PHYSICAL ASSESSMENT AND EXAMINATION OF PATIENTS/CLIENTS POLICY

This procedural document relates specifically to mental health staff working in Somerset Partnership.

Version:	5
Date issued:	**December 2017**
Review date:	**December 2020**
Applies to:	All mental health clinical staff

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DOCUMENT CONTROL

<table>
<tr><td>Reference
CM/Aug/12/PA&EOSUP</td><td>Version
5</td><td>Status
Final</td><td colspan="2">Author
Medical Director</td></tr>
<tr><td colspan="5">Amendments: October 2017 update: addition of requirement to record cuts, bruises or other marks on a body map. This document is based on existing Guidelines first issued in September 2008. The last revision was ratified in September 2010 as V3.0. This policy version 3.3 has been amended to reflect the new Trust Clinical Governance structure and in light of the acquisition of Somerset Community Health in August 2011. It applies only to staff in the mental health and social care directorate. This document replaces the existing Guidelines Version 3.0 Sep 2010 and all previous versions. It is amended in line with the NHSLA Risk Management Standards 2012-2013 for Trusts providing Acute, Community, or Mental Health & Learning Disability Services and Non-NHS Providers of NHS Care.</td></tr>
<tr><td colspan="2">Approving body</td><td colspan="2">Clinical Governance Group</td><td>Date: November 2017</td></tr>
<tr><td colspan="2">Equality Impact Assessment</td><td colspan="2">Impact Part 1</td><td>Date: December 2017</td></tr>
<tr><td colspan="2">Ratification Body</td><td colspan="2">Senior Management Team</td><td>Date: December 2017</td></tr>
<tr><td colspan="2">Date of issue</td><td colspan="3">December 2017</td></tr>
<tr><td colspan="2">Review date</td><td colspan="3">Decembr 2020</td></tr>
<tr><td colspan="2">Contact for review</td><td colspan="3">Medical Director</td></tr>
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1. INTRODUCTION

1.1 There is a strong association between severe and enduring mental illness and physical ill health resulting in increased mortality and morbidity. This health inequality arises as a consequence of a variety of factors including poverty, social deprivation, poor nutrition, substance misuse and reduced access to healthcare and screening programmes. However, increased smoking is a major contributory factor to increased mortality. People with mental health problems have higher rates of obesity, heart disease, hypertension, respiratory disease, diabetes, stroke and breast cancer than the general population. They are more likely to have coronary heart disease before the age of 55 and, once they have this diagnosis, they are less likely to survive for more than five years and yet are less likely to be prescribed statins. Depression doubles the risk of coronary heart disease and people with schizophrenia and bipolar disorder die on average 16 – 25 years sooner than the general population (No Health Without Mental Health, 2011). Many medications used to treat psychiatric illness have side effects that can adversely affect physical health. Furthermore some physical health problems can present solely with psychiatric symptoms and these conditions can potentially go undiscovered in the absence of routine physical assessment.

1.2 Poor physical health outcome is well established in schizophrenia (Phelan et al. 2001) with increased standardised mortality rates due to death from cardiovascular disease, infections, endocrine disorders and other conditions. People with schizophrenia are twice as likely to die from coronary heart disease and four times more likely to die from respiratory disease. They are twice as likely to have bowel cancer. They are more likely to smoke, are less likely to exercise, are more likely to be obese and more likely to have diets high in fat and low in fibre. (NICE Schizophrenia, 2009). There is evidence for a similar picture in other serious mental illness including bipolar disorder. Analysis of primary care records suggests that people with a diagnosis of schizophrenia or bipolar disorder are more than twice as likely to have diabetes than other patients and also more likely to experience ischaemic heart disease, stroke, hypertension and epilepsy (Disability Rights Commission, 2005).

1.3 Anti-psychotic medications may induce weight gain, endocrine changes (leading to an increased risk of diabetes) and also cardiac arrhythmia. There is evidence that psychiatrists and general practitioners are poor at recognising and treating physical conditions in psychiatric patients.

1.4 People with learning disability have reduced life expectancy compared with the general population. They have higher rates of obesity and respiratory disease, and high levels of unmet needs. People with learning disabilities who have diabetes have fewer measurements of their body mass index (BMI) than others with diabetes. Those with stroke have fewer blood pressure checks than others with a stroke. They also have very low cervical and breast cancer screening rates.

1.5 People with eating disorders also have increased mortality mediated through the complications of weight loss and poor nutrition. Acute risk of physical complications can be associated with re-feeding as well as weight loss and careful monitoring of physical health is required. In anorexia nervosa there is increased risk of long term complications including osteoporosis. In bulimia nervosa dental complications are common and electrolyte disturbance can occur in people who are vomiting frequently (NICE Eating Disorders, 2004).

1.6 The National Service Framework (NSF) for Coronary Heart Disease (but not the NSF for Diabetes) identified people with severe mental illness as part of a vulnerable group that require special attention.

1.7 There is evidence that people with mental health problems are likely to have their physical health needs unrecognised, unnoticed or poorly managed. A number of studies suggest that people who use mental health services are much less likely than the general population to be offered spirometry, blood pressure, cholesterol, urine or weight checks, or to receive opportunistic advice on smoking cessation, alcohol, exercise or diet. Reasons include being unaware of and/or late recognition of symptoms, low expectations of healthcare services, difficulties in registration at or attending GP surgeries, communication problems with healthcare professionals, and stigma and discrimination on the part of healthcare professionals.

