South London and Maudsley NHS
NHS Foundation Trust

PHYSICAL HEALTHCARE POLICY

Version:	Version 4.1
Ratified By:	Governance Executive
Date Ratified:	October 2010
Date Policy Comes Into Effect:	October 2010
Author:	Natalie Warman, Assistant Director of Nursing for Physical and Public Health
Responsible Director:	Hilary McCallion, Director of Nursing and Education
Responsible Committee:	Physical Health Committee
Target Audience:	Clinical and Non-Clinical Staff
Review Date:	October 2013

Equality Impact Assessment	Assessor: Natalie Warman	Date: 03.11.11
HRA Impact Assessment	Assessor: Natalie Warman	Date: 03.11.11

Document History

Version Control

Version No.	Date	Summary of Changes	Major (must go to an exec meeting) or minor changes	Author
V1.0	September 2005	N/A	N/A	Sarah Burleigh
V2.0	September 2006	Major policy update	Major	Sarah Burleigh
V3.0	July 2008	Date of review & NHSLA Requirements met	Major	Natalie Warman
V4.0	October 2010	Exceeded review date – major update	Major	Natalie Warman
V4.1	November 2011	New policy template and NHSLA requirements	Minor	Natalie Warman

Consultation

Stakeholder/Committee/ Group Consulted	Date	Changes Made as a Result of Consultation
Physical Healthcare Committee	15.11.11	

Plan for Dissemination of Policy

Audience(s)	Dissemination Method	Paper or Electronic	Person Responsible
All Clinical Staff	Distribute via email	Electronic	Natalie Warman

Contents

1. INTRODUCTION

The physical and public health needs of people with a mental illness are documented within both statutory and clinical literature. The service user's physical health is of equal importance as their mental health, and must be part of a package of care that seeks to reduce health inequalities and improve the wellbeing and experiences of service users.

This policy was developed by the Trusts' Physical Healthcare Committee and consulted and communicated across all CAGS across the organisation including the heads of professions and social care.

The components of the policy are:

- assessment requirements for all new service users
- additional assessment requirements for service users on an inpatient setting
- inpatient investigation
- assessment and management of all service users on antipsychotic medication
- care planning and treatment for all service users
- service users refusing physical healthcare
- communication of physical healthcare and sharing information

2. DEFINITIONS

	Description
Clinical Observations	Assessment of Temp, Pulse, Blood Pressure, respirations, pulse oximetry, AVPU
Physical Health Assessment and Examination	An , assessment and examination of an individual's health, performed by a medical practitioner in SLaM services though maybe performed by another competent practitioner in primary care or a secondary acute provider. The assessment should include the following: Current physical health problems/symptoms Past medical history Family History Lifestyle risks: smoking, , alcohol, drugs, nutrition etc) Record of all currently prescribed medication Adverse reactions to past medications. Allergies ECG as specified by the Maudsley prescribing Blood tests may also be relevant e.g. therapeutic drug levels in line with the Maudsley Prescribing Guidelines.

3. PURPOSE AND SCOPE OF THE POLICY

This policy sets out the requirements for all service users across the lifespan including those who have brief interventions to those receiving long term ongoing care. The extent and the nature of the contact are likely to influence the degree regarding the assessment and management of physical health care concerns.
The focus of this policy is to:

3.1 Promote Patient Safety:

- **By early recognition of when service users are physically deteriorating**
- by minimising and managing the physical health risks associated with the side effects of medication prescribed by SLaM.
- by the ability of clinical staff to identify the early signs of physical healthcare problems, and will refer to or seek advice from appropriate services/professionals whilst being cared for in a mental health setting
- by ensuring that treatment plans that primary care have agreed with service users are ongoing whilst in the care of the Trust.

3.2 Promote Social Inclusion into Primary and Secondary Care:

- by supporting and assisting services users to engage with their local primary care services
- by clinical staff supporting and encouraging service users in the ongoing management of their physical care needs as planned by primary/secondary care.
- by clinical staff liaising with primary care on strategies to engage primary care providers with the assessment and management of the physical healthcare needs of service users.

3.3 Engage Service Users to Access Local Health Promotion and Mental Wellbeing Services:

- by supporting service users to access local community services, such as leisure centres, exercise classes, community smoking cessation clinics, sexual health services, anti and post natal care.
- by supporting service users, to access health screening and surveillance services e.g. cervical screening, well men clinics, annual health screens and developmental screens.

4. ROLES AND RESPONSIBILITIES

4.1 The Trust

Recognises its roles and responsibilities in relation to:

- Care Quality Commission (2010) Choosing Health (2006), NHSLA (2008)
- The National Service Framework (NSF) for Mental Health, Older People (2001) and Children (2004), New Horizons 2010

- NICE clinical guidelines for schizophrenia (2008), bipolar disorder (2006), depression (2004) dementia (2007), Obesity (2006), Eating disorder guidelines (2004), Recognition of the deteriorating patient (2007) and other NICE guidance in relation to the care of peoples physical healthcare needs.
- Essence of care, PEAT, Refocusing the care programme approach policy and positive practice guidance (2008)
- Chief Nursing Officer's review of mental health nursing (DH 2006), and professional bodies and collages which issue supporting documentation and clinical evidence to improve the physical and public health of service users and carers.

4.2 CAG Directors

- are responsible for maintaining partnership arrangements with their local PCTs and through liaising with public health ensure that the health inequalities experienced by service users are communicated to local commissioners
- support local PCTs to assist in the commissioning of appropriate services that are able to meet the physical health needs of people with severe mental illness within primary care
- work with PCTs around commissioning for inpatients who require physical healthcare
- are responsible for the implementation of this policy within their own CAG
- are compliant with the Care Quality Commission standards(2010)
- will ensure that both inpatient and community teams are able to procure medical devices to clinical teams to support the safe assessment and management of patients who physical healthcare needs.
- Will ensure that staff have access to training to meet the physical health requirements for their service users.

4.3 The Assistant Director of Nursing for Physical and Public Health

- will lead the Trust in its developments of the Trusts priorities regarding Physical and Public Health
- will support the CAGS to operationalise the policy
- to support CAGS on the management of physical healthcare for SLaM service users
- to identify the priorities, themes and risks concerning physical healthcare that arise from Serious Untoward Incidents, National Inquires and National Confidential Inquires and work with both clinical and corporate directorates to develop systems to minimise potential harm to patients
- to review complaints concerning physical and public healthcare and make recommendations to improve patient experiences.
- to develop strategies and guidance arising from NICE and other National/ Professional Guidance
- to identify and develop and work with the training and education department and develop competency requirements of clinical and non clinical staff to ensure that they are competent to manage people with physical health care conditions

- to support the CAGS to identify the physical and public health need requirements of their local populations and support them to develop local partnership arrangements with other NHS providers and local commissioners

4.4 All Clinical Staff

- are responsible for being familiar with their responsibilities under this policy and complying with them. They are also required to be familiar with other associated relevant Trust policies such as those for Infection Control, Nutrition, Medical Devices, Social Inclusion Strategy, Manual Handling, Health and Safety, Resuscitation, Incident policy, Mental Capacity Policy (2009), End of Life and Safeguarding Children .
- all clinical staff must be able to assess their own clinical competency; clinical staff should identify their continuing professional development needs through appraisal and supervision.
- nursing staff must have the skills and competency to assess and interpret recordings of temperature, body mass index, blood pressure, urinalysis and blood glucose monitoring and report abnormal results to medical staff so that subsequent action can be taken.
- medical staff are competent in undertaking a full and appropriate medical assessment and examination of service users and are able to interpret investigations and work with other NHS providers to provide appropriate treatment.
- are responsible for recording all appropriate physical healthcare assessments, management plans and risk assessments on the appropriate physical health screens on the Electronic Patient Journey.
- minimise and manage the physical health risks associated with the side effects of medication as prescribed by the Trust
- will follow The Maudsley Prescribing Guidelines
- must be able to conduct alcohol screening using AUDIT (Alcohol Use Disorders Identification Test)
- must be level 1 smoking cessation trained
- ensure that treatment plans that primary/secondary care agreed with service users are ongoing whilst in the care of the Trust
- support and assist services users to engage with their local primary care and health promotion services
- support and encourage service users in the ongoing management of their physical care needs as planned by primary/secondary care.

4.5 Ward Managers and Team Leaders

- will have the knowledge and skills to understand the physical health care priorities for their service users and know who to refer to for additional support and advice. They will assess their own competency and will identify their continuing 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 that there is a safe skill mix within teams to meet the physical health care requirements of service users.
- will ensure that all staff appraisals and personal development plans reflect an individuals training and support needs on physical healthcare and health promotion.
- will ensure that supervision includes the physical health and health promotion of service users.
- will ensure that staff are competent at recording physical health on the appropriate sections of EPJS
- will ensure that clinical rooms are stocked with the appropriate medical devices
- will ensure that the environment is safe and appropriate to provide physical health assessments.
- will ensure that they have completed a risk assessment of the environment, skills and knowledge of their staff before admitting service users who are physically unwell to their environment.
- Will ensure that their services have a range of physical health and well being health promotion materials displayed, these include materials relating to alcohol misuse, exercise, stop smoking services, healthy eating and drug use.

4.6 Non Clinical Staff

- have the responsibility to 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 available from both primary care and secondary care services to clinical staff.

