Minimum Standards for the Physical Assessment and Examination of Inpatients in Mental Health and Learning Disability Services
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1. INTRODUCTION

1.1 Rationale

It is recognised that poor mental health does not exist in isolation: good mental health is linked to good physical health. People with mental illness have significantly higher rates or mortality and morbidity form physical illnesses such as a cardiovascular disease, diabetes mellitus and obesity related conditions.

A holistic approach to providing care to patients will be adopted to help ensure that the care delivered is to both RDaSH and the wider health system supports national drivers to improve physical health and well-being.

1.2 Refocusing the Care Programme Approach (CPA), Policy and Positive Practice Guidance (Department of Health, 2008), identifies ‘experiencing disadvantage or difficulty as a result of physical health problems/disability’ as one of the key characteristics to consider when deciding if support of CPA is required.

The guidance re-emphasises the importance of physical health needs always being assessed and addressed as a high priority and considered as part of a holistic care plan throughout a patient’s admission, including discharge planning.

No Health without Mental Health, DH, February 2011 states that mental health must have equal priority with physical health, that discrimination associated with mental health problems must end and that everyone who needs mental health care should get the right support, at the right time. It made it clear that tackling premature mortality of people with mental health problems is a priority.

The NHS England National CQUIN 2016/17 Improving physical healthcare to reduce premature mortality in people with severe mental illness (PSMI) aims to Improve Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with Psychoses.

Patients should be empowered to access support for their physical health needs. Mental health professionals should consider the service users’ needs holistically and aim to improve their quality of life and their health.

Assessments and care plans should identify and tackle the impact that mental illness symptoms and possible treatment programmes can have on physical health and the impact that physical symptoms can have on an individual’s mental well-being.

This includes an awareness of physical complications associated with common psychiatric conditions and treatments such as lithium, clozapine, ECT, rapid tranquillisation and high dose medications, especially antipsychotics. Certain medications may compound physical health risks, for
example, by causing weight gain or increasing the risk of developing diabetes.

1.3 On-going assessment and follow-up of physical health needs

*Incapacity arising from physical illness or disability* is one of the identified core risk domains within the Clinical Risk Assessment and Management Policy. Whilst the assessment of risk is a continuous process, a formal assessment of risk must be completed at the point of referral, at each subsequent CPA review or when prompted by a significant change of circumstances, e.g. admission, discharge, movement between services, shared care, etc. See Clinical Risk Assessment and Management Policy.

Patients with complex physical health needs may require expert advice and input from specialist health services when specific health conditions are already established or identified in the course of assessment.

In these cases, consideration needs to be given to the most appropriate setting for this care to be provided, as well as:

- Any specialist equipment that may be required
- Staff competence in caring for the patient
- The ward environment

2. PURPOSE

2.1 This Trust Policy is:

- To improve the physical health and well-being of mental health and learning disability patients and reduce health inequalities wherever possible through:
  - a consistent approach to in-patient physical assessment and examination;
  - and, by promoting timely access to expert advice and specialist services when specific conditions are already established or identified in the course of assessment.

- All patients admitted to Mental Health and Learning Disability Inpatient Services will have a physical assessment and examination carried out in line with the procedures set out within the policy. Patients who are an Inpatient for one year or longer will be provided with a physical assessment and examination at least annually.

3. SCOPE

This policy applies to:

- All Mental Health and Learning Disability Inpatient Services provided by the Trust.
• Medical and nursing staff working in those services, including any contracted staff that during the course of their work will either undertake or contribute to the physical assessment and/or examination of service users and are responsible for facilitating appropriate follow-up of physical symptoms.

Physical health assessments for community patients are carried out by community mental health staff and/in conjunction with Primary Care (a minimum of annually) wherever possible. Primary Care is required to offer patients who are on their mental health register an annual health check.

4. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

4.1 Clinical Directors who have Inpatient Services within their areas are responsible for:

• The effective implementation of this policy in their areas of responsibility.
• The implementation of any action plans arising from audits of the policy, which are undertaken at least annually.
• Identifying training needs of medical staff that fall within the remit of this policy.