1.8 Motivation to do something about physical health is further impaired by mental health problems and so service users need encouragement and support. There is a general assumption that people with mental health problems do not attend appointments; however, this is not the case in practice. There is also evidence that service users' experience of diagnostic overshadowing, i.e. practitioners interpret their physical health symptoms and concerns as a mental health issue (Choosing Health, 2006).

1.9 Primary care occupies a central place both as provider and commissioner of services. There has been an array of efforts to remedy health inequalities by improving access to healthcare for those with severe mental health problems. A series of projects and recommendations has been introduced to identify and tackle the physical health needs of these groups with appropriate annual health checks and specialist health screening services. Government policy has endorsed many of these initiatives, for example, in the NSF for Mental Health (Standard 2), in the General Medical Services (GMS) contract for general practitioners and the Quality and Outcomes Framework (QOF).

1.10 Reducing premature death in people with severe mental illness is an overarching indicator in the NHS Outcomes Framework 2012/13. One of the six shared objectives in 'No Health Without Mental Health' is that 'More people with mental health problems will have good physical health'.

2. PURPOSE & SCOPE

2.1 This policy is intended to provide advice and set standards for clinical staff in the mental health directorate in relation to the physical assessment and investigation of service users. The policy particularly applies to mental health directorate medical and nursing staff working in inpatient wards and sets standards for physical examination and investigation at the point of admission and through the inpatient stay. The policy applies to both permanent staff and temporary staff.

2.2 The purpose of the policy is to ensure that best practice, as recommended by NICE (Schizophrenia, 2009; Eating Disorders, 2006; Bipolar, 2006; Nutrition Support 2006) and other National Guidance (Choosing Health, 2006) is incorporated into clinical care within the Trust.

2.3 Whenever carrying out physical assessments of patients and service users, staff will at all times be mindful of the person's protected characteristics and cultural differences. These will be taken fully into account so the assessment or examination is conducted in as sensitive manner as possible which respects their privacy and dignity. Wherever practicable, the examination will be conducted by a staff member of the same gender as the patient. If this is not possible, another member of staff of that gender will be present at the examination. Religious or spiritual beliefs may mean a person of that religion of belief may need to be present with the agreement of the patient.

2.4 Before carrying out any non emergency physical examination, the reasons for it should be clearly explained to the service user; this may need the use of a professional interpreter.

3. DUTIES AND RESPONSIBLITIES

3.1 Duties in respect of the requirements of this document are as follows

3.1.1 The **Trust Board** has a duty to care for patients receiving care and treatment from the Trust and has overall responsibility for procedural documents and delegate's responsibility as appropriate.

3.1.2 The **Lead Director** is the **Director of Mental Health and Social Care** and has devolved responsibility for the implementation of this policy.

3.1.3 The **Identified Lead (Author)** is the **Medical Director** and he will be responsible for producing written drafts of the document and for consulting with others and amending the draft as appropriate.

3.1.4 **Associate Directors/Heads of Service** have responsibility for implementing this policy and for ensuring high standards of physical healthcare within the service for which they have overall responsibility and to ensure adherence to

this policy.

3.1.5 **Line managers** are responsible for ensuring that relevant staff are conversant with this policy and related policies.

3.1.6 **All Medical and inpatient nursing staff** including temporary staff are individually responsible for their actions including complying with this policy.

3.1.7 **The Clinical Effectiveness Team** are responsible for undertaking clinical audits as scheduled within the clinical audt plan.

3.1.8 **The Improving the Quality of Inpatient Services (IQIS) Group**s responsible for the implementation of any clinical audit recommendations agreed by the Medical Audit Group.

3.1.9 **The Clinical Governance Group** is responsible for approving this policy and will ensure it is reviewed at least every three years or sooner in line with local and/or national requirements. The Group is responsible for the overall monitoring of the Clinical Audit plan.

3.1.10 The **Head of Corporate Governance** has responsibility for holding the central database of procedural documents including this guidance and for providing quarterly reports to each Governance Group highlighting which policies are due for review. The Corporate Governance Team also has responsibility for dissemination of the final document and archiving old versions.

4. DEFINITIONS

4.1 **RiO** - Electronic Patient Record

4.2 **What's on** – A monthly update to staff regarding Trustwide issues.

All other explanations of terms used are included in the text of the policy and are not separately stated here.

5. THE POLICY

5.1 Physical Assessment and Examination of Inpatients

5.1.1 All patients admitted to an inpatient ward or transferred from another ward should have **a physical examination completed on admission** (Mental Health Policy Implementation Guide, 2002). This should be documented in the Physical Health/Examination section of the RiO Core Assessment as soon as possible after admission and always within 24 hours. Alternatively, there should be evidence in the progress notes of a valid justification for not doing so, for example (a) reference to a recent physical examination recorded in the correct section of RIO confirmed as adequate or (b) lack of consent/co-

operation. In the latter case the check box should be ticked in the Physical Health/Examination section of the RiO Core Assessment.

5.1.2 When undertaking a physical examination of an inpatient where there are cuts, bruises or other marks on the skin, the assessing clinician should complete a body map to indicate their location. The body map should be used to record any bruising, scars, injuries, red marks or the like, giving as much detail as possible in respect to size colour, and elevation. The body map is located in the General Assessments on RiO.

5.1.3 Where there are potential safeguarding concerns in relation to an injury or self-harm, a body map should be used to identify the site of any injuries. This will be a helpful addition to any subsequent safeguarding enquiries.

5.1.4 Staff should be reminded that a body map constitutes part of the clinical record and could become admissible evidence in any future court proceedings. Whilst staff are not expected to be expert artists they do need to be as accurate as possible, and any injuries should also be described in the written clinical records in addition to being drawn on a body map.

