

# POLICY AND PROCEDURES FOR THE PHYSICAL EXAMINATION AND WELLBEING OF SERVICE USERS within MH and LD services

## Document Summary

*To ensure the wellbeing of all service users who are admitted to any Mental Health or Learning Disability inpatient facility or under care of Community Mental Health and Learning Disabilities services of the Trust. To ensure all service users receive a comprehensive physical examination and any associated necessary further interventions.*

<b>DOCUMENT NUMBER</b>	<b>POL/001/012</b>
<b>DATE RATIFIED</b>	12 June 2018
<b>DATE IMPLEMENTED</b>	June 2018
<b>NEXT REVIEW DATE</b>	June 2020
<b>ACCOUNTABLE DIRECTOR</b>	Deputy Director of Quality and Nursing
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## Important Note:

**The Intranet version of this document is the only version that is maintained.**

Any printed copies should therefore be viewed as “uncontrolled” and, as such, may not necessarily contain the latest updates and amendments.

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## 1 SCOPE

This document applies to all staff working in the Mental Health and Learning Disabilities Services within Cumbria Partnership NHS Foundation Trust, including temporary staff and those working in an honorary capacity.

The focus of this policy is on the physical care of service users whilst they are an inpatient or using community services. It is the responsibility of all staff to provide holistic care to service users in receipt of care from Cumbria Partnership NHS Foundation Trust in collaboration with their GP and other allied professionals

## 2 INTRODUCTION

Cumbria Partnership NHS Foundation Trust is committed to optimising the physical health and wellbeing of all of Service Users who require Mental Health and Learning Disabilities Services. It is a well-researched and documented fact that there is a significant correlation between mental illness or learning disability and poor physical health. Research suggests that people with severe and enduring mental illnesses have a reduced life expectancy of up to 25 years compared to the general population. This is largely due to poor physical health, an unhealthy diet and increased levels of smoking, combined with medication induced weight gain. These factors can lead to an increased risk of developing cardio metabolic disorders, e.g cardiovascular diseases or diabetes. However many of the physical health issues experienced by this group are either preventable or controllable via effective chronic disease management.(DH 2009). Some Service Users are reluctant to attend G.P. practices and/or undergo physical examination; therefore much physical illness goes undetected, often for long periods of time.

The Care Quality Commission published its *2009 survey of mental health acute inpatient services*, and this survey provides useful information about the main issues and problems. For example, the survey highlighted the following areas of concern:

- *Inadequate physical health care* – while the majority of patients (86%) reported having physical health checks in hospital, only 44% of those with physical health problems felt that these were ‘definitely’ taken care of enough

It recommended that adult inpatient services provide individualised whole person care that includes comprehensive physical health assessment and introduced standards to address Service Users physical health care needs. E.g. obesity in all adults admitted to a psychiatric inpatient ward, smoking cessation programmes (HDA 2004) and physical morbidity

New Ways of Working for Psychiatrists (NWW) (2009) recommended that reviewing and altering the jobs and roles of medical staff will impact on other professional roles. This includes the provision of physical health care assessment, diagnosis and interventions. CPFT have developed a range of new roles as part of New ways of working including Assistant Practitioner, Advanced Practitioner and Consultant Nurse.

In 2016 Public Health England and the Department of Health published *“Improving the Physical Health of people with mental health problems: Actions for Mental Health Nurses”*, as a resource for mental health nurses, wherever they work, to take positive action to improve the physical health of people living with mental health problems. It builds on work to ensure parity of esteem between mental and physical health by giving equal attention to the physical health of people with mental health problems as is given to the general population. It states that people with mental health problems should be supported to live healthy lives, and should be empowered to make real progress towards bringing their life expectancy in line with the rest of the population. The resource

supports the Government's commitment to ensure that people living with mental health problems have the same access to health checks and healthcare as the general population. It provides evidence based information about ways in which mental health nurses can improve the physical health and wellbeing of people living with mental health problems by tackling some of the key risk factors for physical health problems. It complements other programmes of work underway to address the physical health needs of people with mental health problems within Health Education England (HEE), NHS England, Public Health England (PHE), Royal Colleges of Nursing, Midwifery, Physicians, Psychiatrists and Pharmacology and within national charities.

The report from the Independent Mental Health Taskforce to the NHS in England has made a number of recommendations, one of which was that PHE should prioritise ensuring that people with mental health problems who are at greater risk of poor physical health get access to prevention and screening programmes. This includes primary and secondary prevention through screening and NHS Health Checks, as well as interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. As part of this, NHS England and PHE should support all mental health inpatient units and facilities (for adults, children and young people) to be smoke-free by 2018.

The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners of services to reward excellence among providers of mental health services through the achievement of quality improvement goals. The CQUIN 2016/17 indicator 3a – Cardio metabolic assessment and treatment for patients with psychoses, aims to ensure that patients with SMI have comprehensive cardio metabolic risk assessments, have access to the necessary treatments/interventions and the results are recorded in the patient's record and shared appropriately with the patient and the treating clinical teams. The cardio metabolic parameters based on the Lester Tool include smoking status; lifestyle (including exercise, diet alcohol and drugs); body mass index; blood pressure; glucose regulation and blood lipids.