4.2 Consultants working in Inpatient Services
Consultants working in Inpatient Services are responsible for:

• Ensuring an appropriate physical health check assessment takes place at admission.
• Supervision of the Trainee Doctors with regard to the effective implementation and audit of this policy.
• Providing physical assessment and examination at least annually to any patient in their care who is an Inpatient for one year or longer.

4.3 Medical Staffing Department
The Medical Staffing Department is responsible for:

• The Induction of the Trainee Doctors twice a year with regard to this policy.

4.4 Service Directors who have inpatient services within their areas are responsible for:

• The effective implementation of this policy in their areas of responsibility.
• The implementation of any action plans arising from audits of the policy, which are undertaken at least annually.
• Identifying training needs of nursing staff and other staff colleagues that fall within the remit of this policy.
4.5 **Modern Matrons/Service Managers**
Modern Matrons/Service Managers are responsible for:

- Advising and instructing nursing staff on the policy requirements via local induction arrangements and ongoing communication mechanisms, such as staff meetings, supervision, etc.
- The purchase, maintenance and availability of the medical equipment which is necessary for undertaking the physical assessment and examination of patients specified in Section 5.3 below.

4.6 **The Admitting Doctor/Nurse**
The Admitting Doctor/Nurse is responsible for:

- Explaining to patients the importance and purpose of the physical assessment and examination, and keeping them informed of the outcomes.
- Completing the physical assessment and examination of all new patients on admission, or where this is not possible, for arranging for it to be completed on the next working day.
- Making a comprehensive record within the patient’s clinical record using the Trust approved Admission Medical Examination Form shown in Appendix A, and filing this within the patient’s clinical record or by completing the electronic admission pack for the relevant service.
- Appropriate following up of physical symptoms by undertaking or requesting any blood/further test(s) that are deemed necessary and for referring to specialist services or primary care for expert advice and/or input as required.

5. **PROCEDURE/IMPLEMENTATION**

5.1 **Requirements for physical assessment and examination of patients on admission to a service, including timeframes**

- All Inpatients should receive a physical assessment and examination at the time of their admission, in line with the assessments as outlined in section 5.8 and 5.9 of the policy and the Admission Medical Examination Form at Appendix A or by completing the electronic admission pack for the relevant service.
- All physical observations taken at the time of admission must be recorded on the trust physical observation and neurological observations charts in the baseline column.
- When undertaking a physical examination the individual patient’s needs are to be taken into account in respect of where and how the physical examination is conducted.
- If this is not immediately possible at the time of admission, the admitting Doctor/Nurse must make arrangements for it to be completed on the next working day.
Where it is not possible to complete the physical assessment and examination at the time of admission, this should be recorded in the patient’s clinical record.

If the patient refuses to consent to a physical assessment and examination this should be recorded in their clinical record. The admitting Doctor/Nurse should still make a record of basic observable physical signs, such as levels of consciousness, respiratory rate, skin colouring/condition, etc.

Any blood/further test(s) that are deemed necessary should be undertaken or requested by the admitting Doctor/Nurse and referral to specialist services for expert advice and input as required.

The outcome of the physical assessment and examination should be recorded using the Trust approved Admission Medical Examination Form shown in Appendix A, and filed within the patient’s clinical record.

In the event that a patient is admitted from another hospital or the Accident and Emergency Department, (A&E Department) and a physical assessment and examination was conducted there, a copy of this will be filed in the patient’s clinical record.

In cases where the patient has a pre-existing physical condition for which they are receiving treatment, the admitting Doctor/Nurse will liaise with the patient’s General Practitioner or specialist service to gather additional information. If this pre-existing condition impacts on the patients physical observations a normal parameter exception care plan must be completed. This should also inform prescribing and reduce the risk of deterioration in health due to incorrect or inaccurate prescribing of such medications as anticonvulsants, anticoagulants, opiates leading to withdrawal symptoms.

