northern health
the northern way of caring

Regional Order Set

Adult Eating Disorders: Medical Stabilization Orders for Inpatient Admissions

PATIENT LABEL

Allergies: ☐ None known ☐ Unable to obtain List with reactions: _____	Admission Weight: _____ kg Admission Height: _____ cm Admission BMI (kg/m^2): _____

Admitting Diagnosis: _____

Admission Instructions: Admit to _____ (MRP)

Code Status: Full Code or ☐ refer to Medical Orders for Scope of Treatment (MOST) (1-27-1-000)

Admission Status:
- ☐ Voluntary Status
- ☐ Involuntary Admission (Certified under Mental Health Act; Form 4 must be completed)
- ☐ Treatment Order for Involuntary Patient (Form 5)
  - Nursing to review Form 13 of Mental Health Act with patient if involuntary status

Consults:
- Northern Health Regional Eating Disorder Program (250-565-7479)
- ☐ St. Paul's on-call Internist for Eating Disorders (604-806-8347 - eating disorder main reception; for after hours, please use St. Paul's main switch board at (604-682-2344)) **also available for urgent service**
- Inpatient registered dietitian consult

☐ Psychiatry ☐ Pharmacist ☐ Social Work ☐ Other: _____

Laboratory:
- ***On Admission:*** Complete Blood Count (CBC); E7 (glucose random, potassium, chloride, sodium, Creatinine/eFGR, urea), extended electrolytes (Calcium, magnesium, phosphorus); liver enzymes (Alk Phos, ALT, AST, GGT, billirubin), INR, Albumin, TSH, ferritin, vit B12, urinalysis
- ***Daily bloodwork x 7 days:*** E7 (glucose random, potassium, chloride, sodium, Creatinine/eFGR, urea), extended electrolytes (Calcium, magnesium, phosphorus then three times a week thereafter on Monday's, Wednesday's and Friday's until discharge
- Fasting lipid profile (cholesterol, triglicerides, HDL) on ***day 3*** of admission

Additional Nursing Measures:
- Fasting Capillary Blood Glucose Monitoring (CBGM) at 0700 x 7 days and as needed
- Non-Fasting Capillary Blood Glucose Monitoring (CBGM) at 1400 x 7 days and as needed

Diagnostics:
- ECG on admission
- ECG on day 7 of admission
- ECG on discharge day

Medications:

Routine Supplementation:
- **potassium chloride** 20 mEq PO tid
- **sodium phosphate** 5 mL (= 20 mmol) PO tid
- **multivitamins with minerals** 2 TABS PO daily
- **thiamine** 200 mg PO daily
- **zinc elemental** 25 mg PO daily x 60 days, then reassess
- **magnesium sulfate** 5 g (= 20 mmol) IV over 4 hours daily x 5 days

☐ Other: _____

Physician signature:_____ **College ID:**_____ **Date:** _____ **Time:**_____

10-111-5385 (IND - DRAFT#4 - 08/20) **Review by December 2023**

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PRN Medications:

- ☐ **acetaminophen** 325 to 650 mg PO q4h PRN pain (max 3250 mg/24 hours)
- ☐ **aluminum/magnesium hydroxide** suspension 15 to 30 mL PO bid PRN indigestion/heartburn
- ☐ **polyethylene glycol 3350** WITH electrolytes (Peglyte or equivalent) 250 mL PO tid PRN constipation

Intravenous:

- Initiate Intravenous Catheter
- ☐ Rehydration Solution _____ Rate: _____ mL/hour
- ☐ If patient is having hypoglycemic episodes, despite being on tube feed, call MD to review blood glucose levels and determine IV orders:

Infuse ☐ D5W *OR* ☐ D10W at _____ mL/h

Dietary and Intake Orders Upon Admission:

- NPO
- Insert nasogastric feeding tube
- Confirm placement with x-ray prior to starting feeds
- Tube feeds and/or oral diet advancement as per dietitian

Tube Feed: If admission occurs during evening, weekends, or holidays, commence tube feeds under these orders:

