Physical Health Assessment & Management

POLICY NO & CATEGORY	**C38**	**Clinical**
VERSION NO & DATE	**2**	**November 2016**
RATIFYING COMMITTEE	**Clinical Governance Committee**	
DATE RATIFIED	**January 2017**	
NEXT ANTICIPATED REVIEW DATE	**February 2021**	
EXECUTIVE DIRECTOR	Exec Director of Nurising	
POLICY LEAD	Associate Director of AHPs and Phsyical Health	
POLICY AUTHOR *(if different from above)*	Director of Pharmacy & Medicines Management Head of Dietetics and Cardiovascular Health Consultant Forensic Psychiatrists Associate Director of AHPs and Phsyical Health	
FORMULATED VIA	Physical health committee, reviewed by the PTC	

POLICY CONTEXT

This policy is a combination of two clinical guidelines that have been brought into one policy. It outlines the expectations of physical health assessment for all service users accepted into services. It reflects prescribing guidance reflected in SPC and MHRA Guidelines, NICE guidelines relating to physical health, the evidence base reflective of the health inequalities and prevalence of premature mortality and most importantly, it reflects service users wish and voice to have better oversight of their health whilst in the care of BSMHFT.

POLICY REQUIREMENT (see Section 2)

For all In patients – When a patient is admitted to a psychiatric hospital the psychiatrist in charge of the patient's treatment assumes responsibility for all aspects of their care, including their physical health. All newly-admitted inpatients must receive a thorough physical examination by a doctor as part of the admission process. This should take place as soon as possible after admission, ideally within 6 hours but no later than 24 hours after admission
For all Community patients – Clinicians should consider the physical health of patients as part of their assessment and management at the point of first referral. For patients on CPA, the care co-ordinator must ultimately be satisfied that the patient has received an assessment of their physical health appropriate to their needs, and that any required actions are being addressed. Mental health services should ensure that physical health checks are carried out and should liaise accordingly with the GP including agreeing how any necessary physical monitoring associated with prescribing is done.

CONTENTS

1. INTRODUCTION

1.1. Rationale (Why)

Physical health assessment is something that is undertaken upon entry into a service and at regular intervals thereafter, dependent upon diagnoses, prescribing and the cardiovascular risk presented by the patient. For the vast majority of patients the primary goal is to develop collaborative care plans to address known Cardiovascular risk factors and to this end the main physical health assessment form is a modified version of a form developed by Rethink, the mental health charity. In addistion there is a brief core health monitoring tool a physical examination form for use by medical staff (and others whose professional training makes this appropriate) and various specific assessments.

The physical observations chart is used during inpatient stay includes core health assessment components of BP, HR, pulse, respiration rate, oxygen saturations, urine output, and indicates if any more detailed daily monitoring is required, such as fluid balance chart, or fasting blood glucose. The NEWS scale is also employed

1.2. Scope (Where, When, Who)

This guidance sets minimum standards for the assessment of the physical health of patients of the Trust by medical staff. The assessment, monitoring and recording of core physical health indices (blood pressure, BMI, Heart rate and blood glucose) are the responsibility of the team managing the patient. This guidance applies to all services within the Trust including inpatient, outpatient and community settings and should be used in conjunction with the physical health assessment forms on RiO.

1.3. Principles (Beliefs)

All patients should receive a physical health examination on entry to inpatient services and regularly thereafter. Community patients should have a physical health check completed and/or physical health advice if they have not received same from their GP practice.

Patients taking medication should be monitored in accordance with the requirements of the summary of product characteristics (SPC), BNFor similar, either by the mental health clinical team or their GP. In either case a record of results should be contained within the RiO record.

2. POLICY (What)

2.1. For all In patients:

When a patient is admitted to a psychiatric hospital the psychiatrist in charge of the patient's treatment assumes responsibility for all aspects of their care, including their physical health.

The admitting clinicians should follow the guidance detailed in this policy to undertake the four defined components of a physical health assessment ie:

1. History taking
2. Core measures assessment(BMI, BP, HR etc)
3. Physical examination

4. Lifestyle screening

All newly-admitted inpatients must receive a thorough physical examination by a doctor as part of the admission process. This should take place as soon as possible after admission, ideally within 6 hours but no later than 24 hours after admission

Physical health should form part of this assessment and of the resultant care plan.

2.2. For all Community patients

Clinicians should consider the physical health of patients as part of their assessment and management at the point of first referral. Therefore the annual health check results must be documented in the care record, and if it is not forth coming from the GP, then it does still need to be undertaken.

