Rotherham Doncaster and South Humber NHS Foundation Trust

Physical Health Policy

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1. Document summary

1.1 What is this policy about?

- This policy is about looking after people's physical health as well as their mental health.
- It tells RDaSH colleagues how to check, record and respond to a person's physical health needs.
- It is for colleagues working in hospital and community services.

1.2 What must colleagues do?

- Ask about the person's physical health.
- Complete the right health checks and tests on time.
- Record the results in the person's health record.
- Make a physical health care plan with the person.
- Act on worrying results or signs that the person is becoming unwell.
- Ask another health service for help when needed.

1.3 Hospital care

- For most people admitted to hospital, colleagues must start a full physical health review within 4 hours. If this is not safe or possible, colleagues must start it as soon as they can.
- Colleagues will check things such as medicines, allergies, blood pressure, pulse, temperature, weight and breathing. Other tests may also be needed.
- Colleagues must keep checking the person's physical health during their stay. Important information must be shared when the person moves to another service or leaves hospital.

1.4 Community care

- Physical health checks may be completed by RDaSH colleagues, a GP or another NHS service. Colleagues should check whether tests have already been done so the person does not have them again without a good reason.

1.5 Choice and support

- Colleagues must explain health checks and ask for the person's agreement. If the person says no, colleagues must listen, record the decision and explain any risks.
- If needed, colleagues will check whether the person can make the decision. Colleagues must follow the Trust's rules when a person cannot make the decision for themselves.
- With the person's agreement, family members and carers can be involved. Colleagues must respect the person's privacy, dignity, communication needs and preferences.

1.6 Colleagues must

- complete and record physical health checks, risk assessments, examinations and investigations within the required timeframes
- identify existing conditions, medicines, allergies, lifestyle risks and any signs of deterioration
- agree and update a physical health care plan with the patient, including monitoring, treatment, referrals and escalation actions
- follow up abnormal findings and referrals, share relevant information with the GP and other services, and support safe transfers and discharge
- seek consent, respect informed refusal and follow the Trust's Mental Capacity Act policy when the patient may lack capacity
- involve carers and families with the patient's agreement, make reasonable adjustments and protect privacy and dignity
- use appropriate contacts to offer brief support on smoking, alcohol, healthy eating, physical activity and access to healthcare

2. Introduction and aim

Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) provides mental health, learning disability and community health services. Physical health assessment and treatment are central to safe, effective care. This policy focuses on specialist mental health and learning disability services. It explains how colleagues must assess, monitor and respond to patients' physical health needs, in line with current NHS guidance and evidence.

People with severe mental illness (SMI) do not always receive timely physical health checks, even though they face major health inequalities. On average, people with SMI die 15 to 20 years earlier than the general population. Smoking is the largest avoidable cause of death, and more than 40% of adults with SMI smoke. Compared with the general population, people with SMI have:

- double the risk of obesity and diabetes
- three times the risk of hypertension
- five times the risk of dyslipidaemia compared to the general population (NHS England, 2018)

NHS guidance has highlighted that people with mental health conditions do not always have equal access to physical healthcare. Colleagues must therefore make sure that physical health needs are identified early and followed up without avoidable delay.

People with learning disabilities also have poorer physical health and may die earlier than people without a learning disability. The Confidential Inquiry into premature deaths of people with learning disabilities found that men died about 13 years earlier and women about 20 years earlier than the general population. It also found that:

- 22% were under the age of 50 when they died
- 42% percent of deaths were identified as being premature due to delays with diagnosis or treatment and problems with identifying needs and providing appropriate care in response to changing needs (Heslop et al., 2013)

Contact with mental health services does not always lead to a physical health assessment, regular monitoring, or support to live more healthily. Mental health nurses and other clinical colleagues are well placed to improve physical health alongside mental health, both in hospital and in the community.
This policy aims to improve patients' physical health and wellbeing and reduce avoidable health inequalities. It sets a consistent approach for physical assessment and examination in inpatient services, physical health checks in community services, and timely referral for specialist advice or treatment when a condition is known or identified.

1.1 Care planning and physical health and wellbeing

Physical health needs must be assessed, treated as a priority and included in the person's overall care plan.

Assessment and care planning must consider how mental illness and its treatment may affect physical health, and how physical symptoms may affect mental wellbeing. Colleagues must be alert to physical complications linked to conditions and treatments such as lithium, clozapine, electroconvulsive therapy (ECT), rapid tranquillisation and high-dose medicines, especially antipsychotics.

