

Negotiating Meal Plans with Eating Disorder Consumers in an Inpatient Setting

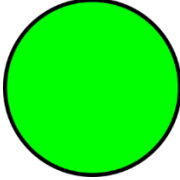
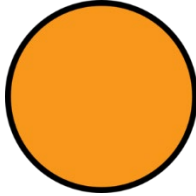
This resource was developed in order to assist dietitians who work in inpatient settings to provide nutrition care to consumers with an eating disorder.

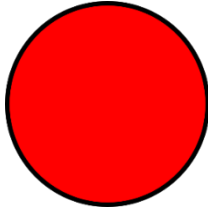
Providing nutritional care and interventions to consumers with an eating disorder can be a challenging task for clinicians. In most inpatient settings, 3-step meal plans are the recommended treatment to facilitate normalisation of eating once the consumer is deemed medically stable.

The aim of inpatient admissions for consumers with an eating disorder is to restore physical health through nutrition restoration and rehabilitation. This includes normalising eating patterns, as well as learning and developing strategies to challenge compensatory behaviours (e.g., purging, restriction, excessive exercise etc.). This resource is not intended to replace established treatment protocols (i.e., nasogastric refeeding if medically compromised). Instead, it should be used in conjunction with local policies and procedures when deemed clinically appropriate to re-commence oral feeding.

The following information provides tips/guidance on how to implement a 2 or 3-step meal plan in a collaborative approach with consumers with an eating disorder. Whenever possible, investigate and align with the consumer's goals and motivations when negotiating a meal plan. Accept that there may be times when the eating disordered part of the consumer is so strong that this may not be possible. Additionally, the suggestions below need to consider what is practical from a foodservice and nursing perspective within your local hospital and health service.

Please note: These guidelines may not be appropriate for people with an Avoidant Restrictive Food Intake Disorder (ARFID) diagnosis. Refer to the QLD Eating Disorder Service (QuEDS) Guidelines ARFID appendix for more information.

<p>Negotiables</p> 	<ul style="list-style-type: none"> • Non-starch vegetables – choose a minimum of 1 vegetable. • Snacks – choice from predetermined list established by the treating dietitian. • Types of fluids (within fluid restriction) outside of the meal plan can be at the discretion of the consumer, if they are free from artificial sweeteners and limited to 3x caffeinated drinks per day. • Foods within the same food groups can be swapped for one another (i.e., mash potato <--> boiled rice <--> bread). • Cultural/Religious/Food allergy considerations – If dietary rules/beliefs have been followed for reasons other than caloric restriction, these are to be catered for when possible (i.e., Kosher, Halal). In exceptional circumstances, foods may be brought in from outside of hospital, ensuring food safety standards are adhered to (ideally foods should be individually packaged, with nutritional labelling). • The nutrition supplement in Step 2 of a 3-step meal plan can be negotiated for flavour preferences. • The timing of additional snacks if required to assist with nutritional adequacy and medical stability (early breakfast or late supper).
<p>Negotiables with limitations</p> 	<ul style="list-style-type: none"> • The timing of mid-meals (no longer than 3 hours in-between a meal or snack). In instances where the consumer is unable to complete Step-1, then Step-2 should be commenced as soon as possible. • Alternative meals/mid-meals when progressing with leave off the ward over mealtimes can be discussed (of similar nutritional value and food group serves). • Vegetarian: If the consumer has been vegetarian for an extensive period, independent of the eating disorder, this may be catered for pending food service availability and/or acceptance of available vegetarian protein sources. • Consumption of all meals/snacks should be encouraged to take place in communal dining areas if possible, or at bedside desk (not in bed). Alternative

	<p>arrangements can be considered by the MDT in extenuating circumstances.</p> <ul style="list-style-type: none"> • Food preferences can be considered, however for ease they should be restricted to 2 changes per dietetic consult, per week only.
<p>Non-negotiables</p> 	<ul style="list-style-type: none"> • Removal/elimination of entire food groups (AGTHE, as well as 'nuts, oils and fats', 'fun foods' as per REAL food pyramid). • Regular meals/snacks (ideally 3 x main meals and 3 x snacks in between main meals). • If Step-1 is not 100% consumed (not 80% or 90%), completion of 100% of Step-2 (oral nutritional supplement) is expected. • Main meals and snacks must consist of protein, carbohydrates, and dietary fats. • Depending on nutrition goals, main meals may also include a minimum 1-2 fruit serves, 1 calcium OR 1 fat/oil serve. • Food serves plated by the kitchen must be standard serves (no 'small portions'). • No 'diet' or 'light' products or artificial sweeteners. • Food to be consumed within a designated time frame (i.e., 30mins for main meals and 20mins for snacks). • No menu items or foods from outside of the hospital to be consumed (this can be discussed once the consumer commences leave off ward). • No changes to the meal plan without discussion with the Dietitian. • Supervision of all meals and snacks is required in hospital.

