

## CLINICAL GUIDELINE ON PHYSICAL HEALTHCARE

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<b>VERSION NUMBER:</b>	2
<b>REPLACES EPUT DOCUMENT</b>	CG55 V1
<b>KEY CHANGES FROM PREVIOUS VERSION</b>	Updated and general refresh to meet NICE guidance and the aspirations of the NHS Long Term Plan. Incorporation of Substance Misuse services; enhancement of older people focus; additional reference to diabetes and atrial fibrillation; updated ECG guidance (Appendix 2).
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### CLINICAL GUIDELINE SUMMARY

The guideline addresses physical health of people with mental illness or substance misuse and supports staff to ensure that service users receive appropriate assessments and interventions for physical health conditions and health risk behaviours. 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.

The guideline covers people using specialist mental health, learning disability or drug and alcohol services provided by Essex Partnership University NHS Foundation Trust (EPUT), as well as the role of EPUT employed staff in Trust provided nursing homes.

The guideline must be read in conjunction with other policies and procedures, especially:

1. Trust Formulary and Prescribing Guidelines
2. Royal Marsden Clinical Procedures Online Manual
3. Mental Capacity Act and Deprivation Of Liberty Safeguards Policy (MCP2)
4. Drug Misuse and Dependence. UK Guidelines on Clinical Management 2017

### **The Trust monitors the implementation of and compliance with this clinical guideline in the following ways;**

Physical Health Subcommittee – reporting to Quality Committee.

Services	Applicable	Comments
Trustwide		
Essex MH&LD	✓	
CHS		
STaRs	✓	

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

**CONTENTS**

- 1 INTRODUCTION**
- 2 SCOPE OF THE GUIDELINE**
- 3 STANDARDS**
- 4 ASSESSMENT OF ALL NEW PATIENTS**
- 5 INVESTIGATIONS**
- 6 INTERVENTIONS**
- 7 RESPONSIBILITIES**

**APPENDICES**

**APPENDIX 1 – BASIC CLINICAL EQUIPMENT FOR PHYSICAL HEALTH ASSESSMENT**

**APPENDIX 2 – GUIDELINE ON MONITORING PSYCHOTROPIC PRESCRIBING IN RELATION TO CARDIOVASCULAR DISEASE**

**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 or substance misuse 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. 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, learning disability or substance misuse. 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 health risk behaviours 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 or substance misuse have a life expectancy that is 15-20 years shorter than the general population, largely due to risks that can be modified by behaviour change or preventative medication. The prevalence of cardiovascular disease (CVD) and metabolic disorders, including type 2 diabetes, is particularly high in people with mental illness and the risk of these conditions is exacerbated by antipsychotic or psycho-active medication.

## CG55 - PHYSICAL HEALTHCARE CLINICAL GUIDELINE

1.5. Service users with comorbidities require care from a wide range of different professionals and organisations but access to services can be difficult for people with mental illness or other vulnerabilities. Barriers to care include structural factors such as how services are organised, and attitudes of staff, to patient factors such as cognitive or illness related symptoms, and access to resources such as mobile phones and technology. “Diagnostic overshadowing” – a process whereby health professionals wrongly assume that physical symptoms are a consequence of a mental illness or learning disability diagnosis – can result in discrimination, where medical symptoms are marginalised or dismissed. Staff need to work with and on behalf of patients to ensure that these barriers to care are addressed proactively and that appropriate clinical information is shared by all responsible for an individual’s care.

### 1.6. **NHS Long Term Plan**

The NHS Long Term Plan sets out a ten-year programme of service improvements, and renews the commitment to service integration across physical and mental health services. The focus on prevention is increased, with ambitions to reduce smoking and alcohol consumption, reduce obesity, and prevent long term conditions such as Type 2 Diabetes and cardiovascular disease.

The national cardiovascular disease (CVD) prevention programme aims to reduce heart attacks, strokes, vascular dementia and kidney disease by improving early detection and treatment of three high-risk conditions. The programme ambition is for people routinely knowing their ‘ABC’ numbers and receiving treatment to live longer and healthier lives.

- **A**trial fibrillation
- **B**lood pressure
- **C**holesterol

*Atrial fibrillation (AF) is characterised by a rapid, irregular heartbeat and is the most common heart rhythm irregularity. The irregular beating commonly causes the formation of blood clots in the heart which increases the risk of stroke by 5 times. Anticoagulation is an effective therapy for managing people with AF who are at risk of stroke and can reduce the risk by 66%.*

1.7. Annual physical health checks for people with severe mental illness are in place in specialist mental health secondary care settings (Lester cardiometabolic screening for smoking, lifestyle risks, blood pressure, weight/BMI, glucose and blood lipids) and in primary care settings (annual physical health checks for people on the SMI register).