1.2 Ongoing assessment and follow-up of physical health needs

Physical illness or disability is a core area of clinical risk. Risk assessment is continuous. Colleagues must complete a formal risk assessment at referral, at each planned review, and after any major change, such as admission, discharge, transfer between services or shared-care arrangements. See the clinical risk assessment and management policy.

1.3 Making every contact count

Making Every Contact Count (MECC) means using suitable routine contacts to have brief, supportive conversations about healthier choices. This may include stopping smoking, healthy eating, physical activity and reducing alcohol use. The level of support should match the person's needs, from brief advice to more structured behaviour-change support. Making every contact count (opens in new window).

3. Procedure

3.1 General principles

A physical health check (PHC) is separate from medicine-specific monitoring. Colleagues must record the PHC in the electronic patient record (EPR) using the RDaSH physical health check template. The check covers:

- smoking, alcohol and substance misuse
- body mass index (BMI), bloods, blood pressure, pulse and electrocardiogram (ECG)
- diet and exercise and access to healthcare (eye test, bowel screening, contact with physical health services)
- current physical symptoms
- family history (ischaemic heart disease, stroke, cancer, diabetes)
- sexual health education and screening (prostate, testicles, pregnancy, breasts and smear)

Using the PHC template helps colleagues meet the minimum standards for antipsychotic monitoring, cardiometabolic screening, general health screening and health promotion for people with SMI.

With the patient's agreement, colleagues should involve carers and family in physical healthcare. They may provide useful health information, receive clear information about assessments and follow-up, ask questions, contribute to the care plan and support healthy choices. Colleagues should avoid unnecessary separation of people with dementia or learning disabilities from those who support them, where this is safe and appropriate.

This approach supports the Triangle of Care and the Trust's commitment to John's Campaign (opens in new window).

3.2 Mental health inpatient services (adult, older people and forensic)

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

Every inpatient must have a full physical health review started within four hours of admission, or as soon as it is safe and practical. The review must include the clinical history, examination, investigations, risk assessments and care planning set out below.

3.2.1.1 Clinical history

- the patient's medical history, existing physical health conditions and any new changes since their last review
- all physical and mental health medicines, including reconciliation within 24 hours, side effects, whether medicines are being taken as prescribed and any prescribing concerns
- allergies and sensitivities
- use of tobacco, alcohol, illegal drugs and misuse of prescribed or other medicines
- level of physical activity
- sexual health, immunisation and oral health history, where relevant

3.2.1.2 Examination

- Complete a full examination of the body systems within four hours of admission. If this is not possible, the admitting clinician must arrange for it to be completed within 24 hours.
- Record baseline blood pressure, heart rate, breathing rate, temperature, oxygen saturation and level of consciousness using NEWS2.

3.2.1.3 Investigations

- Height, weight, relevant blood tests (use recent blood tests if appropriate) and an ECG within 24 hours of admission (see appendices B and C).
- Consideration of other investigations where appropriate such as blood glucose, urine dipstick, urine drug screen, pregnancy test, blood-borne viruses.

3.2.1.4 Assessment and management

- complete a venous thromboembolism (VTE) assessment within 14 hours; see the VTE policy
- complete a Malnutrition Universal Screening Tool (MUST) assessment within 24 hours; see the nutrition policy
- complete a falls risk assessment within 12 hours; see the falls risk assessment and management policy
- complete a tissue viability assessment within six hours. This may be extended to 12 hours if the patient's mental state prevents an earlier assessment; see the tissue viability and wound care manual
- assess hydration and fluid balance
- refer to Speech and Language Therapy if the history or examination identifies signs of swallowing difficulty; see the dysphagia management policy
- assess the risk of withdrawal from drugs or alcohol
- assess and respond to immediate physical health risks, including risks linked to rapid tranquillisation
- review cardiopulmonary resuscitation status where relevant; see the do not attempt cardiopulmonary resuscitation procedure

3.2.1.5 Physical health care plan

Within 24 hours of admission, colleagues must begin an initial physical healthcare plan with the patient, based on the assessment findings. If the patient has more complex needs, colleagues must complete a fuller plan within seven days. The plan must state where care should be provided, what monitoring and treatment are needed, how often reviews and observations are required, what nutrition and other support is needed, and how colleagues will respond to deterioration or refusal of assessment. It must also identify any gaps in the clinical history and how these will be addressed.