5.1.5 All inpatients should have a Venous Thromboembolism (VTE) assessment conducted on admission and again 24 hours after admission to identify those at increased risk of VTE. This should be recorded in the Physical Health/Examination section of the RiO Core Assessment and the procedures within this assessment should be followed.

5.1.6 All inpatients should have a physical examination conducted on at least a 6 monthly basis. This should be documented in the Physical Health/Examination section of the RiO Core Assessment. There is also a care plan library (Physical Health Assessment (inpatient) that provides a framework for translating this guidance into practice.

5.1.7 All patients admitted to an inpatient ward from the community or admitted as a transfer from another ward should have the following **investigations completed at least within 5 days of admission**:

- urea,
- electrolytes,
- creatinine,
- liver function tests,
- gamma-glutamyl transferase,
- glucose,
- full blood count,
- thyroid function test,
- calcium
- electrocardiogram.

Results should be pasted into the Clinical Investigations Section of the RiO core assessment at least within 7 days of admission. Abnormal results should be followed up as clinically appropriate by the inpatient medical team. Any unresolved abnormal results or physical health issues should be clearly stated in discharge information to the GP, including designation for responsibility for follow up and ongoing care.

5.1.8 All patients admitted to an inpatient ward from the community or admitted as a transfer from another ward who are taking psychotropic medication on admission should have recommended investigations completed according to Trust guidelines: 'RECOMMENDED MONITORING IN PATIENTS TAKING PSYCHOTROPICS'. These guidelines are available in the Drug & Therapeutics site on the intranet. Results should be pasted into the Clinical Investigations Section of the RiO core assessment at least within 7 days of admission.

5.1.9 All inpatients should, on an ongoing basis, have recommended investigations completed according to Trust guidelines: 'RECOMMENDED MONITORING IN PATIENTS TAKING PSYCHOTROPICS'. Results should be pasted into the Clinical Investigations Section of the RiO core assessment.

5.1.10 All inpatients should have **an assessment by a doctor on admission** and a medical history should be taken including details of past medical history and current physical health. This should be entered into the Physical Health/Examination section of the RiO core assessment as soon as possible after admission and always within 24 hours. Expert advice should be sought from specialist services when specific conditions are already established or identified in the course of assessment.

5.1.11 All inpatients on older people's wards should have a 'Fall Risk' assessment completed on admission within the 'Risk & Safety' section of the RiO core assessment. Please refer to the Slips, Trips and Falls Policy for more information.

5.1.12 Physical assessment and investigation prior to rapid tranquillisation (RT) and physical monitoring after RT should follow the standards set out in Trust guidelines: 'GUIDELINES FOR RAPID TRANQUILLISATION' which can be found in the Drug & Therapeutics intranet site. Wherever practical ECG monitoring should be conducted in all patients prescribed antipsychotics and at risk of RT (Royal College Consensus Statement 2006). The RT guidelines state that the required assessment should take place on admission whenever practical.

5.1.13 Screening for malnutrition and the risk of malnutrition should be carried out for all hospital inpatients on admission using the Malnutrition Universal Screening Tool within the RiO core assessment (NICE Nutrition Support, 2006). All inpatients should have height and weight measured on admission and entered in the Physical Health/Examination section of the core

assessment to calculate Body Mass Index. Where appropriate there should be active promotion of a healthy diet and advice should be provided to encourage regular exercise.

5.1.14 Smoking status should also be recorded on admission and entered on the Smoking/Physical Activity section of the core assessment. Advice encouragement and support including referral to NHS Stop Smoking Service are offered to help inpatients in their attempt to quit. Nicotine Replacement Therapy is offered, as appropriate, to inpatients who are planning to stop smoking.

5.1.15 There should be **clear arrangements in each inpatient unit for consultant medical responsibility and allocation of non-consultant medical staff.** Local arrangements should be in place for both learning disability as well as general psychiatry patients and should be unambiguous in each individual case.

5.1.16 In all inpatient admissions involving people with learning disability, the responsible **Community Learning Disabilities Nurse** (CLDN) will identify any specific physical health needs that relate to the support of that service user from a learning disability perspective and will communicate these to the inpatient nursing team. This process should make reference to the Health Action Plan and a copy of the plan should be available to the inpatient team to assist in care planning on the ward. This should be obtained at the earliest opportunity on admission and contact made with the CLDN within the first 72 hours.

5.1.17 Trust clinical audit standards for physical investigation and examination of inpatients (except Child and Adolescent Mental Health Services) and for Physical Health Assessment and promotion in long stay inpatients are included as Appendix B and C. These are audit standards against which the Trust can monitor compliance with this guidance and include timeframes for physical assessment consistent with the guidance.

5.2 Physical Assessment in the Community

5.2.1 Medical responsibility for physical health in the community lies with the **general practitioner**. Nevertheless a comprehensive assessment should include past medical history and current physical health. This will help in identification of organic causes of psychiatric disorder, side effects of psychotropic medication and physical health problems (or risk of physical health problems) arising as a complication of psychiatric problems (e.g. osteoporosis in anorexia nervosa).

5.2.2 Care plan reviews should involve a holistic assessment and this encompasses physical health problems including those arising as a consequence of social deprivation, poor nutrition or substance misuse. (Refocusing the CPA, 2008). Particular attention should be paid to the risk of

metabolic and cardiovascular disease, and attention should be given to the promotion of lifestyle and dietary changes that might promote better health outcomes. There should be discussion of any difficulties in accessing primary care services including screening services for cervical and breast cancer, sight and hearing tests and dental check ups.

