

# CLINICAL GUIDELINE ON PHYSICAL HEALTHCARE

<b>CLINICAL GUIDELINE REFERENCE NUMBER:</b>	CG55
<b>VERSION NUMBER:</b>	1
<b>REPLACES SEPT DOCUMENT</b>	CG55 V4
<b>REPLACES NEP DOCUMENT</b>	CP8/PhysicalHealthcare/09/13 V8
<b>KEY CHANGES FROM PREVIOUS VERSION</b>	None
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<b>CONSULTATION GROUPS:</b>	Executive Physical Health Subcommittee; Physical Health Action Implementation Group; Medical Managers
<b>IMPLEMENTATION DATE:</b>	October 2017
<b>AMENDMENT DATE(S):</b>	n/a
<b>LAST REVIEW DATE:</b>	September 2017
<b>NEXT REVIEW DATE:</b>	November 2019
<b>APPROVAL BY EXECUTIVE PHYSICAL HEALTH SUB-COMMITTEE</b>	5 <sup>th</sup> September 2017

<b>CLINICAL GUIDELINE SUMMARY</b>
<p>The guideline sets out the importance of physical health for people with mental illness and supports staff to ensure that service users receive appropriate assessments and interventions for physical health conditions and health risk behaviours.</p> <p>Every mental health worker is expected to develop a good understanding of the importance of physical health and to help service users achieve good health and strengthen their capacity to safely self-manage their conditions.</p> <p>The guideline covers people using specialist mental health or learning disability services provided by Essex Partnership University NHS Foundation Trust (EPUT). It also covers the role of EPUT employed staff in Trust provided nursing homes.</p> <p>The guideline must be read in conjunction with other policies and procedures, especially:</p> <ol style="list-style-type: none"> <li>1. Trust Formulary and Prescribing Guidelines</li> <li>2. Royal Marsden Clinical Procedures Online Manual</li> </ol> <p><b>The Trust monitors the implementation of and compliance with this clinical guideline in the following ways;</b></p> <ol style="list-style-type: none"> <li>1. Executive Physical Health Subcommittee – reporting to Quality Committee.</li> <li>2. Physical Health Action Implementation Group.</li> </ol>

<b>Services</b>	<b>Applicable</b>	<b>Comments</b>
Trustwide		
Essex MH&LD	✓	
CHS		

**The Director responsible for monitoring and reviewing this Clinical Guideline is the Executive Medical Director**

**ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST**

**PHYSICAL HEALTHCARE FOR USERS OF MENTAL HEALTH AND LEARNING  
DISABILITY SERVICES**

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**ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST****PHYSICAL HEALTHCARE****Assurance Statement**

“People with mental health problems will have parity of life expectancy and no higher rates of physical illness than those without these problems” (Royal College of Psychiatrists, 2013).

To contribute to this vision, the Trust will recognise the due importance of physical health for people with mental illness and take action to ensure that service users receive appropriate assessments and interventions for physical health conditions and health risk behaviours. Every mental health worker will have a good understanding of the importance of physical health and will aspire to help service users to achieve good health, to build service users’ capacity to safely self-manage their conditions, and to ‘make every contact count’.

**1.0 INTRODUCTION**

- 1.1 The purpose of this guideline is to support staff to provide a good standard of physical healthcare to people using Essex Partnership University NHS Foundation Trust (EPUT) services, in both community and in-patient settings.
- 1.2 The guideline will cross reference other EPUT policies and guidance that impact on health. Implementation of these policies will support the aspirations of this guideline.
- 1.3 EPUT provides a wide range of community, mental health and rehabilitation services to predominantly vulnerable populations, such as the elderly and people with mental illness or learning disability. Such populations frequently experience multiple health risks and co-morbidities in addition to their primary presenting problem. In particular, rates of obesity, smoking and type 2 diabetes are high in populations with serious mental illness. Making every contact count (MECC) is an approach in which every opportunity is taken to help people improve their health and well-being. A more comprehensive focus on health and life-style choices in every clinical encounter could result in better outcomes for people, achieved more efficiently through early intervention.
- 1.4 Parity of esteem between physical and mental healthcare is a key national policy and priority throughout the health and care economy. People with mental illness have a life expectancy that is 15-20 years shorter than the general population, largely due to modifiable health risks. They have a high prevalence of cardiovascular and metabolic disorders, including type 2 diabetes, and these conditions are exacerbated by antipsychotic medication. This guideline will therefore have a particular emphasis for mental health service provision. Other aspects of ‘parity of esteem’,

including improved access to services and better mental health support for people with physical health conditions will not be addressed by this guideline.