1.8. From 2018-19, the comprehensive health checks should be enhanced to include assessment of nutritional status and physical activity; assessment of illicit substance use; access to national screening programmes; medicines reconciliation and review; general physical health topics such as sexual health and oral health; and follow up interventions for identified health risks or conditions.

## CG55 - PHYSICAL HEALTHCARE CLINICAL GUIDELINE

- 1.9. NICE clinical guidance relevant to this guideline includes:
- Guideline PH48 Smoking cessation in secondary care: acute, maternity and mental health services;
  - Quality standard QS86 Falls in older people
  - Clinical guidance CG178. Psychosis and schizophrenia in adults: prevention and management.
  - Clinical guidance CG185. Bipolar disorder, assessment and management.
  - Guidance, Quality standards and Pathways for Diabetes.
  - Clinical Guideline CG108 and NICE pathway: Atrial Fibrillation; management.

### 2. SCOPE OF THE GUIDELINE

- 2.1. This guideline covers people using inpatient and community specialist mental health and learning disability services. It also covers the practice of EPUT employed staff working in either Trust provided nursing homes (Rawreth Court and Clifton Lodge), or in the Essex Specialist Treatment and Recovery Service (STaRS) which is responsible for prescribing for clients with substance misuse, working in partnership with other agencies and primary care.
- 2.2. The scope of the guideline does not include Community Health Services which provide specialist physical health care to a higher standard and competency than set out in this guideline.
- 2.3. 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. (Trust intranet > Home > Quick links)
- ii. Trust Formulary and Prescribing Guidelines. (Trust intranet > Tools > MH Prescribing guidelines)
- iii. The Maudsley Prescribing Guidelines in Psychiatry. (Basildon Healthcare Library (requires Open Athens login)).
- iv. Drug Misuse and Dependence. UK Guidelines on Clinical Management 2017
- v. The Lester Tool – Positive Cardio-metabolic Health Resource
- vi. ICPG1 - Infection Control policy, particularly Section 3, Infection Prevention and Control in Clinical Practice.
- vii. CG88 - End of Life Clinical Guideline,
- viii. MCP2 - Mental Capacity Act and Deprivation of Liberty Safeguards Policy.
- ix. CLP16 - Consent to Examination or Treatment Policy.
- x. CLP14 - Policy for Cardiopulmonary resuscitation (CPR.)
- xi. CLPG14B - Procedure: Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

## CG55 - PHYSICAL HEALTHCARE CLINICAL GUIDELINE

- xii. CG87 - Clinical Guidelines on the Use of Early Warning Scoring System (MEWS/NEWS2)
- xiii. CP32 - Smoke free policy
- xiv. MHA 1983 Code of Practice (particularly chapter 24)
- xv. RM12 - Catering policy
- xvi. CG80 - Protected mealtimes guidelines.

### 3. 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 <sup>1</sup> and psycho-active drug 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. If 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. These should be documented in a care plan which is regularly reviewed and updated.

## CG55 - PHYSICAL HEALTHCARE CLINICAL GUIDELINE

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 <sup>1</sup> 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. (Consent to Examination or Treatment Policy (CLP 16) may apply).
IP9	If the patient's clinical condition prevents achievement of these standards, this must be documented in the patient's record. (Consent to Examination or Treatment Policy (CLP 16) may apply)
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	Health and social care practitioners will be aware of barriers to healthcare, including diagnostic over-shadowing, and will provide assertive and proactive support and advocacy for service users who need to access other physical health services.

### 3.3. Community and Out-patient Mental Health and Drug and Alcohol Service Standards

C1	All patients accepted within community and out-patient mental health or drug and alcohol services will receive an appropriate physical health assessment.
C2	A detailed medical history will be taken at the first follow up appointment with a doctor or an independent non-medical prescriber (INMP) for all patients who require medical review as part of a comprehensive psychiatric or Essex Specialist Treatment and Recovery Service (STaRS) assessment.
C3	Staff will liaise appropriately with primary care services for all new patients to confirm and document past and current medical history, including medications and ongoing planned treatment and monitoring.

<sup>1</sup> The term 'psychotropic' refers to the full range of prescribed psychiatric medication, including opioids. Staff must be aware that patients may also be taking non prescribed psycho-active substances, which might impact on physical health, and care and prescribing decisions.