5. REQUIREMENTS FOR PHYSICAL ASSESSMENTS, CARE PLANNING AND ONGOING COMMUNICATION OF PHYSICAL HEALTH NEEDS

5.1 Initial Assessment

In liaison with other NHS providers, assess if the service user has any current or previous physical health problems or comorbidites, and whether they are receiving treatment for any of these. Identify the contact details of the services that are providing this care regarding the service user's medication and treatment, and record on the current physical health care assessment screen of the patient journey.

In liaison with other NHS providers assess that the service user has received all appropriate screening and surveillance.

Assess if the service user has any physical difficulties/disabilites that are currently unmet (visual, mobility, hearing, dental, swallowing, urinary/faecal continence).

Assess for risks associated with nutrition and hydration and for the need for assistance with feeding, in accordance with the Trust Nutrition Policy. This assessment should also include the individual's skills and environmental restrictions that may impact upon the ability to provide adequate nutrition and hydration independently.

Assess if the service user has any tissue viability concerns. These may include at risk of developing pressure sores, abscesses, open wounds, cellulitis.

Asses if the service user is at risk of falls

Assess if the service user has any known allergies and record these as alerts on EPJS

Assess if the service user has had any previous reactions to past medications prescribed and record these as alerts on EPJS.

Assess the service user for lifestyle risk factors, (i.e. smoking using brief interventions, alcohol using AUDIT, drugs, sexual behaviour and parental capacity) and record these on the drug and alcohol assessment screen and the brief physical assessment screen.

Assess the service user's immunisation status e.g. BCG, Hepatitis A&B, childhood immunizations, influenza.

Assessment of the service user's baseline clinical observations (see section 9) and other recommended investigations should be conducted before commencing medication for a person's mental illness. These should be done under the recommendations outlined in the Maudsley Prescribing Guidelines. An initial management plan should be made between the prescriber, care team and the service user regarding the frequency of investigations to assess for risks associated with prescribing.

Assessment of the service user's capacity to consent or refuse physical health care must be made. If the team assesses that the service user lacks capacity to consent to treatment for a physical health care problem then the team needs to refer to Mental Capacity Act guidance to assist them in assessing and treating service users for physical ill-health.

The risk assessment must identify the risks associated with the physical health or potential deterioration of a service user's physical health and consider how their mental illness may contribute to this. The risk assessment should include:

- Risks that may cause the service users to rapidly physically derteriorate.
- risks posed to the service user in their ability to engage effectively with other healthcare providers,
- capacity to care for their physical health needs
- understanding of the health problems they experience,
- potential risks of medication on the service user's health.
- ability to care for themselves independently
- environment considerations

- ability to provide adequate nutrition and hydration
- risks that self neglect may contribute to their physical health
- the risks of harmful alcohol use and the risk of withdrawals from alcohol
- a history of falls or is at risk of falls associated with identified potential causes such as multiple pharmacology/ incontinence/ alcohol.
- risk of pressure ulcers and tissue viability concerns.
- the impact of an individuals physical disability/impairment to children, families and carers
- the risk of infection and its impact on the wider community
- The impact of a service user's physical health should be recorded on other assessment screens of EPJS eg, families/carers, accommodation, employment/education, finances

Assess if the service user has a GP and record these details on the Electronic Patient Journey. If a service user is not registered the mental health team will facilitate this. To facilitate this: (see appendix A &B) for service users who do not have a GP).

Assess if the service user is engaging with their GP and is able to attend appointments independently or requires support to do this.

Assess if physical health problems may have occurred due to abuse. If suspected then refer to the Trust guidance on safeguarding children and vulnerable adults.

Other people involved with the service user's care should be invited to contribute to the assessment process e.g. carers, health and social care providers.

Some carers may have physical health problems that will impact on their ability to care for people with a mental health problem, where appropriate carers needs should also be assessed to support them with this role

5.2 On Admission to Inpatient Settings

- All service users need to have a set of baseline clinical observations recorded using the Early Warning Scoring Charts and escalated appropriately as detailed within the guidance for early warning scores. and must be performed by a competent practitioner. Baseline clinical observations include: temperature, pulse, respirations, blood pressure, AVPU and Pulse oximetry will be recorded within the first 12 hours of admission..
- Additonal observations will be required within a week of admission urinalysis, urine drug screen and body mass index by a competent member of the clinical team.
- All service users need to have a medical assessment and examination conducted within 24 hours of admission. The examination should pay attention to any underlying past or current physical problem and in particular to conditions arising as a consequence of the use of psychiatric medication, or having implications for choice of medication. It is the responsibility of the examining doctor to formulate an initial management plan to address

immediate problems identified at the examination, and for recording clearly any additional investigations or examinations which may be necessary and appropriate

- Lifestyle assessment: smoking-using brief interventions, alcohol-using the AUDIT tool, drug use, exercise, sexual health and pregnancy
- All service users should have been offered an impartial observer (a 'chaperone') present during an examination. This applies whether or not you are the same gender as the service user, though the patient should be offered choice of gender (see Apendix C)
- All inpatient service users will have a minimum of physical observations using the Early warning scores charts weekly.
- Service users who are inpatients for 12 months or longer, will have a physical assessment by a medical practitioner annually
- Inpatient areas should include healthy living programs within the ward environment which should include healthy eating, smoking cessation, and physical exercise pathways.

5.3 In Patient Investigations

Following the outcome of the physical assessment and examination of a service user the admitting Dr. will request investigation to compliment the assessment and ensure safe prescribing.

It is the medical doctor's responsibility to check these results and act upon abnormal findings. For paper results the doctor must sign the results and record the results on EPJS; for electronic results the service user's doctor must check the results and transfer them on to EPJS.

In the event of a service user being transferred from one ward/service to another, then any impending results following investigations must be handed over and the responsibility for checking investigations will be with the service user's current medical doctor

Nurses will record blood pressure, pulse, temperature, respirations, pulse oximetry, AVPU, weight, food and fluid intake, Capillary Blood glucose, urinalysis, and a urine drug screen. Any abnormalities should be reported to the medical doctor.

Swabs or specimens must be taken when there is a wound, infected area, urinary catheter or the service user has vomiting and diarrhoea. The infection control team must be informed of the above and of all potential infection control concerns.

Electrocardiogram (ECG) this is to be performed as part of a baseline assessment.

5.4 Patients on Medication Prescribed by the Trust: Prescribing and Monitoring Responsibilities

All service users prescribed medication from the Trust must be monitored for side-effects or contraindications of these medications. Before commencing antipsychotic medication all service users must have baseline observations recorded and any additional investigations identified as appropriate in the Maudsley Prescribing Guidelines. Further monitoring must be in line with the Maudsley Prescribing Guidelines.

If service users are prescribed by the GP then an agreed care plan for monitoring for side effects of medication will be made between the care co-ordinator and the GP.

5.5 Care Planning and Treatment Interventions for SLAM Service Users

- Care planning must be a collaborative process with the service user and where appropriate, his/her carers.
- All service users who have a physical health problem must have a care plan detailing how the service user will access primary/secondary care services and their support needs to enable them to promote engagement with these services.
- As there are likely to be several agencies involved in care delivery management plans should identify the roles and responsibilities of different partners in care provision including mental health team members, primary/secondary/social care, family/carers and the voluntary sector.
- Care plans should identify the frequency and type of physical health checks required for service users who are receiving pharmacological interventions that may result in a deterioration of a service user's physical health, and detail with other services who will provide this care. The Maudsley Prescribing Guidelines should be used.
- All service users with a severe and enduring mental illness must receive routine checks that promote early detection or prevention of physical health problems. These include annual health checks, screening and surveillance with the General Practitioner/primary care team, liason with drug and alcohol services.
- All sites should have information available about the range of local physical health care services; their referral criteria and access arrangements to these services. These are to include smoking cessation, dietician support, promoting physical activities and access to specialist services such a sexual health clinics. This information should include those services provided by SLaM and those provided by other health providers to enable service users to make choices.
- For people subject to CPA, the service user's physical health must be routinely considered in CPA reviews.
- When service users are being transferred within/ referred on/discharged from Trust services, plans must include provision for continued care/treatment of their physical health in conjunction with other health and social care providers and their carers

- Where integrated care pathways are being developed within services they must consider the impact of a service user's physical health and incorporate the appropriate standards from this policy.
- All service user's will be offered copies of their care plans
- In minimising the risks to a service user's physical health, the use of other appropriate services should be considered and sought in accordance with the patients consent. These services may include those provided by: **Acute services:** specialist services e.g. diabetes, epilepsy, liver units, **Primary Care**: GP, District Nurses, Community Modern Matrons, Community Pharmacy, OT, Physiotherapy, Health Visitors, School Nurses, Intermediate care facilities, tissue viability, continence and palliative care, chiropody, dentists, opticians and public health departments. **Social services:** can provide support with homecare, meals, laundry, occupational therapy.

If a service user requires help and support from social services and this is the result of a combination of an individual's physical and mental health, it may be advisable to request a district nursing (DN) assessment on their physical health. DNs can refer to the physical disabilities department of social services; the mental health worker can compliment an assessment to the mental health department of social services. This will enable social services to arrange for appropriate social care funding arrangements, which will be dependant on local social services structures.

Carers should be included in the treatment and care of service users and offered information that will inform and support them in caring for the physical health of service users.