- 1.5 Service users with comorbidities receive care from a wide range of different professionals and organisations. Ensuring access to appropriate clinical information by those sharing responsibility for care is essential.
- 1.6 NICE has published a range of clinical guidance (including guidelines and quality standards) that is relevant to this guideline. Examples include:
  - Guideline PH48 Smoking cessation in secondary care: acute, maternity and mental health services;
  - Quality standard QS86 Falls in older people
  - Quality standard QS80 Psychosis and schizophrenia in adults.
- 1.7 This guideline will contribute to achieving the NHS Outcome framework indicator to reduce premature death in people with mental illness (Indicator 1.5 i - Excess under 75 mortality rate in adults with serious mental illness. The same indicator is repeated in the Public Health Outcome Framework – Indicator 4.09i).

## **2.0 SCOPE OF THE GUIDELINE**

This guideline covers people using inpatient and community specialist mental health and learning disability services. It also covers the practice of EPUT employed nursing and care staff working in Trust provided nursing homes (Rawreth Court and Clifton Lodge). The Trust does not provide medical and pharmacy services in these facilities and these elements of the guideline do not apply to the nursing homes.

The scope of the guideline is limited to specialist mental health and learning disability services because physical healthcare has not traditionally been core business for these services and it is important to get the basics right. It sets out a comprehensive approach to physical healthcare and, while many of the components do apply to all EPUT service users, much of this guideline will be unnecessary and below the standard required from some of our more specialised community health services.

This guideline references a range of EPUT policies, procedures, clinical guidance and care pathways that are relevant to comprehensive management of physical health.

This guideline should be read in conjunction with:

- i. The Royal Marsden Manual of Clinical Nursing Procedures.
- ii. Trust Formulary and Prescribing Guidelines.
- iii. The Maudsley Prescribing Guidelines in Psychiatry. 12<sup>th</sup> Edition 2015.

- iv. The Lester Tool – Positive Cardio-metabolic Health Resource
- v. Infection Control policy ICP1, particularly Section 3, Infection Control in Clinical Practice.
- vi. Mental Capacity Act Policy.
- vii. Consent to examination or treatment clinical guideline (CG 16).
- viii. Cardiopulmonary resuscitation (CPR) policy. (CLP 14) This includes Management of the Deteriorating Patient and “Do Not Attempt Cardiopulmonary Resuscitation” orders).
- ix. Smoke free policy CP32
- x. MHA 1983 Code of Practice (particularly chapter 24)
- xi. Trust Procedural guideline for protected mealtimes (CG80)
- xii. Catering policy (RM12)
- xiii. The Hospital Food Standards Panel’s report on standards for food and drink in NHS hospitals (August 2014)

### 3.0 STANDARDS

#### 3.1 Generic and Environmental Standards

G1	Responsibilities for physical health monitoring and care will be documented in job descriptions, job plans, staff supervision, staff appraisals, and staff personal development plans.
G2	All staff are responsible for ensuring that identified physical health issues are acknowledged and followed up appropriately and systematically.
G3	All service users should have a General Practitioner or appropriate primary care support; Trust staff will help service users to register.
G4	All service delivery sites will have the necessary equipment to enable staff to carry out appropriate physical assessment and examination (Appendix 1).
G5	If the standards are not achieved for non-clinical reasons, such as pathway or systematic issues, this must be reported to the relevant manager who will be responsible for expediting short and medium term solutions.
G6	Appropriate clinical staff should have the facility to order investigations necessary for psychotropic monitoring.