## CG55 - PHYSICAL HEALTHCARE CLINICAL GUIDELINE

C4	The mental health care plan (or drug and alcohol recovery plan which is completed by the drug and alcohol partners) 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 when prescribing psychotropic medication <sup>1</sup> . Ongoing monitoring will be carried out in line with guidance in the Trust Formulary and shared-care arrangements agreed with primary care.
C6	Patients cared for by community or substance misuse 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. ASSESSMENT OF ALL NEW PATIENTS

#### 4.1. GENERAL CONSIDERATIONS

- Staff must seek valid consent for physical health assessments and examinations (Consent to examination or Treatment Policy CLP16).
- If consent is refused, the reasons should be documented in the notes. Staff should make repeated attempts to assess physical health throughout the episode of care.
- Staff should engage with patients to explain the rationale for physical assessments and establish shared commitment and decision making with ongoing monitoring and physical health care planning.
- Reasonable adjustments must be made for people with a physical or learning disability.
- Staff should recognise that patients may be experts in the management of existing long term conditions, such as Diabetes. Staff must respect this expertise, especially when a personalised care plan is needed during a hospital admission.
- If there are concerns or doubts about an individual's capacity to consent to assessment, a formal assessment of their capacity to make this decision should be carried out in line with Trust policy (MCP2 Mental Capacity Act and Deprivation of Liberty Safeguards Policy).
- Staff should consider if the patient is near end of life and if so, follow the principles of the End of Life Clinical Guideline CG88, including identifying if Advanced Care Planning or DNACPR discussions have taken place.



### 4.2. 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.
- Document current and previous health problems in the patients' record and verify with primary care if necessary.
- Look for symptoms and signs of unrecognised cardiovascular disease or risk factors, including atrial fibrillation and hypertension.
- Document family history including cardiovascular disease or early death.
- Staff must be aware of impact of smoking status on metabolism of other drugs, particularly clozapine and olanzapine.
- 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. The Consent to Examination or Treatment Policy (CLP16) may apply when valid consent is not possible.
- The "Drug Misuse and Dependence; UK guidelines on clinical management, 2017" describes the general health assessment and monitoring required for users of substance misuse services. This is carried out in partnership with primary care and other organisations that make up the service partnership.

### 4.3. ASSESSMENT OF HEALTH RISK FACTORS

- Document history of use of relevant public health screening programmes (breast cancer, women aged 50-70; cervical cancer, women aged 25-64; bowel cancer, people aged 60-74; abdominal aortic aneurysm, men aged 65-74).
- Document relevant immunisations; Hepatitis A and B (users of substance misuse services); pneumococcal vaccine (people aged 65 or over, or with certain medical conditions); shingles vaccine (people aged 70-80); annual flu vaccination, (people aged 65 or over, or with certain medical conditions).
- Document lifestyle risks and behaviour - smoking, alcohol (AUDIT tool), substance misuse, physical exercise, and sexual health and behaviour.
- Screen to identify those who are malnourished or at risk of becoming malnourished (MUST tool).
- Assessment of lifestyle risks and behaviour (smoking, diet and physical activity) should be repeated at 12 weeks and then annually.
- More frequent monitoring may be required in patients with ongoing health risks and active physical healthcare plans.

### 4.4. MEDICATION ASSESSMENT

- Document all medication including doses and recent changes. Verify information with primary care or informal carers.
- Complete medicines reconciliation 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. Examples of suitable validated tools include the Liverpool University Neuroleptic Side Effect Rating Scale (LUNTERS) and the Glasgow Antipsychotic Side-effect Scale (GASS).
- Assess for the presence of drug interactions or potential interactions.

## CG55 - PHYSICAL HEALTHCARE CLINICAL GUIDELINE

- Consider the potential effects of specific prescribed medications: diuretics (effect on magnesium), multiple medications (falls), potentially toxic medications, high dose or combination antipsychotics; and non-prescribed psycho-active medication that may have been taken by the patient; as well as 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.
- Monitor physical health and the effects of psychotropic medication for at least the first twelve months after starting psychotropic medication or until the person's condition has stabilised, whichever is longer (NICE guidance CG178). Thereafter, assessments may be transferred to primary care under shared care arrangements and should take place at least annually.