For patients on CPA, the care co-ordinator must ultimately be satisfied that the patient has received an assessment of their physical health appropriate to their needs, and that any required actions are being addressed.

Mental health services should ensure that physical health checks are carried out and should liaise accordingly with the GP including agreeing how any necessary physical monitoring associated with prescribing is done.

3. PROCEDURE

3.1. Assessment:

There are four elements to the assessment of physical health and screening for co-morbidity vulnerability and key risks associated with family history, life style and iatrogenic aspects of medications prescribed. The four elements are as follows:

- History taking
- Core measures assessment(BMI, BP, HR etc)
- Physical examination
- Lifestyle screening

Health screening and assessment elements	**Responsibility**	**Action**	**Mode**
HISTORY TAKING	Admitting clinicians	Ensure it is done	At point of entry to a the service - by the first clinical contact - medical or nursing staff
CORE ASSESSMENT • BLOOD PRESSURE • HEART RATE • WEIGHT • HEIGHT • BMI • BLOOD GLUCOSE LEVEL	Admitting clinician Team Managers and Consultants are responsiblke for ensuring appropriate local arrangements are in place in the various settings	Baseline measures taken These can be taken by nursing staff in teams, for outpatients seeing only a Doctor then the doctor is responsible for ensuring these measurements are done.	on going Monitoring in integrated health and well-being clinics where continued monitoring is indicated. Suitably trained and supervised Health instructors can also undertake this element of health screening

PHYSICAL EXAM In patients and where indicated otherwise.	Admitting doctor	Systems assessment-neurological, cardiovascular ETC	1:1 examination and assessment by a doctor-mandatory for inpatients and other patients as necessary if the patient is not engaging with their GP.
Life style screening • DIET AND HABITS • NUTRITION SCREEN • PHYSICAL ACTIVITY • SMOKING AND BRIEF ADVISE /SIGN POSTING TO STOP SMOKING SERVICES • ALCOHOL AND FAST SCREEN AND BREIF ADVICE/SIGN POSTING	Admitting clinician Team Managers and Consultants are responsiblke for ensuring appropriate local arrangements are in place in the various settings	Nursing staff, health instructors, OT's in teams, for outpatients seeing only a Doctor, then the doctor is responsible for ensuring these assessments are recorded.	At point of entry into a service. Integrated health and well-being clinics Nursing staff – physical health link workers in teams are well supported in addressing life style risk. Health instructors can also fulfil this function and support clinics. All qualified staff should support this.

3.2. CPA Requirements

The CPA process requires the formulation of a care plan to reflect the physical health needs of the patient.

The Core Health Monitoring Form is used for sequential and more regular monitoring of core elements

A care plan should be formulated as part of the Physical Health Assessment to record and monitor these indicators and to enables monitoring of other key parameters (e.g.blood tests, urine screens need to be performed and recorded.)

For example, a patient with impaired liver function should have a cre plan formulated. This may be as simple as saying that this is being attended to by a hepatology clinic.

ECG ordering and report findings can also be captured and recorded in this way.

Appendix 1 outlines how physical health assessments can be incorporated into patients assessment and documented for purposes of adhering to the requirements of the physical health CQUIN.

3.3. Hospital Inpatients

All newly-admitted inpatients must receive a thorough physical examination by a doctor as part of the admission process. This should take place as soon as possible after admission, ideally within 6 hours but no later than 24 hours after admission.

This examination should include the arrangement of routine investigations (including blood tests). All patients must have a base line MEWS score recorded and a careplan which sets out a schedule of physical health monitoring. The MEWS clinical guidance supports its use. Staff must include in the care plan the frequency of MEWS review. If the MEWS observations are recorded on paper forms they should subsequently be entered into RiO.

Capacity to Consent to Examination and Investiagtions (Procedures)

An assessment of capacity to consent to the examination and investigations should be carried out by the admitting doctor. The Trust has produced a flowchart to describe the process of carrying out an assessment of capacity and best interests within the meaning of the MCA. There are three possible outcomes:

- If the patient has capacity and consents, the examination or investigation should be performed.
- If the patient has capacity and refuses, the need for a physical examination and/or investigations should be regularly discussed with the patient throughout the admission. If consent is later given the procedure(s) should then be performed.
- If the patient lacks capacity, then a best interests assessment of the need for physical examination should be carried out. A procedure deemed to be in their best interests should be carried out without delay.
- If part or all of a procedure is deemed not to be in the best interests of a non-capacitous patient then it should not be performed.
- Assessments of capacity and best interests should be regularly reviewed

All assessments under the MCA should be clearly documented in the notes.