#### 3.2 Inpatient Care Standards

IP1	All patients will have baseline observations within 6 hours of admission.
IP2	All patients will receive an appropriate physical assessment and examination by a doctor within 24 hours of admission. In case the physical examination cannot be carried out a clear rationale should be documented and the examination should be attempted as soon as possible.

IP3	All patients will have a basic medicines reconciliation (level 1) within 6 hours of admission.
IP4	Patients with physical healthcare needs will receive appropriate advice, interventions and treatments for identified health risks and physical health conditions.
IP5	All physical health assessments, investigations, results, planned actions and timescales for review will be fully documented in the patient's records. This will include a contemporaneous and up-to date record of current medication.
IP6	An appropriate physical health assessment should be completed before prescribing psychotropic medications. If this standard cannot be met, the reason must be documented in the notes.
IP7	Staff must discuss and document relevant assessment and investigation findings with the patient, including any recommendation for referral or further action.
IP8	If consent to assessment is refused, this will be documented in the notes and re-attempted as early as possible.
IP9	If the patient's clinical condition prevents achievement of these standards, this must be documented in the patient's record.
IP10	Inpatients under the age of 65 with no identified physical health care needs will have weekly vital signs monitoring and a full annual physical health assessment and examination. Adults aged 65 and over will have daily vital signs monitoring unless their condition is stable and they are in long-term care. MEWS scores will be documented.
IP11	When referring people to services, health and social care practitioners should take into account the 'negative' symptoms of psychosis and schizophrenia (such as emotional apathy, lack of drive, poverty of speech, social withdrawal and self-neglect), and ensure services are accessible for people with these symptoms. (NICE quality standard 80 /7)

### 3.3 Community and Out-patient Mental Health Service Standards

C1	All patients accepted on to the caseload will receive an appropriate physical health assessment.
C2	A detailed medical history will be taken at the first follow up appointment with a doctor for all patients taken onto a community caseload who require medical review as part of a comprehensive psychiatric assessment.

C3	Staff will liaise appropriately with primary care services for all new patients taken onto the caseload to confirm and document past and current medical history, including medications and ongoing planned treatment and monitoring.
C4	The mental health care plan will document responsibilities for monitoring any identified physical healthcare needs and for contributing to shared-care of long term conditions as agreed with primary care.
C5	The appropriate investigations will be carried out in prescribing psychotropic medication. Ongoing monitoring will be carried out in line with guidance in the Trust Formulary and shared-care plans agreed with primary care.
C6	Patients cared for by community teams who are stable on medication and have no physical health concerns will be supported in obtaining an annual health check, vaccinations and health screening from primary care services.
C7	Patients with identified physical healthcare needs will receive appropriate advice, interventions and treatments for identified health risks and physical health conditions, in liaison with other relevant care providers.
C8	Patients who are newly diagnosed with long term conditions will have a shared care plan agreed with primary care.
C9	Patients will have access to information, advice and interventions for behavioural health risks including smoking, exercise, healthy eating, alcohol and drug use, and sexual health.

#### **4.0 ASSESSMENT OF ALL NEW PATIENTS**

##### **4.1 INITIAL ASSESSMENT**

- The individual assessment of patients' needs and risks should include a detailed medical and nursing physical health assessment. Patients should be offered a chaperone for the examination.
- Current and previous health problems should be documented in the patient's record and verified with primary care if necessary. Particular attention should focus on the presence or absence of cardiovascular disease, hypertension and diabetes (Required for monitoring psychotropic medication in relation to cardiovascular disease: Appendix 2)
- Review of family history must document cardiovascular disease or early death. (Appendix 2)
- The medical systems review should pay particular attention to current symptoms and signs that may indicate cardiovascular disease or risk factors.
- Be aware of impact of smoking status on metabolism of other drugs, particularly clozapine and olanzapine.

## 4.2 ASSESSMENT OF HEALTH RISK FACTORS

- Assess history of relevant public health screening and immunisation.
- Assess lifestyle and risky behaviour - smoking, alcohol intake, substance misuse, physical exercise, and sexual health and behaviour.
- Screen to identify those who are malnourished or at risk of becoming malnourished (MUST tool - Mobius Form 3.5).
- The lifestyle and risky behaviour review (smoking, diet and physical activity) should be repeated at 12 weeks and then manually and then annually. However, more frequent monitoring may be required in patients with ongoing health risks and active care plans.