The physical examination for patients admitted to new beginnings, aspire drug and alcohol services, is undertaken prior to admission and documented in their appropriate records.

Appendices A to D set out the recommended equipment, assessment responsibilities, service-specific investigations and guidance for nursing colleagues.

The vision-based patient monitoring system may support physical health observations, but it must not replace the standard observations required by this policy.

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.

Colleagues must consider the patient's privacy, dignity, communication needs, reasonable adjustments and preferences when deciding where and how to carry out the examination.

If the assessment or examination cannot be completed on admission, colleagues must record why in the clinical record, state what remains outstanding and arrange completion within the required timeframe.

If the assessment or examination is refused, follow section 3.2.8. Record the refusal and the information given to the patient. The admitting clinician should still record basic signs that can be observed without examination, such as consciousness, breathing rate and skin colour or condition.

In the event that a patient is admitted from another hospital or the accident and emergency department, (A and E department) and a physical assessment and examination was conducted there, a copy of this will be filed or scanned in the patient's clinical record.

If the patient is already receiving treatment for a physical condition, the admitting clinician must check the shared record and contact the GP or specialist service if more information is needed. For an out-of-hours admission, contact must be made when that service next opens. If the condition changes the patient's normal observation range, colleagues must complete a normal parameter exception care plan. This information must guide safe prescribing and help prevent harm caused by missed medicines, incorrect doses or withdrawal from medicines such as anticonvulsants, anticoagulants and opiates.

If the patient smokes, colleagues must explain the Trust's smoke-free policy and offer nicotine replacement therapy within 72 hours of admission, in line with RDaSH guidance. Where an inpatient stop-smoking service is available, make a referral within 24 hours. Where no internal service is available, provide nicotine replacement therapy and e-cigarettes free of charge during the admission and refer the patient to a community stop-smoking service on discharge.

Patients with SMI should still have an annual PHC completed by inpatient colleagues, captured on the appropriate template on SystmOne, if due whilst an inpatient.

3.2.2 During the hospital stay

Colleagues must check the shared record or contact the GP to find out whether a physical health plan already exists. If it does, colleagues must use it throughout the admission and update it when needed.

Side effects of antipsychotic medication are reviewed using the Glasgow antipsychotic side effect scale (GASS) (available in the EPR) or the side effects neuroleptic medication rating scale, easy read version as per the safe and secure handling of medicines policy.

3.2.3 How appropriate follow-up of physical symptoms takes place

When an ongoing physical health need is identified, colleagues must update the physical health care plan described in section 3.2.1.5. The multidisciplinary team or ward review must review and evaluate the plan with the patient and, with the patient's consent, their carers.

If a patient needs referral to another service or hospital, the referring clinician must record the referral date, recipient and contact details, and the planned review date. The referrer must also check that the referral has been received and acted on.

3.2.4 Transfers between mental health inpatients settings and physical heath hospitals

For patients requiring transfer to, and readmission from, a physical health hospital, there should be a comprehensive clinical summary prepared to accompany the patient which includes, but is not limited to:

- physical and mental health condition(s)
- current physical and mental health care plans
- physical and mental health medications and allergies
- monitoring and escalation plans
- a mental health capacity assessment and the status of mental health legislation (if applicable)

3.2.5 Ongoing physical health monitoring

Continue to review and update the physical health care plan in line with sections 3.2.1.5 and 3.2.3.

The care plan should consider symptoms, progress and treatment for long term physical conditions, for example, diabetes, hypertension, and arthritis. This should be reviewed with the patient and documented by medical colleagues (frequency of review should be recorded in the care plan).

Weight and blood pressure (BP) should be checked and recorded a minimum of monthly, or more frequently for patients considered at risk.

Patients should be encouraged to access dental care, chiropody, audiology, dietetics, sexual health counselling and optician where appropriate.

If a referral to a primary care provider, for example, dentist is required, the patient should be supported to make an appointment and attend where appropriate.

3.2.6 Ongoing 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 ward doctor or other appropriately trained clinician.

3.2.7 Chaperones

For any consultation, examination, procedure, treatment or care that is of an intimate nature, a chaperone should be offered. Obvious examples of an intimate examination include examination of the breasts, genitalia and the rectum. 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.

Details of any examinations or procedures should be recorded in the patient's clinical record and the presence or absence of a chaperone recorded, including the name of the chaperone. See chaperoning policy.