- Carers that have physical health problems that will impact on their ability to care for people with a mental health problem, should be supported with information to support them in accessing appropriate health and social care services.

5.6 Patient Refusing Physical Healthcare

- If it is not possible to conduct a physical health assessment or to care for a service user's physical health needs, each attempt must be recorded on EPJS with the reason for why this was not achieved documented on EPJS.
- Staff must make repeated offers throughout a service user's stay in hospital and in the community for a physical health assessment/screen/ annual check and record these on EPJS.
- See Appendix B for further advice.

5.7 Communication of Physical Healthcare and Sharing Information

Underpinning safe and effective care delivery is robust documentation and information sharing with all partners involved in care/treatment provision. Given the range of agencies likely to be involved sharing information in a timely

manner is essential. The Electronic Patient Journey (EPJ) provides a system that facilitates information sharing across teams in the Trust.

If non clinical staff believe that a service user appears to be physically unwell then they should report this to a qualified member of staff, with the exception of an emergency situation.

If a service user is being admitted from a CMHT then the significant ongoing physical healthcare needs/care must be alerted to the inpatient unit.

Clinical staff who assess and record physical observations that are abnormal must report these to a medical doctor responsible for the care of that service user at the time. The agreed plan should be documented on EPJS.
Medical doctors must seek advice from colleagues either within SLaM or specialist colleagues from partner organisations.

The infection control team must be notified of service users who present with a past infection control issue. E.g. MRSA, C. Difflicile, TB or undiagnosed diarrhoea and vomiting.

If a service user is receiving care from another acute or primary care service there must be a clear plan on how services will share information and communicate effectively to manage the continuation of management plans and meet the needs of service users and their carers.

Ward rounds/clinical reviews/ CPA meetings should routinely discuss the service user's physical health care and review any service user's physical observations that have occurred. This should be documented within the ward round documentation and EPJS.

When transferring a service user from ward to ward any physical health care needs must be summarised in writing on EPJS and verbally to the admitting ward.

When discharging service users from inpatient to community any physical health care needs, treatment or care provided during admission must be recorded in the discharge summaries. Copies of letters and care plans should be sent to the GP/ primary care team or specialist teams.

When a referral to Trust services is being made by an external agency, information about ongoing physical health care needs/risks should be provided by the referrer.

Once within Trust services the confidentiality policy should guide practice (SfBH C13). It is good practice to obtain written consent before information is disclosed. Most service users will provide consent if they understand the importance of information sharing in promoting good care delivery. It is good practice to discuss with service users what information will be shared and in what format this will be. Often service users can share in the preparation of such information.

Some service users pose significant risks, staff have a responsibility to share such information with other services that are providing physical and social care. In some circumstances it will be necessary to break confidentiality regarding a service user's physical health, i.e. notifiable infections. This decision should be made by the multi-disciplinary team, including the team leader and medical consultant. The Caldecott Guardian can provide further advice. The service user should be made aware of actions being taken unless there are clear reasons for not doing so. The reasons for breaking confidentiality, and if the service user is not being informed the reasons for this, should be documented.

During treatment (when consent has been given), as a minimum, external 'agencies' (including carers) should be invited to CPA meetings and given copies of care plans. However, it is good practice to maintain regular dialogue with all parties involved in care delivery. Partner agencies should always be informed of significant changes in the service users' circumstances.

5.8 Incidents

Category A: All deaths need to be recorded as a Category A on datix. For inpatients, the MEWS score and date of observations prior to the patient's death need to be recorded on Datix. The Resuscitation audit will also need completing.

Category B: All inpatients requiring an emergency admission to an Acute Trust must be a Category B, the patients MEWS (Physical Observation Score) must be recorded on DATIX

Pressure sores and grade of pressure sore

Hypoglycaemia events Capillary Blood Glucose <4mmols

Category C: All patients that attend A&E but do not require an admission

Category D: All inpatients that are physically unwell or sustain an injury from a fall but are cared for by South London and Maudsley

Category E: All patients that may fall but no injury observed

5.9. Policy Standards

To measure the success of these standards, performance targets will be: 100% for IP1 and IP2, though all other standards will be assessed against a target of:

- Year 1 40%
- Year 2 50%
- Year 3 60%

Inpatient Standards

Measure Number	Improvement measure	Exceptions
IP 1	All service users admitted to in patient services will have baseline observations within 12 hours of admission	If the service users refuses or that they are absent from the ward
IP 2	All service users will have received a full health assessment and examination within 24 hours of admission	If the service user refuses or that they are absent from the ward there should be a care plan on how the issue will be addressed, and when this will be repeated
IP 3	All service users who are identified as having a physical health care need will have an agreed care plan by the care team, which will be reviewed and documented.	If the service user refuses there should be a care plan on how the issue will be addressed.
IP 4	All Service will have baseline observations weekly.	
IP5	All Service users will have an assessment and examination annually	
IP 6	All discharged summaries will include an update on a service user's physical healthcare sent to their GP or appropriate primary health care team.	
IP 7	All service users will have access to stop smoking services	
IP 8	All service users will have access to information on smoking cessation therapy and support, healthy eating options exercise, sexual health and drug and alcohol support.	
IP9	A service users records will have an up to date	

	record of all the service users current medication	
IP10	All service users to have an assessment of their weight, nutrition and hydration and their assistance needs	
IP11	All clinical areas will make adjustments to meet the needs of people with physical disabilities (hoists, high low beds)	

Community Standards

Measure Number	Improvement measure	Exceptions
CP 1	All service users will have a General Practitioner or appropriate primary health care team.	Serve users refusing or unable to register or engage. All service users will be offered support in engaging with primary care and a shared plan between primary care and a CMHT will identify the steps in achieving this
CP 2	In the first 14 days from an initial contact with a new service user, clinical staff will make contact with the service users named primary health care team. To gain a synopsis of the service users relevant past and present physical health history and management. And the date the service user was last reviewed.	
CP 3	The care co-ordinator will agree individual responsibilities for monitoring the physical health care of service users.	
CP4	The responsibilities and named person/service will be recorded within the CPA documentation and invited to contribute to CPA meetings.	
CP5	The care coordinator will obtain the brief summary/encounter record from the GP and document on the date received on the Physical Health Care Screen	
CP 6	All service users will have had an assessment and set of observations on admission to a community team, that have been recorded within the year.	If the service refuses,
CP 7	All service users will have repeated baseline observations and appropriate investigations prior to issuing each new prescription in line with the Maudsley Prescribing Guidelines	

CP 8	All service users will be supported to have an annual health check with their GP or practice nurse and the date of the annual health check recorded on EPJS	
CP 9	All care- coordinators of service users who are newly diagnosed with a long term condition will have an agreed care plan with either the primary care team or specialist services. This will be documented on EPJS	
CP 10	Service users will have access to information on exercise, healthy eating, sexual health, drug and alcohol use and services and smoking cessation programmes and other local health promotion initiatives.	
CP11	A service users will have an up to date record of all the service users current medication	

Training and Supervision Standards

Measure Number	**Improvement measure**	**Exceptions**
TS1	All inpatient nursing staff and HCA will attend MEWS training every 2 years	
TS2	All staff will be Level 1 smoking cessation trained.	
TS3	All clinical staff will be competent to use medical devices in accordance with the medical devices policy	
TS4	All clinical staff will have their physical health knowledge addressed in supervison and appraisal.	

6. Monitoring Compliance

What will be monitored i.e. measurable policy objective	Method of Monitoring	Monitoring frequency	Position responsible for performing the monitoring/ performing co-ordinating	Group(s)/committee (s) monitoring is reported to, inc responsibility for action plans and changes in practice as a result
Duties	Audit	Annual	Natalie Warman Assistant Director Of Nursing	Physical Health Committee
Requirements for physical health assessment of patients on admission to a service including timeframes				
INPATIENTS All service users admitted to in patient services will have baseline observations within 12 hours of admission	Audit of Early Warning Scores observation charts	Annual	Natalie Warman Assistant Director Of Nursing	Medical Devices Committee
INPATIENTS All inpatient service users will have received a full health assessment and examination within 24 hours of admission	Audit EPJS	Annual	Natalie Warman Assistant Director Of Nursing	Physical Health Committee
COMMUNITY All service users will have had an assessment and set of observations on admission to a community team, that have been recorded within the year.	Audit	Annual	Natalie Warman Assistant Director Of Nursing	Physical Health Committee

What will be monitored i.e. measurable policy objective	Method of Monitoring	Monitoring frequency	Position responsible for performing the monitoring/ performing co-ordinating	Group(s)/committee (s) monitoring is reported to, inc responsibility for action plans and changes in practice as a result
Process for ensuring appropriate follow-up of physical symptoms				
All service users who are identified as having a physical health care need will have an agreed care plan by the care team, which will be reviewed and documented	Audit	Annual	Natalie Warman Assistant Director Of Nursing	Physical Health Committee
Ongoing assessment of physical needs for all patients, including timeframes				
INPATIENTS All inpatient Service users will have a minimum of physical observations weekly.	Audit of Early Warning Scores observation charts	Annual	Natalie Warman Assistant Director Of Nursing	Medical devices Committee
INPATIENTS All inpatient service users will have an assessment and examination annually	Insight reports	Quarterly	Natalie Warman Assistant Director Of Nursing	CEOPMR Physical Health Committee
COMMUNITY The responsibilities for physical health and named person/service will	Audit	Annual	Natalie Warman Assistant Director Of Nursing	Physical Health Committee

What will be monitored i.e. measurable policy objective	Method of Monitoring	Monitoring frequency	Position responsible for performing the monitoring/ performing co-ordinating	Group(s)/committee (s) monitoring is reported to, inc responsibility for action plans and changes in practice as a result
be recorded within the CPA documentation and invited to contribute to CPA meetings.				
COMMUNITY All service users will be supported to have an annual health check with their GP or practice nurse and the date of the annual health check recorded on EPJS	Audit	Annual	Natalie Warman Assistant Director Of Nursing	Physical Health Committee

.