5.2 How appropriate follow up of physical symptoms takes place

Where any on-going need has been identified in respect of a patients physical health, a care plan is to be put in place which must clearly state:

- What the identified need is.
- How this identified need is to be met.
- Signs of deterioration and action to be taken by staff.
- What information is to be provided to the patient?
- Who to contact should further advice be required.

The care plan will then be reviewed and evaluated within the multi disciplinary team/ward round meetings. If a patient requires a referral to another department or hospital for review/treatment the referring clinician must record in the clinical records:

- Date of referral.
- Who the referral was made to and contact details.
- Date for when they will review the progress of the referral.
It is the responsibility of the referrer to ensure that any referral they make is received and acted on.

5.3 **On-going assessment of physical health needs of patients who remain in the Inpatient Services for a year or longer**

Any patient who is within the Inpatient Service for a year or longer, will be provided with a physical assessment and examination *at least annually organised* by the Consultant in charge of their care. This will normally be delegated to the relevant Junior Doctor.

Furthermore, older adults should have their routine bloods done on admission, and then repeated as indicated by their medical history and examination. Consideration should also be given to the need for further investigations of blood samples, appropriate radiological investigation and an ECG.

5.4 **Medical Equipment**

Adequate physical assessment requires appropriate and fully functioning medical equipment to be available within all Inpatient Services. The equipment recommended to undertake the examinations outlined in this policy include:

- Examination couch
- Ophthalmoscope
- Auroscope
- Stethoscope
- Sphygmanometer
- Thermometer
- Tendon hammer
- Height measure
- Weighing scales
- Urinalysis sticks
- Tuning forks (128 Hz)
- Neuro-tips
- Disposable gloves

The availability and maintenance of this equipment is the responsibility of the Modern Matrons/Service Manager in conjunction with the Ward Manager and should be listed on the ward’s Medical Devices Inventory. See *Medical Devices Management Policy*.

5.5 **Chaperones**

Anything more than an examination of appearance, pulse or blood pressure should be conducted with a chaperone. The patient should be given the
opportunity to state their preferences in relation to the sex of the chaperone. This must be documented in their health records.

This precaution is particularly important where patients are intoxicated with alcohol or other substances or are elated, and as a consequence may be sexually disinhibited or may misconstrue situations. See Chaperoning Policy.

5.6 Consent

It is important that patients have a clear understanding of the importance and purpose of the physical assessment and examination and are kept informed of the outcomes. See Policy for Consent to Examination or Treatment.

5.7 Aspects of the physical assessment/examination which can be carried out by either Medical or Nursing Staff

These include:

- Weight
- Height
- Body Mass Index (BMI) – calculated from the service user’s weight and height
- Pulse
- Blood pressure
- Level of consciousness – using the Glasgow Coma Scale (if indicated)(Dr only) nursing staff to use AVPU
- Completion of the medication reconciliation document
- Urine testing
- Respiration Rate
- Smoking history
- Record of skin condition, including any cuts, bruises or other wounds. Details as to how these occurred should also be recorded.
- Oxygen saturation levels
- ECG
- Temperature

Nursing Staff can undertake observations for the following:

- Neurological examinations following neurological observations documentation
- Basic extrapyramidal system examination
- Observation of the motor system
- Sensory system

See Appendix B for further guidance for Nurses on the standard physical examinations and required actions.
5.8 Aspects of the physical assessment/examination which can be carried out by Medical Staff only

These include:

- Cardiovascular examination
- Gastrointestinal examination
- Respiratory system examination
- Standard neurological examination
- Examination of the sensory system
- Motor system examination (includes Extrapyramidal System)
- Reflexes

5.9 For Older Peoples’ Services only

- Blood tests – minimum requirements for an older person’s general psychiatric admission are:
  
  * Full blood count
  * Urea and electrolytes
  * Thyroid function test
  * Liver function test
  * Random glucose
  * B12 and Folate
  * Calcium Profile

5.10 For patients admitted for a detoxification programme

- Blood tests – minimum requirement for service users admitted for a detoxification programme:
  
  * Full blood count
  * Liver function test

5.11 For Adult Mental Health Inpatient Services

- Blood test requirements will be determined by Medical staff depending on clinical need.