5.2.3 Consideration should be given to signposting people to appropriate services as well as offering support in accessing services. Health promotion information should be provided and there should be liaison with the general practitioner about referral to appropriate health promotion services including dietician advice, smoking cessation and prescribed exercise programmes. A sample patient information leaflet is given in Appendix A. In people with severe mental illness (including schizophrenia and bipolar disorder), investigations should include thyroid, liver and renal function tests, blood pressure, full blood count, blood glucose and lipid profile. Electroencephalogram, CT scan or MRI scan should be considered if an organic aetiology is suspected. (NICE Bipolar, 2006).

5.2.4 In people with severe mental illness (including schizophrenia and bipolar disorder), care plans should include arrangements for an annual physical health check undertaken in a primary care setting. Primary care registers of people with severe mental illness facilitate this annual review. The annual health check should include lipid levels (including cholesterol in all patients over 40 even if there is no other indication of risk), glucose levels, weight / height, blood pressure, smoking status and alcohol use. The results of the annual review should be given to the person, and to healthcare professionals involved in primary and secondary care. A clear agreement should be made jointly between primary and secondary care about responsibility for treating any problems (NICE Schizophrenia, 2009; NICE Bipolar, 2006).

5.2.5 The care plan should include clear arrangements for responsibility (as jointly agreed between primary and secondary care) for monitoring the physical effects of psychiatric medication as recommended in Trust guidelines: 'RECOMMENDED MONITORING IN PATIENTS TAKING PSYCHOTROPICS'. Further guidance is available in Trust prescribing guidelines located in the Drug &Therapeutics intranet site (e.g. 'SOMERSET PARTNERSHIP LITHIUM GUIDELINES' and 'GUIDELINES FOR ANTIPSYCHOTIC PRESCRIBING').

5.2.6 There is a care plan library (Physical Health (community) that provides a framework for translating this guidance into practice.

5.2.7 Patients with bulimia nervosa who are vomiting frequently or taking large quantities of laxatives (especially if they are also underweight) should have their fluid and electrolyte balance assessed. Patients with enduring anorexia nervosa should be offered an annual physical and mental health review in primary care, which should include referral, when appropriate, to screening services for osteoporosis. People with anorexia nervosa are at high risk in

terms of their physical safety and medical risks should be assessed according to the South London and Maudsley Guidelines (A Guide to the Medical Risk Assessment For Eating Disorders, 2009; www.eatingresearch.com). This guidance provides recommendations for brief essential medical examination and clinical investigations as well as values of concern and alert in relation to these parameters. Patients with an eating disorder who are vomiting should have regular dental reviews and should be given appropriate advice on dental hygiene. People with type 1 diabetes and an eating disorder should have intensive regular physical monitoring because they are at high risk of retinopathy and other complications (NICE Eating Disorders, 2004). There is a care plan library for eating disorder, which includes assessment and management of physical health.

5.2.8 People presenting with suspected dementia should undergo the following investigations at the time of presentation, usually within primary care: routine haematology, biochemistry tests (including electrolytes, calcium, glucose, and renal and liver function), thyroid function tests and serum vitamin B_{12} and folate levels. A midstream urine test should always be carried out if delirium is a possibility. Structural imaging should be used in the assessment of people with suspected dementia to exclude other cerebral pathologies and to help establish the subtype diagnosis (NICE Dementia, 2006).

5.2.9 There should be identification of the needs of people with dementia arising from ill health, physical disability, sensory impairment, communication difficulties, poor nutrition, dental problems and learning disabilities. Care plans should record these needs and the means of addressing them. Vascular and other modifiable risk factors (for example, smoking, excessive alcohol consumption, obesity, diabetes, hypertension and raised cholesterol) should be reviewed in people with dementia (usually in primary care), and if appropriate, treated. Problems with physical health should be considered in the assessment of people with dementia presenting with worsening of non cognitive symptoms (NICE Dementia, 2006).

5.2.10 There is a requirement for people with learning disability to be assisted in drawing up a Health Action Plan, usually with the assistance of carers and their general practitioner. The Community Learning Disability team should make use of the Health Action Plan in reviewing the needs of people under their care and use it to identify any lack of access to treatment so that assistance can be offered either in the form of advice, signposting or direct support.

5.2.11 A high proportion of people with learning disability will also suffer from epilepsy. Epilepsy will sometimes be managed by a Somerset Partnership learning disability consultant, and this will include the use of antiepileptic medication. New assessment of people with learning disability and epilepsy should include appropriate physical investigations including blood tests, electroencephalogram (EEG) and neuro-imaging. Somerset Partnership staff that become aware of anyone who has had a first seizure should ensure that

they are referred within 7 days for assessment in the first seizure clinic held in the general hospital setting.

5.2.12 In all people with learning disability and epilepsy there should be an annual review of treatment and medical responsibility for the review should be clearly documented and jointly understood between the general practitioner and the consultant psychiatrist. Somerset Partnership consultants usually conduct annual reviews at Joint Epilepsy Clinics accompanied by the Community Learning Disability Nurse. Through documentation the review should demonstrate when treatment is ineffective, or poorly tolerated, or when compliance is poor and medication should be adjusted accordingly. There is a requirement for annual blood tests as routine monitoring for most antiepileptic medication (further guidance is given for medications with indications in general psychiatry in 'RECOMMENDED MONITORING IN PATIENTS TAKING PSYCHOTROPICS').