7. Associated Documentation

8. References

Department of Health (1999) 'The *National Service Framework for Mental Health'.* London, DH.

Department of Health (2001) The National Service framework for older people, London DH

Department of Health (2004) The National Service framework for Children London DH

Department of Health (2006) Choosing Health: Supporting the physical health needs of people with a severe mental illness. London DH

Department of Health (2008) Refocusing the care programme Approach Policy and Positive Practice Guidance, London DH

Department of Health (2005). *'Supporting People with Long Term Conditions.'* London, DH.

Department of Health (1999) 'The *National Service Framework for Mental Health'.* London, DH.

Department of Health (2004) *Standards for Better Health* DH

Department of Health (2006) *From Values to action: The Chief Nursing Officer's review of mental health nursing* London, DH

Disability Rights Commission (2006) Closing the gap Equal *Treatment investigation report Part 1* Disability Rights Commission

Disability Rights Commission (2006) Report to the DRC Formal Inquiry Panel to the DRC's Formal Investigation into the inequalities in physical health experienced by people with a mental illness and people with learning disabilities LONDON *Disability* Rights Commission

National Institute for Mental Health in England. (2004). 'Mental *Health Policy Implementation Guide: Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings.'* London, DoH.

National Institute for Clinical Excellence (2002). *'Clinical Guideline 1: Schizophrenia - Core interventions in the treatment and management of schizophrenia in primary and secondary care'.* NICE, London

National Institute for Clinical Excellence (2006) Bipolar Disorder: The Management of bipolar disorder, adults, children and adolescents in primary and secondary care

National Clinical Practice Guideline, Number 38, NICE London

National Institute for Clinical Excellence (2004) Eating Disorder Guideline: www.nice.org.uk/CG009NICEguideline

National Institute for Clinical Excellence (2006) Dementia: Supporting people with dementia and their carers in health and social care CG42 NICE, London

National Institute for Clinical Excellence (2004) the assessment and prevention of falls in older people CG21, NICE, LONDON

National Institute for Clinical Excellence (2004) Depression: management of depression in primary and secondary care - NICE guidance CG23 NICE LONDON

National Institute for Clinical Excellence (2006) Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children- NICE Guidance CG43 NICE LONDON

National Institute for Clinical Excellence (2007) Antenatal and postnatal mental health: Clinical management and service guidance- NICE CG45 NICE LONDON

National Institute for Clinical Excellence (2010) Public Health- preventing harmful drinking and diagnosis and clinical management of alcohol related physical complications.

9. Freedom of Information Act 2000

All Trust policies are public documents. They will be listed on the Trusts FOI document schedule and may be requested by any member of the public under the Freedom of Information Act (2000).

APPENDIX 1: Registering patients who do not have a GP

All service users must have a named GP or equivalent primary care team providing their primary care unless the patient is unwilling or unable to engage then the care becomes the responsibility of the Trust.

- If a service user is not registered the mental health team will facilitate this. To facilitate this:

- Staff must attempt to have contacted three GP services. Names of local GPs and contact details can be found on the service users local PCT. If three local GPs refuse to register the patient then the team will need to contact the Primary Care Trust (PCT) PALS who will require the patients name, address and date of birth. The PCT will then forward the service user the details of a GP that will register the patient.

Contact the GP surgery to complete the registration forms. (If possible have the name of the last GP so that the patient's primary care medical records can be transferred).

As part of the registration process the patient will need to attend a new patient check usually with the practice nurse. It is useful at this appointment to discuss with practice staff a clear plan for sharing information and communication between agencies. This should be documented as part of the patients physical care plan on EPJS.

APPENDIX 2: Assertive management of service users on eCPA/ongoing management of service users who are not engaging with primary care services

The physical health care guidance advises staff to support and facilitate service users to register and attend primary care services for physical health problems as indicated.

However, for some service users with complex needs and under eCPA, and/or in ongoing care, this may not happen. Below is a list of some possible reasons for this and suggested responses for the team in the different situations:

1. The service user with physical health problems who will not go out to the GP practice but are willing to be seen at home

Response: The community team will need to liaise with primary care services to arrange a home visit by the GP

2. Service users with physical health problems who decline to have contact with primary care services but are willing to be seen by the community team doctor

Response: The community doctor, if possible in liaison with the GP, should manage the service user's physical health problems

3. Service users with physical health problems who decline to attend primary care services or have further assessment of their physical health and on assessment by the community team and have capacity to do so

Response: The community team will need to continue to try and discuss the service user's health with him/her and monitor it as much as the service user agrees, and continue to review his/her capacity in relation to this issue

4. Service users with physical health problems who decline medical examination and are assessed as lacking capacity to do so

Response: For this group the individual may be taken to hospital for urgent treatment of the physical health problem under The Mental capacity Act (2005), although this still may lead to delays; in-patients with a long-term mental illness using the MHA 1983 may be more expeditious

These categories may not cover every community patient for whom there are physical health concerns but indicate the sorts of approach to consider in these situations.

APPENDIX 3: Impartial Observers/ Chaperones

A chaperone does not have to be qualified but will ideally:

- be sensitive, and respectful of the patient's dignity and confidentiality
- be prepared to reassure the patient if they show signs of distress or discomfort
- be familiar with the procedures involved in a routine intimate examination
- be prepared to raise concerns about a doctor if misconduct occurs.

In some circumstances, a member of staff, or a relative or friend of the patient may be an acceptable chaperone.

If either the person conduction the examination or the patient does not wish the examination to proceed without a chaperone present , or if either is uncomfortable with the choice of chaperone, the examination may be delayed to a later date when a chaperone (or an alternative chaperone) will be available, if this is compatible with the patients best interests.

Any discussion about chaperones and its outcome should be discussed. If a chaperone is present, their name and job title should be recorded on EPJS. If the patient does not want a chaperone, you should record that the offer was made and declined

APPENDIX 4: Mandatory ECG Requirements

ECG required	Regulatory authority	Proportion of SLaM patients
Tricyclic antidepressants	NICE	10-15%
Haloperidol	MHRA/SPC	40-50%
Antipsychotics (high dose)	NICE, RCPsych	10%
Methadone (> 100mg)	NICE	< 5%
Polypharmacy with QT-prolongation drugs	Maudsley Guidelines	20%
Rapid tranquillisation (specific situations)	Maudsley Guidelines/ NICE	< 5%

APPENDIX 5: Recommended Medical Devices

1.Recommended medical equipment for psychiatric wards

Examination couch
Ophthalmoscope/Auroscope
Stethoscope
Alcometer
Sphygmomanometer
Oximeter
Thermometer
Tendon hammer
Snellen chart
Tuning fork (256Hz)
Height measure
Weighing scales
Disposable gloves
Urinalysis sticks
Blood sugar monitoring device
Peak flow meter
Urine Drug screening
Syringes with retractable needles
Dressings (as recommended in the dressing selections booklet)
Suction equipment
Emergency Bag
Copy of Glasgow Coma Scale/clinical observation charts
Sharps boxes
Pathology bottles/vacutaners

Desirable equipment for inpatient specialist settings

Urinary catheters
Neurological testing pins

2. Community Teams

Stethoscope
Sphygmomanometer
Thermometer
Urinalysis sticks
Syringes with retractable needles
Dressings
Sharps boxes
Disposable gloves
Blood sugar monitoring device

Desirable equipment for community clinic rooms

Examination couch
Ophthalmoscope/Auroscope
Height measure
Weighing scales
Pathology bottles/vacutaners

APPENDIX 6: Activities of living assessment

Domain	Prompts
Senses	Level of sensory functioning with or without aids/adaptations Capacity to use and maintain aids/adaptations correctly Access to aids and adaptations
Communication	Ability to express views and desires using appropriate verbal and non-verbal methods of communication in a manner understandable by most people.
Breathing	Ability to control level of breathing and activities that precede bouts of breathlessness. Knowledge of physical limitations and ability to act appropriately. Factors that impact upon ability to breath (smoking, underlying illness, medication, anxiety) Respiration rate and pulse oximetry range
Hygiene	Ability to meet personal hygiene (to include body, hair and oral hygiene) Consider motivation/ physical impairments. Do they require encouragement or assistance or they are self-initiating. If yes can they be supported with aids and adaptations, or assistance Access to personal care items
Skin integrity	Skin integrity is intact and is not at risk of breaking down/ damage. Does not require dressings, or aids to maintain skin integrity**.** Risks of pressure sores (Waterlow assessment) Behaviours that affect skin integrity (self harm, injecting drug use, reduced mobility from sedation) Broken areas requiring wound assessment chart completing
Dressing	Ability to dress appropriately for climate, environment and own standards of self-identity Access to clean clothes. Ability to clean clothes and laundry services
Transfers	Ability to get on and off the bed, toilet and in and out of bath independently, or level of assistance required to facilitate this (this may be associated with physical impairment or mental health conditions such as anxiety/ motivation). Risk of falls, Does the service user have the correct height furniture to support safe transfers
Sleeping	Description of sleep patterns, routines and interventions applied to achieve a comfortable sleep. Presence of emotional and/or physical problems that may interfere with sleep.

