Kent and Medway
NHS and Social Care Partnership Trust

Physical Health & Examination Policy

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DOCUMENT TRACKING SHEET

PHYSICAL HEALTH & EXAMINATION POLICY

Version	Status	Date	Issued/approved by	Comments
V0.1	Draft	01.04.07	Clinical and Cost Effectiveness Committee	
V1.0	Approved	01.04.07	Clinical and Cost Effectiveness Committee	
V2.0		10.08.07	Policy Manager	Formatting
V2.1	Approved	06.11.08	Policy Manager	Formatting/ Update
V2.2		2.08.09		Reviewed Duties, clarified Monitoring section, refocused
V3.0	Approved	27/10/09	Trustwide Clinical Governance Patient Safety Group	
V.4.0	Approved	27/03/ 2012	Trust wide Patient Safety Group	Reviewed whole policy
	amended			Appendix C
V 4.1	Policy review	April 2015		Whole policy reviewed by physical health lead nurse
V5.0	Approved	April 2015	Trustwide Patient Safety Group	Ratified
V5.1	Draft	May 2016	Policy reviewed by Physical health lead nurse	Add section for continuing care units Added minimum frequency of MNEWS2 for each inpatient each care group
V6.0	Approved	May 2016	Trustwide Patient Safety & Mortality Group	Ratified
V6.0	Approved	Nov 2018	Lead Nurse Physical Health/Policy Manager	Review date amended to May 2019 from May 2018 as it should have been published with a 3-year review date.
V6.1	Approved	May 2019	Trust Wide Patient Safety and Mortality Review Group	Three-month extension to review date agreed.
V6.2	Draft	July 2019	Reviewed by Interim Lead Nurse – Physical health	Policy Reviewed and updated
V6.3.	Draft	August 2019	Reviewed by TWPHG	Circulated for Comments to group
V.6.4	Draft	November 2019	Comments added from TWPHG review	For ratification at TWPS and MRG
V6.5	Final	December 2019	Comments added from CCG re leaflet	For ratification at TWPS and MRG
V7.0	Final	January 2020	Trust Wide Patient Safety and Mortality Review Group	Ratified
V7.1	Draft	2022	Trust Wide Patient Safety and Mortality Review Group	Ratified
V8.0	Final	March 2023	Trust Wide Patient Safety and Mortality Review Group	Approved by Chief Nurse

V9.0	Final	September 2024	Trust Wide Patient Safety and Mortality Review Group	Approved by Chief Nurse
V10.0	Final	March 2025	Trust Wide Patient Safety and Mortality Review Group	Approved by Chief Nurse

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RELATED POLICIES/PROCEDURES/PROTOCOLS/FORMS/LEAFLETS

	Reference
Physical health strategy	KMPT.CliG.167
CPA Policy	KMPT.CliG.001
Nutritional Standards in Mental Health & Learning Disabilities Inpatient Services Policy	KMPT.CliG.040
Resuscitation Policy	KMPT.CliG.010
MRSA Screening policy	KMPT.CliG.051
The Prevention and management of pressure Ulcers Policy	KMPT.CliG.120
Consent to Treatment	KMPT.CliG.049
Falls Prevention Policy	KMPT.HS.006
Medical Devices Policy	KMPT.CliG.004
Smoke free policy	KMPT.CliG.108
VTE Prevention Policy	KMPT.CliG.102
Mental Capacity Act Policy	KMPT.CliG.052
Safe Administration and Monitoring of Injections Policy (incorporating Standard Operating Procedures)	KMPT. CliG.013225.02
Clozapine Policy	KMPT.CliG.132.09
Medicines Management Policy	KMPT.CliG.008
Chaperone Policy	KMPT.CliG.062
Rapid Tranquillization guidance	
Summer resilience Plan	
Winter resilience plan	
Physical Health Monitoring and Assessment for patients prescribed antipsychotics within Community Settings Standard Operating Procedure (SOP)	Awaiting ratification

SUMMARY OF CHANGES

Date	**Author**	**Changes (brief summary)**
January 2020	Lead Nurse, Physical Health	Updated references Included relevant relating policies Added section regarding NEWS 2 and eObs Add section re Lester tool Add section re MBU ACP responsibilities / role Add appendix re physical health monitoring for antipsychotic medications Add appendix for guidance regarding screening and intervention Added appendix re physical health strategy Update GASS assessment

February 2022	Head of Nursing for Physical Healthcare	Added in Section 11: GPs are to be informed if a patient is refusing physical health checks within CMHTs and staff must record mental capacity assessment activity related to physical health monitoring within RiO.
May 2022	Head of Nursing for Physical Healthcare	Discussed with CRCG concerning practice and informing GP. It was agreed that a patient's first refusal for physical health checks must be reported to their GP. Policy amended to reflect this change.
June 2024	IPC and PH Matron- PH policy working group	Physical health check matrix added and individual table removed. Reference to Continuing care units removed Care groups changed to Directorates
January 2025	Matron for IPC and physical health	All reference to physical health from within RiO changed to Physical Health portal within RiO PH matrix updated

CONTENTS

EXECUTIVE SUMMARY

There is a wealth of evidence documenting the increased risk of physical illness and complications for people with a range of mental health problems. Physical and mental health is also inextricably linked so, in many instances, by improving one you improve the other.

The physical health and examination policy is intended to ensure that mental health service users receive physical health care to meet their needs, regardless of which service they find themselves in. It describes to the Directorates what is expected in terms of physical health assessments, documentation and follow up of service user's physical health needs and supports working with other teams, and services, to best meet those needs.

The policy also contains a track and trigger system to aid the early detection and appropriate management of the physically deteriorating service user on inpatient units. The aim of this is to be more timely and responsive and therefore improve the likelihood of a better outcome.

1 INTRODUCTION AND PURPOSE

1.1 People with mental health disorders are at significantly increased risk of a range of physical illnesses and conditions compared with the general population (NHS England, 2019). Those with coexisting physical and mental health problems are also at an increased risk of these conditions negatively impacting on each other.

1.2 People with serious mental illness (SMI) are up to five times more likely to develop type 2 Diabetes, almost twice as likely to die from coronary heart disease and four times more likely to die from respiratory disease, as the general population. Their life expectancy is 15-20 years less than the general population, mainly due to poor physical health (NHS England, 2024).

