Isle of Wight NHS
NHS Trust

MARSIPAN POLICY

Management of Really Seriously ill People with Anorexia Nervosa

Document Author	Authorised
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Lead Director: Clinical Director Mental Health and Learning Disabilities	
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DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification / Approval
Aug 15	0.1		Clinical Director MH & LD	New Policy	
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NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

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1 Executive Summary

1.1 The Royal Colleges of Psychiatrists have published the MARSIPAN and Junior MARSIPAN Guidelines in an attempt to improve the management of patients with severe Anorexia Nervosa in general medical and paediatric units. This followed the review of a number of cases of young people with severe Anorexia Nervosa who died due to re-feeding syndrome, underfeeding syndrome and other complications of Anorexia Nervosa and its treatment.

1.2 Recommendations of the guidelines include:

- Medical and psychiatric ward staff need to be aware that patients with Anorexia Nervosa being admitted to a medical ward are often at high risk.

- Physical risk assessment in these patients should include body mass index (BMI), physical examination, including muscle power, blood tests and ECG.

- Most adults with severe Anorexia Nervosa should be treated in Specialist Eating Disorder Units.

- Criteria for medical admission are the need for treatments (such as intravenous Infusion) not available on a psychiatric ward or the unavailability of a suitable Specialist Eating Disorder Unit bed.

- The Inpatient Medical Team should be supported by a Senior Psychiatrist, preferably an Eating Disorder Psychiatrist. If an Eating Disorder Psychiatrist is unavailable, support should come from a Liaison or General Psychiatrist.

- The Inpatient Medical Team should contain a Physician and a Dietician with specialist knowledge in eating disorders, preferably within a Nutrition Support Team, and have ready access to an Eating Disorder Psychiatrist.

1.3 These guidelines can be accessed in full by following the web link in the References section below (Section 12).

1.4 The key tasks of the Inpatient Medical Team are to:

1) Safely re-feed the patient to avoid re-feeding syndrome caused by too rapid re-feeding.
2) Avoid underfeeding syndrome caused by too cautious rates of re-feeding.
3) Manage, with the help of psychiatric staff the behavioural problems common in patients with Anorexia Nervosa, such as sabotaging nutrition.
4) Occasionally to treat patients under compulsion with the support of psychiatric staff.

This Policy has been developed by the Isle of Wight NHS Trust MARSIPAN Steering Group in response to the above recommendations.

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2 Introduction

2.1 This document addresses the care of seriously ill patients with an eating disorder who are admitted to medical or paediatric wards within the Isle of Wight NHS Trust.

2.2 Adult patients with severe anorexia nervosa should ideally be treated in specialist eating disorder units.

2.3 This procedural document has been produced in response to the Royal College of Psychiatrists' Junior MARSIPAN (2012) and MARSIPAN report (2014), which addressed concerns over a number of patients with severe anorexia nervosa dying due to under treatment, some on medical inpatient wards.

2.4 The Joint Commissioning Panel for Mental Health (2013) recommends that MARSIPAN guidelines be adhered to when an anorexia nervosa patient is admitted to a medical unit whose physical health is unstable and cannot be safely managed in a Specialist Eating Disorder Service.

2.5 Criteria for medical admission are the need for treatments not available on psychiatric wards (e.g. intravenous infusion, artificial ventilation, cardiac monitoring, central venous pressure lines, total parenteral nutrition, cardiac resuscitation, treatment of serious medical complications).

2.6 This Policy starts with guidance on the acute management of ill patients and then considers pathways for such patients.

2.7 It is important that this Policy is used by all staff to initiate treatment for patients with anorexia outside of normal working hours, as delays in treatment at such times can have severe and fatal consequences.

3 Definitions

3.1 **MARSIPAN**: Management of Really Sick Patients with Anorexia Nervosa.

3.2 **Anorexia Nervosa**: Anorexia nervosa is a serious mental health condition. It is an eating disorder in which people keep their body weight as low as possible. People with anorexia usually do this by restricting the amount of food they eat, making themselves vomit and exercising excessively. The condition often develops out of an anxiety about body shape and weight that originates from a fear of being fat or a desire to be thin. Many people with anorexia have a distorted image of themselves, thinking that they're fat when they're not. Anorexia most commonly affects girls and women, although it has become more common in boys and men in recent years. On average, the condition first develops at around the age of 16 to 17.