3.2.8 Consent

Colleagues must explain the purpose and importance of the physical assessment or examination, seek the patient's consent and keep them informed of the findings. If the patient refuses, colleagues must respect and record the decision where the patient has capacity, explain the risks and offer the assessment again as soon as practical. See the consent to care and treatment policy.

If there is concern about the patient's capacity to make this decision, colleagues must follow the Trust's Mental Capacity Act policy and make a best-interests decision where required. See Mental Capacity Act policy.

3.2.9 Discharge from inpatient care

It is the responsibility of the inpatient consultant, supported by the Multidisciplinary team (MDT) to communicate any modified or existing physical health care plan, including any investigations and their outcomes to the patient's GP and Community team.

3.3 Community teams (adult mental health, older people's mental health, child and adolescent mental health, learning disability, drug and alcohol services)

During the mental health assessment or annual review recorded in SystmOne, colleagues must ask every patient about smoking and alcohol use. Offer smokers brief advice and a referral to a stop-smoking service where suitable. If a patient drinks above lower-risk levels, offer brief advice or referral to a specialist service.

For many patients using community mental health services, the GP or another primary care service will provide physical healthcare. RDaSH will initially offer an annual physical health check to:

- those meeting SMI criteria
- those who are on the first episode of psychosis pathway

Before completing a check, RDaSH colleagues should ask the patient's GP whether one has already been completed. This avoids repeated tests and inconvenience. Colleagues must record the assessment in the EPR physical health check tool and share the physical health and wellbeing care plan with the GP.

Where a local shared-care agreement applies, the GP will complete the physical health check. Patients with SMI who use secondary mental health services should be supported to register with a GP and attend primary care reviews. For patients taking antipsychotic medicines, RDaSH remains responsible for physical health and side-effect monitoring for at least the first 12 months, or until the patient's condition is

stable if this takes longer. Responsibility may then transfer to primary care under the local shared-care agreement.

Side effects of medication are reviewed using a validated rating scale, for example, GASS (in the EPR) or the side effects neuroleptic medication rating scale, easy read version.

3.4 Early interventions in psychosis

Early intervention service patients will be offered a specific comprehensive physical health assessment as per NICE standards including:

- comprehensive physical health assessment within 12 weeks for adults having treatment for first episode of psychosis
- 12-month review repeated annually until discharge or transfer of care (NICE, 2015b)

3.5 Learning disability services

Patients with a learning disability access the Learning Disability Health Action team and have an annual health check with their GP. Community nurses will complete a physical health assessment with the patient who will be given the back page which documents the actions required; this is also sent to the GP Practice.

3.6 Older people's mental health services

Older adults, frail adults and adults with dementia, referred into a community team service for older people's mental health provision will have an initial physical health history and physical examination by their GP and Primary Care team, which is shared with RDaSH in the patient's referral.

Primary care would be expected to undertake physical health checks where it forms part of an annual shared care monitoring arrangement. Secondary care services are responsible for physical health monitoring where it does not fall under a shared care agreement and is condition or medication specific.

3.7 Drug and alcohol services

Though the PHC assessment tool on the EPR is not currently used by the service, patients will have assessments that review:

- registration with GP
- physical health history, including any current illnesses, long term conditions and disabilities
- risks to health from current and past substance use will be assessed, for example, overdose, blood-borne viruses (BBVs), injecting related problems, severity of dependence and withdrawal
- disability issues that may affect engagement, for example, mobility problems, eyesight problems, hearing loss
- smoking
- pregnancy
- contraception
- sexual health risks
- dental and oral health problems

Tests or investigations (if relevant to the individual) may include:

- urine drug testing
- breathalyser
- BBVs (with appropriate pre-test discussion)
- LFTs

Patients undergoing only psychological or psychosocial treatment will not routinely receive further medical or nursing assessment.

3.8 Child and adolescent mental health services

Children and young people with bipolar disorder, psychosis or schizophrenia should be given healthy lifestyle advice at diagnosis and at annual review. They should also have their treatment monitored for side effects (with baseline physical health investigations, 12 weeks after starting treatment and every 6 months; NICE 2015c).

Physical health assessments are currently undertaken by way of a focussed history enquiring about the child's medical history and any family history of physical illness. Further physical health checks and assessments are determined by any prescribed medication and associated monitoring.