1.3 There is evidence that people who use mental health services are much less likely than the general population to be offered blood pressure, cholesterol, urine or weight checks, or to receive advice on smoking cessation, alcohol, exercise or diet. It is essential that there is a programme to deliver improved physical health and wellbeing for people with functional and organic mental health disorders.

1.4 Poor physical health is not however a concern only for people with a severe mental illness. People with a learning disability have a higher prevalence of being both under and overweight than the general population and similarly people with neurological problems can develop weight changes which have an adverse effect on their prognosis. Weight is also a concern for people with eating disorders.

1.5 Older people with mental health problems also experience physical health problems associated with the ageing process and people with certain types of dementia are more at risk from cardiovascular events. Older people are also more likely to be under nourished.

2 OBJECTIVE

2.1 This policy and accompanying Physical health check matrix in appendix A- sets minimum standards for the assessment and management of physical health needs in both inpatient and community settings. Medical and nursing staff must use this policy alongside their clinical judgement to undertake additional examinations or assessments, as required by the service user. This includes when antipsychotic medication is commenced or increased. If any physical health needs are identified, the required care and intervention must be included in the individuals' care plan and communicated to the service user's GP.

3 SCOPE AND RESPONSIBILITY

3.1 This policy applies to all service users in inpatient and community settings, in all areas of the organisation, and to all doctors, registered and non-registered nurses (including students) and clinical staff employed by or seconded into the organisation.

4 DUTIES AND RESPONSIBILITIES

4.1 The Trust Chief Executive, through the Chief Medical Officer, has overall responsibility to have processes in place to ensure that staff are aware of this policy and adhere to its requirements.

4.2 The Heads of Nursing & Quality, Service managers and Matrons are responsible for ensuring that all operational managers in their own areas are aware of this policy,

understand its requirements and supporting its implementation with relevant staff who has received appropriate training.

4.3 Consultant psychiatrists are responsible for ensuring procedures are understood and carried out by medical staff involved in the implementation of the policy.

4.4 Clinical Team Managers (Inpatient and community) are responsible for implementing the policy with their immediate staff and ensuring that staff undertake their duties set in the policy.

4.5 Members of Clinical Teams have responsibility to comply with the requirements of this policy.

4.6 All service users admitted to an inpatient unit must have a full physical health examination completed by a doctor within 24 hours but within a maximum of 72 hours of admission, with regular reviews taking place during their admission, (a minimum of yearly). This assessment must be documented within the service user's physical portal within RiO.

4.7 A physical health assessment must be undertaken with all new community service users on the initial visit but must be within 28 days. Physical health assessments must be completed a minimum of annually. This must be done in liaison with Primary Care, and any investigations and results communicated to the service users GP, Psychiatrist and lead professional/HCP. For further information see the shared care protocol (Appendix I). This assessment must be documented within the physical within the physical health portal within RiO..
Perinatal services do not offer physical health checks as these are performed via maternity/primary care services. They would however, receive checks for antipsychotic medication.

4.8 All lead clinicians must ensure that:

4.8.1 Every service user has a GP

4.8.2 Every service user within the community setting should receive a physical health assessment, with appropriate follow up & monitoring, as described in the Physical Health check Matrix Appendix A. For further guidance regarding screening and intervention see Lester Tool, (Appendix G).

4.8.3 Side effects of medication are reviewed at appropriate intervals as determined by guidance and at least annually using a validated rating scale, (see Appendices E&F).

5 REQUIREMENTS FOR PHYSICAL ASSESSMENT OF INPATIENT SERVICE USERS

This policy describes a minimum level of physical health care to be offered to service users but recognises that in many cases more frequent or comprehensive assessments may be necessary. The need for this remains an important clinical judgement for the MDT.

5.1 This is a joint responsibility of the ward/junior doctor and admitting nurse. All service users must have a comprehensive physical examination within 24- 72 hours of admission. This is to be completed by the admitting Doctor and Nurse. This must be recorded on the Physical portal within RiO and any ongoing health issues care planned.

5.2 Any physical health assessment involving a service user undressing and/or intimate examinations must be undertaken in the presence of a chaperone. This protects both service user and staff from inappropriate actions or allegations of inappropriate behaviours or actions. This is particularly, but not exclusively, important in the cases of physical examinations or procedures involving opposite gender service users and staff.

5.3 Patients must be provided with the 'Your physical health assessment' leaflet in Appendix J.

5.4 Consideration must be given to gender, religious and cultural sensitivities in relation to physical assessments at all times.

5.5 Medical staff are responsible for;

5.5.1 Conducting a full physical and neurological examination of all newly admitted service users within 24- 72 hours.

5.5.2 All service users on anti-psychotic medication must receive an assessment of side effects using a validated rating scale, such as the Glasgow Antipsychotic Side-effect Scale (GASS) or LUNSERS (Appendices E and F), as soon as is practicable after admission. This may be delegated to another appropriately trained member of staff.

5.5.3 If an examination is not possible, (e.g. service user refuses or is too disturbed), the reason must be clearly stated in the notes and relevant observations documented, (e.g. nutritional status, gait, abnormal movements, appearance, etc.), and a care plan created to follow up and offer a physical assessment at a later time. This need must be incorporated into the service users care plan and a full physical examination completed at the earliest possible stage but always within 72 hours of admission. If the service user refuses and their health shows signs of deterioration or if they have a chronic condition, (e.g. diabetes), they must have an assessment under the Mental Capacity Act to support a best interest decision to undertake the minimal interventions required to prevent further deterioration. For further guidance see Mental Capacity Policy.

5.5.4 The physical health assessment must be recorded on the Physical Health portal within RiO.

5.6 Nursing staff are responsible for:

5.6.1 Baseline observations which must include; temperature, manual pulse, respirations, blood pressure, blood glucose.

5.6.2 Weight, height, Body Mass Index (BMI)- including waist measurement

5.6.3 Urinalysis.

5.6.4 Nutritional assessment through the use of the Malnutrition Universal Screening Tool (MUST).

5.6.5 Assessment of bowel habit and continence.

5.6.6 All service users admitted should have an assessment of skin integrity and an assessment of the risk of developing a pressure injury using the Waterlow score. (See prevention and management of pressure ulcer policy).