## 4.3 MEDICATION ASSESSMENT

- All medication including doses and recent changes must be listed. Information may need to be verified with primary care or informal carers.
- Medicines reconciliation should be undertaken in line with Appendix 18 of the Procedural Guidance for the Safe and Secure Handling of Medicines (CLPG13-MH).
- Assess for the presence of side effects and document using a suitable tool such as the Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) (Mobius form 2.5). The Glasgow Antipsychotic Side-effect Scale (GASS) is an alternative validated tool.
- Assess for the presence of drug interactions or potential interactions.
- Consider the potential effects of specific medications: diuretics (effect on magnesium), multiple medications (falls), potentially toxic medications, high dose or combination antipsychotics, unstable control of relevant symptoms etc.
- A joint review of medication by medical, pharmacy, and nursing staff should be considered for all inpatients.
- A specific review of medications associated with an increased risk of falls should be documented for all patients aged 65 years or above or for any other patient identified with a risk of falls.
- A joint review of medication may be indicated in community patients with risk factors.
- The Trust Formulary (Chapter 2) and this guideline (Appendix 2) set out detailed information about monitoring psychotropic medication.
- NICE guidance CG178 places responsibility on secondary care mental health teams to assess the service user's physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. Thereafter, assessments may be transferred to primary care under shared care arrangements and should take place at least annually.



#### 4.4 ADDITIONAL ASSESSMENT FOR INPATIENTS

- The medical assessment should be completed as soon as possible after admission, and as a minimum, within 24 hours. Any refusal of assessment by the patient should be documented in the notes and the assessment should be reattempted.
- Baseline observations of vital signs should be completed as soon as possible, but as a minimum, within 6 hours of admission. Vital signs will be monitored in inpatients by the Modified Early Warning Score (MEWS). The thresholds for scoring MEWS can be adjusted by the doctor following medical assessment, to take account of pre-existing medical conditions that affect baseline scores, for example, COPD. The frequency of MEWS monitoring will be determined after the initial assessment but will be a minimum of daily in older people wards and weekly in adult wards.
- Additional specialist assessments may be indicated, as determined by specific policy and eligibility criteria:
  - Slips, Trips and Falls Clinical Guideline CG58; All people aged 65 and over, and younger patients considered at risk of falls must have a falls risk assessment completed within 24 hours of admission. (Mobius Form 2.25 06)
  - The falls risk assessment and subsequent management plans include assessments for postural hypotension, sleep assessment (Mobius form 3.33 04) and continence assessments. (Mobius form 3.33 08 and 09).
  - VTE assessment: all in-patients should be assessed for significantly reduced mobility relative to their normal state. A full VTE risk assessment (Mobius form 3.16) should be carried out in;
    - i. people with significantly reduced mobility,
    - ii. people aged over 60 years
    - iii. women admitted to the Mother and Baby Unit.
 The VTE risk assessment should be repeated if there is a change in the patient's physical health condition.
  - Hydration: (GULP Dehydration Risk Screening Tool Assessment – Mobius Form 3.33 01)
  - Clinical Guideline For The Prevention And Management Of Pressure Ulcers CG11; the Waterlow risk assessment tool will be completed within 6 hours of admission by a registered nurse, documented in the records and reviewed at least monthly. (Mobius Form 3.33 06)
  - Nutritional risk assessment using MUST (Malnutrition Universal Screening Tool) will be completed at first clinic appointment or on admission to an inpatient unit; screening is to be repeated weekly for inpatients. (Mobius Form 3.5)

#### 4.5 FOLLOW-UP ASSESSMENTS

- An annual physical health assessment should be carried out in all patients.
- More frequent physical health assessments may be required for patients with identified health care needs, and should be documented as part of the care plan
- Treatment side effects should be assessed in the early stages of starting new treatments, after any dose changes, and regularly at reviews during the treatment period.
- Other psychotropic monitoring should be carried out as specified in the Trust Formulary and Prescribing Guidelines
- If the necessary skills and competencies are not available from within the Trust, the care plan should document actions to ensure that health needs are met. This might include referral too, or shared care with primary care or specialist providers.