5.12 Venepuncture difficulties

- For some patients, difficulties may be encountered when undertaking Venepuncture. Help and advice can be sought from the trust clinical skills team.
6. **TRAINING IMPLICATION**

6.1 **How the organisation assesses the competency of all staff involved in the physical assessment and examination of patients.**

In order for practitioners to be competent to safely carry out the required investigations the RDaSH clinical skills team have provided educational programmes, clinical skills packages based on The Royal Marsden’s Hospital Manual of Clinical Nursing Procedures, training resources and assessment tools to support proficiency in each essential skill.

The RDaSH Clinical Skills Assessment is a method of assessing practitioners’ skills across a wide range of clinical procedures. It can be used across the professions and can assess competence at different levels. RDaSH Clinical Skills Assessment places the patient at the centre of the process by assessing pre, during and post-procedural competences. It also allows the recognition of actions that deal with any complications that may arise.

RDaSH Clinical Skills Assessment Tool can be used to assess competency in the majority of clinical procedural skills, initial training is via simulation or part task trainers to support patient safety and then staff are required to undertake assessments in the workplace recorded by a competent practitioner. If staff already have these skills they are required to be assessed at least once using the same framework as new staff to provide evidence of competency.

The competency of staff involved in the physical assessment and examination of patients can also be assessed as follows on an ongoing basis:

- Through the monitoring of staff attendance on relevant training, including any update training, such as Resuscitation training.
- Through supervision and appraisal processes
- Clinical records audit
- Through the monitoring of any complaints which relate to the physical health care of a patient.
- Discussion / review of patients care in clinical supervision

Whilst there are no specific training needs identified in relation to this policy, inpatient clinical staff will be made aware of their individual responsibilities in the following ways:

- At induction for Trainee Doctors and Newly Qualified Nurses
- Details of the policy review will be published in the Trust’s Weekly News Bulletin.
- Staff attendance at the Physical Health and Wellbeing training.
7. **MONITORING ARRANGEMENTS**

<table>
<thead>
<tr>
<th>Area for Monitoring</th>
<th>How</th>
<th>Who by</th>
<th>Reported to</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duties</td>
<td>Clinical audit</td>
<td>Clinical Audit Department</td>
<td>Quality and Safety Sub Committee</td>
<td>Annually</td>
</tr>
<tr>
<td>Physical assessment of patients when they are admitted to a service, including timeframes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How appropriate follow up of physical symptoms take place</td>
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</tr>
<tr>
<td>Ongoing physical assessment of physical needs for all patients, including timeframes</td>
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<td></td>
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</tr>
<tr>
<td>How the Trust assesses the competency of all staff involved in the physical assessment and examination of patients</td>
<td>Clinical audit Staff training attendance Monitoring complaints Discussion / review of patients care in clinical supervision</td>
<td>Clinical Audit Department Clinical Directors/ Consultants</td>
<td>Annually, plus ongoing</td>
<td></td>
</tr>
</tbody>
</table>

8. **EQUALITY IMPACT ASSESSMENT SCREENING**

The completed Equality Impact Assessment for this Policy has been published on the Policy’s Trust web page.

8.1 **Privacy, Dignity and Respect**

The NHS Constitution states that all patients should feel that their privacy and dignity are respected while they are in hospital. High Quality Care for All (2008), Lord Darzi's review of the NHS, identifies the need to organise care around the individual, *'not just clinically but in terms of dignity and respect'*. As a consequence the Trust is required to articulate its intent to deliver care with privacy and dignity that treats all service users with respect. Therefore, all procedural documents will be considered, if relevant, to reflect the requirement to treat everyone with privacy, dignity and respect, (when appropriate this should also include how same sex accommodation is provided).