5.6.7 Smoking status.

5.6.8 Alcohol and substance misuse

5.6.9 Blood tests

5.6.10 Blood glucose monitoring

5.6.11 Moving and Handling assessment

5.6.12 Falls assessment

5.6.13 ECG recording

Please note this may be undertaken by another health care professional with appropriate training and guidance

5.7 Health check questions to be used in the assessment also include:

5.7.1 Lifestyle history - diet, exercise level and alcohol and drug use.

5.7.2 Health promotion advice including smoking cessation advice.

5.7.3 Current medication history.

5.7.4 Comprehensive symptoms review.

6 CONSENT

6.1 In the event of refusal to consent to physical health monitoring with detained individuals, physical health risks should be discussed, reviewed and evaluated daily by the responsible medical team and the nursing team. Each case should be treated individually and advice can be sought via the Mental Health Act office or through the Trust Legal department.

6.2 Reference to the Code of Practice should be sought in terms of patient's subject to and detained under the Mental Health Act.

6.3 The Act defines medical treatment for mental disorder as; *medical treatment which is for the purpose of alleviating or preventing a worsening of a mental disorder, or one or more of its symptoms or manifestations.*

6.4 This includes treatment of physical health problems only to the extent that such treatment is part of, or ancillary to, treatment for mental disorder (eg treating wounds self-inflicted as a result of mental disorder). Otherwise, the Act does not regulate medical treatment for physical health problems.

7 FOLLOW UP OF PHYSICAL SYMPTOMS/POSITIVE RESULTS

7.1 Consultant psychiatrists must follow up physical outcomes of service users with their respective Junior Doctors, at each service user ward clinical review, and further follow up and review if agreed, and document in the service user's notes.

7.2 The nursing staff must refer any changes in the service user's physical health to the ward doctors following any vital signs monitoring and record in the service user's records (RIO and NEWS2).

7.3 Where a service user's physical health deteriorates to the extent that specialist medical assessment and interventions are required, then transfer to an acute trust with appropriate facility to treat will occur, (see section 8 the deteriorating service user).

7.4 Symptoms, progress and treatment, of long-term physical conditions such as diabetes, hypertension, COPD, should be monitored and reviewed by the Psychiatrist/ and or GP and their team whilst the service user is an inpatient. When the service user is discharged, they should be reviewed by the service user's GP as appropriate and at a minimum every 6 months.

7.5 Physical Health must be discussed at all service user reviews and outcomes, and interventions must be clearly documented in the service user's notes, physical health portal and care plan. Where a service user is found to have a physical health risk identified an intervention/plan must be documented. Where the service user declines the intervention, this should be documented and discussed at further opportunities with the service user.

7.6 Chronologies of physical health needs/complaints should be used when there are complex physical health needs, requiring multi referral and or monitoring of referral or when patients are verbalising pain or symptoms consistently. This will ensure that physical health needs and referrals/follow up are not missed, and assumptions are not made regarding the causation

8 ON-GOING PHYSICAL HEALTH CARE OF ALL SERVICE USERS

8.1 Health promotion for inpatients – all service users must have access to appropriate health promotion information, including access to exercise, smoking cessation support, drug and alcohol services and appropriate dietary advice.

8.2 On discharge from inpatient care, the GP would be made aware of the physical healthcare needs that arose during the service users' admission via the Electronic Discharge Notification (EDN). It is the Responsible Clinicians responsibility to ensure that the GP receives a full discharge summary that includes all physical investigations undertaken and medication prescribed. When the service user is being discharged to the CMHT/OP a handover must take place by the respective staff.

8.3 All inpatient services should monitor and record service user's NEWS 2 regularly as per the Physical Health Check Matrix in Appendix A. These are minimum frequencies and if the service user's physical health deteriorates, then more frequent recording should be undertaken.

8.4 Any patient admitted to the physical health hospital or had an Emergency department episode must have NEWS2 completed within 2 hours of return. Neurological observations should also be considered dependant on reason for admission.

8.5 A full Physical health review, examination and investigations must be repeated as per the Physical Health check Matrix (Appendix A)

8.5.1 Service users must be referred to local services for specialist nurse services, dental care, chiropody/ podiatry, dietician support, sexual health counselling and care, and an optician, where there is an assessed need.

8.5.2 Any physical health problem experienced or suspected during an inpatient episode must be referred to the duty doctor immediately.

9 THE DETERIORATING SERVICE USER – INPATIENT

9.1 Service users who have been admitted to hospital, and their families and carers, have a right to expect the best possible care in relation to all aspects of their (the service user's) health. Should their health deteriorate this means ensuring prompt and effective treatment.

9.2 Of primary importance is the ability to monitor service user's physical health and detect and understand early signs of deterioration so that prompt and appropriate action can be taken.

9.3 To ensure that this happens a "Track and Trigger" system using the National Early Warning Score (NEWS2) tool (Appendix C), must be adopted with all inpatients*, to help identify the deteriorating service user and give guidance on when escalation needs to occur. In situations where the cumulative score of the NEWS2 assessment is 4 or more (or 3 in one area) this indicates an urgent response is required, a score of 7 or more should illicit an emergency response.

*(pregnant patients and those up to six weeks postpartum, at the mother and baby unit, should be monitored and escalated using the Maternity Early Warning Score tool (Appendix D).

9.4 Physical Health Observations - Service users can deteriorate rapidly so all inpatient service users must have a NEWS2 assessment and a Blood Glucose monitoring recorded on admission, or if they refuse, as soon as possible afterwards and if they become clinically unwell:

Please note consent is not required for the following observations and should always be documented when assessing physical health.

- Respirations
- Level of consciousness

9.5 The NEWS2 or MEWS for Mother and Baby observations must be recorded immediately on eObs when completing physical observations

9.6 If the NEWS2 observations are outside of normal parameters, or if there is cause for clinical concern, staff should escalate to senior team members and clear guidance should be documented by the medical team if the frequency of observations has been increased or parameters adapted to the service users' base line.