Children under community eating disorder services have the following undertaken as part of their initial assessment:

- height, weight, percentage median BMI
- blood pressure and pulse (sitting and standing for both)
- bloods investigations: full blood count, urea and electrolytes, blood glucose, lipid profile, magnesium, bone profile, liver function test, thyroid function test, vitamin B12, folate, ferritin, amylase
- ECG

Blood investigations are repeated as clinically indicated. At the start of treatment, weight and sitting and standing blood pressure is checked weekly. Further monitoring is determined by clinical progress. An ultrasound scan of the pelvis and DEXA bone scan may be considered dependent upon clinical factors.

4. Responsibilities

4.1 Care coordinator or lead professional

The care coordinator or lead professional must make sure the patient's physical health needs are assessed, recorded, followed up and shared with the right services. Their responsibilities are to:

- offer or arrange suitable health-promotion support for common conditions
- contact the GP each year to confirm that an annual physical health check has been completed. If primary care cannot complete it because of barriers linked to mental health, homelessness or GP registration, arrange an assessment through secondary care where possible
- share physical health needs with primary care and help the patient access screening and health-improvement support
- record physical health needs, checks and outcomes in the EPR physical health check tool

- work with NHS, public and voluntary services to improve outcomes
- obtain relevant physical health results from primary care
- follow local service arrangements where these tasks are completed by another appropriate team or clinic

4.2 Acute and primary liaison learning disabilities nurses

The acute and primary liaison learning disabilities nurses will facilitate:

- support people with learning disabilities when they use primary and secondary healthcare
- support health-promotion and health-experience groups
- support health action planning and monitor annual health checks
- help GP practices keep learning disability registers and resource information up to date
- provide learning disability awareness and health-passport training across NHS services
- provide Easy Read health information

4.3 Admitting clinician

The admitting clinician is responsible for:

- explain why the assessment and examination are needed and keep the patient informed of the findings
- complete the assessment and examination on admission, or arrange completion within 24 hours if this is not possible
- record a full account in the inpatient physical health examination template in the EPR
- follow up symptoms and abnormal findings, arrange any further tests and refer to primary care or specialist services when needed

4.4 Consultants (medical and non-medical) working in inpatient services

Consultants working in inpatient services are responsible for:

- confirming whether an appropriate physical examination has taken place at admission or within 24 hours of admission (Royal College of Psychiatrists, 2017)
- supervision of the doctors in training, colleagues and associate specialist doctors and other clinicians in regard to the effective implementation and audit of this policy
- ensuring physical assessment and examination is provided at least annually to any patient in their care who is an inpatient for one year or longer

4.5 Care group medical directors

Care group medical directors 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
- identifying training needs of medical colleagues that fall within the remit of this policy

4.6 Modern matrons or service managers

Modern matrons or service managers are responsible for:

- advising and instructing nursing colleagues on the policy requirements via local induction arrangements and ongoing communication mechanisms, such as colleagues 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 appendix A

4.7 Care group directors

Care group directors 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 colleagues and other colleagues that fall within the remit of this policy

4.8 Physical health and wellbeing strategy group

The role of the physical health and wellbeing strategy group is:

- lead the Trust's work to improve physical health and wellbeing
- promote relevant NHS guidance and standards
- review and share learning from physical health-related illness and deaths
- support care groups to deliver agreed physical health targets and actions
- monitor progress and provide assurance that physical health priorities are being delivered

5. Training

Colleagues must be trained and assessed as competent before carrying out physical health investigations or clinical skills. The RDaSH clinical skills team provides learning programmes, clinical skills packages, training resources and assessment tools to support safe practice.

Managers must make sure colleagues understand the parts of this policy that apply to their role. Awareness will be supported through induction, Trust communications and physical health and wellbeing training.

Training and awareness sessions include:

- trust induction (health and wellbeing session)
- life support training (as specified by the colleagues training matrix)
- clinical skills training
- recognising and assessing medical problems in psychiatric settings (RAMPPS)

Other requirements identified by colleagues and manager may include:

- wellness and recovery action planning (WRAP)
- making every contact count (MECC)
- medicines management
- dysphagia
- falls
- behaviour change and motivational interviewing

- smoking cessation (very brief advice)
- malnutrition universal screening tool (MUST) training
- pressure sores
- frailty

6. Monitoring Arrangements

Unless a subsection states otherwise, the Clinical Audit Department will complete these audits annually and report the findings to the Quality Committee.

6.1 Physical assessment of patients when they are admitted to a service, including time frames

- How and who by: Clinical audit by Clinical audit department.
- Reported to: Quality committee.
- Frequency: Annually.