<table>
<thead>
<tr>
<th>Indicate how this will be met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consideration has been given with regard to privacy, dignity and respect within this policy.</td>
</tr>
</tbody>
</table>

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8.2 Mental Capacity Act

Central to any aspect of care delivered to adults and young people aged 16 years or over will be the consideration of the individual's capacity to participate in the decision-making process. Consequently, no intervention should be carried out without either the individual's informed consent, or the powers included in a legal framework, or by order of the Court. Therefore, the Trust is required to make sure that all staff working with individuals who use our service are familiar with the provisions within the Mental Capacity Act. For this reason all procedural documents will be considered, if relevant to reflect the provisions of the Mental Capacity Act 2005 to ensure that the interests of an individual whose capacity is in question can continue to make as many decisions for themselves as possible.

Indicate how this will be met

All individuals involved in the implementation of this policy should do so in accordance with the Guiding Principles of the Mental Capacity Act 2005. (Section 1)

9. LINKS TO ANY ASSOCIATED DOCUMENTS

- Chaperoning Policy
- Policy for Consent to Examination or Treatment
- Clinical Risk Assessment and Management Policy
- Care Programme Approach Policy
- Medical Devices Management Policy
- Resuscitation Policy
- Management of Service Users with Mental Health problems and Learning Disability Policy

10. REFERENCES

- Department of Health (2006) Choosing Health: Supporting the physical health needs of people with severe mental illness (commissioning framework)
- Department of Health (2008) Refocusing the Care Programme Approach, Policy and Positive Practice Guidance

11. APPENDICES

A Admission Medical Examination Form
B Guidance for Nursing Staff on Standard Examinations and Required Action
# APPENDIX A

**Admission Medical Examination Form**

<table>
<thead>
<tr>
<th>M1: Capacity and Consent status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the patient have the capacity to consent to a physical examination</td>
</tr>
<tr>
<td>Is the patient able to give informed consent?</td>
</tr>
<tr>
<td>If No, are they subject to detention Mental Health Act (please give details)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M2: General Physical Condition:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Mark clearly any recent or old bruises, cuts, scars, injuries)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M3: Circulatory System:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse:</td>
</tr>
<tr>
<td>Oedema:</td>
</tr>
<tr>
<td>BP:</td>
</tr>
<tr>
<td>Apex Beat:</td>
</tr>
<tr>
<td>Peripheral Circulation:</td>
</tr>
<tr>
<td>JVP:</td>
</tr>
<tr>
<td>Heart Sounds:</td>
</tr>
<tr>
<td>ECG:</td>
</tr>
</tbody>
</table>
**M4: RESPIRATORY SYSTEM:**
- Clubbing:
- Dyspnoea:
- Trachea:

  ![Lung Icon]

  Oxygen saturation level:

---

**M5: ALIMENTARY SYSTEM:**
- Mucous Membranes?
- Dentition?

---

**M6: NERVOUS SYSTEM:**
- Level of Consciousness
- Cranial Nerves
- Pupils
- Fundi
- Limb Tone
- Limb Power
- Co-ordination
- Tremor

  Reflexes:
  - Right: B T S K A PL Clonus
  - Left: B T S K A PL Clonus

  Sensation

---

**M7: Other findings**

---

**M8: Blood tests required:**
- Yes [ ]  No [ ]

  If yes, please state for which tests:
  - …………………………………………………
  - …………………………………………………
  - …………………………………………………

  ECG required:
  - Yes [ ]  No [ ]

  Any other tests: (Please state)
  - …………………………………………………
  - …………………………………………………

---

**Weight:**

**Height:**

**BMI:**

**Urine testing:**

**Smoking history:**
<table>
<thead>
<tr>
<th>GLASGOW COMA SCALE:</th>
<th>Eye Response (4)</th>
<th>Verbal Response (5)</th>
<th>Motor Response (6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Only to be completed when there are concerns over patient’s level of consciousness)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 or more ⇒ Mild Brain Injury</td>
<td>1. No eye opening.</td>
<td>1. No verbal response.</td>
<td>1. No motor response.</td>
</tr>
<tr>
<td>9-12 ⇒ Moderate injury</td>
<td>2. Eye opening to pain.</td>
<td>2. Incomprehensible sounds.</td>
<td>2. Extension to pain.</td>
</tr>
<tr>
<td>8 or less ⇒ Severe Injury</td>
<td>3. Eye opening to verbal command.</td>
<td>3. Inappropriate words.</td>
<td>3. Flexion to pain.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Orientated.</td>
<td>5. Localising pain.</td>
</tr>
<tr>
<td>TOTAL GCS SCORE:</td>
<td>Best Eye Response:</td>
<td>Best Verbal Response:</td>
<td>Best Motor Response:</td>
</tr>
<tr>
<td></td>
<td>........</td>
<td>........</td>
<td>........</td>
</tr>
</tbody>
</table>
GUIDANCE FOR NURSING STAFF ON STANDARD PHYSICAL EXAMINATIONS AND REQUIRED ACTIONS