9.7 NEWS2 provides a formulation which calculates a level of risk that matches with a category which then triggers clear actions to be taken as follows: -

<u>KMPT Escalation Plan for NEWS 2 Scores</u>

Aggregate Score 7 or More – Immediate escalation to the medical team and consider prompt transfer to physical health hospital as well as continuous monitoring including Sepsis Screen

Aggregate Score 4 – 6 or 3 in any individual parameter – Urgent response required from the medical team, if the medical team cannot attend the patient consider prompt transfer to physical health hospital with frequent monitoring including Sepsis Screen

Aggregate Score 1-3 – Inform a Registered Nurse and/or the medical team for review and repeat NEWS 2 Observations Hourly until a senior clinician has reviewed

and documented a care plan for the patient, including any changes to monitoring frequency.

0 – Continue routine monitoring as per KMPT guidance

9.8 Once the service user has been assessed, if they require further investigation or treatment they should be taken to A&E as soon as possible. In a life-threatening emergency staff should call 999/2222 without delay.

9.9 When communicating critical information between professionals a structured communication tool such as SBARD (Situation, background, assessment, recommendation and decisions) is appropriate to ensure that the necessary information is communicated clearly and that an appropriate decision is promptly made and documented.

9.9.1 The service user's NEWS2 should be discussed / viewed using eObs overview within all handovers.

9.10 If the service users' NEWS2 are not within normal parameters however have been deemed normal for the individual, medics are to complete the eObs form regarding NORMAL BASELINE.

9.11 For the service user with hypercapnic respiratory failure consider Scale 2 within eObs and ensure this is captured within the careplan. Service users who have chronic obstructive pulmonary disease (COPD) and have target oxygen saturations of 88-92% should be on scale 2 in NEWS2 on eobs.

10 PHYSICAL ASSESSMENTS OF SERVICE USERS WITHIN THE ACUTE DIRECTORATE

For the purpose of this document and required physical health checks; the Home Treatment Team comes under the Acute directorate guidance.

10.1 All service users meeting the acceptance criteria for the Acute Directorate, and offered a service are to have their physical health needs met through physical health assessments and subsequent physical tests and interventions as guided by the physical health portal and Physical health check Matrix (Appendix A), alongside Lester tool (Appendix G). These are minimum frequencies and if the service user's physical health deteriorates, then more frequent recording should be undertaken.

10.2 Within 72 hours, for service users who are in receipt of the Home Treatment Team (HTT) a physical Health assessment should be undertaken if not already been completed or out of date (within the last year). If an up to date physical health assessment is in place; consent should be sought, and obtained, and baseline observations (See 5.6.1) must be undertaken and check information has not changed. This must be recorded on the physical health portal within RiO and any ongoing health issues care planned. If the service user refuses permission, this must be recorded within RiO.

10.2.1 Physical health assessments must be completed a minimum of annually. This must be done in liaison with Primary Care, and any investigations and results communicated to the service users GP, Psychiatrist and lead professional/HCP. For further information see the shared care protocol

(Appendix I). This assessment must be documented within the physical portal within RiO.

10.3 For service users who are over the age of 65 there may be additional checks required as in Appendix A If delirium is suspected obtain a midstream or catheter specimen of urine test for culture and sensitivity to exclude / confirm urinary infection as the cause

11 REQUIREMENTS FOR PHYSICAL ASSESSMENT OF SERVICE USERS WITHIN THE COMMUNITY DIRECTORATE (To be changed to MHT and MHT+ when fully operational)

11.1 All service users meeting the acceptance criteria for Community Services and offered a service must have their physical health needs met through a physical health assessment and subsequent physical tests and interventions as guided by the physical health portal on RiO and Physical health check Matrix (Appendix A) alongside the Lester tool (Appendix G). These are minimum frequencies and if the service user's physical health deteriorates, then more frequent recording should be undertaken.

11.2 For all service users in community services consent should be sought and obtained, and a physical health assessment must be undertaken. This must be recorded on the Physical Health portal within RiO and any ongoing health issues care planned. If the service user refuses consent, this must be recorded within RiO and this should be offered again. NEWS2 community form (Appendix C) should be utilised and the track and trigger escalation plan followed. Respirations and Conscious levels should still be documented if the patient declines all other physical health observations.

11.3 The lead clinician is responsible for ensuring that service user's GP is made aware of any abnormal results in the physical health assessment.

11.4 If a service user refuses their physical health check in the community, their GP must be informed even if it is their first refusal.

12 REQUIREMENTS FOR PHYSICAL ASSESSMENT OF SERVICE USERS WITHIN THE FORENSIC AND SPECIALIST DIRECTORATE

12.1 All service users meeting the acceptance criteria for the Forensic and Specialist Directorate, and offered a service are to have their physical health needs met through physical health assessments and subsequent physical tests and interventions as guided by the physical health portal and Physical health check Matrix (Appendix A), alongside Lester tool (Appendix G). These are minimum frequencies and if the service user's physical health deteriorates, then more frequent recording should be undertaken.

12.2 Community service user's permission should be sought and obtained, and a physical health assessment must be undertaken. This must be recorded on the Physical Health portal within RiO and any ongoing health issues care planned. If the service user refuses permission, this must be recorded within RiO and this should be offered again.

12.3 The lead clinician is responsible for ensuring that service user's GP is made aware of any abnormal results in the physical health assessment.

12.4 As part of the ongoing treatment and care, whilst in hospital, physical health assessments and lifestyle assessments, and advice, are to be provided as an integral part of the care plan.

13 PATIENTS COMMENCED ON ANTIPSYCHOTIC MEDICATION

13.1 For all patients commenced on an antipsychotic medication please refer to the Physical Health Monitoring and Assessment for patients prescribed antipsychotics within Community Settings Standard Operating Procedure (SOP) in Appendix D.

14 PATIENTS WITH LEARNING DISABILITY

14.1 The Mencap (2019) charity characterised a person with a learning disability as having reduced intellectual ability and difficulty with everyday activities. This can include challenges with household tasks, socialising, and managing money, and these difficulties can persist throughout a person's life. People with a learning disability may take longer to learn and may require support to develop new skills, comprehend complex information, and engage with others. Needs that occur for individuals are lifelong and originate during the developmental period (icd.who.int, n.d.).