3.3 **Body Mass Index (BMI):** Body mass index (BMI) is a measure of body fat based on height and weight that applies to adult men and women. The actual calculation is your weight (in kilograms) divided by your height (in metres) squared.

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4 Scope

4.1 This document applies to patients with an eating disorder, who are seriously physically unwell and require admission to a medical or paediatric ward, Isle of Wight NHS Trust. Usually such patients will have a BMI of less than 15.

4.2 This document covers all age ranges and makes recommendation in line with the Junior MARSIPAN guidelines (for under 18 year olds) and adult MARSIPAN guidelines.

5 Purpose

5.1 The purpose of this document is to:

- Ensure the patient receives appropriate physical and mental health care that is overseen by a multidisciplinary team (The Isle of Wight NHS Trust MARSIPAN Group).
- Ensure that all staff involved in the care of seriously ill patients with an eating disorder provides consistent, high quality physical and mental health care in a coordinated way.
- To provide advice for nursing, medical, psychiatric and dietetics staff, including those working out of hours who may have limited experience working with people with eating disorders.
- Ensure patients with an eating disorder, who are seriously physically unwell and require admission to a medical or paediatric ward, achieve medical stability. Wherever possible this should be achieved in a collaborative way that provides psychological as well as physical benefit.

6 Roles and Responsibilities

6.1 The physical health treatment of a patient with severe anorexia nervosa remains the responsibility of the consultant physician/paediatrician and their multidisciplinary team supported by the mental health and dietetics service.

6.2 **All clinicians** admitting patients with a presumed eating disorder have a responsibility to ensure appropriate tests and investigations in line with MARSIPAN guidance are carried out.

6.3 **General Ward and Paediatric Nurses** have a responsibility to ensure that patients with a presumed eating disorder who are admitted to the ward are promptly referred to the dietetics department and liaison psychiatry department/child and mental health service dependent upon the patient's age.

6.4 **Dietetics staff** have a responsibility to ensure that patients with eating disorders who are admitted to a medical or paediatric ward have nutrition plans that prevent re-feeding or under-feeding syndromes from developing.

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6.5 **Liaison psychiatry** staff have a responsibility to support the medical and dietetics team in the management of the patient with a severe eating disorder and ensures prompt referrals are made to specialist eating disorder units for further nutritional management. If the patient is currently open to the mental health service the liaison psychiatry team will be that community service. If the patient is not open to the mental health service the liaison psychiatry team will be the self-harm and liaison team based at Sevenacres.

7 Policy detail/Course of Action

7.1 Adults (18 Years and older)

7.1a Admitting Medical Team

1) When a patient with a presumed BMI of less than 15 is referred to the hospital medical team for admission the patient should be admitted to a medical bed for on-going management.

2) When a patient with a presumed BMI of less than 15 is referred to the hospital medical team for admission the following investigations should be carried out and documented in the patient's care record:

SYSTEM	Investigation	Concern	**Alert**
Nutrition	Body Mass Index (BMI)	<14	**<12**
	Weight loss/week	>0.5 kg	**>1.0 kg**
	Skin Breakdown	<0.1cm	**>0.2cm**
	Purpuric rash		**+**
Circulation	Systolic Blood Pressure (BP)	<90	**<80**
	Diastolic Blood Pressure	<70	**<60**
	Postural drop (sit –stand)	>10	**>20**
	Pulse Rate **	<50	**<40**
	Unable to sit up at all		**+**
Temperature		<35	**<34.5**
Bone Marrow	White Cell Count (WCC)	<4.0	**<2.0**
	Neutrophil count	<1.5	**<1.0**
	Haemoglobin (Hb)	<11	**<9.0**
	Platelets	<130	**<110**
Salt /water balance	Potassium	<3.5	**<3.0**
	Sodium	<135	**<130**
	Magnesium	0.5-0.7	**<0.5**
	Phosphate	0.5-0.8	**<0.5**
	Urea	>7	**>10**
Liver	Bilirubin	>20	**>40**
	Alkaline Phosphatase	>110	**>200**
	Aspartate Aminotransferase	>40	**>80**
	Alanine Aminotransferase	>45	**>90**
	Gamma-glutamyltransferase	>45	**>90**
Nutrition	Albumin	<35	**<32**
	Creatinine Kinase	>170	**>250**
	Glucose	<3.5	**<2.5**