3.4. Medical history

Must be to the standard expected from a competent doctor.

3.5. Examination

The admitting doctor should conduct and document a full physical examination.

Investigations

As described above, any investigations are subject to the MCA procedures for assessing capacity and (if necessary) best interests.

The admitting doctor should arrange for routine blood tests, including as a minimum:

Full blood count	Liver function tests
Thyroid function tests	
Urea and electrolytes	Fasting blood glucose and lipids

This list is the minimum standard – any other aspects of examination thought necessary by the admitting doctors should be included. These might include HbA1C, B12 and folate, Vitamin D levels, blood borne viruses etc.

Repeat Examinations

The entire physical assessment should be repeated annually while the individual remains an inpatient. This should be done on or around the anniversary of their original admission to hospital (rather than date of transfer to different wards / hospitals during the admission), or using an alternative consistent anniversary (e.g. the individual's date of birth).

3.6. iaison with other health services

The treating team should liaise both with primary and secondary care as appropriate. Direct referrals for specialist assessment in secondary care settings (e.g. for review by a cardiologist) may be made, but the patient's GP should be informed. In situations where the patient has no GP or (such as in long-stay hospital inpatients) has had no recent contact with them, full details should be documented and passed on to appropriate agencies at the point of discharge.

Every effort should be made to continue existing contact with secondary care services, including attendance at outpatient appointments etc.

3.7. Community Patients

Standards

Clinicians must consider the physical health of patients at the point of first contact and thereafter. All outpatients should be in contact with a GP so meeting physical health needs should be appropriately shared with primary care. Clinical teams should develop a good working relationship with the practices who care for their patients. This includes agreeing means of exchanging information and avoiding duplication of procedures. The approach taken will vary.

The physical health assessment must be recorded within 3 weeks of admission to a service. If deferred because the patient is unable or unwilling to participate it must be completed as far as is possible within 3 months of admission to a service.

Ideally the patient's GP will hold primary responsibility for the patient's physical health. In certain cases such as when a drug prescribed by secondary care, the treating team will need to have greater involvement. It may be appropriate for the treating psychiatrist to conduct physical examinations, order blood tests or other investigations. The the results of these should be shared with the GP. As part of a patient's care plan, the prescribing doctor must be satisfied that the patient is receiving monitoring appropriate to the medication prescribed.

It may also be appropriate for other clinical staff to give general advice about physical health and collect basic information (such as height, weight, BMI etc.). Care plans around physical health should be formulated and reviewed as part of the CPA process.

Capacity to Consent

Issues of capacity apply equally to procedures undertaken in the community. If people lack capacity, then compulsory psychiatric treatment under the MHA 1983 should be considered since treatment of mental illness can be vital in addressing phyical health deterioration. The GP must be informed and asked to participate in the assessment and management of deteriorating health.

If the patient has capacity but refuses physical healthcare, the refusal must be respected and communicated to the referring GP.

3.8. Home treatment

All patients must have a core health assessment and physical health assessment using the modified Rethink form. The nature of a crisis and the priority gien to its resolution may mean that the physical health assessment is completed within two weeks. It is not expected that home treatment staff would necessarily be able to deliver brief advice or interventions around life style issues to a patient in crisis. Required investigations and assessments should be undertaken prior to prescribing relevant drugs. Where they are not, a rationale should be clearly recorded on RiO.

For patients coming from a CMHT, a health assessment may have been completed in the past 12 months, meaning that a repeat is unnecessary depending on the patient's history and presentation

For HTT patients it may well be appropriate to perform an ECG during the episode of HTT

Repeat Examinations

Physical health should be formally reviewed at least annually and most patients should have this carried out by their GP. This might form part of a CPA review process, be linked to the anniversary of the patient's entry into the service or to their date of birth.

Mental health services should ensure that physical health checks are carried out and should liaise with the GP.

Liaison with other health services

The first contact point for all physical health issues should be the GP. Direct liaison with secondary care (e.g. referral to a cardiologist) should not occur other than exceptional circumstances. If this is done, the GP should be made fully aware of the contact.

4. RESPONSIBILITIES

All staff must work in a collaborative fashion with each other and with patients and carers to ensure that physical health needs are met. This is part of their core job role.