### 3 STATEMENT OF INTENT

This Policy:

- Defines the responsibility of the Trust and its clinical staff in promoting physical wellbeing within MH and LD services, identifying and meeting the physical health care needs of those using their service, working in partnership with the Service User and their GP.
- Provides an agreed core physical examination/assessment as well as direction to other more specialist assessments tools which may be used for certain conditions.
- Provides ongoing reviews of physical health and wellbeing
- Provides guidance to clinicians in relation to audit (local and national e.g. cardio metabolic risk) training and development and necessary examination equipment and its location.

### 4 DEFINITIONS

**Inpatient Service** refers to Cumbria Partnership NHS Foundation Trust managed hospital units (wards/step-up, step-down units) providing 24hour care and treatment to services users.

**Community service** refers to Mental Health and Learning Disability services, either scheduled or unscheduled, provided by Cumbria Partnership NHS Foundation Trust to service users residing in their own homes, residential units, care homes and care facilities.

**Nursing Staff** includes health care assistants, assistant practitioners and qualified staff who have completed the physical health training supplied by the Learning Network.

**Suitably Qualified Health Professional** includes Advanced Practitioners and Medical staff

**Physical Health Proforma** Is the physical health assessment tool that will include assessment of all physical systems of the service user and is on the electronic records system - RIO

## **5 DUTIES**

### **5.1 Chief Executive**

The Chief Executive has ultimate accountability and responsibility for the physical health of service users and the implementation of this policy. This is delegated through organisational structures and accountability frameworks to ensure staff providing direct clinical care are provided with the appropriate tools and training.

### **5.2 Nominated Director**

The Deputy Director of Quality and Nursing is the accountable Director for this Policy and will be responsible for providing assurance reports to the appropriate committee.

### **5.3 Admitting Practitioners**

Access to inpatient beds in CPFT occurs via the ALIS teams for adult mental health wards, the Learning Disability Consultant and Community Teams for learning disability units and the Admission/Discharge Coordinators for the older adult functional unit and dementia assessment Units.

### **5.4 Mental Health and Learning Disability Units**

All patients admitted to a mental health or learning disability ward in CPFT should not require acute medical attention. The practitioners making the decision to admit to an inpatient ward are responsible for ensuring the patient is medically fit for admission. This may involve liaising with a suitably qualified practitioner such as medical staff in A&E departments, general practitioners or staff in acute hospitals dependent on where the patient is being admitted from. Due consideration should be given to the environment in which the patient is being admitted, the skills of the staff available, access to medical and emergency services.

### **5.5 Care Co-ordinator role**

The Care Co-ordinator role will be assigned to a qualified clinical professional and usually this will be the person who is best placed to oversee the care package, resource allocation, personal budget and will ensure the physical health assessment, screening and monitoring of the patient is undertaken and agreed support plan is in place. This involvement will continue throughout inpatient episodes of care.

### **5.6 Nursing Staff**

The Admitting Nurse will complete the NEWS, WATERLOW, smoking and alcohol assessment within 4 hours of admission on the physical health proforma in RIO. If the service user does not consent then they will be asked daily until consent is gained and this shall be documented. The

nurse will request the full physical examination from either the Doctor or Advanced Practitioner during core working hours.

## **5.7 Suitably Qualified Professionals**

Suitably qualified professionals who are trained to carry out a full physical examination will include medical staff and Advanced Clinical Practitioners. Within 24 hours or as soon as possible during core working hours (9-5 Monday to Friday) all inpatients will be offered a full physical examination using the In Patient Physical Health Pro forma found on RIO

Out of core hours, medical cover for urgent medical needs is available on all sites as per locally arranged agreements

## **5.8 Ward Manager/ Team Leader**

Ward Managers and Team Leaders are responsible for ensuring that their ward/ department/services retains an inventory of necessary equipment (Appendix 5) and that it is checked on a monthly basis and maintained in good working order (Appendix 6). Ward Managers/Team Leads will ensure a stock of support supplies or replacements are available within the ward e.g. batteries, masks in varying sizes etc. They are responsible for ensuring the implementation of this policy within their teams/ clinical areas.

## **5.9 Health Workers in the Community**

Community Health workers have a duty to ensure that physical healthcare needs are identified supported and access to treatment is facilitated and the trained practitioner will carry out the Community Physical Health pro forma in RIO (The CPA framework supports the assessment and interventions to promote physical health and wellbeing in mental health). Health Action Plans are used to support the physical health needs of people with learning disabilities in community settings.

## **5.10 All Staff**

All Trust staff in all settings have responsibilities for optimising physical health amongst Service Users through providing health promotion advice, information and encouraging participation in related activities and utilising resources within partner organisations e.g. Allied Health Professionals & Public Health. Examples include:

- Health awareness and self-care (self-examination)
- Smoking cessation
- Substance use cessation
- Healthy eating
- Exercise and activity e.g. Carlisle United CPFT football group
- Healthy Living Groups

# **6 THE PHYSICAL EXAMINATION PROCEDURES**

## **6.1 The Aims of the Physical Examination**

The aims of the physical examination are to:

- Obtain a detailed history of the Service Users physical health;

- Identify any current physical health care problems;
- Make a diagnosis of relevant problems;
- Develop and agree a treatment plan which might include further detailed specific assessment or referral to a specialist;
- Develop and agree a care plan that addresses health and well being preventative goals in relation to healthy diet, exercise, smoking, alcohol and drugs, physical condition management and psychotropic drug monitoring.
- Evidence of any physical injury (bruising, laceration, pressure sores, fractures, signs of drug abuse etc) should be detailed accordingly on the body chart included in the proforma. If during physical examination concerns are raised regarding safeguarding then the appropriate policy should be implemented.

