

MARSIPAN: The role of the adult psychiatric team

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Video:

**A PATIENT WITH ANOREXIA
NERVOSA SPEAKS OF HER
EXPERIENCES IN A WARD.**

ASSESSMENT

Areas to Assess

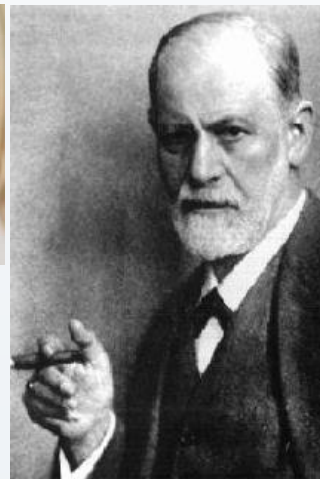
- Physical state
- Mental state
 - Body image disturbance
 - Depression, suicidality, OCD
 - Cognitive changes
 - Need for MHA assessment
- Treating Sabotaging behaviours
- Relationships with
 - family and friends
 - ward staff
 - other patients
- Family issues

Bio-Psycho-Social

Bio-Psycho-Social assessment

- Skills required: Mental health nursing, medical nursing, psychiatric, medical, dietetic
- Each assesses, preferably together
- Meet to compare observations

Lab tests



Physical state



Mental state



Family

Psychiatric and medical staff



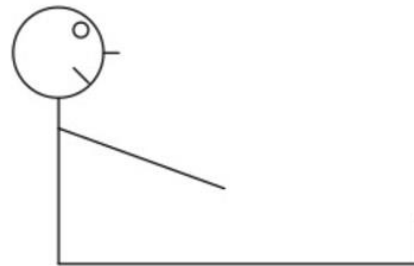
Assessing Physical risk in AN

This must begin in Primary Care

Observation	Interpretation		
Symptoms		eg can go up stairs?	
Examination	eg Hydration	SUSS test	Pulse, BP
BMI	Hi risk: <13	Med risk: 13-15	Low risk: >15
Blood tests	eg U and E	P, Mg	LFTs, CK, FBC
ECG	eg HR (<40)	QTc (>450ms ♂, >470 ♀)	T waves abnormal
Any worrying result	= High risk		

Sit Up Squat Stand (SUSS) Test: Description and scoring

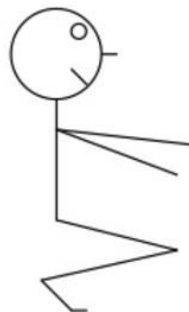
SitUp



Sit Up: Patient lies on the floor and sits up without, if possible, using his/her hands

- 0: Unable,**
- 1: Able only using hands to help**
- 2: Able with noticeable difficulty**
- 3: Able with no difficulty**

SquatStand



Squat Stand: Patient squats down and rises without, if possible, using his/her hands

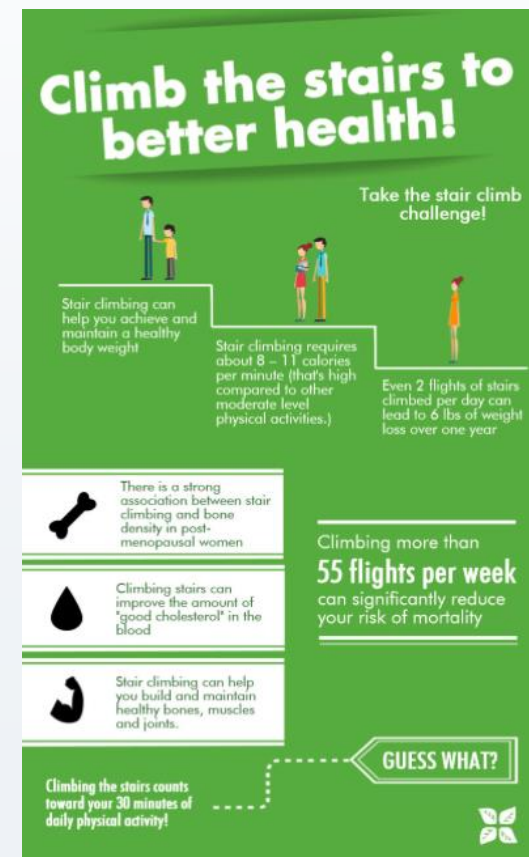
Mental state



- Body image distortion: “There’s so much more fat to go”
- Fear of death: Patient may not want to die, but may fear fat more
- However, may have suicidal ideas