- Initiate Isosource Fibre 1.2 at 15 mL/h
- Flush with 50 mL water, every 4 hours
- If serum phosphourous, magnesium, potassium levels are not low on day 2; increase tube feed to 25 mL/h. No further increases after that until RD is able to assess patient

Additional Nursing Measures:

- All meals to be supervised by nursing staff or 1:1; including 30 minutes post snack and 60 minutes post meals No bathroom privileges during this time unless accompanied by staff members. Patients are encouraged to use bathroom prior to all meals and snacks
- No outside food or drink, chewing gum, caffeine or artificial sweeteners
- No meal plan substitutions unless reviewed by dietitian
- May have up to a maximum of 1 litre of free water daily

Vital Signs: (reassess every 24 hours)

- Continuous cardiac monitoring (telemetry) if heart rate is under 50 beats per minute when patient is awake or sleeping or if heart rate shift is more than 20 beats per minute when standing; or if any heart block, junctional rhythm, T wave changes, QTc greater than 565
- Routine vital signs every 4 hours until stable
- Nurses to perform orthostatic vitals twice daily x 5 days (once after lying supine for 5 minutes and once after standing for 2 minutes) and adjust activity requirements accordingly. Please refer to table for activity levels and vital sign frequency
- Strict bed rest first 24 hours then nurses to reassess activity levels daily

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Nursing Assessment: (asleep or awake)	**Other Reported Symptoms:**	**Activity Levels and Vital Sign Frequency**
- Heart rate less than or equal to 50 bpm or over 100 bpm (refer to telemetry standards) - Blood pressure less than 90/60 mmHg - Orthostatic shifts in blood pressure greater than or equal to 20 mmHg - Orthostatic shifts in heart rate greater than or equal to 20 bpm (refer to telemetry standards)	- Shortness of breath - Chest pain - Syncope	**Level 1:** • Complete bed rest; nurse to assist to bathroom; sponge bath only; no off unit privileges except to medical tests or procedures via wheel chair or stretcher; • Vital signs every 4 hours and orthostatic vitals twice daily
- Heart rate 50 bpm or greater; less than 100 bpm - Blood pressure greater than 90/60 mmHg - Orthostatic shifts in blood pressure between 10 to 19 mmHg - Orthostatic shifts in heart rate between 10 to 19 bpm	- Dizziness	**Level 2:** • Ad lib to bathroom as per nurses discretion; shower seat and limit showers to 10 minutes; no off unit privileges except to medical tests or procedures via wheel chair or stretcher; • Vital signs every 4 hours and orthostatic vitals twice daily
- Heart rate 50 bpm or greater; less than 100 bpm - Blood pressure greater than 90/60 mmHg - Orthostatic shifts in blood pressure less than 10 mmHg - Orthostatic shifts in heart rate less than 10 bpm		**Level 3:** • Ad lib to bathroom as per nurses discretion; shower PRN; access to common area or 10 minute walks on unit up to 3 times a day; off unit privileges as per physicians orders only (see below); medical tests or procedures via wheel chair or stretcher; • If after 5 days of initial vital sign protocol - routine vital signs every 6 to 8 hours and orthostatic vital signs every Monday, Wednesday, and Friday until discharge (vital signs may be omitted if patient is asleep between 2400 and 0600) • Off unit privileges 30 minutes twice daily accompanied by family in wheel chair - *As per physician's discretion only when patient measurements meet level 3 activity criteria

Additional Nursing Measures:

- Weight checks every Monday and Thursday morning post void, before breakfast, in gown and undergarments only; patient's back to the scale - do not share weight
- Restrict patient access to scales while on unit

Contact physician on call if (patient awake or asleep):

- Patients heart rate is less than or equal to 40 beats per minute
- Patient's temperature is less than or equal to 35.5 degrees celcius
- Patient's blood glucose is less than 4 mmol/L

Physician signature:_____ **College ID:**_____ **Date:** _____ **Time:**_____