14.2 It is well-recognised that, people with Learning disabilities experience health inequalities. Death occurs at a younger age and the prevalence of long-term morbidities is higher than in the general population (Doherty et al., 2020). In 2017 England became the first country in the world to establish a programme of work aimed at improving health care for people with a learning disability and autistic people. The programme is called Learning from Lives and Deaths - people with a learning disability and autistic people (LeDeR) and sets out three aims:

- Improve care for people with a learning disability and autistic people.
- Reduce health inequalities for people with a learning disability and autistic people.
- Prevent people with a learning disability and autistic people from early death. (Kings College London, 2021)

14.3 A theme highlighted in every annual LeDeR report is that of Diagnostic overshadowing which is best defined as symptoms of physical ill health mistakenly attributed to either mental ill health, as a result of behavioural problems or as being inherent in the person's learning disabilities (Disability Rights Commission 2006). To mitigate risks related to diagnostic overshadowing the reports recommend that “Health outcomes for people with a learning disability should continue to be monitored closely through annual health checks” (P.47 King's College London 2023).

14.4 Everyone over the age of 14 who is on their GPs learning disability register must have an annual health check and the NHS Long Term Plan (NHS England, 2019) set an ambition that by 2023/24, at least 75% of people aged 14 or over with a learning disability will have had an annual health check.

14.5 All patients who have a diagnosed learning disabilities when they are admitted to KMPT community or inpatient services require this diagnosis to be recorded on the disability monitoring form in RiO. They will be asked if they are already on their GP learning disability register and receiving an annual health check or will be offered support to access one.

15 TRAINING AND AWARENESS AND COMPETENCY

15.1 All nursing and support staff undertaking physical observations should have a yearly competency assessment completed by their line manager or other appropriate person (Appendix K).

15.2 If any nursing or support staff are found to not be competent in this area, or if others raise concern, should be supported through the 1-2-1 and appraisal process in order

to agree and plan training to acquire the necessary knowledge and skills. Staff who are found to be not competent in accurate assessment of physical health observations should not be undertaking these tasks without supervision.

15.3 Nursing and support staff should only complete physical health assessment if they have received training on the related medical devices and are competent to use them.

15.4 The physical health team deliver a one day 'Physical health in mental health' course. All staff undertaking physical health and well-being advice are recommended to attend this course. Staff who have undertaken this training are responsible for providing support and education for other healthcare professionals.

15.5 All registered front line clinical staff will be trained to use the early warning (NEWS2) recording charts/eObs as part of their induction.

16 MEDICAL DEVICES

Please refer to the Medical Devices Policy for full guidance

16.1 All staff who are required to undertake physical health assessments should have access to the appropriate and serviced medical devices.

16.2 Wards must have access to resuscitation equipment which is regularly maintained. It is the responsibility of the ward manager to ensure appropriate and fully functioning medical equipment is available on all wards, that the equipment is regularly maintained, and staff receive the appropriate training concerning medical devices.

16.3 Community Team Hubs must have access to a defibrillator and rescue kit.

16.4 Only medical devices from the Trust wide approved medical devices list should be purchased. A full list is available via i-Connect. http://i-connect.kmpt.nhs.uk/document-library/medical-devices-forms-and-procedures/89.

16.5 All equipment should be in good working order and annually checked and calibrated following the Organisation's, Acceptance Testing and Recalibration Procedure (please see Medical Devices Policy for further information).

16.6 It is the responsibility of the ward manager to ensure appropriate and fully functioning medical equipment is available on all wards, that the equipment is regularly maintained.

17 STAKEHOLDER INVOLVEMENT

17.1 This policy was developed with input from Matrons, Deputy Chief Nurse, Heads of Nursing and the Physical health team

17.2 The leaflet has been reviewed by service users and carers in Appendix J.

18 RECORD KEEPING

18.1 All service user physical health assessments, examinations and monitoring data must be recorded on the appropriate Open RiO forms. Further physical health related forms for completion include body map, falls assessment as appropriate.

18.2 A service user's record is a basic clinical tool used to give a clear and accurate picture of their care and treatment, and competent use is essential in ensuring that an individual's assessed needs are met comprehensively and in good time (General Medical Council, 2015, NMC, 2018)

18.3 All NHS Trusts are required to keep full, accurate and secure records, (Data Protection Act 1998), demonstrate public value for money, (Auditors Local Evaluation), and manage risks, (NHS Litigation Authority, Information Governance Toolkit, Essential Standards). Compliance with this Policy and these legal and best practice requirements will be evidenced through information inputted into the electronic record, Open RiO.

18.4 For full details of the specific information needed to ensure compliance with this policy see the Data Entry Guide.

19 EQUALITY IMPACT ASSESSMENT

19.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decision they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Organisation has carefully considered any potential negative outcomes that can occur before implementation. The Organisation will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes.

20 HUMAN RIGHTS

20.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Organisation must ensure that requirements of the Human Rights Act are properly upheld.

21 AUDIT AND MONITORING

What will be monitored	How will it be monitored	Who will monitor	Frequency	Evidence to demonstrate monitoring	Action to be taken in event of non-compliance
Processes for physical assessment on all inpatients from admission and within 72 hours ongoing assessment are followed, by appropriate staff within timeframes within all care groups.	Weekly stats sent to managers via Performance Team Cliq checks	Cliq check team Physical health matron /CQUIN Lead	Weekly Bi-monthly	Reports	Required change to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate, and lessons will be shared with all the relevant stakeholders
Process for physical assessments in the community after a period of six weeks	Quality account reports BI reports monthly Within 1-2-1's with clinical leads	Service managers, Heads of Nursing Matrons Clinical lead nurse	Quarterly reports	Reports IQPR meeting minutes Bi monthly directorate physical health forum minutes	Required change to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate, and lessons will be shared with relevant stakeholders

APPENDIX A- PHYSICAL HEALTH CHECK MATRIX

PH Checks Frequency Matrix V3

APPENDIX B ABBREVIATIONS & DEFINITIONS

Abbreviation	Meaning
SMI	Serious Mental Illness
GP	General Practitioner
RC	Responsible Clinician
BMI	Body Mass Index
BP	Blood Pressure
CMHT/OP	Community Mental Health Team/Older Person
TPR	Temperature, Pulse and Respirations
NEWS2	National Early Warning Score 2
BLS	Basic Life support
ILS	Immediate Life Support
eObs	Electronic observations
HTT	Home Treatment Team
MHT	Mental Health Together
MHT +	Mental Health Together Plus
MEWS	National Early warning score 2

APPENDIX C THE NATIONAL EARLY WARNING SCORE CHART

BC-Physical-Observation-Chart-NEWS2-

APPENDIX D – MEWS CHART

MEWS.docx

LUNSERS

Liverpool University Neuroleptic Side Effect Rating Scale

Date Reviewed – JUNE 2024

Patient's Name…….....Date of Birth……
NHS Number……..