## 6.2 Consent

Prior to undertaking a physical examination and subsequent assessments the service user's consent should be obtained. This should be undertaken in line with Trust Policy for Consent. (POL/001/010 Consent policy)

Consent is the principle that a person must give their permission before they receive any type of medical treatment, examination, psychological support or other care interventions. It is the duty of the person carrying out the procedure or intervention to assess a person's capacity and obtain informed consent prior to the intervention. Refusal to consent must be recorded in the case notes, and the request to repeat the examination must be undertaken daily and at the earliest opportunity.

## 7 PHYSICAL CARE AND WELLBEING OF SERVICE USERS WITHIN THE COMMUNITY

Whilst it is the responsibility of all staff to provide holistic care to service users in receipt of care from the M H and LD services within the Cumbria Partnership NHS Foundation Trust, it is vital that patients are referred to the most appropriate services for further and specialist reviews where and when required

The CPA framework supports the assessment and interventions to promote physical health and wellbeing in mental health. Service users living in community settings will be encouraged and supported, when indicated, to attend General Practice healthcare centre (include GP Surgeries) regarding physical health matters by their assigned care co-ordinator and other community workers.

Care co-ordinators will also promote and support service users to undergo healthcare checks and annual reviews with their GP as part of their care plan.

Health Action Plans are to be used to support the physical health needs of service users including people with learning disabilities in community settings.

*Please see Standard Operating Procedure (SOP1) for the Management of Physical Health Clinics in Community Mental Health Assessment and Recovery Teams (CMHARTs) (Appendix 1)*

## 8 PHYSICAL CARE AND WELLBEING OF SERVICE USERS WITHIN INPATIENT SERVICES

The assessment of the physical health of service users admitted to hospital units will be undertaken as detailed below.

### 8.1 Physical Screening Assessment Tool

All patients will be offered and encouraged to have a physical screen on admission to the inpatient ward regardless of time of admission. This will be offered by the nursing staff and will be recorded on the relevant assessment tools on RIO

The nurse will undertake the following physical observations for all admissions and should be completed within 4 hours of admission or when the service user consents. Those in Bold typeface are the minimum requirements

- **NEWS (National Early Warning Score ) (incorporating BP, TPR, SpO2)**- will be carried out on a daily basis for the first three days of admission, then weekly, and when physical observations are required out with that
- **MUST Tool (Malnutrition Universal Screening Tool ) including Height, Weight, Body Mass Index (BMI)**- This will be carried out on admission and weekly unless otherwise stated in care plan. Identify also whether a swallowing risk assessment is required
- **Allergies and history of adverse reactions to drugs. Illicit substance abuse and over the counter medication use will be recorded**
- **Diet and Lifestyle, Smoking, alcohol consumption, evidence of intoxication, substance misuse**
- **Presence of any underlying medical conditions, medications, and infection risk such as MRSA, Hep C etc as per Infection Control Policy**
- Urinalysis
- BM (if appropriate i.e. if Diabetic)
- Cognitive Impairment
- Skin condition: evidence of self harm, open wounds, injection sites
- Waterlow score - carried out on admission and ongoing review will be dependent on risk score (POL/001/069 Pressure Ulcer Prevention/ Management Policy)
- ECG (Electrocardiogram)

### 8.2 Triage

The nurse will undertake an initial triage following results of the physical observations and if there are any concerns about physical health care risks then local arrangements for obtaining medical intervention should be initiated.

### **8.3 Full Physical Review on In-Patient units**

***Please see Standard operating Procedure (SOP2) -The procedure for the full physical examination of patients on admission to hospital (Appendix 2)***

### **8.4 Unscheduled Physical Examinations**

The focussed physical examination will be conducted after history taking has identified the differential diagnosis.

## **9 MANAGEMENT OF CO MORBID HEALTH PROBLEMS**

Service Users may present with a range of health problems which co-exist.

- All Service Users whose MUST score is 2 or above should be offered referral to specialist services for further assessment and management.
- Anyone admitted with co-morbid problems (e.g. Diabetes) whose BMI is above 27 should also be referred on for specialist assessment and treatment. All assessments for referral should be made using the MUST documentation as per CPFT Nutritional Care and Support Policy.
- Any Service Users who smoke will be offered health promotion materials and staff can provide brief interventions.
- Service Users who drink alcohol to excess, will be offered health promotion materials and will be encouraged to make a self-referral or supported to self-refer to the Drug and Alcohol Recovery Team.
- Service Users who use illicit drugs will be offered health promotion materials and encouraged to make a self-referral to or supported to self-refer to Drug and Alcohol Recovery Team/ UNITY as per the Dual Diagnosis Policy.
- Co-existing physical health problems will be managed on an individual needs led basis and Care planned.