6.2 How appropriate follow-up of physical symptoms take place

- How and who by: Clinical audit by Clinical audit department.
- Reported to: Quality committee.
- Frequency: Annually.

6.3 Ongoing physical assessment of physical needs for all patients, including timeframes

- How and who by: Clinical audit by Clinical audit department.
- Reported to: Quality committee.
- Frequency: Annually.

6.4 Availability of medical examination equipment on inpatient wards

- How and who by: Clinical audit by Clinical audit department.
- Reported to: Quality committee.
- Frequency: Annually.

6.5 How the trust assesses the competency of all colleagues involved in the physical assessment and examination of patients

- How:
    - clinical audit
    - colleagues training attendance
    - monitoring complaints
    - discussion and review of patients care in clinical supervision
- Who by:
    - clinical audit department
    - consultants
- Reported to: Quality team.
- Frequency: Annually plus ongoing.

6.6 Physical health assessments for community patient

- How and who by: Audit via SystmOne (EPR) by Clinical audit department.
- Reported to: Quality committee.
- Frequency: Annually.

6.7 Implementation of serious incident action plans that include physical health care

- How and who by: Review of action plans by Care group directors.
- Reported to:
- Frequency: Quarterly.

7. Related documents and references

- The move to personalise care procedure
- Chaperoning policy
- Clinical risk assessment and management policy
- Consent to care and treatment policy
- Dysphagia management policy
- Medical devices management policy
- Mental Capacity Act 2005 policy
- Nutrition policy (promoting good nutrition for patients)
- Smoke free policy
- Patients with a mental health problem and learning disability, management policy
- Bariatric policy (care of the bariatric patient)
- Patient falls prevention and management policy
- Tissue viability and wound care manual
- Resuscitation policy manual
- Safe and secure handling of medicines manual
- Venous thromboembolism (VTE) policy
- Department of Health. (2008). Refocusing the care programme approach: Policy and positive practice guidance. london: Department of Health.
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- National Institute for Health and Care Excellence (2015b) Psychosis and schizophrenia in adults quality standard (QS80) (opens in new window).
- National Institute for Health and Care Excellence (2015c) Bipolar disorder, psychosis and schizophrenia in children and young people Quality standard (QS102) (opens in new window).
- National Institute for Health and Care Excellence (2016) Medicines Optimisation Quality Standard (QS120) (opens in new window).
- NHS England. (2016). The five-year forward view for mental health, report from the Mental Health Taskforce. Leeds: NHS Mental Health Taskforce. (opens in new window).

- NHS England. (2018). Improving physical healthcare for people living with severe mental illness (SMI) in primary care: guidance for CCGs. London: National Health Service England. (opens in new window).
- Royal College of Psychiatrists. (2017). Standards for Inpatient Mental Health Services. 2nd edition. (opens in new window).

8. Appendices

8.1 Appendix A Medical equipment

All inpatient services must have enough suitable, working medical equipment to complete the assessments and examinations required by this policy. The recommended equipment is:

- examination couch
- ophthalmoscope
- auroscope
- stethoscope
- sphygmomanometer
- thermometer
- tendon hammer
- height measure
- weighing scales
- urinalysis sticks
- tuning forks (128 Hz)
- neuro-tips
- disposable gloves

Modern matrons and service managers, working with ward managers, are responsible for making sure this equipment is available, maintained and recorded on the ward's medical devices inventory.
See medical devices management policy.

8.2 Appendix B Medical and nursing assessment responsibilities

Medical or nursing colleagues may carry out the following parts of the physical assessment or examination, provided they are trained and competent to do so:

- measure and record weight, height, BMI, pulse, blood pressure, breathing rate, temperature and oxygen saturation
- assess consciousness using the appropriate tool: medical colleagues may use the Glasgow Coma Scale and nursing colleagues must use AVPU
- complete medicines reconciliation, urine testing and smoking history
- record bruises, cuts, wounds and skin condition on a body map in the EPR, including any known cause
- offer every inpatient an ECG and complete it within 24 hours of admission
- complete VTE, MUST, falls and tissue viability assessments within the timeframes in section 3.2.1.4
- assess hydration and fluid balance, refer possible swallowing difficulties to Speech and Language Therapy, and record NEWS2

Nursing colleagues 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 D for further guidance for nurses on the standard physical examinations and required actions.