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ECG (if BMI<15, low Potassium, drugs prolonging QTC prescribed)	Pulse rate	<50	**<40**
	Corrected QT interval (QTC)		**>450 msec**
	Arrythmias		**+**
Differential Diagnosis Thyroid Function Test, Erythrocyte Sedimentation Rate			

- **Any abnormal result is an indication for concern, monitoring and consultation/referral to specialist Eating Disorders Service. Score/s in the concern area.**

- **Score/s in the concern area**

- Regular review of parameters (c.weekly) and assessment of capacity with urgent referral to eating disorders and appropriate medical intervention if needed. As this signifies medical risk this should also be shared with the carer.

- **Score/s in the Alert area**

- Immediate contact and referral to eating disorders unit and physicians if out-patient with assessment of capacity. The patient will need urgent specialist and medical assessment. If in-patient – immediate contact with on-call physicians.
- This table gives values of concern for each part of the assessment and is followed by a management protocol based on risk

- * The baselines for these tests may vary between laboratories.
- ** A tachycardia in the presence of signs and investigations of severe risk may be a harbinger of imminent cardiovascular collapse.

3) When a patient with a presumed BMI of less than 15 is referred to the hospital medical team for admission the MARSIPAN Checklist (Appendix A) should be completed and placed in the patient's record.

4) If the patient has not been transferred to a specialist eating disorder unit bed within 7 days the medical team will ensure a weekly multidisciplinary meeting is held (involving a liaison psychiatry representative, a dietician and a medical team representative) to co-ordinate care.

5) Depending on which medical ward the patient is admitted a referral to the gastroenterology physicians for advice and possible transfer of care should be completed.

7.1b <u>Admitting Nursing Staff</u>

1) When a patient with a presumed BMI of less than 15 is admitted to a medical ward the admitting nursing staff should complete a Malnutrition Universal

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Screening Tool (MUST) form and refer the patient to the hospital dietician team.

2) When a patient with a presumed BMI of less than 15 is admitted to a medical ward the admitting nursing staff should make a referral to the liaison psychiatry team to assess and advise on management (including use of the Mental Health Act).

3) When a patient with a presumed BMI of less than 15 is admitted to a medical ward the nursing staff should ensure no nutritional supplement drinks are given to the patient until the dietician has prepared a nutrition plan. Nursing staff should offer ½ portions from the normal menu until the dietician has reviewed the patient.

4) If a 1:1 nurse is required the ward manager should discuss with acute psychiatry service manager the patient's needs to ascertain which pool the respective nurse should be sourced from.

7.1c <u>Liaison psychiatry Team</u>

1) The liaison psychiatry team will visit at least every other working day to assess the admitted patient and provide support to the medical team, the dietician, the ward staff and any 1:1 nurse.

2) The liaison psychiatry team will, from day one of admission, lead on finding a specialist eating disorder bed so that the patient can be transferred when safe to do so. If the patient becomes medically stable and no specialist eating disorder unit bed is available a multi-disciplinary team discussion (between the medical team, liaison psychiatry team and dietician) will be held to identify the most appropriate place for the patient to wait.

3) The liaison psychiatry team will support the medical team in ensuring that a weekly multidisciplinary review takes place.

4) The liaison psychiatry team will provide advice, support and training to the general ward staff, medical team, dietician and 1:1 nursing staff in managing challenging behaviours that are associated with anorexia nervosa sufferers. These include falsifying weight, disposing of feed and exercising on the bed.

7.1d <u>Dietician</u>

1) When a patient with a presumed BMI of less than 15 is admitted to a medical ward and referred to the dietetics team, a dietician will provide a next working day assessment of the patient.

2) An individualised nutrition plan will be developed in line with Adult MARSIPAN guidance.

3) A dietician will assess and provide support to the medical team for at least a week or until it is felt less frequent reviews are required.