Mobility	The level of assistance required by the person to tackle activities of daily living. Include awareness of obstacles to safe mobility, dangers to personal safety, mobility out doors, ability to access public transport. Does the service user require adaptations? Does the service user need encouragement with mobility and gentle exercise
Eating and Drinking	Ensure Nutrition Screening Tool completed. The level of independence in identifying and choosing food and drink in accordance to hunger/thirst. Ability to manage own eating and drinking and level of assistance. Are there risks associated with eating and drinking (swallowing impairment, rapid eating, excessive eating) Does medication cause an increase in appetite that requires monitoring
Continence	Awareness of need to eliminate urine, the ability to maintain periods of continence, proper use of Incontinence aids, and able to select appropriate environment to eliminate urine. Does the service user require a referral to continence services? Awareness of need to Eliminate faeces, the ability to maintain periods of continence, proper use of incontinence aids, and able to select appropriate environment to eliminate faeces.
Pain control	Ability to identify pain type and location and alter behaviour in order to reduce or alleviate it. Ability to express presence of pain and seek help.
Medication	The ability to take medication independently and understands the medications contribution to their health. The ability to recognise and report side effects
Risk awareness	Awareness of potential threats to personal safety from environment, and to take appropriate decisions to remove/ resolve this threat, level of support required in assessing this risk.
Additional physical health needs	Identified needs that are not specific to any of the previous domains but which are considered important to the overall assessment of the person's health status.
Daily routines	Are they able to fulfil their daily routine? Do they feel satisfied with their daily routine or is there something they want to develop?
Access to community resources	Does the accessibility of community resources (shops, banks etc) allow or inhibit their activities of daily living

Additional needs of carers in relation to physical health	Care needs of relatives and carers arising from their relationship with the older person or their role as carer. Needs that are important to the maintenance of an established relationship or the transition to a new role.

APPENDIX 7: ALCOHOL ASSESSMENT AUDIT

Questions	Scoring system				Your score	
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 8	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,

16 – 19 Higher risk, 20+ Possible dependence

APPENDIX 8: Tissue Viability/ Wound Assessment Chart

Name **D.O.B.** **Ward** **Consultant/GP**	
Type of wound: Please √ Ulcer (venous) Ulcer (arterial) Ulcer (mixed) Diabetic foot ulcer Pressure Ulcer Traumatic; Surgical: Malignant: Burn: Sinus/fistula Other (please specify) Was the wound prior to admission Yes/No	**Factors affecting delay in wound healing: Please √** Anaemia Medications Diabetes Allergies Peripheral vascular disease Mobility Other: **Waterlow score** **Nutritional score**
Location of wound:	**Size of wound:** Please map or attach digital photograph with measurements;
Referrals & Date • Not appropriate • Specialist teams(e.g. TVNs Continence, Diabetologist • Dietician • Podiatrist • Other (specify)	**Plan**

Date of Assessment					
Nature of wound bed please use Kings chart Epithialising Clean granulating Overgrannulation Infected malodorous Sloughy Necrotic					
Surrounding skin tissue: Healthy Inflamed Scaly/dry/ Eczema Cellulits Macerated					
Exudate: Serous=S Heamoserous=H Purulent=P Pus=PU Blood=B					
Size: Max length(L),width (W)and depth (D) recorded					
Odour **Yes/no**					
Pain At dressing change Continuous Score 0-3					
Wound swab **Date**					
Swab result: organism isolated					
Wound assessed by: **(Signature of Nurse)**					
Review date:					

WATERLOW PRESSURE ULCER RISK CALCULATOR

Add scores, several scores per category may be used to calculate Waterlow score. NB. Document each sub-score on opposite charts as shown.

1. BUILD/ WEIGHT FOR HEIGHT	**2. SKIN TYPE VISUAL RISK AREAS**	**3. SEX/ AGE**	**4. SPECIAL RISKS**
a) Average 0	a) Healthy 0	a) Male 1	**TISSUE MALNUTRITION**
b) Above Average 1	b) Tissue Paper 1	b) Female 2	a) e.g: Terminal Cachexia 8
c) Obese 2	c) Oedematous 1	c) 14-49 1	b) Cardiac Failure 5
d) Below Average 3	d) Dry 1	d) 50-64 2	c) Peripheral Vascular Disease 5
	e) Clammy (Temp) 1	e) 65-74 3	d) Anaemia 2
	f) Discoloured 2	f) 75-80 4	e) Smoking 1
	g) Broken/ Spot 3	g) 81+ 5	**8. NEUROLOGICAL DEFECT**
5. CONTINENCE	**6. MOBILITY**	**7. APPETITE**	e.g: a) Diabetes b) M.S. c) CVA d) Motor sensor e) Paraplegia 4 - 6
a) Complete/ catheterised 0	a) Fully 0	a) Average 0	**9. MEDICATION**
b) Occasionally incontinent 1	b) Restless/ fidgety 1	b) Poor 1	
c)Cath/Incont. of faeces 2	c) Apathetic Restricted 3	c) N.G. Tube 2	a) Steroids 4 b) Cytotoxics
d) Doubly incontinent 3	d) Inert/ Traction 4	d) Nil By Mouth/	c) High dose anti-
		Chairbound	Anorexic	inflammatory

WATERLOW SCORE

DATE										
SUB-SCORES USED e.g. a,b,f	**1**									
	2									
	3									
	4									
	5									
	6									
	7									
	8									
	9									
WATERLOW SCORE										
GRADE OF PRESSURE ULCER										
PRESSURE RELIEVING INTERVENTION										
NURSE'S SIGNATURE										

PRESSURE ULCER ASSESSMENT FORM

PATIENT _____ **NURSE** _____**GP**_____

CLASSIFICATION OF PRESSURE ULCERS

GRADE 1* Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration/hardness.

GRADE 2 Partial thickness skin loss involving epidermis, dermis or both. Ulcer is superficial and presents clinically as an abrasion or blister.

GRADE 3 Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.

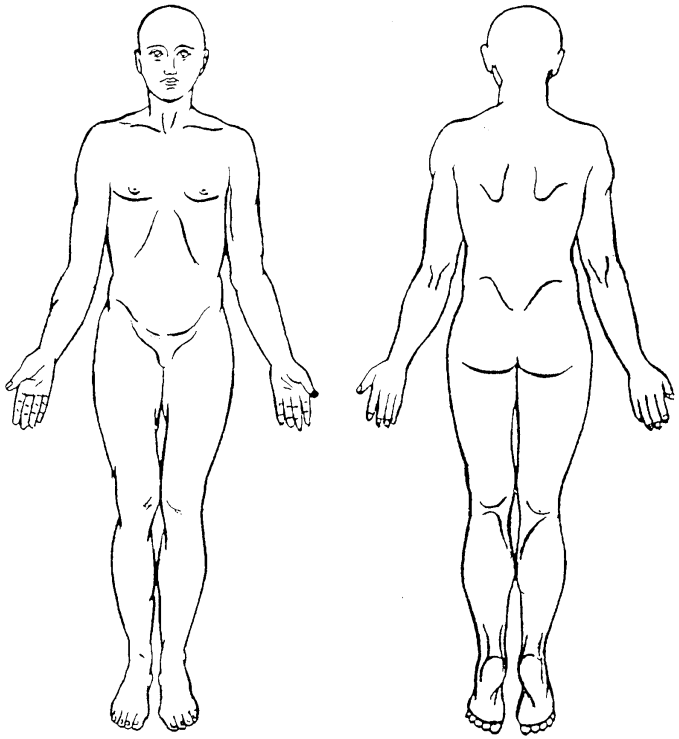
GRADE 4 Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

*** CRITERIA FOR A GRADE 1 PRESSURE ULCER IN PATIENT'S WITH DARKLY PIGMENTED SKIN**

- Assess for erythema and/or inflammation with localised changes in skin temperature in comparison to the surrounding tissue, oedema and/or induration.

WOUND CLASSIFICATION GRADING

Please mark any pressure ulcers/abrasions/reddened areas using wound grade number on diagrams below.



DATE ULCER/S CHARTED ...../...../.....

King's College Hospital NHS
NHS Trust

APPENDIX 10: Continence Assessment Form

CLIENTS NAME:	
NAME OF ASSESSOR:	

WARD:	ASSESSMENT DATE:
ADDRESS: TEL NO:	DESIGNATION:
DATE OF BIRTH:	AGE:
N.O.K/CARER:	
GP NAME: ADDRESS:	
CONSULTANTS:	

1. MEDICAL/SURGICAL HISTORY

OBSTETRIC HISTORY –NUMBER OF PREGANCIES

2. MEDICATION

3. HISTORY OF INCONTINENCE

Onset: 0-12 Mths ❑ 1-3 Yrs ❑ Over 3 Yrs ❑ Over 10 Years ❑

4. HAS THERE BEEN DETERIORATION IN THE PATIENTS CONTINENCE SINCE ADMISSION – OUTLINE ANY POSSIBLE BEHAVIOURAL ISSUES ASSOCIATED WITH INCONTINENCE.