Service users Name	
Raters Name	
Assessment Number	
Assessment Date	

Please indicate how much you have experienced each of the following symptoms in **the last month** by ticking the appropriate boxes.

		NOT AT ALL (0)	**VERY LITTLE** (1)	**A LITTLE** (2)	**QUITE A LOT** (3)	VERY MUCH (4)
1.	**Rash**	☐	☐	☐	☐	☐
2.	**Difficulty staying awake during the day**	☐	☐	☐	☐	☐
3.	**Runny nose**	☐	☐	☐	☐	☐
4.	**Increased dreaming**	☐	☐	☐	☐	☐
5.	**Headaches**	☐	☐	☐	☐	☐
6.	**Dry mouth**	☐	☐	☐	☐	☐
7.	**Swollen or tender chest**	☐	☐	☐	☐	☐
8.	**Chilblains**	☐	☐	☐	☐	☐
9.	**Difficulty in concentrating**	☐	☐	☐	☐	☐
10.	**Constipation**	☐	☐	☐	☐	☐
11.	**Hair loss**	☐	☐	☐	☐	☐

		NOT AT ALL (0)	VERY LITTLE (1)	A LITTLE (2)	QUITE A LOT (3)	VERY MUCH (4)
12.	**Urine darker than usual**	☐	☐	☐	☐	☐

Patient's Name…….....Date of Birth……
NHS Number……..

		NOT AT ALL	VERY LITTLE	A LITTLE	QUITE A LOT	VERY MUCH
13.	**Period pains**	☐	☐	☐	☐	☐
14.	**Tension**	☐	☐	☐	☐	☐
15.	**Dizziness**	☐	☐	☐	☐	☐
16.	**Feeling sick**	☐	☐	☐	☐	☐
17.	**Increased sex drive**	☐	☐	☐	☐	☐
18.	**Tiredness**	☐	☐	☐	☐	☐
19.	**Muscle stiffness**	☐	☐	☐	☐	☐
20.	**Palpitations**	☐	☐	☐	☐	☐
21.	**Difficulty in remembering things**	☐	☐	☐	☐	☐
22.	**Losing weight**	☐	☐	☐	☐	☐
23.	**Lack of emotions**	☐	☐	☐	☐	☐
24.	**Difficulty in achieving climax**	☐	☐	☐	☐	☐
25.	**Weak fingernails**	☐	☐	☐	☐	☐
26.	**Depression**	☐	☐	☐	☐	☐
27.	**Increased sweating**	☐	☐	☐	☐	☐
28.	**Mouth ulcers**	☐	☐	☐	☐	☐
29.	**Slowing of movements**	☐	☐	☐	☐	☐
30.	**Greasy skin**	☐	☐	☐	☐	☐

31.	**Sleeping too much**	☐	☐	☐	☐	☐
32.	**Difficulty passing water**	☐	☐	☐	☐	☐
33.	**Flushing of face**	☐	☐	☐	☐	☐
34.	**Muscle spasms**	☐	☐	☐	☐	☐
35.	**Sensitivity of sun**	☐	☐	☐	☐	☐
36.	**Diarrhoea**	☐	☐	☐	☐	☐

Patient's Name…….....Date of Birth……
NHS Number……..

		NOT AT ALL	**VERY LITTLE**	**A LITTLE**	**QUITE A LOT**	**VERY MUCH**
37.	**Over-wet or drooling mouth**	☐	☐	☐	☐	☐
38.	**Blurred vision**	☐	☐	☐	☐	☐
39.	**Putting on weight**	☐	☐	☐	☐	☐
40.	**Restlessness**	☐	☐	☐	☐	☐
41.	**Difficulty getting to sleep**	☐	☐	☐	☐	☐
42.	**Neck muscles aching**	☐	☐	☐	☐	☐
43.	**Shakiness**	☐	☐	☐	☐	☐
44.	**Pins and needles**	☐	☐	☐	☐	☐
45.	**Painful joints**	☐	☐	☐	☐	☐
46.	**Reduced sex drive**	☐	☐	☐	☐	☐
47.	**New or unusual skin marks**	☐	☐	☐	☐	☐
48.	**Parts of body moving of their own accord e.g. foot moving up and down**	☐	☐	☐	☐	☐
49.	**Itchy skin**	☐	☐	☐	☐	☐
50.	**Periods less frequent**	☐	☐	☐	☐	☐

51.	**Passing a lot of water**	☐	☐	☐	☐	☐

Patient's Name…….....Date of Birth……
NHS Number……..

LUNSERS SCORE SHEET

Service users name	
Assessors name	
Date of test	

Total LUNSERS score (all 51 questions)		**Score 0-4** 'Not at all' 0 'Very little' 1 'A little' 2 'Quite a lot' 3 'Very much 4
"Red Herring" item score: (questions 3,8,11,12,25,28,30,33,42,45)		Score as above (>20 high)
Total minus "red herring" score:		
(0-40 = low, 41-80 = medium, 81-100 = high, >101 = very high)		

Neuroleptics and doses (including PRN's) at the time of assessment:

1.
2.
3.
4.
5.

Other relevant drugs and doses (e.g. anticholinergics, antidepressants etc.):

LUNSERS is a fully validated and comprehensive *self-rating scale* for measuring the *distress* from side effects of neuroleptics at any particular time (Day *et al, B J Psych* 1995, **166**, 650-653). The scale rates the severity of recognised neuroleptic side effects as well as some "red herring" items to distinguish where many effects are attributed inappropriately to drugs. Users of the scale must read the article above to familiarise themselves with the test.