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7.2 Children and Adolescents (17 Years and below)

7.2a Admitting Paediatric Medical Team

1) When a patient with a presumed eating disorder is admitted to the paediatric ward the admitting medical team (and nursing team) will carry out a risk assessment (in accordance with the risk assessment framework within the Junior MARSIPAN guidelines) to identify whether the patient is red, amber, green or blue risk.

2) When a patient with a presumed eating disorder is referred to the paediatric team for admission the following investigations should be carried out and documented in the patient's care record:

SYSTEM	Investigation
Nutrition	Body Mass Index (BMI)
	Weight loss/week
	Skin Breakdown
	Purpuric rash
Circulation	Systolic Blood Pressure (BP)
	Diastolic Blood Pressure
	Postural drop (sit –stand)
	Pulse Rate **
	Unable to sit up at all
Temperature	
Bone Marrow	White Cell Count (WCC)
	Neutrophil count
	Haemoglobin (Hb)
	Platelets
Salt /water balance	Potassium
	Sodium
	Magnesium
	Phosphate
	Urea
Liver	Bilirubin
	Alkaline Phosphatase
	Aspartate Aminotransferase
	Alanine Aminotransferase
	Gamma-glutamyltransferase
Nutrition	Albumin
	Creatinine Kinase
	Glucose
ECG (if BMI<15, low Potassium drugs prolonging QTC prescribed)	Pulse rate
	Corrected QT interval (QTC)
	Arrythmias
Differential Diagnosis Thyroid Function Test, Erythrocyte Sedimentation Rate	

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3) The medical team will ensure a weekly multidisciplinary meeting is held (between child and adolescent mental health service representative, dietician and medical team representative) to co-ordinate care.

7.2b Admitting Nursing Staff

1) When a patient with a presumed eating disorder is admitted to the paediatric ward the nursing team (and medical team) will carry out a risk assessment (in accordance with the risk assessment framework within Junior MARSIPAN guidelines) to identify whether the patient is red, amber, green or blue risk.

2) When a patient with a presumed eating disorder is admitted to the paediatric ward the admitting nursing staff should make a referral to the child and adolescent mental health service to provide advice on management (including use of the Mental Health Act).

3) When a patient with a presumed eating disorder is admitted to the paediatric ward the admitting nursing staff should make a referral to the dietician to provide advice on nutritional management.

4) When a patient with a presumed eating disorder is admitted to the paediatric ward the nursing staff should follow 'Anorexia Nervosa within an Inpatient Paediatric setting - Protocol for the Nursing Management (including Dietetic Guidelines)'.

5) If a 1:1 nurse is required as assessed by the Child and Adolescent Mental Health Service additional funding for this will need to be agreed by the CCG with appropriate staff usually being sourced from the paediatric bank.

7.2c Child and Adolescent Mental Health Team

1) The Child and Adolescent Mental Health Team will visit every weekday to assess the admitted patient and provide support to the medical team, the dietician, the ward staff and any 1:1 nurse.

2) The Child and Adolescent Mental Health Team will, from day one of admission, lead on finding a specialist eating disorder bed, if appropriate, so that the patient can be transferred when safe to do so.

3) The Child and Adolescent Mental Health Team will support the medical team in ensuring that weekly multidisciplinary reviews take place.

4) The Child and Adolescent Mental Health Team will provide advice, support and training to the general ward staff, medical team, dietician and 1:1 nursing staff in managing challenging behaviours such as falsifying weight, disposing of feed and exercising on the bed.

7.2d Dietician

1) When a patient with a presumed eating disorder is admitted to the paediatric ward and referred to the dietetics team, a dietician will provide a next working day assessment of the patient.

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2) An individualised nutrition plan will be developed in line with the Junior MARSIPAN guidance.

3) A dietician will assess and provide daily weekday support to the medical team for at least a week or until it is felt less frequent reviews are required.

8 Consultation

8.1 This policy was developed by the MARSIPAN steering group. Members included a consultant psychiatrist, consultant physicians, dietetics, adult and child/adolescent service managers and nursing staff.