#### 4.6 OBSERVATIONS

- Baseline clinical observations should be done manually. These include temperature, pulse – rate and rhythm, blood pressure, respiration rate, oxygen saturation, and a basic CNS assessment AVPU (alert, voice, pain, unresponsive).
- Additional observations include weight, height and girth, BMI, and peak flow if asthmatic.
- The frequency of routine and ongoing observations will be determined as part of the care plan.
- The NICE quality standard 80 set out the monitoring requirements for new adult patients with psychosis and schizophrenia. It is good practice to apply this standard to all people using specialist mental health and learning disability services:
  - For patients prescribed psychotropic medication, follow Trust Formulary guidance on weight monitoring frequency as this is medication specific (plot on a chart).
  - All patients, repeat baseline weight measurement at 12 weeks, at 1 year and then annually.
  - Monitor waist circumference annually (plotted on a chart)
  - Review pulse and blood pressure at 12 weeks, at 1 year and then annually.

### 5.0 INVESTIGATIONS

#### 5.1 BASELINE TESTS

- A full blood screen may be indicated for new patients, for the annual health check in stable patients, or as part of medication monitoring.
- This will usually include FBC, U&Es, LFTs, TFTs, blood glucose, HBA<sub>1c</sub>; calcium, phosphate and magnesium, fasting lipids, and prolactin. If fasting samples are impractical then non-fasting samples are satisfactory for most measurements except for triglycerides.
- Urinalysis for proteinuria.

- ECG is required for patients at risk of cardiovascular disease, with independent vulnerability factors, or being prescribed higher risk medication (Appendix 2).

## 5.2 ONGOING MONITORING

- All patients commencing medication will have a repeat fasting blood glucose, HbA1c and blood lipid levels at 12 weeks, at 1 year and then annually.
- Patients on psychotropic medication will need regular physical health monitoring. Monitoring guidance for specific medications is set out in the Trust Formulary and Prescribing Guidelines.
- Patients on Lithium need monitoring of serum lithium levels and corrected calcium in addition to physical health monitoring.
- Patients on clozapine must be registered with the Clozapine Monitoring Service before prescribing, and follow the clozapine management protocol in Section 2 of the Trust Formulary and Prescribing Guidelines.
- ECG monitoring requirements are set out in Appendix 2.

## 5.3 CARDIOVASCULAR RISK CALCULATOR

- Consider use of the Joint British Societies Risk Calculator (JBS3) to support patient care <http://www.jbs3risk.com/>. The calculator will help to monitor, inform and communicate advice and information about cardiovascular risk.<sup>1</sup>
- JBS3 models the 10 year risk of heart attack or stroke, which is generally low in young people, even in those with significant risk factors. The advantage of JBS3 is that it also estimates life time CVD risk and models the impact of life style behaviour change on survival. The gains in extra years survival can be substantial in young people with significant risk factors.

<sup>1</sup> The JBS3 calculator is a free online tool and is based on the QRISK2 tool used as part of the national health-checks. The advantage of the JBS3 calculator over the QRISK2 tool is that it allows estimation of lifetime risk and modelling of the impact of interventions. This is more suitable for EPUT service users who, by dint of their age, are at low short term risk but high lifetime risk.

## 6.0 INTERVENTIONS

### 6.1 Information (advice, signposting, physical health advocacy).

- Multidisciplinary approaches are needed to manage life time risks. As part of 'Making every contact count', all staff should be able to Ask, Assess, and Advise patients on evidence based ways to target behavioural risk factors. Specific lifestyle interventions should be discussed in a collaborative, supportive and encouraging way, taking into account the person's preferences.