Medical Staff are responsible for:

- Conducting physical health examinations
- Ordering and interpreting pathology, ECG and other tests
- Arranging the referral of patients to other trust teams such as physiotherapy, dietetics, speech and language therapy, diabetes care and podiatry as

appropriate. Alternatively, to consult with such teams to receive advice on appropriate management.

- Arranging the referral of patients to appropriate specialist services for follow up examination/consultation or to lifestyle services, e.g. smoking cessation
- Providing advice on improving physical health
- Working with unit physical health leads to improve physical health of patients
- Liaising with GPs over on-going physical health needs and arranging/obtaining results of monitoring tests where appropriate and applicable

Nursing staff are responsible for:

- Physical observations of patients and recording of metrics
- Working with medical staff to conduct physical health tests/measures
- Providing advice on improving physical health
- Working with unit physical health leads to improve physical health of patients
- In community, where appropriate, provide agreed physical health clinics focusing on the physical health of patients.
- Respond to patients concerns over physical health or physical health monitoring of patients where appropriate
- Referral of patients to other trust teams such as physiotherapy, dietetics, speech and language therapy, diabetes care and podiatry as appropriate to the needs of the service user. Alternatively, to consult with such teams to receive advice on appropriate management.
- Refer patients to medical staff where there are concerns over physical health or results of physical health/monitoring results

Other clinicans:

Other clinicans are responsible for:

- Providing advice on improving physical health
- Working with unit physical health leads to improve physical health of patients

5. DEVELOPMENT AND CONSULTATION PROCESS:

- An outline of who has been involved in developing the policy and procedure including Trust forums and service user and carer groups.

Consultation summary	
Date policy issued for consultation	
Number of versions produced for consultation	

Committees / meetings where policy formally discussed		**Date(s)Physical health committee Sept 2012** **CD's 2 weeks prior to CGC**
Where received	**Summary of feedback**	**Actions / Response**
Physical health committee CGC Connect CD's Lead nurses Programme clinical leads in HTT- medical and nursing	Need to incude MEWS and relate to physical health. Need to more clearly state expectations around community and capacity issues Responsibilities and accountability need more clarity. Home treatment expectations need to be clear.	Amended to reflect inclusion of MEWS scoring. Amended to reflect responsibilities. Addition for training Clarity re CQUIN and physical helaht base line assessment. Home treatment paragraph that reflects expectations in HTT.

6. AUDIT AND ASSURANCE

The Trust Physical Health Committee is responsible for overseeing the development of this policy.

See policy monitoring template below.