8.2 This policy has been consulted and shared with Medical, Psychiatric, Dietetics and Nursing professionals who are using and implementing this policy.

8.3 The policy has been consulted and shared with the Mental Health and Learning Disabilities Quality Group, Policy Management Group and Clinical Standards Group.

9 Training

9.1 The MARSIPAN Protocol does not have a mandatory training requirement but the following non mandatory training is recommended:-

9.2 A half-day annual training event for all staff involved in the implementation of the MARSIPAN Protocol will be arranged by the MARSIPAN Steering Group.

9.3 It is anticipated that training in relation to the Junior MARSIPAN guidance will come from a joint collaboration between the paediatric team and child and adolescent mental health service.

9.4 If deemed appropriate training from a child and adolescent specialist eating disorder service can be considered.

9.5 Training in relation to Adult MARSIPAN guidance will come from an adult specialist eating disorder service.

10 Monitoring Compliance and Effectiveness

10.1 Following approval of the MARSIPAN Policy an implementation programme will follow, which will include internal audits to ascertain its effective implementation.

10.2 The implementation programme will include:

- Quarterly MARSIPAN Steering Group meetings.
- Development of audit standards from this policy to enable practice to be compared against these.
- Twice yearly audits of a sample of patients admitted to the Isle of Wight NHS Trust with a presumed eating disorder.

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10.5 The MARSIPAN Steering Group will responsible for overseeing the completion of the audits.

10.6 Results of the audit will be fed in to the Mental Health and Learning Disability Clinical Business Unit quality group meetings and Medicine Clinical Business Unit quality group meetings.

10.7 The MARSIPAN Steering Group will oversee the production of action plans and make changes as appropriate to reduce any identified risks

11 Links to other Organisational Documents

11.1 None

12 References

12.1 Adult MARSIPAN (2014) http://www.rcpsych.ac.uk/files/pdfversion/CR189.pdf

12.2 Junior MARSIPAN (2012) http://www.rcpsych.ac.uk/files/pdfversion/CR168nov14.pdf

12.3 The Joint Commissioning Panel for Mental Health (2013) Guidance for commissioners of eating disorder services

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Appendix A

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

Document title	MARSIPAN POLICY: For Management of Seriously Ill People with Anorexia Nervosa.

Totals	**WTE**	**Recurring £**	**Non Recurring £**
Manpower Costs	**0**	**0**	**0**
Training Staff	**0**	**0**	**0**
Equipment & Provision of resources	**0**	**0**	**0**

Summary of Impact: Training for hospital teams in the being aware of this policy and their respective roles and responsibilities.

Risk Management Issues: Nil

Benefits / Savings to the organisation: Prompt management of these patients will lead to quicker transfer from medical or paediatric wards to appropriate onward destination.
Reduced mortality for patients.

Equality Impact Assessment

- Has this been appropriately carried out? YES
- Are there any reported equality issues? NO

If "YES" please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

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13 Manpower	WTE	Recurring £	Non-Recurring £
a. Operational running costs			
Additional staffing required - by affected areas / departments:			
Totals:	0	0	0

Staff Training Impact	**Recurring £**	**Non-Recurring £**
Affected areas / departments		
e.g. 10 staff for 2 days		
Totals:	0	0

14 Equipment and Provision of Resources	Recurring £ *	Non-Recurring £ *
Accommodation / facilities needed		
Building alterations (extensions/new)		
IT Hardware / software / licences		
Medical equipment		
Stationery / publicity		
Travel costs		
Utilities e.g. telephones		
Process change		
Rolling replacement of equipment		
Equipment maintenance		
Marketing – booklets/posters/handouts, etc		
Totals:	**0**	**0**

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	

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Equality Impact Assessment (EIA) Screening Tool

Document Title:	MARSIPAN POLICY
Purpose of document	The Management of Really Seriously Ill People with Anorexia Nervosa
Target Audience	*Isle of Wight NHS Staff who work on medical or paediatric wards.*
Person or Committee undertaken the Equality Impact Assessment	*Dr Alexis Bowers, Clinical Director*