## 10 ECGS

ECGs must be offered to all service users.

ECG's should also be carried out for any service user, inpatient or community who may be prescribed an antipsychotic, if:

- They have a diagnosis of Schizophrenia **and** if high dose (i.e. greater than BNF maximum dose) antipsychotics are prescribed. Should be carried out every 1-3 months in early stages of high dose therapy.
- Physical examination shows specific cardiovascular risk (e.g. diagnosis of high blood pressure).
- There is a personal history of cardiovascular disease (known ischaemic / structural heart disease QTc prolongation).
- The requirement is specified in the Summary of product Characteristics for the antipsychotic (e.g. Haloperidol, Pimozide, Sertindole) (NICE CG178: Psychosis and schizophrenia in adults: prevention and management).
- ECGs may also be carried out for other medication e.g. clozapine prior to initiation, or if cardiovascular problems arise during clozapine treatment; venlafaxine, if required due to dose or cardiovascular risk; and prior to initiation of Lithium.
- Or if the service user complains of chest pain that could be cardiac in nature.

ECG QTc results

< 440ms (men), <470ms (women) - no action unless other abnormalities

>440ms (men), > 470ms (women) - consider reduction in dose or switch to drug of lower risk

>500ms- stop suspected causative drug(s) switch to drug of lower risk

<http://www.rcpsych.ac.uk/PDF10%20Natarajan%20and%20Mahalingappa%20IC2012.pdf>  
(slide 50 and advice on ECGs in high doses- slide 47)

## 11 PHYSICAL HEALTH AND PSYCHOTROPIC MEDICATION

### Antipsychotic Medication

The provision of safe medicines management for service users, which reduces potential harm and adverse reactions caused by medication, is essential to improve service user choice and concordance with their medication. All care coordinators will ensure that the schedule in Appendix (Appendix 6) is followed for service users who are prescribed antipsychotic medication for the year following any new prescription of antipsychotic.

If the antipsychotic is changed the monitoring should start again at initiation. Following this period, monitoring should be undertaken by primary care as part of the GP Quality and Outcomes Framework (QOF). If a service user does not attend their annual health check, the GP should inform the care co-ordinator, and the service user should be followed up to attend. Further details of the primary care and secondary care responsibilities for prescribing and monitoring of antipsychotics and other medications are detailed in the appropriate Cumbria Shared Care guidelines.

Other medications that staff should be aware of are listed below however please check with your local pharmacist and CPFT medicines management site for further details

### Lithium

British National Formulary Guidance for the monitoring of lithium levels during lithium initiation and after dosage changes must be followed.

When stable treatment levels reached the Lithium level should be checked every 3 months and Renal and Thyroid function tests completed every 6 months.

### Clozaril

CPFT has a pathway which should be followed and should seek guidance within the clozaril pathway

## **12 EQUIPMENT REQUIRED FOR PHYSICAL EXAMINATION**

Each inpatient ward will have available appropriate equipment to enable a thorough physical examination. A full list of available equipment is contained in Appendix 5 of this policy.

A monthly audit of this equipment will be conducted, see Appendix 6 and outcome records retained within the ward for use in Clinical Governance activities. Ward Managers will be responsible for ensuring stock is replenished or equipment is fixed or upgraded as necessary.

## **13 TRAINING**

Training will be provided to support this policy in accordance with the Trust's Training Needs Analysis. Attendance at training will be managed in accordance with the Learning and Development Policy.

All qualified inpatient nurses will receive local training in the use of the equipment listed in Appendix 5.

Suitably qualified others (including Consultants) will maintain general physical health skills in identifying and treating common physical ailments through CPD identified through appraisal.

Medical staff, Advanced Practitioners and Nurse Consultants will develop their physical health care assessment skills through CPD identified through appraisal.

**14 MONITORING COMPLIANCE WITH THIS POLICY**

The table below outlines the Trusts' monitoring arrangements for this policy/document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report	Group / committee / individual responsible for ensuring that the actions are completed
<ul style="list-style-type: none"> <li>• <b>Patients have received a physical examination within 24 hours of admission and if not, reason documented in the notes.</b></li> <li>• <b>ALIS Patients have received a physical examination and if not reason documented in the notes.</b></li> <li>• <b>CMHT patient have been referred for a physical examination if they meet the criteria as per policy</b></li> <li>• <b>The Physical health proforma has been completed as per policy.</b></li> <li>• <b>Patients have received an ECG on admission</b></li> <li>• <b>Patients have had a NEWS completed on first three days of admission</b></li> <li>• <b>There is evidence of a care plan/ treatment plan following the examination.</b></li> </ul>	<p>Audit of 5 Clinical Records per CMHT/ ALIS</p> <p>Audit of 5 clinical records per ward</p>	Advanced Practitioners	Annual	Trust's 'Improving Physical Health Care' Working Group	Care Groups
Staff have completed training associated with this policy in line with TNA	Compliance with training will be monitored in accordance with the Learning and Development Policy				

**15 REFERENCES/ BIBLIOGRAPHY**

DH (2009):*New Ways of Working for Psychiatrists*. Department of Health, London

DH (2009): *New Horizons: Towards a Shared Vision for Mental Health*. Department of Health, London

Health Development Agency (2004) *Smoking and patients with mental health problems*. HDA London