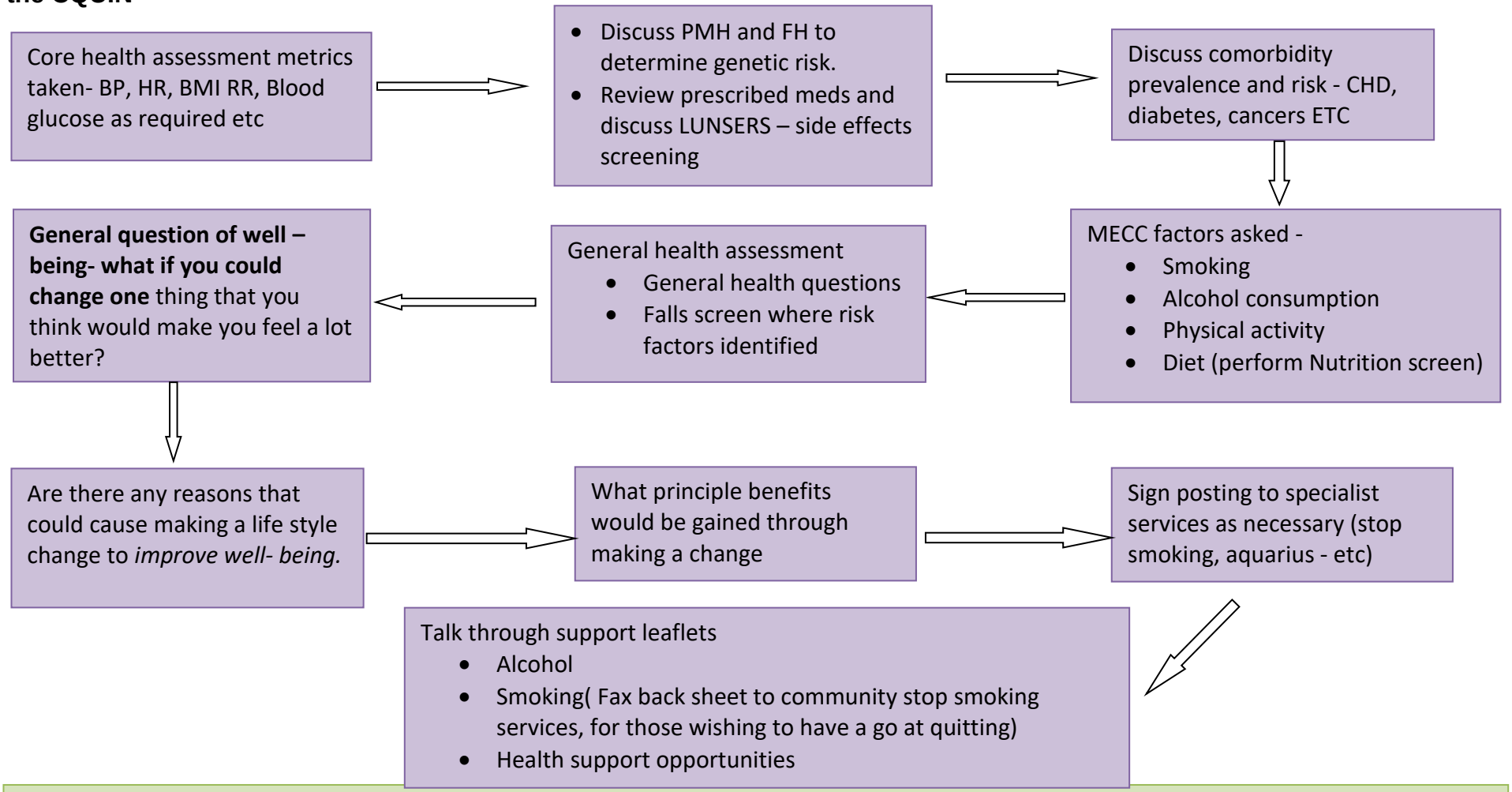
Policy monitoring plan

Element to be monitored	Lead	Tool	Frequency	Reporting Arrangements	Acting on Recommendations & Lead(S)	Change in Practice & Lessons to be shared
Core health assessment • Time frame from admission to a service • completeness	Associate Director of AHP & Physical health services Programe clinical leads	RiO report POMUK audits annually Assoc. Dir report	Quarterly review Annually	Physical health committee Programe clinical leads to audit compliance around timeframes specific to service area in the policy.	CD's Associate Director of AHP & Physical health services	CLINICAL LEADS IN AREAS
Physical health examination For in patients only	Lead for medical staff for physical health	RiO report	Real time through insight Quarterly review	Physical health committee	CD's Lead for medical staff for physical health	CD's → Consultants
History taking	Associate Director of AHP & Physical health services	RiO report	Real time through insight Quarterly review	Physical health committee	CD's Associate Director of AHP & Physical health services	CLINICAL LEADS IN AREAS- consultants & lead nurses with clinicians
Life style risk indicators	Associate Director of AHP & Physical health services	RiO report	Real time through insight Quarterly review	Physical health committee	CD's Associate Director of AHP & Physical health services	CLINICAL LEADS IN AREAS
Acting on health anomalies	Lead nurses Medical staff in teams	Team audits audit programme rotating through operational teams & prog areas. Junior Dr audits.	Bi Annual audits One team per programme area	Physical health committee	Committee members of physical health committee	Lead Nurses & CD's
Adequate side effects monitoring	Lead nurses Pharmacy	Team audits Pharmacy will produce a list of patients being	Bi annual audits rotating through	PTC	Director of Pharmacy & the associate director for medicines management. Associate Director for AHP & physical health services	PTC/Physical health committee ↓ Lead nurses

		prescribed medications Teams will audit side effects monitoring. Annual POMUK audits				

Appendix 1

Conversation framework that enables adequate physical health assessment and incorporated screening elements as it relates to the CQUIN



Refer to Doctor for physical examination if PMH or FMH or assessment findings indicate as such. Refer to the guideline for examination of physical health in SMI patients on connect - clinical guidelines

Appendix 2 – COVID-19 Policy Update

NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Physical Health Assessment & Management – COVID-19 Update

PHYSICAL HEALTH GUIDELINES – TO UPDATE THE BSMHFT PHYSICAL HEALTH POLICY V4

This guideline is written in response to the Covid 19 pandemic and addresses the changes that will be made to routine, non-urgent physical health care for inpatients and outpatients of BSMHFT.