5.2.13 Trust clinical audit standards for Physical Health Promotion in a Community/Outpatient setting are included in Appendix D. These are audit standards against which the Trust can monitor compliance with this guidance.

6. TRAINING REQUIREMENTS

6.1 Induction Training and RCPA training (as specified within the Trust Training Needs Analysis).

6.2 For further training detail please refer to the Training Needs Analysis Matrix, the Learning and Development and Mandatory Training Policy and the Training Prospectus accessible on the Trust Intranet within Learning & Development.

6.3 Clinical Audit reports are notified to Trust staff in the What's On newsletter, which contains a hyperlink to the full audit report. Lessons Learned will also be highlighted in What's On News. Clinical Audit standards have been circulated with What's On News and are available on the intranet. Clinical audit reports are presented at the Medical Audit meeting, which is attended by doctors in training and other medical staff.

7. MONITORING COMPLIANCE AND EFFECTIVENESS

7.1 The Clinical Governance Group is responsible for approving this policy and will ensure it is reviewed at least every three years or sooner in line with local and/or national requirements. The Group is also responsible for the overall monitoring of the Clinical Audit plan

7.2 Audit of this policy is incorporated into the Trust Clinical Audit plan and appropriately prioritised according to an agreed system for determining the frequency of audit. Audit of this policy is supported by Clinical Audit Standards, which have been developed for (a) physical examination and

routine investigation in inpatient wards, (b) physical health assessment and promotion in a community/outpatient setting, (c) physical health assessment and promotion in long stay inpatients, (d) rapid tranquillisation, (e) nutrition support in adults, (f) smoking cessation and (g) eating disorders. The Medical Audit Group will sign off key recommendations from clinical audit report and the IQIS Group will monitor implementation of these recommendations.

7.3 A number of performance measures are also reported to the Trust Board on a monthly basis within the performance dashboard. These measures relate to inpatient admissions and include physical health, VTE and nutrition assessment.

8. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

8.1 References

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Department of Health. (2011). The NHS Outcomes Framework 2012/13. Available from: www.dh.gov.uk

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8.2 Cross reference to other procedural documents

Clinical Audit Policy
Guidelines for Antipsychotic Prescribing
Learning Development and Mandatory Training Policy
Lithium Guidelines
Medicines Policy
Medicines Reconciliation Policv
Rapid Tranquillisation Guidelines
Record Keeping and Records Management Policy
Recommended Monitoring in Patients Taking Psychotropics
Integrated Care Planning Approach (ICPA) Policy
Slips, Trips and Falls Prevention and Management Policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

Relevant Objective within Trust Strategy

Trust Service Development Plans:

To further improve the mental health and wellbeing of people living in Somerset, ensuring that more people with mental health problems regain the fullest quality of life in line with the national mental health strategy.

9. APPENDICES

9.1 For the avoidance of any doubt the appendices in this procedural document are to constitute part of the body of this procedural document and shall be treated as such.

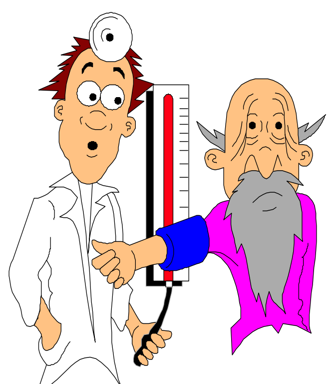
Appendix A	POMH-UK, Looking After Your Physical Health.
Appendix B	Clinical Audit Standards. Physical Examination and Routine Investigations in Inpatient Wards
Appendix C	Clinical Audit Standards. Physical Health Assessment and Promotion in Long Stay Inpatients
Appendix D	Physical Health Assessment and Promotion in a Community/Outpatient Setting

APPENDIX A

Somerset Partnership

NHS Foundation Trust

Looking after your physical health



If you're taking antipsychotics, it's especially important to have regular physical health checks (at least once a year, or more frequently if advised) because of the risk of serious side-effects that may **occur**

What checks should I have?

1. **Blood tests** to look at:
   - Glucose levels—an indicator of diabetes
   - Lipid levels—an indicator of cholesterol (high cholesterol increases the risk of heart disease and stroke)
2. **Weight**—putting on too much weight, a side effect of many antipsychotics, can increase the risk of diabetes and heart disease.
3. **Blood pressure**—high blood pressure may also contribute to the development of heart disease.

The table opposite is to help you keep track of your recent test results and when the next ones are due

Keep a record of your physical health checks here……….

	Most recent result	Date next due	Most recent result	Date next due	Most recent result	Date next due	Most recent result	Date next due	Most recent result	Date next due
Blood Pressure										
Weight										
Glucose										
Lipids										
Other										
Other										

Some useful contacts

Name & contact details for person on my mental health team who will help me arrange physical health check appointments and explain the results to me:	
Mind — national association for mental health — can send you helpful information about physical activity, food and mental health	**Mind** **15-19 Broadway** **London E15 4BQ** *Phone: 020 8519 2122 www.mind.org.uk*
The British Heart Foundation can send you lots of information about improving and maintaining your heart health	**British Heart Foundation** **17 Fitzhardinge Street** *London W1H 6DH* **Phone: 08450 70 80 70 www.bhf.org.uk**
Diabetes UK— They are available to answer enquiries and send useful information aboutType 1 and Type 2 diabetes	**Diabetes UK** **10 Parkway** **London NW1 7AA** **Phone: 08451 20 29 60 www.diabetes.co.uk**
The Blood Pressure Association can send you information on how to recognise and prevent High Blood Pressure. They also have information about the treatments that are available.	**Blood Pressure Association** **60 Cranmer Terrace** **London, SW17 OQS** **Phone: 020 8772 4944** **www.bpassoc.org.uk**