National Institute for Clinical Excellence (2014) Clinical Guideline CG178: *Psychosis and schizophrenia in adults: prevention and management*

National Institute for Clinical Excellence (2014) Clinical Guideline CG185: *Bipolar disorder: assessment and management*

National Institute for Clinical Excellence (2018) Guideline NG89: *Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism*

NHS England (March 2016) *Commissioning for Quality and Innovation (CQUIN)*

Public Health England and the Department of Health (2016) :*Improving the Physical Health of people with mental health problems: Actions for Mental Health Nurses*

## **16 RELATED TRUST POLICY/PROCEDURES**

CPFT - POL/001/001: Care Co-ordination Policy

CPFT - POL/001/010: Consent Policy

CPFT - POL/001/021: Dual Diagnosis Policy

CPFT - POL/001/042: Infection Prevention and Control Policy

CPFT - POL/001/032: Joint Care Policy for patients with Physical, Mental or Learning Disability Needs

CPFT - POL/001/013: Medicines Policy

CPFT - POL/001/044: Nutrition and Hydration for Adults Policy

CPFT - POL/001/082: NEWS policy

CPFT - POL/001/069: Pressure Ulcer Prevention/ Management Policy

CPFT - POL/001/065: Venous Thromboprophylaxis (VTE ) Policy.

## **APPENDIX 1- STANDARD OPERATING PROCEDURE (SOP 1) - THE MANAGEMENT OF PHYSICAL HEALTH CLINICS IN COMMUNITY MENTAL HEALTH ASSESSMENT AND RECOVERY TEAMS (CMHARTS)**

(Full details on SharePoint)

### **1. RESPONSIBILITIES**

- 1.1. All clinical staff should be aware of their own responsibility and accountability when carrying out procedures and must always adhere to professional codes of practice and ensure their clinical competence is maintained.
- 1.2. The local Team Lead and Clinical Team Lead(s) have responsibility for managing and reporting on the management of physical health clinics.
- 1.3. Delivery of the physical health clinics will be monitored at regular local meetings in each CMHART with the leadership team for that CMHART and approaches for managing any immediate pressures or issues formulated and/or escalated to Network Level.
- 1.4. The Network Manager, and Clinical Directors hold accountability for physical health clinics county wide for CMHART's with additional advice from the Professional Lead for AMH Psychological Therapies, the Associate Medical Director, the Occupational Therapy Professional Lead and any others as required.

### **2. CRITERIA**

- 2.1. A service user will be referred into a local CMHART Physical Health Clinic if:
  - They require physical health monitoring whilst on antipsychotic medication – especially in line with shared care guidance (See **Appendix 1 – Shared Care Guidance**)
  - They would benefit from physical health monitoring whilst on any other mental health medication
  - They require physical health and/or cardio-metabolic monitoring as part of antipsychotic poly pharmacy or are on a high dose of antipsychotic

### **3. STRUCTURE**

- 3.1. Each local CMHART will have a Physical Health Clinic
- 3.2. The frequency of local CMHART Physical Health Clinics will be based on local demand and will be staffed according to that demand
- 3.3. Each local CMHART Physical Health Clinic will have access to the following equipment:
  - BP machine
  - Stethoscope
  - ECG machine
  - Couch

- Weighing scales
- Height measure
- Tape measure
- Venepuncture equipment
- Electronic thermometer

## **4. PROCESS**

4.1. Where a service user meets the criteria to access a local CMHART Physical Health Clinic, the following process will be followed:

### **4.1.1. Referral into the Clinics**

4.1.1.1. To refer into a local CMHART Physical Health Clinic, the local CMHART prescriber will send a notification to the Physical Health Clinic Coordinator and local CMHART admin advising them of the referral.

### **4.1.2. Making an Appointment**

4.1.2.1. On receipt of the RiO notification from the prescriber, Local CMHART admin will:

- Book an appointment for the service user on RiO in the HCP diary for the Physical Health Clinic Coordinator.
- Generate the appointment letter in RiO using the standard Physical Health Appointment letter template.
- Send out an appointment letter to the service user and the service users GP

### **4.1.3. Physical Health Screening**

4.1.3.1. Once in clinic with the service user, the local CMHART practitioner will carry out the physical health checks prescribed in the Physical Health Clinic template in the Physical Health folder in the service users RiO Clinical Portal and complete the form in RiO whilst in clinic. The checks for each service user will include the following checks:

- Weight/BMI/Waist Measurement
- Nutritional Status/Diet/Level of physical activity
- BP (systolic and diastolic)
- Pulse
- Blood glucose and HbA1c
- Lipid profile
- Liver function
- FBC
- Renal function

4.1.3.2. Where an ECG is required:

- This will be undertaken by the practitioners running the local CMHART Physical Health Clinics
- Interpretation of the ECG will only be done by a medic in the MIU in each locality.
- The local CMHART practitioner who has taken the ECG will call the relevant PCAS prior to faxing the ECG over for interpretation and The ECG will be attached to an ECG Referral Form (See **Appendix 2** – ECG Referral Form)
- Local CMHART practitioner(s) running the clinic will check that the ECG Referral Form has been faxed back to the local CMHART once the ECG has been interpreted by the PCAS

4.1.3.3. The local CMHART practitioners running the clinics will comply with the Trusts Infection Prevention and Control Policy (**POL/001/042**) and the Trust's mandatory infection prevention and control training must be completed by all local CMHART practitioners running these clinics

4.1.3.4. Local CMHART practitioners running the clinics will provide service users with the smoking cessation, diet and exercises information as appropriate.