The following examinations must be completed by medical colleagues, or by another clinician who has the required training and competence:

- cardiovascular examination
- gastrointestinal examination
- respiratory system examination
- standard neurological examination
- examination of the sensory system
- motor system examination (includes extrapyramidal system)
- reflexes

8.3 Appendix C Service specific investigations

8.3.1 For older people's mental health inpatient services

These blood tests will usually be completed before admission. If they have not been done, the admitting clinician should consider the following minimum tests within 24 hours of admission. These tests help identify possible physical causes for symptoms and provide baseline results. For all investigations in this appendix, colleagues must check the results and record the outcome within 24 hours of the investigation.

- full blood count
- urea and electrolytes
- thyroid function test
- liver function test
- glycosylated haemoglobin (HbA1c)
- B12 and folate
- calcium profile

8.3.2 For patients admitted for a detoxification programme

Patients admitted for a detoxification programme must have, as a minimum, the following blood tests:

- full blood count
- liver function test
- urea and electrolytes
- clotting screen

8.3.3 For adult mental health inpatient services

Within 24 hours of admission, patients should have the following minimum tests to identify possible physical causes for symptoms and provide baseline results. Recent results may be used when this is clinically appropriate. The clinician must decide whether results are recent enough for the patient's needs and circumstances.

- full blood count
- urea and electrolytes
- thyroid function test
- liver function test
- glycosylated haemoglobin (HbA1c)
- lipids
- B12 and folate
- calcium profile

8.4 Appendix D guidance for nursing colleagues on standard physical examinations and required actions

8.4.1 Body mass index (BMI)

- **A healthy BMI is between 18.5 and 24.9:** Record the patient's weight in kilograms and height in metres. Use the formula below to calculate BMI.

  BMI = weight (kg)/height (m)2.

- **BMI below 18.5:** Tell the medical team by the next working day. A low BMI may show weight loss linked to an eating disorder, physical illness or neglect. f the patient's health is at immediate risk, contact the medical team at once and agree where and how the patient can be cared for safely.
- **BMI between 25 and 29.9:** This is classed as overweight. Offer weight-management advice when the BMI is above 27 and the patient has another risk factor, such as smoking or diabetes.
- **BMI of 30 or above:** This is classed as obese. Complete MUST within 24 hours of admission and follow the nutritional action plan for the patient's MUST score.

8.4.2 Pulse rate

A normal pulse rate is between 60 and 100 beats per minute (bpm).

If the pulse is below 60 bpm or above 100 bpm, tell the medical team because an ECG may be needed. Consider the patient's mental state. If anxiety may have affected the result, support the patient to relax and repeat the pulse.

8.4.3 Blood pressure (BP)

If blood pressure is 160/100 mmHg or higher, refer the patient to the medical team for further assessment.

8.4.4 Temperature

Use NEWS2 and the patient's normal range when assessing temperature. Report a temperature of 36°C or below, or above 37°C, to the medical team. Escalate urgently if the temperature triggers a NEWS2 score and the patient also has changing blood pressure readings or other signs of deterioration.

8.4.5 Things to note when doing skin observations

- Record any bruising seen on admission, transfer or discharge on a body map in the EPR.
- Record the colour and overall condition of the skin.
- Record all wounds and scars and, where known, how they happened.
- Record and respond to any signs of self-harm.

8.4.6 Neurological examination

During a neurological examination, assess and record the person's level of consciousness, orientation, memory and speech.

8.4.7 Basic extrapyramidal system examination

Observe and record the patient's movement, including reduced movement, unusual movements and the way they walk.

8.4.8 Observation of the motor system

When observing the motor system, focus on the pattern of weakness as well as its severity. The pattern may help identify the likely cause.

There are three essential patterns to note:

- weakness on one side of the body, which may indicate damage on the opposite side of the brain
- weakness in both legs, which may indicate spinal cord damage
- weakness mainly in the hands or feet, which may indicate damage to the peripheral nerves rather than the brain or spinal cord

If any of these are evident in a patient, who has no previous history, nursing colleagues should ask a member of the medical team immediately for advice.

8.4.9 The sensory system

A sensory assessment needs the patient's cooperation and mainly relies on what they report. Ask clearly about changes in sight, hearing, smell, taste, itching, numbness, tingling or any other unusual sensation.

If there is anything which a member of nursing colleagues is unsure of or concerned about, they must contact a member of the Medical team immediately for advice.