - Interruption of disordered behaviors
 - Anticipate behavioral challenges
 - Initiate ED treatment plan for community

Challenges with Admissions of Eating Disorder Patients to Acute Medical Wards

- Ideal setting for prevention of refeeding complications and preventing morbidity due to acute starvation
- Less than ideal setting for interrupting ED behaviors

Psychiatry in the Acute ED Patient

- Diagnostic Review
- Care plan Development
- Behavioural Limitations
- Management of Acute Psychiatric Symptoms
- Assessment and Treatment of Psychiatric Co-morbidities
- Psychiatric Medication Review
- Certification (initial/review extended leave)
- Review of Community Resources and Referral

The Multidisciplinary Team

- A team approach to dealing with an ED needed
 - Dietitian, Internist or GP with experience, Psychiatrist, Nursing
- Set clear admission and discharge criteria
- Reevaluate all goals daily
- Set a time limit for the admission if possible.
- Develop discharge plan and activate ED services if a new patient

STANDARD TREATMENT CARE PLAN FOR ADMITTED PATIENTS WITH EATING DISORDERS

Current patient of EDP: Yes No Certified: Yes No

Indications/Admission:

- Low weight
- Abnormal lab values
- Severe restriction of intake
- Bedside room community/hospital

Goals of Admission:

- Correct electrolyte imbalance
- Refeeding/Weight gain
- Interruption of symptoms ** Transfer to 4NW (Eating Disorders Unit) will only occur if/when indicated

Parameters for discharge:

- Normal lab values
- Weight gain (as determined by EDP)
- Increase in skin fold measurement (as determined by EDP)
- No episodes of hypohyolemia
- Transfer to community hospital

Medical-Nutritional Treatment:

EDP Dietitian: _____ Local: _____

- Monitor N/C small bore enteral tube feed as ordered
- If NG tube comes out re-insert as soon as possible
- Monitor vitals, unfasted bloods and IV to determine medical status
- Meal tray to be arranged by EDP dietitian
- Dietitian to do SF weekly
- To be weighed once a week by Dietitian ONLY – redirect pt if she is trying to weigh self
- IV hydration and electrolyte supplementation as ordered

Psychiatric Treatment:

- Request Consult Liaison Psychiatry (pager 3-4991) Request made: Yes No **PLEASE NOTIFY 2222222** i.e. certification, sedation, management of anxiety, etc.
- Eating Disorder Nurse Educator Consult (NE) order made through SDM
- NE: _____ Local/Pager: _____
- EDP Psychiatrist to follow (Psych consult aware) DR: _____
- No self-harm/escape permitted
- 1:1 constant care (please request constant guidelines from EDP Nurse Educator)
- 1:1 constant care to remain within arms length at all times
- NO contraindications to food allowed including beverages
- Visiting hours only (may need to limit visitors – please indicate limitation and assess as needed)
- Certified community skills not to be self-terminated – 1:1 constant to assist
- Bathing privilege: keep door ajar and patient within view at all times
- Privacy – provide medication as ordered
- Do not allow blanket to be pulled up over face/head. Keep blankets at chest level.

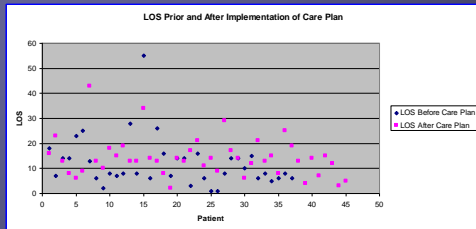
Review of Data

- A chart review of all patients admitted with the diagnosis of “eating disorders” was reviewed for 2004-2006 (pre-care plan) and for 2010- August 2012 (post care plan)
- Length of Stay Data was reviewed
- Qualitative Review of Charts for Therapy Interfering Behaviours was conducted (i.e. tubes pulled, feeds shut off etc.)
- Interviews were conducted with ward nurses re perception of pre and post care plan patient care

Review of Data

	(n)	Total LOS (TLOS)	Avg TLOS	“Outliers” TLOS > 15 days
2010-2012	45	641	14.244	13
2004-2006	37	446	12.054	13
Total sample size	82			

Review of Data



Review of Data

- **Quantitative estimate:** TLOS < after behavioural plan was instituted. Our data suggests that this is *not* the case.
- However scatter plot of LOS data shows more consistency in LOS (see graph)
- Also review of data shows that post initiation of care plan there were less repeat admissions 4 v s 7 repeats and for each of these patients there were less individual repeat admissions post care plan (2004-2006 data set patients with 7 and 10 individual admissions v s patients in 2010-2012 data with on average 2 admissions).

Review of Data

- Review of Qualitative Data also indicates an improvement in care with less therapy interfering behaviours (standing, stretching, pulling out NG tubes, manipulating NG tubes, hiding food)
- RN reports improvement in communication, admission objectives and coordination of care after care plan. Prior to care plan RN's did not have a sense of goals, who was most responsible for care, and noted more patient and family disruption and difficult behaviours
- Dieticians report improved communication and consistent care

Learning Objective 3

To review the benefits of an interdisciplinary model of care for complex medical and psychiatric patients

Multidisciplinary Care of Eating Disorder Patients Supported by Evidence

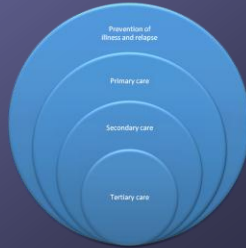
- Paucity of evidence based randomized controlled trials to recommend salient components of a comprehensive eating disorder service
- Experienced clinicians and centres provide multidisciplinary team approach for most effective service
- Increased patient satisfaction and compliance with multidisciplinary model of care

Review of our Team at SPH

- Increased Accountability
- Decreased team, patient, family distress
- Improved Communication
- Better Team Functioning
- Clear Boundaries and Goals for Patients
- Shortened Admission

Central Premise for Treatment

- Evidence supports a stepped continuum model consisting of multidisciplinary, integrated services, and emphasizing efficiency, efficacy, and continuity of care.
- Intervention begins with the least restrictive treatment possible, guided by an individual's needs and services available.
- The results of a given intervention are continuously monitored and adjusted, with an individual stepping up or down to more appropriate treatments as required.
- Readiness and motivation are significant elements determining successful recovery, and suggest the importance of matching services to an individual's need.



Clinical Practice Guidelines for the BC Eating disorders Continuum of Services

Josie Geller, Ph.D., R. Psych.
November 2011

Commissioned by Gerrit van der Leer, Director, MHSU Branch, BC Ministry of Health

What's on the Menu?

The Short Treatment Allocation Tool for Eating Disorders (STATED):