SYMPTOMS IDENTIFIED (PLEASE CIRCLE)	**MANAGEMENT REQUIRED**
FREQUENCY URGENCY LEAKS WITH URGENCY NOCTURIA	**URGE** INCONTINENCE
LEAKING ON COUGHING, SNEEZING, PHYSICAL ACTIVITY	**STRESS** INCONTINENCE
POOR STREAM HESITANCY STRAINING HISTORY OF UTI	VOIDING DIFFICULTIES **/ OVERFLOW** INCONTINENCE
LEAKAGE ASSOCIATED WITH FUNCTIONAL / COGNITIVE / MENTAL IMPAIRMENT.	**PASSIVE** / FUNCTIONAL INCONTINENCE

5. SEXUAL DIFFICULTIES *(RELATED TO INCONTINENCE)*

6. BOWELS

NO PROBLEM ❑ CONSTIPATION ❑ DIARRHOEA ❑ FAECAL INCONTINENCE ❑

IMPACTION

NORMAL FOR CLIENT)

7. FLUID INTAKE (COMPLETE A FREQUENCY /; VOLUME CHART)

SUFFICIENT (AT LEAST 8 CUPS) ❑ INSUFFICIENT ❑ IN EXTREME ❑

8. MOBILITY

NO PROBLEM ❑ PROBLEM ❑

PLEASE SPECIFY

ITY

NO PROBLEM ❑ PROBLEM ❑ DIFFICULTY WITH CLOTHING, ETC ❑

PLEASE SPECIFY

10. ATTITUDE TO INCONTINECE

CARER POSITIVE ❑ APATHY ❑ DISTRESS ❑ ACCEPTANCE ❑ DENIAL ❑

CLIENT POSITIVE ❑ APATHY ❑ DISTRESS ❑ ACCEPTANCE ❑ DENIAL ❑

11. MENTAL STATE OF CLIENT

ALERT ❑ ANXIOUS ❑ CONFUSED ❑ DEPRESSED ❑

DEMENTIA ❑ LEARNING DIFFICULTY ❑ ALCHOLOL USE ❑ SUBSTANCE USE ❑

OTHER

12. SOCIAL NETWORK

LIVES ALONE ❑ CARER ❑ COMMUNITY NURSE ❑ CPN ❑

OTHER

13. TOILET FACILITIES

EASILY ACCESSIBLE ❑ ADAPTED TOILET ❑ COMMODE ❑

INSIDE TOILET ❑ OUTSIDE TOILET ❑

PLEASE SPECIFY

14. PHYSICAL EXAMINATION BY NURSE, IF APPROPRIATE

GENITALIA/VAGINAL ❑ RECTAL EXAMINATION

RASH/EXCORIATION ❑ BLEEDING ❑

15. INVESTIGATIONS UNDERTAKEN

URINE TEST (LABSTIX) ❑ MSU ❑ CSU ❑

RESULT _____

DATE _____

RESIDUAL URINE MLS _____

FREQUENCY / VOLUME CHART ❑ BLADDER SCAN ❑

16. PATIENT INFORMATION

SERVICE LEAFLET(S) ❑ SPECIFY: _____

TREATMENT LEAFLET(S) ❑ SPECIFY: _____

PRODUCT INFORMATION ❑ SPECIFY: _____

LOADED RECTUM ❑

17 INCONTINENCE AIDS & EQUIPMENT

PRODUCTS USED AT PRESENT – PRIVATE PURCHASE ? YES ❑ NO ❑

STATE PRODUCT USED AT TIME OF ASSESSMENT_____-
_____

IF PRODUCT REQUIRED STATE PRODUCT GIVEN ON THE WARD _____
_____

18. ANY OTHER INFORMATION

19. SUMMARY

20.REASON FOR REFERRAL

- **RECURRENT UTI** ❑
- **ANATOMICAL CAUSE** ❑
- **CHRONIC CONSTIPATION**
- **CHALLENGING BEHAVIOUR ASSOCIATED WITH INCONTINENCE**
- **URINARY RETENTION**
- **URINARY CATHETER ASSOCIATED PROBLEMS**
- **TO TEACH INTERMITTENT SELF CATHETERISATION**
- **MALE PATIENTS WITH REDUCED URINARY FLOW RATES**
- **FEMALE PATEINTS WITH SUSPECTED VOIDING DYSFUNCTION**
- **FEMALE PATIENTS WITH SYMPTOMATIC PELVIC ORGAN PROLAPSE**
- **CONTAINMENT PRODUCT ADVICE**
- **THOSE WHO ARE BEING CONSIDERED FOR SURGERY TO TREAT URINARY INCONTINENCE**

WHEN REFERRING TO THE CONSULTANT NURSE – CONTINENCE CARE - PLEASE LIASE WITH YOUR WARD CONTINENCE LINK NURSE, FIRST

21. DISCHARGE PLAN

GP ❑ DIETICIAN ❑ CPN ☐ D/N ❑

PHYSIO ❑ CONTINENCE NURSE ❑

OT ❑ MEDICAL STAFF ❑

APPENDIX 11: EPJ Physical Health Screen

GP	Dr E Pase	Trust ID	22-25-42	Care Coordinator	Janie Stewart
Consultant	Anil Kumar	Gender	Female	Care Type	CPA
Primary Worker		Legal Status	Section 3	**Current Physical Health**	
Alert					

Score Information
Weight (e.g. 92.7 kg)
Height Measure
Height (e.g. 1.82 m)
Click here to calculate the BMI and Nutrition Score (or recalculate following changes)
Body Mass Index

Assessment

1. Relationship with GP

Does the patient currently engage with primary care?	☐ Yes ☐ No ☒ Not Known
Date of last annual health check	
Date GP Encounter Record was last obtained or	

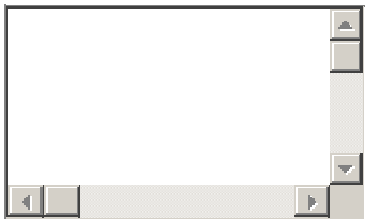
Enter details of the patient's relationship with primary care, e.g. has the patient had any recent contact with his/her GP?

2. Ongoing physical health problems

☐	☐	☑	☐	☑	☐	☑
Hypertension	Cardio Vascular Disease	Diabetes	Respiratory Disease	Cancer	Stroke	Epilepsy

i) Comments/symptoms, e.g. shortness of breath, cough, chest pains, headaches, weakness or fatigue, abdominal pain, diarrhoea or constipation, blood in stools, nausea or vomiting, heartburn, urinary frequency,

allergies, skin problems, backache, etc. Record whether symptoms might be related to current medication or use of other drugs and alcohol.



ii) Diagnosed conditions, e.g. hypertension, hepatitis B & C, epilepsy, diabetes, SLF (lupus), sickle cell disease , Parkinson's disease.

3. Current Medication for physical health

Please ensure that the current medication information has been completed (Medication Tab).

4. Physical health screens

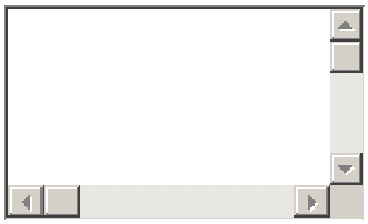
i) Enter details of vaccinations received, e.g. including hepatitis B, influenza, TB, etc.

ii) Does the patient smoke tobacco?

☐ Yes ☒ No

If Yes, how many cigarettes/roll-ups/ cigars do they smoke per day?	20000000		
Was advice to stop given to patient?	☑ Yes	☐ No	
Is the patient motivated to try and quit?	☑ Yes	☐ No	☐ Uncertain
Was brief intervention offered?	☐ Yes	☐ No	☑ Uncertain
Was NRT offered	☐ Yes	☐ No	☑ Uncertain
Was the patient referred to a smoking ce	☑ Yes	☐ No	☐ Uncertain
iii) Does the patient drink alcohol?	☑ Yes	☐ No	
If Yes, how much?			

iv) Gender - specific screens. Enter relevant details, e.g. frequency and last date of: for women – cervical smear and breast exam. For men - testicles examined.



For women (if appropriate) is the If Yes, please refer to your local perinatal mental health service	☐ Yes	☐ No

v) When did the patient last visit: Dentist	
When did the patient last visit: Optician	
vi) When did the patient last have full Nutrition Screen? To schedule next screen please see Trust Nutrition Policy	

5. Lifestyle issues e.g. include details about diet, physical exercise, sexual activity etc. Note recent weight change.

Actions to improve physical health are recorded in the Physical Health Care Plan. These may include management of identified symptoms, areas for promoting a healthier lifestyle, smoking cessation and recommended screens. For all inpatients the Inpatient Physical Health Examination must also be completed.

Assessment

1. Relationship with GP

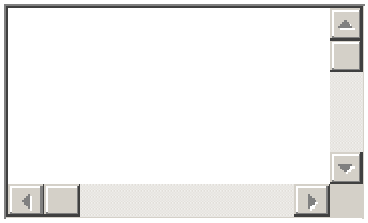
Does the patient currently engage with primary care?	☐ Yes	☐ No	☒ Not Known
Date of last annual health check			
Date GP Encounter Record was last obtained or			

Enter details of the patient's relationship with primary care, e.g. has the patient had any recent contact with his/her GP?