Designed by Mo Hutchison, service user consultant, for POMH-UK, a national quality improvement programme for Mental Health prescribing managed by the Royal College of Psychiatrists: www.rcpsych.ac.uk/pomh

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APPENDIX B

PHYSICAL EXAMINATION AND ROUTINE INVESTIGATIONS IN INPATIENT WARDS PRACTICE STANDARDS (Derived from an Untoward Incident Review, and Physical Assessment and Examination of Service Users Policy)

Agreed by Practice Standards Group May 2008, reviewed September 2010
Updated 03/01/2012

Service area(s) to which standards apply:				
		All		**CAMHS**
	√	**Inpatient Adult**		**Community Adult**
	√	**Inpatient Older**		**Community Older**
	√	**Rehab & Recovery**		**Drugs Service**
		Eating Disorders	√	**Learning Disabilities**

Standards and policy due for review	September 2012
Audit regularity	42 months
Previous audits	2009 A418
	2011 A478

PHYSICAL EXAMINATION AND ROUTINE INVESTIGATIONS IN INPATIENT WARDS PRACTICE STANDARDS				
Ref No	**Standard**	**Compliance**	**Exceptions**	**Definitions**
284	All patients admitted to an inpatient ward from the community or admitted as a transfer from another ward should have the following tests completed at least within 5 days of admission: U&E, Cr, LFT, glucose, Gamma GT, FBC, TFT, Ca, ECG, Discretionary: B12, Folate, VDRL / TPHA. Results should be pasted into the Clinical Investigation section of the RiO core assessment at least within 7 days of admission.	100%	Lack of consent/co-operation with this valid justification documented in the notes. Blood tests taken recently prior to admission (these should be pasted into RIO progress notes and confirmed as adequate in the notes by the admitting doctor).	None
285	All patients admitted to an inpatient ward from the community or admitted as a transfer from another ward who are taking psychotropic medication on admission should have recommended investigations completed according to Trust guidelines: 'RECOMMENDED MONITORING IN PATIENTS TAKING PSYCHOTROPICS'. Results should be pasted into the Clinical Investigation section of the RiO core assessment at least within 7 days of admission.	100%	Lack of consent/co-operation with this valid justification documented in the notes. Blood tests taken recently and recorded on RiO.	None

PHYSICAL EXAMINATION AND ROUTINE INVESTIGATIONS IN INPATIENT WARDS PRACTICE STANDARDS				
Ref No	**Standard**	**Compliance**	**Exceptions**	**Definitions**
286	All patients admitted to an inpatient ward or transferred from another ward should have a physical examination completed within 24 hours of admission. This should be documented in the Physical Health/Examination module in the RiO core assessment.	100%	Lack of consent/co-operation with this valid justification documented in progress notes. Physical examination undertaken recently and recorded on RiO.	Lack of consent/co-operation can be recorded using the appropriate tick box in the Physical Health/Examination module. Alternatively, there should be evidence in the progress notes of a record of valid justification, for example reference to a recent physical examination recorded in the correct section of RIO confirmed as adequate or lack of consent/co-operation.
287	All inpatients should have a physical examination conducted on at least a 6 monthly basis. This should be documented in the Physical Health/Examination module in the RiO core assessment.	100%	Lack of consent/co-operation with this valid justification documented in the notes.	Lack of consent/co-operation can be recorded using the appropriate tick box in the Physical Health/Examination module. Alternatively, there should be evidence in the progress notes of a record of valid justification, for example reference to a recent physical examination recorded in the correct section of RIO confirmed as adequate or lack of consent/co-operation.
288	All inpatients should have routine tests conducted on at least an annual basis (Recommended: U&E, Cr, LFT, glucose, Gamma GT, FBC, TFT, Ca, ECG, Discretionary: B12, Folate). Results should be pasted into the Clinical Investigation section of the RiO core assessment.	100%	Lack of consent/co-operation with this valid justification documented in the notes.	There should be evidence in the progress notes of a record of valid justification.

PHYSICAL EXAMINATION AND ROUTINE INVESTIGATIONS IN INPATIENT WARDS PRACTICE STANDARDS				
Ref No	**Standard**	**Complianc e**	**Exceptions**	**Definitions**
289	All inpatients should have recommended investigations completed according to Trust guidelines: 'RECOMMENDED MONITORING IN PATIENTS TAKING PSYCHOTROPICS'. Results should be pasted into the Clinical Investigation section of the RiO core assessment.	100%	Lack of consent/co-operation with this valid justification documented in the notes.	There should be evidence in the progress notes of a record of valid justification.

APPENDIX C

Physical Health Assessment and Promotion in long stay Inpatients.