### 4.5. ADDITIONAL ASSESSMENT FOR INPATIENTS

- In acutely ill patients, consider delirium, pain and sepsis as possible causes.
- The Confusion Assessment Method (CAM) is a suitable screening tool for delirium (delirium guideline in development).
- The Abbey pain scale should be used in people with no reliable verbal communication, including dementia, if they could potentially be in pain. The assessment should be repeated daily whilst the dose of analgesia is being titrated in response to pain.
- Complete the Trust VTE (Venous Thromboembolism) risk assessment for all in-patients within five days, and if required, administer prophylaxis within 24 hours of assessment. Repeat the VTE risk assessment if there is a change in the patients' physical health condition or mobility.
- Complete a falls risk assessment for all people aged 65 and over, and aged 50-64 who are considered to be at risk of falls, within 24 hours of admission. (Slips, Trips and Falls Clinical Guideline CG58). This includes assessments for postural hypotension, sleep and continence.
- Complete a hydration assessment for patients at risk (GULP Dehydration Risk Screening Tool Assessment).
- Complete a Waterlow risk assessment for all patients vulnerable to pressure ulcer development within 6 hours of admission (Clinical Guideline for the Prevention and Management of Pressure Ulcers CG11).
- Complete a nutritional risk assessment using MUST (Malnutrition Universal Screening Tool) at first clinic appointment or on admission to an inpatient unit; screening is to be repeated weekly for inpatients.

### 4.6. ROUTINE OR FOLLOW-UP ASSESSMENTS

- An annual physical health assessment should be carried out for all patients, with a focus on cardiovascular and lifestyle risk factors.
- 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 or drug and alcohol recovery plan.
- Treatment side effects should be assessed in the early stages of starting new treatments, after any dose changes, and at reviews during the treatment period.
- The Care Plan or Drug and Alcohol Recovery Plan should document whether active or ongoing monitoring or care is being provided by primary care services or specialist professionals outside of EPUT. Healthcare professionals have a duty to liaise and share appropriate clinical information to ensure that all health needs continue to be met.

### 4.7. OBSERVATIONS

- Baseline clinical observations should be done manually. These include;
  - temperature
  - pulse – rate and rhythm
  - blood pressure
  - respiration rate
  - oxygen saturation
  - basic CNS assessment AVPU (alert, voice, pain, unresponsive)

*(Note that a dinamap monitor will not provide an accurate measure of pulse or blood pressure in patients with atrial fibrillation).*

- Additional observations include weight, height and girth, BMI, and peak flow if asthmatic.
- Baseline observations of vital signs should be completed as soon as possible, but as a minimum, within 6 hours of admission and repeated daily in older people wards and weekly in adult wards, unless the healthcare plan indicates that more frequent monitoring is required.
- Vital signs will be monitored in inpatients by calculation of the Modified Early Warning Score (MEWS) and plotted on the chart.
- For new patients with psychosis, baseline observation will be repeated at 12 weeks, 1 year and then annually.

## 5. INVESTIGATIONS

### 5.1. BASELINE TESTS

For new patients, these might include:

- Haematology profile: haemoglobin/full blood count; and if indicated, ferritin, vitamin B12, serum folate levels, inflammatory markers such as CRP or ESR.
- Renal profile: sodium, potassium, magnesium<sup>2</sup>, urea, creatinine, estimated glomerular filtration rate. Urinalysis for proteinuria or sample for albumin–creatinine ratio.
- Liver profile: alkaline phosphatase, bilirubin, alanine aminotransferase, gamma-glutamyl transferase, total protein, albumin.
- Bone profile: alkaline phosphatase, calcium, corrected calcium, phosphate levels.
- Glycaemic control: glucose, HbA1c (glycated haemoglobin).
- Lipid profile: cholesterol, triglycerides, high-density lipoprotein cholesterol.
- Endocrine profile: thyroxine, thyroid-stimulating hormone, prolactin.
- Blood borne virus (BBV) testing for all new substance misuse patients and thereafter annually or as necessary. (Trust Protocol for dried blood spot testing for BBV – SSOP61)
- ECG is required for patients with cardiovascular risk factors (including hypertension and irregular pulse), a history of cardiovascular disease, with independent vulnerability factors (as set out in Appendix 2), or those being prescribed higher risk medication.

### 5.2. ONGOING MONITORING

- All patients starting psychotropic medications need repeat blood tests for glucose, HbA1c and blood lipid levels at 12 weeks, at 1 year and then every year as part of the annual physical health check.
- 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 using the Joint British Societies Risk Calculator (JBS3) or the QRISK3 calculator to discuss health behaviours and cardiovascular risk with patients. <http://www.jbs3risk.com/>
- Using the calculator may help to engage patients and communicate information and advice about interventions to reduce cardiovascular risk.
- The JBS3 is a free online tool that allows estimation of lifetime cardiovascular risk in people aged over 30 and provides a visual display of the impact of health behaviour change on disease free additional years. This is particularly

<sup>2</sup> Low serum potassium or magnesium levels are associated with QT interval prolongation, exacerbating the risk of drug induced prolonged QTc and arrhythmias. Low electrolyte levels can be caused by diuretics, starvation, chronic alcoholism, and prolonged vomiting or diarrhoea.

relevant for younger people who may have a low ten year risk but a high lifetime risk.