2. Ongoing physical health problems

Hypertension	Cardio Vascular Disease	Diabetes	Respiratory Disease	Cancer	Stroke	Epilepsy
☐	☐	☑	☐	☑	☐	☑

i) Comments/symptoms, e.g. shortness of breath, cough, chest pains, headaches, weakness or fatigue, abdominal pain, diarrhoea or constipation, blood in stools, nausea or vomiting, heartburn, urinary frequency, allergies, skin problems, backache, etc. Record whether symptoms might be related to current medication or use of other drugs and alcohol.



ii) Diagnosed conditions, e.g. hypertension, hepatitis B & C, epilepsy, diabetes, SLF (lupus), sickle cell disease , Parkinson's disease.

3. Current Medication for physical health

Please ensure that the current medication information has been completed (Medication Tab).

4. Physical health screens

i) Enter details of vaccinations received, e.g. including hepatitis B, influenza, TB, etc.

ii) Does the patient smoke tobacco? ☐ Yes ☉ No

If Yes, how many cigarettes/roll-ups/ cigars do they smoke per day? 20000000

Was advice to stop given to patient?	☑ Yes	☐ No	
Is the patient motivated to try and quit?	☑ Yes	☐ No	☐ Uncertain
Was brief intervention offered?	☐ Yes	☐ No	☑ Uncertain
Was NRT offered	☐ Yes	☐ No	☑ Uncertain
Was the patient referred to a smoking ce	☑ Yes	☐ No	☐ Uncertain
iii) Does the patient drink alcohol?	☑ Yes	☐ No	
If Yes, how much?			

iv) Gender - specific screens. Enter relevant details, e.g. frequency and last date of: for women – cervical smear and breast exam. For men - testicles examined.

For women (if appropriate) is the patient pregnant?
If Yes, please refer to your local perinatal mental health service ☐ Yes ☐ No

v) When did the patient last visit: Dentist	
When did the patient last visit: Optician	
vi) When did the patient last have full Nutrition Screen? To schedule next screen please see Trust Nutrition Policy	

5. Lifestyle issues e.g. include details about diet, physical exercise, sexual activity etc. Note recent weight change.

Actions to improve physical health are recorded in the Physical Health Care Plan. These may include management of identified symptoms, areas for promoting a healthier lifestyle, smoking cessation and recommended screens. For all inpatients the Inpatient Physical Health Examination must also be completed.

APPENDIX 12: Physical Health Care Committee Terms of Reference

INTRODUCTION

Improving the quality and care of service users is essential if improvement in health outcomes and experiences of health care are to be achieved. The physical health care needs of people with a mental illness are as important as the individual's mental health care and must be part of a holistic package of care.

To achieve this, mental health workers must receive relevant training to enable them to broaden their skills and provide improved health assessments; engage in health promotion activities and involve other professionals and service users in the planning and delivery of health care.

RATIONALE

It is estimated that 17.5 million adults in Great Britain may be living with a chronic illness and incidence is highest among the most disadvantaged groups, such as those who are unemployed, those with a mental illness etc (DoH, 2005).

National Service Frameworks have been developed for some long term conditions such as coronary heart disease, diabetes and mental health. The National Service Framework (NSF) for mental health makes explicit recommendations about the physical health care of people with a Serious Mental Illness (SMI) (NSF, DoH 1999).

The Chief Nursing Officer's review of mental health nursing (DoH 2006) recommends that Mental Health Nurses (MHN) are competent to support physical and well being by identifying and responding to unmet physical health needs by referring to medical and primary care staff.

Choosing Health (2005) states that those with a mental illness are at particular risk of experiencing health inequalities; and that the NHS must support them in making informed choices to improve their health with particular reference to reducing obesity; reducing smoking, increasing exercise, improving sexual health and in alcohol harm reduction.

Standards for Better Health (2004) and NHSLA (2008) state that all organisations need to have minimum standards and systems in place to support the assessment and management of patients who have physical and public health.

CURRENT EVIDENCE

Common Health Problems

The association between severe mental illness and physical health problems is well established (Phelan et al, 200). The life expectancy of individuals with a mental illness is nine years less than the general population (Disability Rights Commission 2006). Therefore people with a mental illness are at a greater risk of premature mortality than the general population.

Prevalence is particularly high for cardiovascular disease, type 2 diabetes, HIV/AIDS, cancers, sexual health problems and epilepsy (Disability Rights Commission 2006 and Running on Empty 2005). People with schizophrenia are nearly twice as likely to receive a diagnosis of a long term illness such as diabetes; are more likely to have bowel or breast cancer and have higher incidences of HIV/AIDS compared with the general population (Disability Rights Commission 2006 and Lambert et al 2003).

A hospital sample of patients staying in longstay psychiatric care showed that men were nearly twice as likely and women more than three times likely to be obese and the general population (Disability Rights Commission 2006). The association and risk factors between diabetes and schizophrenia is complex. Risk factors may include: weight gain as a side effect of anti-psychotic and mood stabilizer medication; family history of type 2 diabetes; ethnic origin and a sedentary lifestyle (Running on Empty 2005).
Risks associated with prescribing: prolonged Q-T intervals, early onset of diabetes, withdrawal fits during detoxification

Health Behaviours
In the general population there is evidence that cigarette and heavy alcohol use (Harris & Barraclough, 1998), poor diet and lack of exercise (Paffenbarger, 986) all contribute significantly to the increased mortality rates. Smoking, alcohol consumption, substance abuse, poor diet and a lack of exercise are more prevalent amongst those with an SMI (Lambert et al 2003, Richardson et al 2005, Goldman 999, Brown et al 999). Between 62 and 8 % of people with an SMI smoke tobacco compared with 25% of the general population (Brown et al 999). Multiple sexual partners and intravenous drug use may account for higher rates of HIV and AIDS.

Healthcare provision
Service users are less likely to report the beginnings of a physical health condition. Their experiences of stigmatising behaviours from health care professionals may prevent people with an SMI seeking help with a physical health care condition. Service users receive fewer screening or diagnostic checks such as cholesterol or spirometry from a General Practitioner in comparison to the general population (Disability Rights Commission 2006). Many clinicians and service users are unaware of the availability and resources to support service users with their physical health care. Service users report “diagnostic overshadowing” in which professionals interpret physical symptoms in their clients as a mental health issue (Disability Rights Commission 2006). In a study by Nash (2005) 7 % of nurses stated that they currently gave physical health care support to their clients yet 45% of the total sample had not received any formal training.

Environment and Employment
Poor social skills; social isolation; lack of motivation are some contributing factors as to why this vulnerable group of service users do not receive the physical health care they deserve (Phelan et al 2001).

People with who live in group situations such as care homes, or hostels are more likely to adopt riskier lifestyles if the prevalence of these behaviours amongst other residents is high.

Incidences in SLAM learning from incidents that have occurred:
Current data suggests that associated incidents have occurred arising from: Diabetic ketoacidosis and hypoglycaemia, choking, collapse, falls, a delay in recognising symptoms of physically acutely unwell patients.

South London and Maudsley NHS
NHS Foundation Trust

PHYSICAL AND PUBLIC HEALTH CARE COMMITTEE

TERMS OF REFERENCE

Overall aim or purpose:	Ensure that the Trust's Physical Health Care policy is up to date and reflects current good practice and guidance. To monitor the implementation of the Trust's Physical health care policy Produce guidance and recommended pathways on the management of physical health conditions. Develop education and training plans to ensure that staff are competent to assess and produce management plans for people who have physical health needs. To review adverse incidents involving physical health care annually to ensure that lessons are learnt in rleation to physical healthcare To review Trustwide audits on physical and public health and make recommendations to CAGS. To support the implementation of the Social Inclusion and Recovery Strategy. Identify appropriate NICE/National guidance and make recommendations to CAGS on their implementation and report to the SLaM NICE Implementation Group. Provide a strategic framework to demonstate compliance with The Care Quality Commision Standards and NHSLA. For CAGS to feedback to the committee on local physical health plans.
Specific areas of focus	• Development and implementation of the Physical and Public Health Care Policy • ePJS • Metabolic syndrome and diabetes • NICE Guidance CG50 • Pathways- continece, tissue viability, smoking cessation, falls • Knowledge and Competencies • Annual updates from local CAG Physical

Healthcare Forums

Chair: Natalie Warman (Assistant Director of Nursing Physical and Public Health Care)

Members:

- Assistant Director of Nursing, Physical and Public Health Care
- Consultants
- SpR
- ST's (1 – 6)
- Occupational Therapy, Dietician, Social work, Speech and Language therapy. Physiotherapy, fitness coordinators
- Nurse Consultant, Dual Diagnosis
- Infection Control
- Heads of Nursing
- Modern Matrons
- Clinical Coordinators
- Education and Training
- Patient Safety Officer
- Pharmacy co-opted to meeting as required
- ePJS Project Manager co-opted to meeting as required

.

Membership of this group should be the same person each time to achieve consistency (or a well briefed deputy). All Directorates should be represented and there should be a spread of professional groups.