Derived from NICE CG 38 Bipolar disorder; NICE CG Schizophrenia, NICE CG 9 Eating Disorders; DoH Refocusing the CPA (2008); DoH Choosing Health (2006); Disability Rights Commission Equal Treatment closing the Gap (2006) and Physical Assessment and Examination of Service Users Policy

Agreed by Practice Standards Group 09/11/2009, reviewed September 2010
Updated 03/01/2012

Service area(s) to which standards apply:				
		All		**Community Adult**
		All Inpatient Ward		**Community Older**
	√	**Inpatient Adult**		**CAMHS**
	√	**Inpatient Older**		**Eating Disorders**
	√	**Rehab & Recovery**		**Learning Disabilities**

Date Practice Standards due for review	September 2012
Audit regularity	Every 24 months
Previous audits	A459 2011

Physical Health Assessment and Promotion in long stay Inpatients				
Ref No	**Standard**	**Complian ce**	**Exceptions**	**Definitions**
490	All long stay inpatients (>6/12) who suffer from Severe Mental Illness should be informed of their eligibility for an annual physical health check in primary care and care plans should include reference to measures to monitor and facilitate access.	100%	Equivalent annual physical health check (see definition) conducted by inpatient medical team	This standard applies to all patients with a diagnosis of schizophrenia and related psychoses (F20-F29) or bipolar disorder (F31). For all patients care plans should record their eligibility for an annual health check and should record measures to facilitate access. Annual health checks in primary care will normally include: an enquiry about smoking, alcohol and drug use, blood pressure check, cholesterol check where clinically indicated, measurement of BMI, check for the development of diabetes, cervical screening where appropriate and an enquiry about cough, sputum and wheeze (Quality and Outcomes Framework guidance for GMS contract 2009/10).
491	There should be a request made to primary care for findings from annual physical health checks to be forwarded to the inpatient consultant and the information should be entered in the correct section of the core assessment.	100%	Equivalent annual physical health check (see definition) conducted by inpatient medical team	There should be evidence of correspondence requesting findings from annual physical health checks for all patients with a diagnosis of schizophrenia and related psychoses (F20-F29) or bipolar disorder (F31). Where information is provided this should be recorded in the Physical Health/Examination or the Clinical Investigations section of the core assessment as appropriate. There should be a clear account of where responsibility lies for following up abnormal results (normally primary care).
492	In long stay inpatients (>6/12) with severe mental illness there should be liaison with primary care about referral to appropriate health promotion services including dietician advice, smoking cessation and prescribed exercise programmes.	100%	Equivalent health promotion services available in an inpatient setting and noted in the care plan	Care plans should include reference to health promotion services in all patients with a diagnosis of schizophrenia and related psychoses (F20-F29) or bipolar disorder (F31).

Physical Health Assessment and Promotion in long stay Inpatients				
Ref No	**Standard**	**Compliance**	**Exceptions**	**Definitions**
493	All long stay inpatients (>6/12) who suffer from Severe Mental Illness should be informed of their eligibility for screening programmes in primary care and care plans should include reference to measures to monitor and facilitate access.	100%	None	This standard applies to all patients with a diagnosis of schizophrenia and related psychoses (F20-F29) or bipolar disorder (F31). For all patients, care plans should record their eligibility for screening in primary care and should record measures to facilitate. Current screening programmes are as follows: (a) cervical screening – 3 yearly for women aged 25 –45 years and 5 yearly for women aged 45 to 65 years, (b) breast screening – 3 yearly for women aged 50 – 70 years and (c) retinopathy screening annually for all people with a diagnosis of diabetes. Screening programmes are being rolled out for bowel cancer and cardiovascular disease.
494	All long stay inpatients (>6/12) who suffer from Severe Mental Illness should be informed of the importance of dental check ups and care plans should include reference to measures to monitor and facilitate access.	100%	None	This standard applies to all patients with a diagnosis of schizophrenia and related psychoses (F20-F29) or bipolar disorder (F31). For all patients, care plans should include reference to dental health
495	All long stay inpatients (>6/12) who are taking psychotropic medication should have recommended investigations completed according to Trust guidelines: 'RECOMMENDED MONITORING IN PATIENTS TAKING PSYCHOTROPICS'.	100%	Patient does not consent to blood test or other valid clinical reason (see recording requirement)	Results should be pasted into the Clinical Investigations section of the Core Assessment. Any refusal to consent or other valid clinical reason not to undertake investigations should also be recorded

APPENDIX D

Physical Health Assessment and Promotion in a Community/Outpatient Setting.

Derived from NICE CG 38 Bipolar disorder; NICE CG Schizophrenia, NICE CG 9 Eating Disorders; DoH Refocusing the CPA (2008); DoH Choosing Health (2006); Disability Rights Commission Equal Treatment closing the Gap (2006) and Physical Assessment and Examination of Service Users Policy

Agreed by Practice Standards Group 09/11/2009, reviewed 20/09/2010
Updated 03/01/2012

Service area(s) to which standards apply:				
		All	√	**Community Adult**
		All Inpatient Ward	√	**Community Older**
		Inpatient Adult		**CAMHS**
		Inpatient Older		**Eating Disorders**
		Rehab & Recovery		**Learning Disabilities**

Standards and policy due for review	September 2012
Audit regularity	Every 24 months
Previous audits	

Physical Health Assessment and Promotion in a Community/Outpatient Setting				
Ref No	**Standard**	**Complian ce**	**Exceptions**	**Definitions**
452	There should be an assessment of physical health issues including those relating to substance misuse at every initial assessment for community patients including those seen in outpatients and relevant medical history, substance use history and current physical health problems should be recorded.	100%	None	The Alcohol / Substance Misuse, Physical Health/Examination modules of the core assessment should be completed at every initial assessment. Smoking Cessation should be completed when the client is accepted on to CPA.
453	There should be an assessment of current medication at every initial assessment for community patients including those seen in outpatients.	100%	None	The Medication History section of the core assessment (under development) should be completed at every initial assessment. All psychiatric medication should be recorded at each initial assessment and non-psychiatric medication should be recorded whenever new medication is prescribed or a recommendation is made to alter a prescription. If information is not obtainable at initial assessment this fact should be recorded in the Medication core assessment.