Treatment-Sabotaging behaviours

- Reducing calories
 - switched off IV
 - discarded feeds
 - getting rid of and hoarding of food
 - laxatives, vomiting
- Increasing energy output
 - microexercising
 - Standing
 - getting cold
- Weight falsification
 - water loading
 - weights



Lessons to learn

- Of all conditions, AN requires a Bio-Psycho-Social approach
- Physical risk assessment is mandatory
- Psychiatric assessment looks at motivation, sabotaging behaviours, cognitive state and suicidal risk
- Capacity and need for compulsion must be assessed
- With the family, look at potential resources, unhelpful responses and begin to support the family in an unbearable situation

MANAGEMENT

Principles of management

- Location of care
- Establishing a Bio-Psycho-Social team approach
- Safe refeeding
- Managing sabotaging behaviours
- Managing family distress
- Managing staff difficulties
- Decisions on transfer and discharge

Safe refeeding: an area where disagreements between professionals occur

- Main tasks are:
 - Refeed
 - Avoid (manage) refeeding syndrome (RFS)
 - Avoid underfeeding syndrome (UFS)
- See MARSIPAN for details



CRI89

MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa

2nd edition

COLLEGE REPORT

Sabotaging behaviours: eg exercise



- Predict at assessment
- Establish best approach (eg information, discussion, persuasion, sedation)
- Include in care plan
- Escalate to more senior staff if necessary

Staff difficulties



- Written and verbal information
- Clear expectations and boundaries
- Escalate to more senior staff if required
- Discuss in staff group regularly
- Special attention to temporary staff

Managing Family distress

Family Anxiety

- Meet and explain

Family disagreements

- Parents in therapy?

Complaints

- Document and address everything

Calls +++

- One family member as contact

Requests for second opinions

- Agree but use formal channels

Decisions on transfer and discharge

- Why transfer?
 - Medical management
 - Behavioural management
- Choice of unit
 - SEDU
 - Secure psych unit
 - Medical ICU
 - General medical
- Discharge
 - Physical and mental state
 - Home support
 - Adequate follow up

**HOW CAN A HOSPITAL
MANAGEMENT ENSURE THAT
THEY ARE PREPARED FOR
SEVERE AN?**

Essential tasks for the hospital

- Set up a MARSIPAN group
- Write a MARSIPAN policy
- Set up a Pop-up MARSIPAN team
- Distribute brief guidance
 - One page advice
 - Checklist

Surgical Checklist: Atul Gawande

Surgical Safety Checklist



Patient Safety
A World Alliance for Safer Health Care

Before induction of anaesthesia

(with at least nurse and anaesthetist)

Has the patient confirmed his/her identity, site, procedure, and consent?

- Yes

Is the site marked?

- Yes
- Not applicable

Is the anaesthesia machine and medication check complete?

- Yes

Is the pulse oximeter on the patient and functioning?

- Yes

Does the patient have a:

Known allergy?

- No
- Yes

Difficult airway or aspiration risk?

- No
- Yes, and equipment/assistance available

Risk of >500ml blood loss (7ml/kg in children)?

- No
- Yes, and two IVs/central access and fluids planned

Before skin incision

(with nurse, anaesthetist and surgeon)

Confirm all team members have introduced themselves by name and role.

Confirm the patient's name, procedure, and where the incision will be made.

Has antibiotic prophylaxis been given within the last 60 minutes?

- Yes
- Not applicable

Anticipated Critical Events

To Surgeon:

- What are the critical or non-routine steps?
- How long will the case take?
- What is the anticipated blood loss?

To Anaesthetist:

- Are there any patient-specific concerns?

To Nursing Team:

- Has sterility (including indicator results) been confirmed?
- Are there equipment issues or any concerns?

Is essential imaging displayed?

- Yes
- Not applicable

Before patient leaves operating room

(with nurse, anaesthetist and surgeon)

Nurse Verbally Confirms:

- The name of the procedure
- Completion of instrument, sponge and needle counts
- Specimen labelling (read specimen labels aloud, including patient name)
- Whether there are any equipment problems to be addressed

To Surgeon, Anaesthetist and Nurse:

- What are the key concerns for recovery and management of this patient?

Assessing

Does the patient have anorexia nervosa?

Yes

Not sure and psychiatric review requested

Is the risk high?

BMI <13 (adults) or below 0.4th BMI centile (<70% median BMI for age) (under 18)?

Recent loss of ≥ 1 kg for two consecutive weeks?

Acute food refusal or intake <400 kcal/day?

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: eg Bradycardia? QTc >450ms?

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

High risk of refeeding syndrome?