- Health and social care practitioners should be aware of the impact of social factors, such as inadequate housing, lack of access to affordable physical activity, poor cooking skills and limited budget for food, on continued healthy eating and physical activity. (NICE Quality standard 80 / 7)
- Patients should be signposted to relevant community services, including health trainers, which can provide more intensive support to develop a personal health plan.
- Support on how to stop smoking should be given, at every available opportunity, with provision of self-help material and referral to more intensive support, e.g. stop smoking services.
- Brief advice and support on healthy eating, cooking, and shopping should be provided. In particular, consider the role of 'fast food', fizzy drinks and lack of fibre in the diet.
- Both physical activity and exercise are important for reduction of cardiovascular risk. Patients should be advised to increase levels of sustained physical activity as part of an active lifestyle (walking, cycling or other aerobic activity) AND to avoid prolonged sedentary behaviour.
- The physical health assessment may reveal long standing health problems and unmet needs, for example, lack of appropriate follow up of a long term condition. Staff should act as health advocates, and address immediate health concerns of inpatients and liaise with primary care services to ensure appropriate follow-up or referral of community patients.

## **6.2 Life style interventions**

- Patients who smoke should be offered behavioural counselling, group therapy, pharmacotherapy or a combination of treatments that have been proven to be effective.
- Nicotine replacement therapy (NRT), varenicline or bupropion should be offered to people who are inpatients or who are planning to stop smoking and have planned a target stop date.
- Health trainer support is available in the community and can provide practical support with planning and implementing health programmes.
- Healthy eating and physical activity programmes should be considered as part of the care plan and provided by the Trust if necessary (NICE Quality standard 80 / 7).

## **6.3 Interventions for physical health or long term conditions**

- Interventions should be offered in line with NICE guidelines for lipid modification, preventing type 2 diabetes, hypertension, and prevention of cardiovascular disease. Treatment of high lipids, diabetes and hypertension is normally supervised by the GP. Agreement about shared responsibility and care is recommended with primary care on an individual patient basis. The psychiatrist remains responsible for monitoring physical health for the first twelve months or until the condition has stabilised.

- Patients who develop new physical health conditions, or exacerbations of long term conditions whilst inpatients should be assessed, investigated and have an appropriate care plan, including management within NICE guidelines or referral for more expert advice. Access to expert advice should be flexible, particularly for acutely ill inpatients who may be unable to travel.
- The management of a wide range of physical health procedures in inpatient services is covered by the Royal Marsden Manual of Clinical Nursing Procedures and the Infection Control policy, section 3 (in Clinical Practice).

#### **6.4 Shared decision making on medication, as part of care plan.**

- Discussions about medication should involve the patient, the GP and the psychiatrist, and in more complex cases, the pharmacist too.
- The Choice and Medication website, accessed via the Trust intranet, is designed to support shared decision making. <http://www.choiceandmedication.org.uk/eput/>
- The side effects of medication should be monitored and the rationale for continuing, changing or stopping the medication be clearly documented and discussed with the patient. The role of the crisis plans should be considered with respect to medication adherence and shared decision making between the patient and prescriber.

### **7.0 RESPONSIBILITIES**

#### 7.1 The Trust Board will ensure:

- That this guidance is implemented throughout the organisation;
- That resources are aligned to achieving good practice in physical healthcare;
- That management systems support good practice in physical healthcare.
- That care pathways are designed to support good practice in physical healthcare.

#### 7.2 The Medical Director will;

- Lead implementation of this guidance through a multidisciplinary clinical collaboration;
- Ensure that the guidance is reviewed and updated regularly, in accordance with recommended best practice and national guidance;
- Ensure that implementation of the guidance is monitored through quality assurance activities.

7.3 Directors and Associate/Deputy Directors/Senior Managers will:

- Develop and lead strategies for specific work-streams that support implementation of the guidance.
- Ensure that services offer a range of health promotion programmes, information, encouragement and support.
- Review complaints about physical healthcare and recommend action to improve care.
- Work with Training Leads to ensure that staff develop and maintain the relevant competencies to deliver appropriate physical healthcare.
- Support and manage staff capacity to achieve good practice as set out in the guidance.
- Ensure that staff in mental health teams (inpatient and community) have resources, equipment and facilities to implement this guideline.
- Consider economies of scale when procuring medical equipment and devices for front line service areas.