#### 4.1.4. **Post Screening**

4.1.4.1. Each local CMHART will follow their local procedures for blood transport.

4.1.4.2. Once the ECG and pathology reports have been returned, the local CMHART practitioner running the Physical Health Clinics will:

- Print out:
  - The Physical Health Clinic form in the Physical Health folder in the service users Clinical Portal
  - The ECG Referral Form and the pathology results
- Send the Physical Health Clinic form, ECG Referral Form and a copy of the ECG to the service users GP
- Outcome the appointment in RiO.
- Ensure all documentation is uploaded in RiO.
- Request local CMHART admin to book a follow up appointment for the service user as required.

4.1.4.3. Where immediate issues/concerns are identified practitioner will initially contact the prescriber and/or GP. In the event of the Prescriber/GP both being unavailable then the issue should be escalated to the Clinical Team Lead.

ALCOHOL WITHDRAWAL IS A SEPARATE CONCERN THAT MUST BE DOCUMENTED and may require treatment on a medical unit (see Dual Diagnosis Policy for guidance on referral pathway).

**APPENDIX 2 - STANDARD OPERATING PROCEDURE (SOP2) - THE PROCEDURE FOR THE FULL PHYSICAL EXAMINATION OF PATIENTS ON ADMISSION**

During core working hours and at the earliest opportunity following admission, all inpatients will be offered a full physical health review by a suitably qualified practitioner. This should be within 24 hours of admission during core working hours (Monday to Friday 9-5) with the consent of the patient,

- The examination should take place in the appropriate treatment room within the ward, where all the equipment required is available to use.
- The full physical review will be structured and recorded using the In Patient pro forma found on RIO
- Bloods should be taken at this time and include FBC, U&E, LFT's, TFT , HBA1C, B12 and Folate, Calcium and Albumin and Lipid Profile, and any other indicated on history or findings. Blood results should be checked within 3 hours of them being taken by a suitably qualified professional. This can be done electronically.
- Privacy and dignity will be respected at all times and suitably qualified persons conducting the examination may require a chaperone with them at times.
- During physical assessment the cultural and religious beliefs of the service user must be taken into consideration.
- It is the responsibility of the clinical team to ensure that the physical examination is carried out and the results clearly recorded in the appropriate documentation and any necessary actions are taken.
- It is also the responsibility of the Ward team to ensure that all referrals identified are actually made and followed up.
- Out of hours protocol developed for each in-patient site should be followed and recorded accordingly. Refer to Cumbria Hospital On Call protocol (CHOC)
- Venous Thromboprophylaxis (VTE). All patients will be assessed on admission for risk of VTE and receive adequate and appropriate anti thrombotic care to guard against the risk of unnecessary harm arising out of VTE. This will be reviewed at the MDT every week to determine whether there are any changes to patient's condition that would increase risk of VTE. (Appendix 3)
- Following examination, a treatment plan will be discussed between the service user and the clinical team, including the medical staff / Advanced Practitioner undertaking the physical assessment. For those who lack capacity their advocate or relative where appropriate will be included in the discussion.
- A treatment plan will be drawn up and used as part of the Service Users inpatient care plan. This will be referred to by the clinical team on a daily basis. The treatment plan might include ongoing monitoring, further assessment or tests, additional treatment regime or referral for specialist interventions.

- Physical examinations should not be limited to the time of admission and review of physical healthcare should be undertaken at regular intervals as required by physical condition or in response to the findings of the assessment.
- As a minimum, any Service User who has been in hospital for 6 months must have a full physical examination repeated.

Service users who present with dual diagnosis need should be jointly managed with the Drug and Alcohol service in line with the Dual Diagnosis Policy.

Service Users admitted for detoxification will be managed through the Trust Alcohol detoxification guideline approved by the Trusts Medicines Management Group.

**ALCOHOL WITHDRAWAL IS A SEPARATE CONCERN THAT MUST BE DOCUMENTED** and may require treatment on a medical unit (see Dual Diagnosis Policy for guidance on referral pathway).

**APPENDIX 3 - ASSESSING RISK OF VENOUS THROMBOEMBOLISM (VTE) IN PSYCHIATRIC INPATIENTS**

Does the patient:

- Have (or has already had) significantly reduced mobility for three days or more, or
- Have ongoing reduced mobility relative to their normal state, combined with one or more additional risk factors for VTE (see box 1)

**NO** → Risk assessment complete. **(Low Risk)**  
Prophylaxis not usually required

↓  
**YES (High risk)**

Can the patient be prescribed low molecular weight heparin (LMWH) (see box 2 for bleeding risk factors/ contraindications)

**NO** → Consider below knee anti-embolism stockings (see box 3)

↓  
**YES**

Prescribe Enoxaparin 40mg daily. In patients with a creatinine clearance of <30ml/min prescribe Enoxaparin 20mg daily by subcutaneous injection.