Issue/Challenges	Useful Phrases/Responses
'You can't make me eat'	<ul style="list-style-type: none"> • 'How your body receives nutrition (food, oral nutrition supplement, NGT bolus) is your choice, but having no nutrition (refusing meals/boluses) is not an option'.
Complaints about hospital food/ Attempting to negotiate	<ul style="list-style-type: none"> • 'This meal plan is structured to help fuel your body in a safe, sustainable way. The more changes we make, the less effective it will be in helping with your recovery.' • 'I can imagine it must be difficult consuming hospital foods that you would not normally eat at home...'
Low engagement	<ul style="list-style-type: none"> • Prompting questions to explore eating attitudes and beliefs can help provide rationale for the meal plan being initiated. These include: <ul style="list-style-type: none"> ○ Are there particular rules or factors that influence your food choices? ○ What have been your main sources of information about food and healthy eating? ○ How strictly do you apply these rules to yourself? ○ What are the consequences if you don't stick with your rules?
Difficulty making decisions	<ul style="list-style-type: none"> • 'I can see your eating disorder is giving you a hard time now, should I make the choices on your behalf, and we can try this again next review?' • Consider limiting the options provided (e.g., 'would you prefer <i>this</i> or <i>that</i>?').
Boundary Setting	<ul style="list-style-type: none"> • Communicate expectations around meal planning. • Limit meal planning changes to maximum of one occasion per week. • Changes to the meal plan to be done collaboratively between the consumer and dietitian only, within allocated review times.
Escalating behaviours	<ul style="list-style-type: none"> • Utilise the 4C's; <ul style="list-style-type: none"> ○ Calm: Role model relaxed body language and a peaceful tone of voice. ○ Confident: The more confident you appear; the more reassured consumers will feel. ○ Consistent: Stick with what was agreed and don't negotiate. ○ Compassionate: Understand the difficulty they're facing.
Minimising guilt or shame - Externalising the eating	<ul style="list-style-type: none"> • What did the eating disorder say to trick you into skipping lunch?

<p>disorder: Differentiate between the client and the disease.</p>	<ul style="list-style-type: none"> • What might be helpful for you to battle the eating disorder next time in a similar situation? • It sounds like the eating disorder is taking a lot away from you. • How are the eating disorder values different to your own values? • What does the eating disorder tell you about yourself? • When is the eating disorder likely to take advantage of you?
<p>Clear expectations and communication</p>	<ul style="list-style-type: none"> • Provide rationale for meal plan, as well as for each decision (why something is negotiable in a meal plan, as well as why other aspects are non-negotiable). • Always provide opportunities for clients to contribute to decision making, to foster self-efficacy. • Make consequences of behaviours clear. 'If your eating disorder is preventing you from consuming your meal/snack in its entirety, we will provide you with an oral nutrition supplement to ensure you do not miss out on the nutrition you require'. • Communicate changes to meal plan to the consumer and the multidisciplinary team. • Set time frames for menu planning with the consumer.
<p>Provide positive reinforcement</p>	<ul style="list-style-type: none"> • Link efforts to reaching meaningful outcomes, knowing what the consumer is looking forward to outside of hospital.
<p>Restrictive diet practices (Veganism, food allergies)</p>	<ul style="list-style-type: none"> • Require confirmation from family members regarding long-term behaviours or recent change due to the eating disorder. • Obtain collateral to ensure food allergies are medically confirmed. • Set a limit of food 'dislike' options (not whole food groups) with the consumer at the start of admission.
<p>Validation of feelings ('You are making me fat'/ 'I feel too full/sick')</p>	<ul style="list-style-type: none"> • 'I understand you may be experiencing bloating/discomfort. This is normal when starting a meal plan. This should start to settle in time with regular, adequate nutrition'. Encourage use of distraction techniques. • 'Weight is gained disproportionately during nutritional rehabilitation but will redistribute over time'.

Summary:

- Providing nutritional care and intervention to eating disorder individuals can be challenging.
- Refer to QuEDS for more information on providing inpatient care for eating disorder consumers (via QH intranet)

at: http://hi.bns.health.qld.gov.au/mental_health/eating_disorder/default.htm

- Peer support can also be provided via QuEDS on request.

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