1. To be completed and attached to all procedural/policy documents created within individual services.

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

		Positive Impact	Negative Impact	Reasons
Gender	Men	*Y*	*N*	*Improved health*
	Women	*Y*	*N*	*Improved health*
Race	Asian or Asian British People	*Y*	*N*	*Improved health*
	Black or Black British People	*Y*	*N*	*Improved health*
	Chinese people	*Y*	*N*	*Improved health*
	People of Mixed Race	*Y*	*N*	*Improved health*

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	White people (including Irish people)	*Y*	*N*	*Improved health*
	People with Physical Disabilities, Learning Disabilities or Mental Health Issues	*Y*	*N*	*Improved health*
Sexual Orientation	Transgender	*Y*	*N*	*Improved health*
	Lesbian, Gay men and bisexual	*Y*	*N*	*Improved health*
Age	Children	*Y*	*N*	*Improved health*
	Older People (60+)	*Y*	*N*	*Improved health*
	Younger People (17 to 25 yrs.)	*Y*	*N*	*Improved health*
Faith Group		*Y*	*N*	*Improved health*
Pregnancy & Maternity		*Y*	*N*	*Improved health*
Equal Opportunities and/or improved relations		*N/A*	*N/A*	*N/A*

Notes:

Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

3. Level of Impact

If you have indicated that there is a negative impact, is that impact:

	YES	NO
Legal (it is not discriminatory under anti-discriminatory law)	N/A	N/A

Intended

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain

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how below:

N/A
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:

N/A
3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?

N/A

Scheduled for Full Impact Assessment	Date:
Name of persons/group completing the full assessment.	
Date Initial Screening completed	

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MARSIPAN checklist

for Really Sick Patients with Anorexia Nervosa

Assessing

Does the patient have anorexia nervosa?

- ☐ Yes
- ☐ Not sure and psychiatric review requested

Are there significant risk factors?

- ☐ BMI <13 (adults) or <70% median BMI for age (under 18)?
- ☐ Recent loss of ≥1 kg for two consecutive weeks?
- ☐ Little or no nutrition for >5 days?
- ☐ Acute food refusal or <500 kcal/day for >2 days in under 18s?
- ☐ Pulse <40?
- ☐ BP low with postural dizziness?
- ☐ Core temperature <35°C?
- ☐ Na <130 mmol/L?
- ☐ K <3.0 mmol/L?
- ☐ Raised transaminase?
- ☐ Glucose <3 mmol/L?
- ☐ Raised urea or creatinine?
- ☐ ECG: e.g. bradycardia? QTc >450 ms?

Is the patient consenting to treatment?

- ☐ Yes
- ☐ No and assessment for compulsory detention requested

Refeeding

Is intensive medical care needed?

- ☐ Yes
- ☐ No and regular risk monitoring in place

Increased risk of refeeding syndrome?

- ☐ Low initial electrolytes
- ☐ Low BMI (<13 or mBMI <70%)
- ☐ Significant comorbidities (e.g. infection, cardiac failure, alcoholism, uncontrolled diabetes)
- ➔ Start at 5–10 kcal/kg/day
- ➔ Monitor electrolytes twice daily and build up calories swiftly: avoid underfeeding

Lower risk of refeeding syndrome?

- ➔ Start at 15–20 kcal/kg/day and build up swiftly
- ➔ Avoid underfeeding syndrome

Give all adults oral thiamine and Pabrinex®

Monitor

- ➔ Electrolytes (especially P, K)
- ➔ ECG
- ➔ Vital signs
- ➔ BMI

Managing

Are medical and psychiatric staff collaborating in care?

- ☐ Yes
- ☐ No and psychiatric consultation awaited

Are nurses trained in managing medical and psychiatric problems?

- ☐ Yes
- ☐ No and appropriately skilled staff requested/training in place

Are there behaviours that increase risk?

- ☐ Purging behaviours
- ☐ Falsifying weight
- ☐ Disposing of feed
- ☐ Exercising
- ☐ Self-harm, suicidality
- ☐ Family distress/anxiety
- ☐ Safeguarding concerns
- ➔ Mobilise psychiatric team to advise on management

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See full report: Royal College of Psychiatrists, Royal College of Pathologists, Royal College of Physicians. *MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa, 2nd edition* (College Report CR189). Royal College of Psychiatrists.