- Box 2. Bleeding Risk**
- Active Bleeding
  - Acquired bleeding disorders
  - Anticoagulant use (eg.warfarin)
  - Lumbar puncture/epidural/spinal anaesthesia within 4 hours
  - Acute stroke
  - Thrombocytopenia (Platelets <75 x 10<sup>9</sup>/l)
  - Uncontrolled hypertension (>230/120mmHg)
  - Untreated inherited bleeding disorders
  - Recent high bleeding risk procedure (eg neurosurgery, eye surgery)

- Enoxaparin contraindications:**
- Bleeding disorders
  - Thrombocytopenia
  - Recent cerebral haemorrhage
  - Severe hypertension
  - Peptic ulcer
  - Major trauma/Recent surgery to eye/nervous system
  - Acute bacterial endocarditis
  - Spinal anaesthesia with treatment doses of heparin/LMWH
  - Hypersensitivity to heparin/LMWH

**Box 1. Risk Factors for VTE**

- Active cancer
- Age over 60 years
- Critical care admission
- Dehydration
- Known thrombophilias
- Obesity (BMI >30kg/m<sup>2</sup>)
- One or more significant medical co-morbidities (eg. Heart disease; metabolic, endocrine or respiratory conditions; acute infection; inflammatory conditions)
- Personal history or first degree relative with history of VTE
- Pregnancy/less than 6weeks postpartum (advise d/w O&G)
- Recent Surgery (#hip/ortho surgery/>90mins anaesthetic/significant immobility)
- Use of HRT or oestrogen containing contraception
- Varicose veins with phlebitis

## **APPENDIX 4 - USING THE NEWS OBSERVATION CHART**

The NEWS chart provides a standardised system for recording routine clinical data for all patients in hospital. This consistent format, if used in all hospitals, would provide familiarity in recognition of patient data and facilitate training in the measurement and recording of such data in a systematic and standardised way by all NHS staff.

The NEWS chart contains dedicated sections to record the frequency of monitoring as defined by the score and the clinical response to a change in score, eg an escalation in acute care – this will facilitate tracking of the response to changes in the NEWS score. The NEWS chart also contains dedicated sections to record urine output and pain severity. These do not form part of the NEWS score.

Please note that when the measured physiological parameter exceeds the range on the chart, the actual value should be recorded on the chart.

Please also note that the NEWS is not designed to replace recognised generic scoring systems such as the GCS or disease-specific systems.

***The Chart has been made available in A3 size and is available from the resuscitation team.***

### **The NEWS educational tool**

The Royal College of Physicians' NEWS Development and Implementation Group (NEWSDIG) commissioned the NHS Training for Innovation team to work with members of NEWSDIG, including representation from the Royal College of Nursing and the National Outreach Forum, to develop a standardised generic NEWS chart that would be suitable for downloading for use by clinical teams across the NHS. Alongside, an online training package focused on the use of NEWS has been developed to facilitate implementation (<http://tfinews.ocbmedia.com>).

### Example of National Early Warning Score Chart (NEWS)\*

PHYSIOLOGICAL PARAMETERS	3	2	1	0	1	2	3
Respiration Rate	≤8		9 - 11	12 - 20		21 - 24	≥25
Oxygen Saturations	≤91	92 - 93	94 - 95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0		35.1 - 36.0	36.1 - 38.0	38.1 - 39.0	≥39.1	
Systolic BP	≤90	91 - 100	101 - 110	111 - 219			≥220
Heart Rate	≤40		41 - 50	51 - 90	91 - 110	111 - 130	≥131
Level of Consciousness				A			V, P, or U

\*The NEWS initiative flowed from the Royal College of Physicians' NEWS Development and Implementation Group (NEWSDIG) report, and was jointly developed and funded in collaboration with the Royal College of Physicians, Royal College of Nursing, National Outreach Forum and NHS Training for Innovation



## The NEWS scoring system

In some settings, patients will have an impaired level of consciousness as a consequence of sedation, eg following surgical procedures. Thus, the assessment of consciousness level and the necessity to escalate care should be considered in the time-limited context of the appropriateness of the consciousness level in relation to recent sedation.

For patients with known hypercapnoeic respiratory failure due to chronic obstructive pulmonary disease (COPD), recommended British Thoracic Society target saturations of 88–92% should be used. These patients will still 'score' if their oxygen saturations are below 92 unless the score is 'reset' by a competent clinical decision-maker and patient-specific target oxygen saturations are prescribed and documented on chart and in the clinical notes.

All supplemental oxygen when administered, must be prescribed.