Low initial electrolytes

Very low BMI

Significant co-morbidities (Infection, Cardiac failure)

➔ 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

Monitor

➔ electrolytes (especially P, K)

➔ ECG

➔ Vital signs

➔ BMI

Managing

Are medical and psychiatric staff collaborating in care?

Yes

No, psych 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?

Falsifying weight

Disposing of feed

Exercising

Self harm, suicidality

Family distress/anxiety

Safeguarding concerns

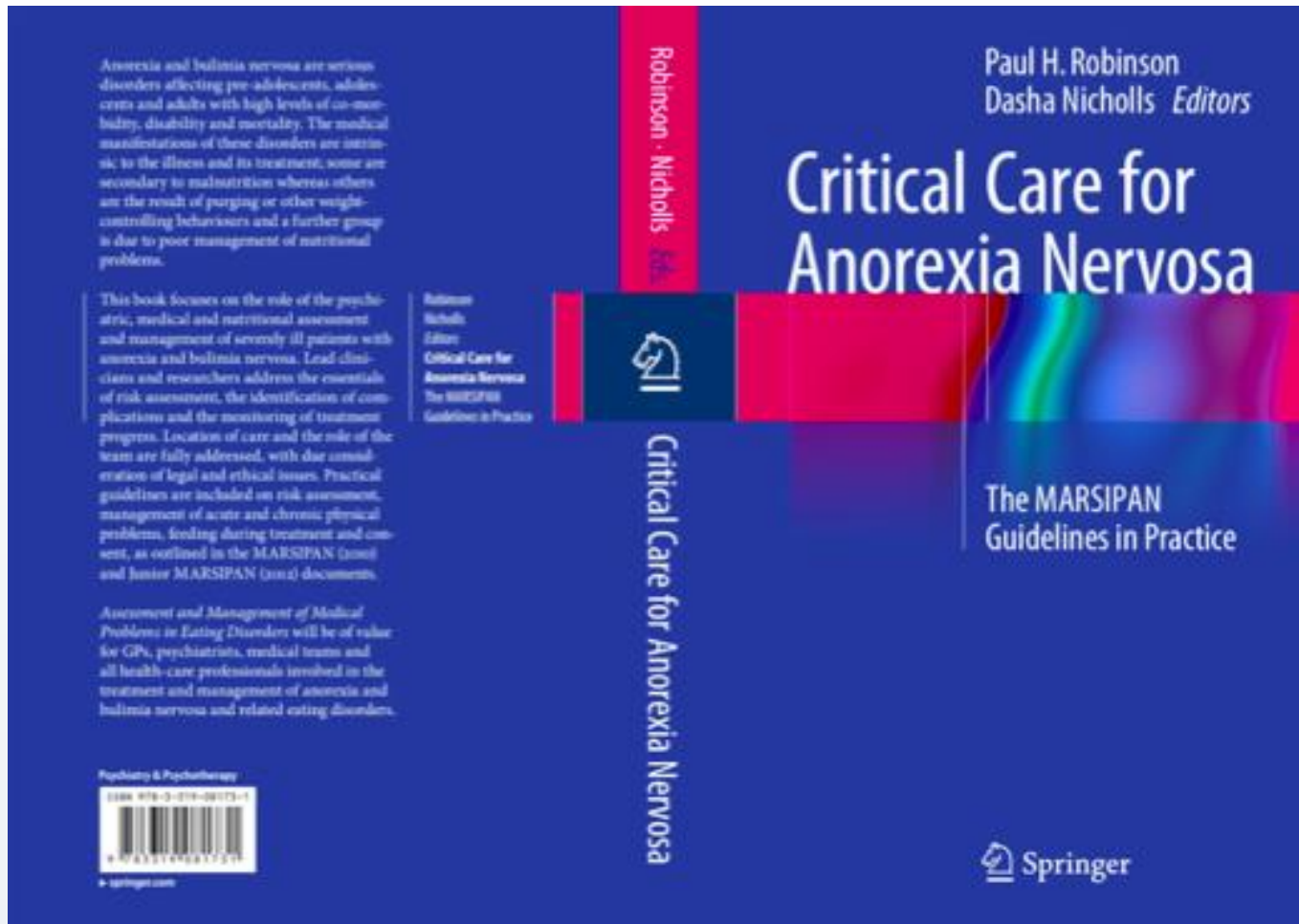
➔ Mobilise psych team to advise on management

Using the checklist

- Available as post-cards and on line
- To all front line clinicians
- Particularly dietitians and junior doctors



Further reading



Available soon

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(Listserve)