It should be read in conjunction with the Deteriorating Patient policy and the associated guidelines in managing patients with Covid19 infection.

Outpatients

- Although the usual requirements for clinical care ask us to monitor the cardiometabolic indicators of our patients, during the pandemic this will be difficult, due to staff illness, patient illness, and the need to socially isolate unless essential interventions are required
- Annual physical health checks requiring face to face contact will therefore not be required during this period (blood tests such as lipids, HBa1c, blood pressure and pulse, BMI)
- Some blood tests may still need to be taken in relation to medication, for example clozapine blood tests or monitoring for lithium, in these situations unless the patient has symptoms of covid19 infection, these can be taken (with consideration to handwashing and use of PPE)
- No routine ECG need to be taken at this time - if the patient has concerns about their physical health in relation to cardiovascular disease, or to acute physical illness they should be advised to call 111 or to contact their GP
- Physical health checks that can be done remotely, without face to face contact (eg completion of the Rethink form via a video consultation) can take place as usual, if there are sufficient staff resources to do so. This may be an important aspect of clinical care currently, for example for service users with reduced access to primary care or no GP (eg FIRST team)
- If there is key physical information about underlying health conditions, this should be recorded as usual within the case record
- If the patient is suspected of suffering from Covid19, this must be recorded in the Infection Control section of Rio (Assessments, Physical Health Assessments, Infection Control) - this will send a notification to the Infection Control team

Inpatients

- Prior to admission, the admitting team will ask **screening questions** of the patient to check if there are suspicions of infection with covid 19 and all patients will be swab tested for Covid 19 – the

patient should be isolated until the results of the test are available, and if positive, isolation should continue according to advice from the Infection Control Team

- When the patient is admitted (if they are not suffering with any symptoms), the admitting doctor must check if the patient has any **underlying health conditions** (diabetes, COPD, any illness or treatment affecting the patient's immunity)and make this clear to the rest of the clinical team as well as documenting in the Systemic Enquiry form on Rio
- History taking- still essential (but take precautions if suspected or confirmed covid 19 case, such as social distancing or use of PPE)
- **Physical examination – only to complete if there is a clinical need at the time of admission, and use appropriate PPE if required . Document in the clinical record the reason for your decision. If an examination has not been performed, the need for this to take place should be reviewed on a regular basis by the clinical team.**
- Core assessment- physical observations must still be taken by nursing staff
- Pregnancy testing must be arranged if relevant
- Blood borne virus testing may still be relevant
- Any essential blood tests must be taken, but routine blood tests are not required at this time
- Malnutrition risk – especially in the presence of any positive diagnosis. – use MUST tool and refer to dietician
- Falls risk, pain management and mobility may also need assessing - refer to physio team if required
- Choking risk-use dysphagia screening tool and refer to Speech and Language Therapist.
- Lifestyle questions – not essential at this time but can be asked if resources are available to do so
- ECG; if safe to do so (with PPE if patient is suspected of having covid 19) - if haloperidol is being planned or for individuals on High Dose Antipsychotics (ie over 100% BNF max), an ECG must be taken. For those starting lithium, an ECG is required if they have established CVD or significant risk factors for CVD. That is what has always been in prescribing guidelines and is reflected in the shared care agreements.

Liaison with primary care

- At the current time, only essential clinical information must be shared with primary care colleagues – for example results indicating a new, significant physical illness which needs immediate treatment , medication changes and so on

- There is no need to share routine clinical information at present

- Electronic discharge summaries are still required to be sent to primary care services

Other physical health advice:

- Drugs and the immune system: The use of substances for example cannabis, cocaine, heroin, including alcohol and tobacco are all substances can all have an impact on the immune system. Substance use may contribute to a higher risk of infections and with a lower immune response. This in turn may cause the body to become more susceptible to other infections. It is unclear at this point whether substance users are more susceptible to COVID19, however, reducing or stopping substance use may minimise the risk of catching the virus and lessen subsequent complications. Those smoking substances e.g. crack cocaine, cannabis and tobacco may be particularly at risk of the negative effects of the virus on the lungs.

- National advice regarding supporting with alcohol dependence can be found here: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0157-Specialty-guide_-Alcohol-Dependence-and-coronavirus_8-April.pdf

Please refer to full policy for further details regarding Physical Health located in the Clinical section of the policy page under C 38.

To view the Quality Impact Assessment for this document please click on the below link:

Quality Impact Assessment