### 6. INTERVENTIONS

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

- Multidisciplinary approaches are needed to manage health risk behaviours. 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.
- Chapter 17 of the Trust Formulary and Prescribing Guidelines (MH) provides detailed advice on prescribing NRT for Trust service users. A risk assessment is required before offering Bupropion or Varenicline in patients with a history of psychiatric illness.
- Health trainer support is available in the community and can provide practical support with planning and implementing health programmes.

## CG55 - PHYSICAL HEALTHCARE CLINICAL GUIDELINE

- 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).
- Health and social care practitioners should be able to identify and provide brief advice to people with harmful levels of drinking. Higher risk patients with possible alcohol dependency should be referred to appropriate services for treatment.

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

- Immunisation for Hepatitis A&B should be offered to all service users within substance misuse services.
- Patients with newly identified physical health conditions should be assessed and investigated, and, if required, further expert advice on immediate management and follow up should be sought from primary care or community health services.
- Patients with newly identified atrial fibrillation require further assessment of the underlying cause of AF and a risk assessment for stroke. Medical staff should liaise with primary care to ensure that appropriate investigations and risk assessment are carried out and preventative treatment with long term anticoagulation is considered.
- Patients experiencing deterioration of long-term conditions whilst inpatients should be managed within the relevant NICE guidelines. If the medical team have significant clinical concerns, expert advice should be sought from primary care or the Acute Trust.
- The psychiatrist remains responsible for monitoring physical health and the effects of psychotropic medication for the first twelve months or until the condition has stabilised. If physical health risks or conditions are detected, responsibility for further treatment should be agreed between primary and specialist mental health services on an individual patient basis. Treatment of high lipids, diabetes, hypertension and atrial fibrillation is normally supervised by the GP.
- Health and social care practitioners will be aware of barriers to healthcare, including diagnostic over-shadowing, and will provide assertive and proactive support and advocacy for service users who need to access other physical health services.
- 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. Management of Diabetes mellitus in Inpatients (*Pathway currently in development*)

- As a principle, patients with diabetes who require treatment with insulin should self-manage during a hospital admission. Where possible, they should monitor their blood sugars and decide appropriate doses of insulin in response to these results.
- Patients being treated with insulin will be identified within 4 hours of admission, and the admission risk assessment will include capacity for self-management of diabetes and self-administration of insulin.

## CG55 - PHYSICAL HEALTHCARE CLINICAL GUIDELINE

- Staff must be aware that patients on insulin treatment are experts in the management of their condition, most having received intensive educational support at the start of treatment. This expertise should be respected.
- Insulin treatment is critical for patients who need it and staff must ensure that insulin is available from the point of admission. If the patient's own supply of insulin is not available, a supply should be obtained from pharmacy, contacting the on-call pharmacist out of hours, if necessary.
- Patients on insulin require 2 to 4 injections per day as part of a personalised dose schedule. Doses of insulin vary with each meal according to the carbohydrate content, as well as the background levels of physical activity.
- Patients need exclusive access to a blood glucose monitor and will measure their blood sugar several times a day. The preferred option is for the patient to use their own equipment and they may need access to their phone app to perform the dose calculations.
- Patients will need access to appropriate snacks 24/7 in order to optimise blood sugar regulation.

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

- Discussions about psychotropic<sup>1</sup> medication should involve the patient, the GP and the psychiatrist, and in more complex cases, include the pharmacist.
- The Choice and Medication website, accessed via the Trust intranet, is designed to support shared decision making.  
<http://www.choiceandmedication.org/eput/>
- The side effects of medication should be monitored and the rationale for continuing, changing or stopping the medication should be clearly documented and discussed with the patient. The role of the crisis or recovery plans should be considered with respect to medication adherence and shared decision making between the patient and prescriber.

## 7. 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;
- That the 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 health and care providers to provide appropriate treatment.
- Any physical health issues identified will be followed up by the identifying clinician. It is this health professional's responsibility to ensure that action is taken in a timely fashion; that there is appropriate escalation and involvement of the multidisciplinary team; and that there is a safe transfer of responsibility and care between teams, and between specialist and primary care services.

**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 and staff in the Substance Misuse services will:**

- Ensure that each patient on the caseload or accepted into specialist services has the opportunity for an annual assessment of their physical health, either undertaken by their GP or by the specialist services.
- If the assessment is undertaken by the GP, the results should be requested for the patient record to inform the care provided by EPUT.
- Ensure that assessments are appropriate and relevant to the clinical circumstances of the patient, including end-of-life situations.

**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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