Physical Health Assessment and Promotion in a Community/Outpatient Setting				
Ref No	**Standard**	**Compliance**	**Exceptions**	**Definitions**
454	There should be ongoing assessment and recording of current medication whenever clinically indicated for community patients including those seen in outpatients.	100%	None	The Medication section of the core assessment should be updated with a record of current psychiatric medication at each CPA review and also whenever new medication is prescribed or a recommendation is made to alter a prescription. In addition the Medication section of the core assessment should be updated with a record of non-psychiatric medication whenever new medication is prescribed or a recommendation is made to alter a prescription.
455	There should be an assessment of Body Mass index for specified groups of patients in the community including those seen in outpatients.	100%	Patient does not consent to recording of weight and / or height (or other valid clinical reason recorded in the notes).	BMI should be recorded in the Weight and Height section of the Physical Health/Examination module in the core assessment. This should be recorded at least annually (for audit purposes at least once in the last 15 months) but if information is available from GP records this can be used as the source of height / weight when available. This standard applies to all patients (a) on Level 2 CPA, or (b) with a diagnosis of schizophrenia and related psychoses (F20-F29), bipolar disorder (F31) and eating disorders (F50) or (c) where there is clinical concern of malnutrition (defined as any of the following: unintentional weight loss, fragile skin, poor wound healing, apathy, wasted muscles, poor appetite, altered taste sensation, impaired swallowing, altered bowel habit, loose fitting clothes, or prolonged intercurrent illness).
456	All community patients including those with seen in outpatients who suffer from Severe Mental Illness should be informed of their eligibility for an annual physical health check in primary care and care plans should include reference to measures to monitor and facilitate access.	100%	None	This standard applies to all patients with a diagnosis of schizophrenia and related psychoses (F20-F29) or bipolar disorder (F31). For all patients on Level 2 CPA care plans should record their eligibility for an annual health check and should record measures to facilitate access. For all patients on Level 1 CPA there should be a record of this in an outpatient letter or other document specified as the care plan equivalent. Annual health checks in primary care will normally include: an enquiry about smoking, alcohol and drug use, blood pressure check, cholesterol

Physical Health Assessment and Promotion in a Community/Outpatient Setting				
Ref No	**Standard**	**Complian ce**	**Exceptions**	**Definitions**
				check where clinically indicated, measurement of BMI, check for the development of diabetes, cervical screening where appropriate and an enquiry about cough, sputum and wheeze (Quality and Outcomes Framework guidance for GMS contract 2009/10).
457	There should be a request made to primary care for findings from annual physical health checks to be forwarded to the care co-ordinator and the information should be entered in the correct section of the core assessment.	100%	None	There should be evidence of correspondence requesting findings from annual physical health checks for all patients with a diagnosis of schizophrenia and related psychoses (F20-F29) or bipolar disorder (F31). Where information is provided this should be recorded in the Physical Health/Examination or Clinical Investigations section of the core assessment as appropriate. There should be a clear account of where responsibility lies for following up abnormal results (normally primary care).
458	In people with severe mental illness there should be liaison with primary care about referral to appropriate health promotion services including dietician advice, smoking cessation and prescribed exercise programmes.	100%	None	Care plans or other correspondence such as outpatient letters should include reference to health promotion services in all patients with a diagnosis of schizophrenia and related psychoses (F20-F29) or bipolar disorder (F31).
459	All community patients including those seen in outpatients who suffer from Severe Mental Illness should be informed of their eligibility for screening programmes in primary care and care plans should include reference to measures to monitor and facilitate access.	100%	None	This standard applies to all patients with a diagnosis of schizophrenia and related psychoses (F20-F29) or bipolar disorder (F31). For all patients on Level 2 CPA care plans should record their eligibility for screening in primary care and should record measures to facilitate access. For all patients on Level 1 CPA there should be a record of this in an outpatient letter or other document specified as the care plan equivalent. Current screening programmes are as follows: (a) cervical screening – 3 yearly for women aged 25 –45 years and 5 yearly for women aged 45 to 65 years, (b) breast screening – 3 yearly for women aged 50 – 70 years and (c) retinopathy screening annually for all people with a diagnosis of diabetes. Screening programmes are being rolled out for bowel cancer and cardiovascular disease.

Physical Health Assessment and Promotion in a Community/Outpatient Setting				
Ref No	**Standard**	**Compliance**	**Exceptions**	**Definitions**
460	All community patients including those seen in outpatients who suffer from Severe Mental Illness should be informed of the importance of dental check ups and care plans should include reference to measures to monitor and facilitate access.	100%	None	This standard applies to all patients with a diagnosis of schizophrenia and related psychoses (F20-F29) or bipolar disorder (F31). For all patients on Level 2 CPA care plans should include reference to dental health. For all patients on Level 1 CPA there should be a record of this in an outpatient letter or other document specified as the care plan equivalent.
461	All patients who are taking psychotropic medication and who have an open referral to a doctor should have recommended investigations completed according to Trust guidelines: 'RECOMMENDED MONITORING IN PATIENTS TAKING PSYCHOTROPICS'.	100%	Patient does not consent to blood test or other valid clinical reason (see recording requirement)	Results should be pasted into the Clinical Investigations section of the Core Assessment. Any refusal to consent or other valid clinical reason not to undertake investigations should also be recorded. Although investigations may be completed in primary care there should be clear documentation of responsibility for monitoring including follow up of abnormal results, either in a care plan or other documentation such as an outpatient letter (normally this will lie with the prescriber).