**Reproducing this chart:** please note that this chart must not be reproduced and only use those provided by the resuscitation team

**APPENDIX 5 - EQUIPMENT AVAILABLE ON EACH INPATIENT WARD AND CMHT/CRHT**

**INPATIENT WARD:**

- BP Monitor
- Pulse Monitor
- Oxygen saturation monitor – all 3 usually combined in one machine
- Ophthalmoscope
- Aura scope for ears
- Tendon hammer for eliciting reflexes
- Stethoscope for chest/heart
- ECG machine (for use with Venlafaxine and some antipsychotic medication)
- Electronic Thermometer
- BM monitoring devise (for Diabetes)
- Urine Drug Screen kits
- Alcohol Breathalyzer for detoxification patients
- Weighing Scales
- Height measure for BMI measurements
- Tape measure

**Equipment available on each CMHT/CRHT:**

- Weighing Scales
- Height measure for BMI measurements
- Tape measure
- BP monitor

**APPENDIX 6 - MONTHLY AUDIT OF PHYSICAL EXAMINATION EQUIPMENT**

	<b>STANDARD Date:</b>	Tick if completed
1	The ward has a lead person identified for ensuring responsibility for the Clinic and monitoring of its equipment.	
2	The Clinic is prepared to receive patients undergoing physical examinations:- <ul style="list-style-type: none"> <li>• All clinical areas are clean and tidy</li> <li>• The bed is prepared with clean sheet/appropriate disposable sheeting and a pillow.</li> <li>• All Clinical equipment is accessible.</li> <li>• Venepuncture tray is stocked and ready for use with appropriate equipment, tourniquet, swabs, plasters, selection of laboratory forms, in date blood bottles, Clozaril packs, and a selection of needles, venflons &amp; syringes.</li> <li>• That all clinical stock (i.e. dressing packs etc) are appropriate and in date.</li> </ul>	
3	All Clinical waste bins are closed and no more than $\frac{3}{4}$ full, full bins are signed as per manufacturer's instructions.	
4	There is a trolley containing all Physical examination equipment as per policy	
5	All Physical examination equipment is in working order	
6	There is in place a weekly signed check sheet to record that all equipment is present and in working order.	
7	All staff are aware of clinical protocol and policy	

**APPENDIX 7 - ANNUAL AUDIT OF PHYSICAL EXAMINATION**

	<b>STANDARD</b>	<b>Date:</b>	Tick if completed	Comments
1	<ul style="list-style-type: none"> <li>• <b>Patients have received a physical examination within 24 hours of admission and if not, reason documented in the notes.</b></li> </ul>			
2	<ul style="list-style-type: none"> <li>• <b>ALIS Patients have received a physical examination and if not reason documented in the notes.</b></li> </ul>			
3	<ul style="list-style-type: none"> <li>• <b>CMHT patient have been referred for a physical examination if they meet the criteria as per Trust policy</b></li> </ul>			
4	<ul style="list-style-type: none"> <li>• <b>The Physical health proforma has been completed as per Trust policy.</b></li> </ul>			
5	<ul style="list-style-type: none"> <li>• <b>Patients have received an ECG on admission</b></li> </ul>			
6	<ul style="list-style-type: none"> <li>• <b>Patients have had a NEWS completed on first three days of admission</b></li> </ul>			
7	<ul style="list-style-type: none"> <li>- <b>There is evidence of a care plan/ treatment plan following the examination</b></li> </ul>			
8				

**APPENDIX 8 - RECOMMENDED PHYSICAL HEALTH MONITORING FOR ALL PATIENTS ON ANTIPSYCHOTICS**

	Baseline for all patients	1 month	3 months	6 months	12 months and continuing annual check-ups
	First year only Secondary care responsibility				Primary care responsibility
<b>Antipsychotics</b>	BP, pulse Weight and Height (BMI) Waist circumference Blood glucose Lipid profile (Glucose and lipids taken as fasting if possible) Thyroid function Renal function FBC LFTs Smoking/alcohol status ECG*** Prolactin (risperidone, amisulpride)*  Drug screen and chest X-ray if appropriate  EEG, MRI, CT if organic aetiology or co-morbidity suspected	Weight (BMI)** Waist circumference Blood glucose (olanzapine)  (FBC if taking olanzapine and valproate)	BP Weight (BMI) (more often than 3 monthly if gains weight rapidly) Waist circumference Blood glucose Lipids (both more often if evidence of elevated levels) FBC	Weight (BMI) (more often if gains weight rapidly)	BP, pulse Weight (BMI) Blood glucose Lipids Thyroid function Renal function FBC LFTs Smoking/alcohol status  In addition to above CSIP/NIMHE recommend for QOF indicator MH9: <ul style="list-style-type: none"> <li>• pulse</li> <li>• advice on smoking cessation</li> <li>• peak flow to assess for COPD</li> <li>• drug/alcohol use</li> <li>• cervical screening up to date, dietary advice</li> <li>• HIV/Hep C status if appropriate</li> </ul>

\*Prolactin - baseline also in all children and adolescents, and if symptoms of raised prolactin develop.

\*\*Children and adolescents – weight and height weekly for 1 month, monthly for 6 months then every 6 months. Waist circumference may also be measured as indicator of weight gain and risk factor.

\*\*\*ECG all inpatients on antipsychotics before commencing treatment if possible. ECG all outpatients on antipsychotics if specified in SPC and consider if signs of, or personal history of, cardiovascular risk.

(Note extra FBC tests are mandatory for Clozapine – weekly for 18 weeks, every 2 weeks to 1 year then every 4 weeks) Refs: NICE clinical guideline CG185: Bipolar disorder: assessment and management, NICE clinical guideline 178 Psychosis and schizophrenia in adults: prevention and management, Maudsley guidelines 9<sup>th</sup> Edn, BNF, CSIP/NIMHE Best practice guidance for primary care staff (September 2006).