Responsible to: Clinical Effectiveness and Audit Committee and the Clinical Risk Committee.

Roles and Responsibilities As per TOR's

Frequency of Meetings: Bi-monthly meetings
Venue – Maudsley

Quorum: Assistant Director of Nursing.
Representation from three professional groups.

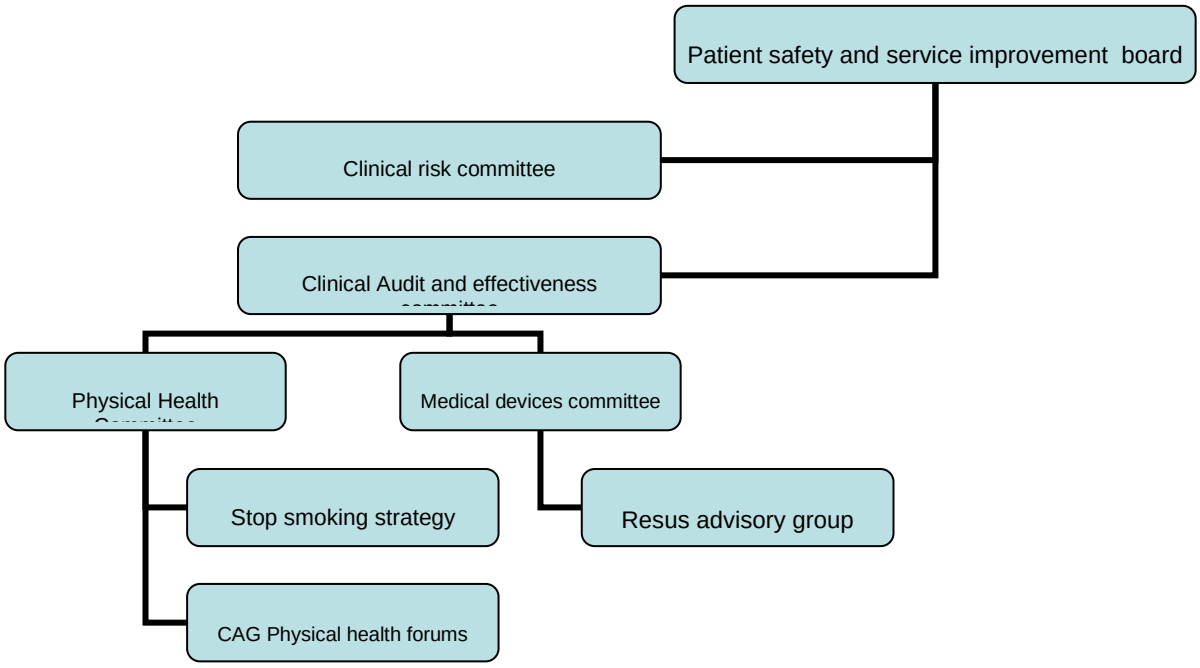
Record Keeping: Minutes will be taken at the meeting and will be circulated within two weeks of the meeting

Lifespan of Group: Ongoing. Group will be reviewed annually to measure progress against aims and objectives.

Links to: Medical Devices Committee. SLaM NICE Implementation Group. Social Inclusion and Recovery Group, Nutrition

Steering Group, Infection Control Committee, Education Group. Local Physical healthcare Groups. Stop smoking strategy group

LINE OF REPORTING



South London and Maudsley NHS
NHS Foundation Trust

APPENDIX 13: EQUALITY IMPACT ASSESSMENT

EQUALITY IMPACT ASSESSMENT

PART 1 – INITIAL SCREENING

1. Name of the policy / function / service development being assessed?

Physical Healthcare Policy

2. Name of person responsible for carrying out the assessment?

Natalie Warman

3. Describe the main aim, objective and intended outcomes of the policy / function / service development?

Aim: To promote patient safety by recognising, addressing and minimising any physical deterioration of service users; promote social inclusion into primary and secondary care; and engage service users to access local health promotion and mental wellbeing services.

4. Is there reason to believe that the policy / function / service development could have a negative impact on a group or groups?

~~YES~~ / NO

Which equality groups may be disadvantaged / experience negative impact?

Race	~~YES~~	/	NO
Disability	~~YES~~	/	NO
Gender	~~YES~~	/	NO
Age	~~YES~~	/	NO
Sexual orientation	~~YES~~	/	NO
Religion / belief	~~YES~~	/	NO

Other (e.g. refugees, behavioural difficulties) …… ~~YES~~ / NO

5. What evidence do you have and how has this been collected?

None

Some

Substantial

6. Have you explained your policy / function / service development to people who might be affected by it?

~~Yes~~ / No

If 'yes' please give details of those involved

7. If the policy / function / service development positively promotes equality please explain how?

8. From the screening process do you consider the policy / function / service development will have a positive or negative impact on equality groups? Please rate the level of impact and summarise the reason for your decision.

Positive:	High (highly likely to promote equality of opportunity and good relations)	Medium (moderately likely to promote equality of opportunity and good relations)	Low (unlikely to promote equality of opportunity and good relations)
Negative:	High (highly likely to have a negative impact)	Medium (moderately likely to have a negative impact)	Low (probably will not have a negative impact)
Neutral:	High (highly likely)		

Reason for your decision:

Date completed: 03/11/11……..

Signed …N. Warman …….. Print name …Natalie Warman……..

If the screening process has shown potential for a high negative impact you will need to carry out a full equality impact assessment

Please send an electronic copy of the completed assessment, action plan (if required), any relevant monitoring reports used and a summary of replies received from people you have consulted, to:

1. Kay.harwood@slam.nhs.uk
2. Your Service Equality Lead

Appendix 14 – Human Rights Act Assessment

To be completed and attached to any procedural document when submitted to an appropriate committee for consideration and approval. If any potential infringements of Human Rights are identified, i.e. by answering Yes to any of the sections below, note them in the Comments box and then refer the documents to SLaM Legal Services for further review.

For advice in completing the Assessment please contact Paul Bellerby, Legal Services [paul.bellerby@slam.nhs.co.uk]

HRA Act 1998 Impact Assessment	Yes/No	If Yes, add relevant comments
The Human Rights Act allows for the following relevant rights listed below. Does the policy/guidance NEGATIVELY affect any of these rights?		
• Article 2 - Right to Life [Resuscitation /experimental treatments, care of at risk patients]	NO	
• Article 3 - Freedom from torture, inhumane or degrading treatment or punishment [physical & mental wellbeing - potentially this could apply to some forms of treatment or patient management]	NO	
• Article 5 – Right to Liberty and security of persons i.e. freedom from detention unless justified in law e.g. detained under the Mental Health Act [Safeguarding issues]	NO	
• Article 6 – Right to a Fair Trial, public hearing before an independent and impartial tribunal within a reasonable time [complaints/grievances]	NO	
• Article 8 – Respect for Private and Family Life, home and correspondence / all other communications [right to choose, right to bodily integrity i.e. consent to treatment, Restrictions on visitors, Disclosure issues]	NO	
• Article 9 - Freedom of thought, conscience and religion [Drugging patients, Religious and language issues]	NO	
• Article 10 - Freedom of expression and to receive and impart information and ideas without interference. [withholding information]	NO	
• Article 11 - Freedom of assembly and association	NO	
• Article 14 - Freedom from all discrimination	NO	

Name of person completing the Initial HRA Assessment:	Natalie Warman, Assistant Director of Nursing for Physical and Public Health
Date:	03/11/11
Person in Legal Services completing the further HRA Assessment (if required):	N/A
Date:	

Appendix 15 – Checklist for the Review and Approval of a Policy

This checklist must be used for self-assessment at the policy writing stage by policy leads and be completed prior to submission to an appropriate Executive Committee/Group for ratification.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Style and Format**		
	Does the document follow The South London and Maudsley NHS Foundation Trust Style Guidelines? i.e.:		
	• The Trust logo is in the top left corner of the front page only and in a standard size and position as described on the Intranet	✓	
	• Front page footer contains the statement about Trust copyright in Arial 10pt	✓	
	• Document is written in Arial font, size 11pt (or 12pt)	✓	
	• Headings are all numbered	✓	
	• Headings for policy sections are in bold and not underlined	✓	
	• Pages are numbered in the format Page X of Y	✓	
2.	**Title**		
	Is the title clear and unambiguous?	✓	
3.	**Document History**		
	Is the document history completed?	✓	
4.	**Definitions**		
	Are all terms which could be unclear defined?	✓	
5.	**Policy specific content**		
	Does the policy address, as a minimum, the NHSLA Risk management Standards at Level 1 where appropriate	✓	
6.	**Consultation and Approval**		
	Has the document been consulted upon?		
	Where required has the joint Human Resources/staff side committee (or equivalent) approved the document?		
7.	**Dissemination**		
	Does the document include a plan for	✓	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	dissemination of the policy?		
8.	**Process for Monitoring Compliance**		
	Is it explicit how compliance with the policy will be monitored?	✓	
9.	**Review Date**		
	Is the review date identified on the cover of the document?	✓	
10.	**References**		
	Are supporting references cited?	✓	
11.	**Associated documents**		
	Are associated SLaM documents cited?	N/A	
12.	**Impact Assessments**		
	Is an Equality Impact Assessment included as the appendix of the document?	✓	
	Is a HRA Assessment included as an appendix of the document?	✓	