**Body Mass Index (BMI): A healthy BMI is one that is between 18.5 and 24.9**

The service user should be weighed (in kilograms) and their height (in centimetres) recorded. Their body mass index (BMI) is calculated by: weight in kilograms divided by height in meters squared.

\[ \text{BMI} = \frac{\text{weight (Kg)}}{\text{height (M)}^2} \]

**BMI below 18.5:**
Report to medical team during the next working day as this is a lean BMI which could be an indication of weight loss due to an eating disorder, or neglect. If the patient's BMI is deemed to be so low that their health is at immediate risk of further deterioration then this should be reported to a medic immediately and a discussion should take place to decide how and where the patient should be managed safely.

**BMI between 25 and 29.9:**
A BMI in this range is considered to be over weight, and anyone over 27 with co-morbidity (smoker, diabetes etc) should be offered weight management advice.

**BMI between 30 and above:**
A BMI in this range is considered obese. Anyone over 30 is to be referred to the Dietician.

**Pulse rate:**
A normal pulse rate is between 60-100 bpm
If it is below 60 bpm, or above 100 bpm, medical staff should be notified as an ECG may be indicated. (qualified staff should take into consideration the patients mental state, and repeat a pulse rate if the patient is presenting with high levels of anxiety once relaxation techniques have been undertaken).

**Blood pressure:**
If this is recorded as 160/100 or higher, refer to the medical team for further investigation.

**Temperature:**
37 is normal for an adult therefore any reading 36 or below, or above 37 needs to be reported to the medical team. A temperature that scores on the EWS, which is accompanied by a fluctuating blood pressure, needs to be reported urgently (a fluctuating BP would require a number of readings over a short period of time likely to be undertaken when a concern regarding someone’s physical health is raised).

**Things to note when doing skin observations:**
- Condition and colour of the skin
- Make a full record of any bruising, wounds, or scars
- If there are any scars enquire and document how these were sustained
- Any evidence of self harm

**Neurological examination**
When undertaking a neurological examination you are testing and making a record of the following:
- Level of consciousness
- Orientation
- Memory
- Speech
Basic extrapyramidal system examination
This will be undertaken by observing and making a record of the following—
- The service user’s movements and, in particular, any abnormal movements and poverty of movement
- Observe how they walk

Observation of the Motor System
When examining the motor system, attention should be paid to the pattern of any weakness, as opposed to its extent or severity, as this is more likely to indicate the origin of the weakness.
There are three essential patterns to note:
1. Weakness to one side of the body (hemiplegia), which is indicative of contralateral brain damage (damage to the opposite side of the brain).
2. Weakness of both legs (paraparesis), which is suggestive of spinal cord damage.
3. Weakness which is limited to the distal portions (towards extremities) of the limbs which is a feature of damage to the peripheral nervous system rather than the central nervous system.
If any of these are evident in a service user, who has no previous history, nursing staff should ask a member of the medical team immediately for advice.

The Sensory System
An examination of the sensory system requires the cooperation of the patient, and depends mainly on their report rather than actual observation. Staff will need to ask specific questions about the service users:
- Sight
- Hearing
- Sense of smell
- Sense of taste
- Any itching or other sensations they may be experiencing

IF THERE IS ANYTHING WHICH A MEMBER OF NURSING STAFF IS UNSURE OR CONCERNED ABOUT, THEY MUST CONTACT A MEMBER OF THE MEDICAL TEAM IMMEDIATELY FOR ADVICE