Document Upload Name: Form Lunsers. Document Type: Reports/Assessments

APPENDIX F GLASGOW ANTIPSYCHOTIC SIDE-EFFECT SCALE (GASS)2019
PLEASE REFER TO CLOZAPINE POLICY FOR FURTHER GUIDANCE

Name: **Age:** **Sex: M / F**

Please list current medication and total daily doses below:

This questionnaire is about how you have been recently. It is being used to determine if you are suffering from
excessive side effects from your antipsychotic medication.
Please place a tick in the column which best indicates the degree to which you have experienced the following side effects.
Also tick the **end or last** box if you found that the side effect was distressing for you *© Waddell & Taylor, 2007*

Over the past week:	*Never*	*Once*	*A few times*	*Everyday*	*Tick this box if distressing*
1. I felt sleepy during the day					
2. I felt drugged or like a zombie					
3. I felt dizzy when I stood up and/or have fainted					
4. I have felt my heart beating irregularly or unusually fast					
5. My muscles have been tense or jerky					
6. My hands or arms have been shaky					
7. My legs have felt restless and/or I couldn't sit still					
8. I have been drooling					
9. My movements or walking have been slower than usual					
10. I have had uncontrollable movements of my face or body					
11. My vision has been blurry					
12. My mouth has been dry					
13. I have had difficulty passing urine					
14. I have felt like I am going to be sick or have vomited					
15. I have wet the bed					
16. I have been very thirsty and/or passing urine frequently					
17. The areas around my nipples have been sore and swollen					
18. I have noticed fluid coming from my nipples					
19. I have had problems enjoying sex					
20. **Men only:** I have had problems getting an erection					
21. Is constipation a problem? (if reported refer to appendix 2 within Clozapine Policy see below)					

Tick yes or no** for the **last three months	*No*	*Yes*	*Tick this box if distressing*
22. **Women only**: I have noticed a change in my periods			
23. **Men and women**: I have been gaining weight			

GLASGOW ANTIPSYCHOTIC SIDE-EFFECT SCALE (GASS)

Staff Information

1. Allow the patient to fill in the questionnaire themselves. Questions 1-21 relate to the previous week and questions 22-23 to the last three months.

2. Scoring

For questions 1-21 award 1 point for the answer “once”, 2 points for the answer “a few times” and 3 points for the answer “everyday”.
Please note zero points are awarded for an answer of “never”.

For questions 22 and 23 award 3 points for a “yes” answer and 0 points for a “no”.

Total for all questions = ……

Date completed: ……

Action taken: ……

……

3. For male and female patients, a total score of:

0-12 = absent/mild side effects
13-26 = moderate side effects
Over 26 = severe side effects

4. Side effects covered by questions:

1-2 sedation and CNS side effects
3-4 cardiovascular side effects
5-10 extra-pyramidal side effects
11-13 anticholinergic side effects
14 gastro-intestinal side effects
15 genitourinary side effects
16 screening for diabetes mellitus
17-20 and 22 prolactinaemic side effects
21 constipation side-effects **(complete also risk assessment in appendix 2)**
23 weight gain

The column relating to the distress experienced with a particular side effect is not scored but is intended to inform the clinician of the service user’s views and condition.

MANAGEMENT OF PATIENTS WHO HAVE CONSTIPATION (Refer to clozapine policy for further guidance)

Constipation in patients who are taking clozapine can be fatal.

PREVENT Constipation

- Ask about and encourage adequate hydration, physical activity, and a high-fibre diet.
- Review all medications (especially anti-cholinergics and opiates) and re-assess need.
- Patients at elevated risk for constipation include: Patients on opiates or medications with anticholinergic activity, patients with poor hydration and those who are sedentary and on low-fibre diets
  - In these patients, consider prophylactic use of laxatives when starting clozapine or other medications known to cause constipation. (Stool softeners also may be helpful)
  - Encourage adequate hydration, physical activity and a high fibre diet.

ASK about Bowel Function

- Before starting clozapine and during inpatient admission stool chart should be attached to the drug chart. In the community at each regular clinical assessment ask about bowel function and encourage monitoring of bowel function by patient, family and other providers

TREAT Constipation

- If patient is reporting symptoms, refer to the doctor to be assessed. Signs and symptoms that warrant immediate medical attention is abdominal pain, distension, vomiting, overflow diarrhoea and blood in the stools. It is important to establish the patient's baseline bowel habit. If there is a change to this or the patient has fewer than three bowel movements in a week an abdominal examination should be done.
- If there is no doctor available to review the patient the care coordinator should be contacted to facilitate urgent GP appointment.
- Stop other medicines that may be contributing to constipation and reduce clozapine dose if possible. Please be aware that if a large solid mass has formed this may be difficult to pass and stimulant laxatives must be used with softeners or osmotic laxatives. **AVOID bulk forming laxatives in this patient group.**

Class of laxatives	
Osmotic	Laxido Orange (macrogols) one to three sachets daily or Lactulose 10-20ml twice a day
Stimulant	Senna 7.5mg-15mg at night or Bisacodyl 5-10mg at night
Softener	Docusate sodium 100mg-200mg twice a day (up to 500mg a day in divided doses

Ensure the ward staff / clinic lead in the CMHT or care co-ordinator follows up by contacting the patient within 72 hours to see if constipation has resolved. This should be documented in the patients RiO progress notes.

APPENDIX G LESTER TOOL

NCAP-Lester-Tool-intervention-framew

APPENDIX H PHYSICAL HEALTH IN MENTAL HEALTH 1 DAY COURSE

This one-day course aims to increase knowledge regarding physical health within mental health setting. Subjects include -