7.4 Team Leaders/Ward Sisters/Charge Nurses will ensure:

- That all staff, including new employees, whether temporary or permanent are made aware of the guidance and are managed to implement good practice.
- That supervision includes the physical health and health promotion of services users;
- That staff access relevant training to develop and maintain the requisite competencies;
- That inpatient and community teams are able to procure medical devices to support the safe assessment and management of patients who have physical healthcare needs;
- That they identify any patients who have not had a physical health assessment and report this to the consultant psychiatrist, Responsible Clinician (RC) or doctor on call.

7.5 Consultant psychiatrists or the Responsible Clinician (RC) will ensure:

- That all patients who receive a service from the Mental Health, Drug and Alcohol and Learning Disability services have their physical health needs assessed during their initial assessment.
- That further examinations are undertaken as appropriate, depending on the patient's circumstances.
- That medical staff under their supervision are aware and understand this guidance and adhere to its requirements.
- The responsibility for individual inpatient medical treatment, including decisions on physical healthcare needs and clinical management rests with the consultant psychiatrist or RC in conjunction with the remaining multi- disciplinary team;
- His medical team is aware of the guidance and the choice of medication website.

## 7.6 All clinical staff:

- Will be familiar with their responsibilities under this guidance and other associated Trust Policies and procedures;
- Will have the knowledge and skills to understand the physical health care priorities for their service users and know who to ask for additional support and advice;
- Will act within their professional responsibilities, identifying professional development needs via supervision and appraisal;
- Will have knowledge of local healthcare support services for physical health and health promotion initiatives and know how to support service users with access to these services.
- Will ensure appropriate liaison with primary care and other relevant services.
- Will be responsible for recording physical healthcare assessments, management plans and risk assessments on the appropriate physical health record.
- Will be responsible for reporting any abnormalities in physical health assessments or observations that they have undertaken, to the medical doctor responsible for the care of that patient at the time.
- Must minimise and manage the physical health risks associated with the side effects of medication as prescribed by the Trust and follow the Trust Formulary and Prescribing Guidelines and the Maudsley Prescribing Guidelines.
- Will be level 1 smoking cessation trained
- Will ensure that patients maintain current physical health treatment plans whilst in the care of the Trust
- **All qualified nursing staff** must have the skills and competency to assess and interpret recordings of temperature, pulse, blood pressure respirations, oxygen saturation and AVPU and use the Modified Early Warning Score to detect early signs of deterioration of inpatients and escalate to medical staff for timely intervention
- **All qualified nurses** should be competent to assess and interpret body mass index, urinalysis and blood glucose monitoring and report abnormal results to medical staff so that subsequent action can be taken.
- Medical staff must be competent to undertake a full and appropriate medical assessment and examination of patients and be able to interpret investigations and work with other NHS providers to provide appropriate treatment.
- Any physical health issues identified will be followed up by the doctor who identified them in the first instance. It is this doctor's responsibility to ensure that action is taken in a timely fashion and that there is a safe transfer of care between teams.

7.7 Non-clinical staff will:

- Report to a trained clinician if a service user informs them that they are feeling physically unwell;
- Will call for emergency care if they witness and feel that the service user is experiencing a life threatening event;
- Will make investigation results accessible and available to clinical staff;
- Will make reports from both primary care and secondary care services available to clinical staff.

7.8 Care Co-ordinators will:

- Ensure that each patient on their caseload has the opportunity to have an annual assessment of their physical health, either undertaken by their GP or by the team doctor. If the assessment is undertaken by the GP then they should request the information obtained to inform the care provided by the team.

7.9 Pharmacy staff will:

- Provide advice on the safe and effective use of medicines, including appropriate dosing, side effects and required monitoring.
- Facilitate patients receiving Clozapine being registered with the relevant Clozapine Monitoring Service.

7.10 The practice development and workforce development & training teams will:

- Work with clinical and non-clinical staff to develop competencies to manage people with physical healthcare conditions;
- Ensure that the training provided by the organisation for all levels of staff around physical healthcare reflects the principles of this guidance.

<b>END</b>
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