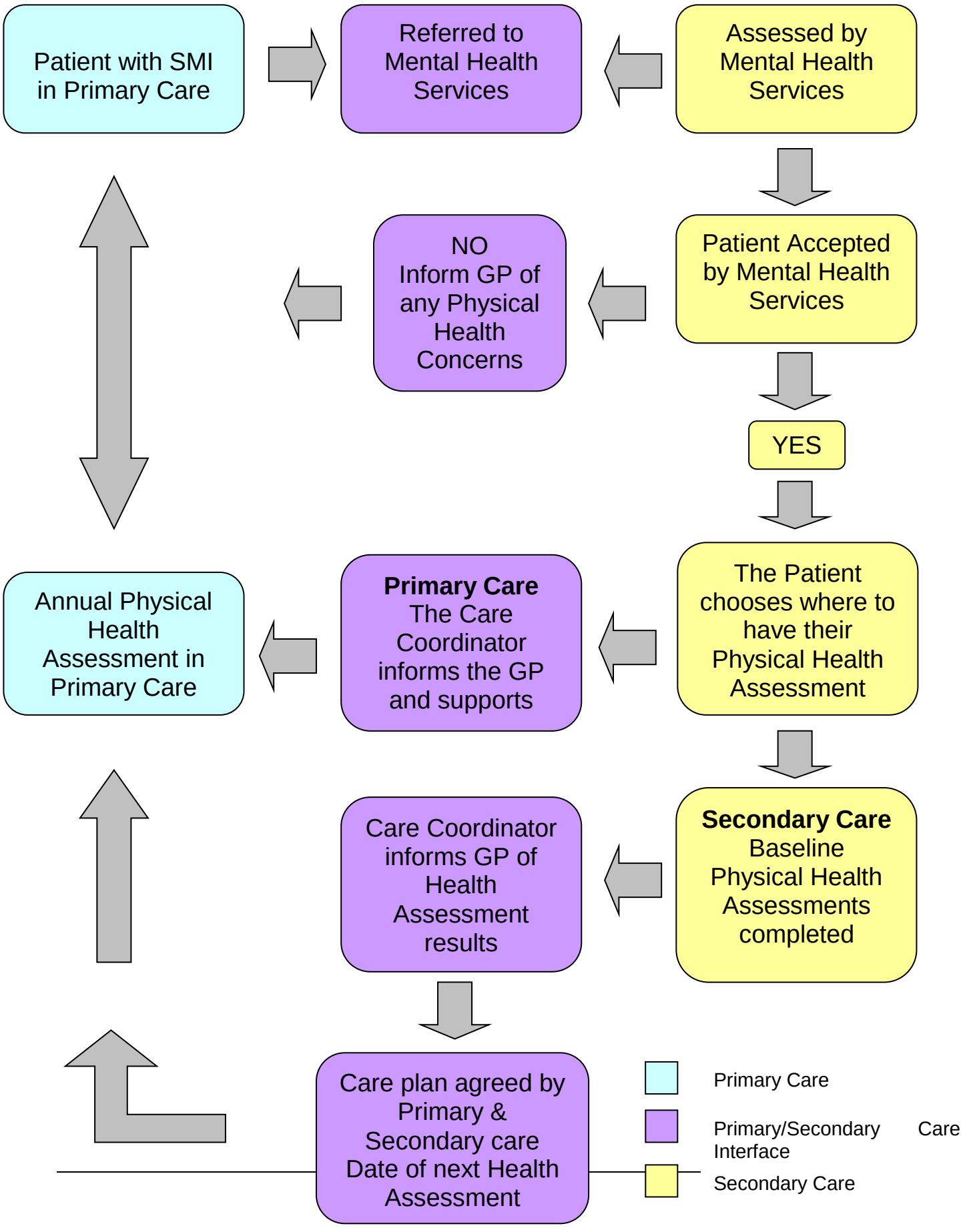
The 6 Cardiometabolic risks factors

- Diabetes – glucose regulation
- Lipids
- Blood pressure
- BMI
- Smoking
- Lifestyle
- Identifying a physically deteriorating patient

    - Lester tool
    - Falls prevention
    - Early Warning scores
    - Constipation
    - Pain assessment
    - Pressure injury prevention/management
    - Wound care
    - Nutrition
    - Medication side effects
    - Developing ideal settings for physical health assessment and interventions.
    - The role of the physical health champion

APPENDIX I PRIMARY/SECONDARY SMI SHARED CARE PROTOCOL

Physical Health and Severe Mental Illness (SMI)The Interface between Primary Care and Secondary Mental Health



Physical Health and Severe Mental illness (SMI)
The roles of Primary Care and Secondary Mental Health Services

Primary Care **GP Practice**	**Secondary Care –** **Mental Health Services**
Records	
The GP practice can produce a register of people with schizophrenia, bipolar disorder and other psychoses	Facilitate the physical wellbeing of clients with mental health and learning disability needs within in-service user areas, community Teams, Rehabilitation Teams etc
On-going management	By Offering 1 to 1 Consultations and referring to appropriate Services and Health Care Professionals
Those service users with schizophrenia, bipolar affective disorder and other psychoses with a review recorded in the preceding 15 months. In the review there must be evidence that the service user has been offered routine health promotion and prevention advice appropriate to their age, gender and health status	<u>Physical Health Assessments will include</u> B P + Pulse Weight, Height and BMI Illness/disease History Bloods (Glucose/Hba1c and Lipids)
Those service users on lithium therapy with a record of serum creatinine and TSH in the preceding 15 months	Collaborate and Integrate with Local Health Care Teams and Work alongside Health Promotions
Those service users on lithium therapy with a record of lithium levels in the therapeutic range within the previous six months	Facilitate Healthy Living Groups & Physical Activity Groups
Those service users on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate	<u>Lifestyle Issues</u> Dietary and physical activity advice, Smoking, alcohol and drug advice
Those service users with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by the practice team within 14 days of non-attendance	<u>Medication Management</u> Medication details + clients understanding of their medication. Assessment and management of medication side effects. LUNSERS/GASS

APPENDIX J YOUR PHYSICAL HEALTH ASSESSMENT LEAFLET

Your Physical Health Assessment-

APPENDIX K MEDICAL DEVICES STAFF COMPETENCY FORM 2019

Medical Devices Staff Competency Form 20

APPENDIX L- PHYSICAL HEALTH MONITORING AND ASSESSMENT FOR PATIENTS PRESCRIBED ANTIPSYCHOTICS WITHIN COMMUNITY SETTINGS STANDARD OPERATING PROCEDURE SOP-

to be added when ratified

APPENDIX M PHYSICAL HEALTH MINIMUM MONITORING REQUIREMENTS FOR COMMONLY PRESCRIBED PSYCHOTROPHIC MEDICATIONS

physical health monitoring requirer

APPENDIX O THE PHYSICAL HEALTH STRATEGY

https://staffroom.joinblink.com/#/hub/01910e03-4c1f-759a-9b6b-577464082ac4