Pennine Care NHS
NHS Foundation Trust

Policy Document Control Page

Title

Title: Mental Health Services Physical Health Policy for Service Users Aged 18 Years and Over

Version: 6

Reference Number: CL42

Keywords

- Physical Health
- Mental Health

Supersedes

Supersedes: version 5

Description of Amendment(s):

- **The policy has been re-organised and up-dated**
- **New sections in relation to in-patient physical health intervention and review**
- **Updated information in relation to Care Programme Approach**

Originator

Originated by: Carol Palk

Designation: Modern Matron Service Improvement

Equality Analysis Assessment (EAA) Process

Equality Relevance Assessment Undertaken by: Carol Palk

ERA undertaken on: 15/02/16

ERA approved by EIA Work group on:

Where policy deemed relevant to equality -

EAA undertaken by: Carol Palk

EAA undertaken on: 15/02/16

EAA approved by EIA work group on: 20/05/16

Approval and Ratification

Referred for approval by: Carol Palk

Date of Referral: 03/09/15

Approved by: Physical Health Steering Group

Approval Date: 03/09/15

Date Ratified by Executive Directors: 6th June 2016

Executive Director Lead: Director of Nursing

Circulation

Issue Date: 6th June 2016

Circulated by: Performance and Information

Issued to: An e-copy of this policy is sent to all wards and departments

Policy to be uploaded to the Trust's External Website? YES / NO

Review

Review Date: 3rd September 2018

Responsibility of: Carol Palk

Designation: Modern Matron Service Improvement

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

Date Posted: 6th June 2016

TABLE OF CONTENTS

GLOSSARY OF ABBREVIATIONS

AUDIT	Alcohol Use Disorder Identification Test
BMI	Body Mass Index
CAMHS	Children and Adolescent Mental Health Services
CL	Clinical
CO	Corporate
CPA	Care Programme Approach
CQC	Care Quality Commission
CRHT	Crisis Resolution Home Treatment Team
DCA	Department for Constitutional Areas
DH	Department of Health
EAA	Equality Analysis Assessment
ERA	Equality Relevance Assessment
GP	General Practitioner
HR	Human Resources
IPDR	Individual Performance and Development Review
IGG	Integrated Governance Group
LDQ	Leeds Dependence Questionnaire
MDT	Multidisciplinary Team
MEWS	Modified Early Warning Score
MH	Mental Health
MM	Medicines Management
MRSA	Methicillin-Resistant Staphylococcus Aureus
MUST	Malnutrition Universal Screening Tool
NHLSA	National Health Service Litigation Authority
NICE	National Institution for Health and Clinical Excellence
NRT	Nicotine Replacement Therapy
PAD	Pennine Assessment Document
SADQ	Severity of Alcohol Dependence Questionnaire
SMI	Serious Mental Illness

1. INTRODUCTION

1.1 Background

In 2006 the Department of Health reported that people with a diagnosis of Serious Mental Illness (SMI) were twice as likely to suffer from cardiovascular disease and four times more likely to die from respiratory disease than the general population. Contributory factors were identified as modifiable lifestyle behaviours, such as tobacco smoking, physical inactivity and nutritional factors (DH, 2005), and additionally self-neglect, alcohol and substance misuse, and the effects of psychotropic medication (Cormac et al, 2004).

In 2014 NHS England reported that people with severe and enduring mental illness still have a life expectancy of 10 to 15 years shorter than average, although some research suggests that this figure may be higher. De Hert et al (2011) carried out a systematic review to identify prevalence figures and factors contributing to morbidity and mortality rates. It was found that people with SMI are much more likely to be obese and it is known that obesity is associated with metabolic syndrome. Metabolic syndrome is a cluster of symptoms occurring together that carries a 5-6 fold increased risk of developing Type II Diabetes Mellitus and a 3-6 fold increased risk of mortality due to coronary heart disease. There is also an increased prevalence of many other conditions. This study confers with previous findings that life style factors account for much of the increased risk for this group, but suggests that other contributory factors include side effects of antipsychotic medication and disparities in access and quality of physical health care.

Section 4 of the Health and Social Care Act 2012 states that the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service. The Department of Health asked the Royal College of Psychiatrists to consider the issues involved in the apparent disparities between physical and mental health. In 2013, 'Whole-person care: from rhetoric to reality' defined 'parity of esteem' as simply valuing mental health and physical health equally. It was asserted that, amongst other things, a parity approach would require positive changes in attitudes to mental health, and in knowledge, priorities, professional training and practice, all of which are necessary to reduce the stigma experienced by those with mental health problems and to improve the assessment and care they receive.

1.2 Purpose

The purpose of this policy is to establish minimum standards of physical healthcare for users of Mental Health services across Pennine Care NHS Foundation Trust in order to mitigate physical health risks as far as possible and promote parity of esteem.

The overarching objectives of the policy are to:

- Work towards the goals highlighted in 'Whole-person care: from rhetoric to reality' that are relevant to the services outlined in the policy scope:
    - People with mental health problems will have parity of life expectancy and no higher rates of physical illness than those without these problems
    - Mental health problems will be recognised as a risk factor in physical illness and vice versa.
    - People with mental health problems will receive the same quality of physical healthcare as those without a mental health problem
    - People with mental health problems will receive appropriate intervention and support to address the factors affecting their much higher rates of health risk behaviour
- Achieve the 'Fundamental Standards of Quality and Safety' where they apply to physical health care (Care Quality Commission, 2015).
- Ensure that secondary services undertake regular assessment of the mental and physical needs of the service users; addressing all issues relevant to the individual's quality of life and wellbeing (NICE, 2002); working collaboratively with other local providers to ensure people with mental health needs access physical healthcare services and physical health checks.
- Ensure that service users have a written plan of care commensurate with the level of intervention required to meet both mental and physical health needs (Refocusing the Care Plan Approach, DH 2008) and recognising the impact that mental illness symptoms and possible treatment programmes can have on physical health and the impact that physical symptoms can have on an individual's mental wellbeing.

1.3 Scope

The use of the term 'service user' throughout the policy refers to service user, client, resident or patient, regardless of the treatment setting.

Pennine Care NHS Foundation Trust recognises the importance of providing an holistic care package to service users addressing physical health care and mental healthcare needs though the Care Programme Approach (CPA) process or through individual care planning as appropriate to the service.

It is recognised that mental health services provide physical and mental health care in diverse settings including inpatient and community based settings. This policy establishes standards to ensure that physical health care appropriate to the needs of the individual is delivered equitably across the Trust irrespective of the treatment setting.

This policy applies to all inpatient and secondary community mental health services provided by the Trust for adults of working age and older people; individuals with substance misuse problems; and adults with learning disabilities under the care of

mental health services. This policy also applies to individuals aged 16-18 years of age if admitted to an adult ward.

2. AIMS OF THE POLICY

This policy aims to ensure that the physical health care needs of service users are identified, that appropriate action is taken, and that there is no discrimination on the basis of the individual's age (where applicable to this policy); disability; gender (including transgender); ethnicity; religious belief or sexual orientation.

2.1 Policy standards

- All service users will have the opportunity to participate in assessment to identify any physical health needs. Physical health assessment on admission to mental health in-patient services is a key indicator of effective care (CQC, 2015). In services where physical health assessment is the responsibility of another agency rather than the Trust, service users will be offered access support or alternative arrangements where necessary.
- Service users will be involved in the planning of physical health care to meet basic, essential or specific needs identified in the assessment, as appropriate to the care setting.
- Health will be monitored and other provider services will be involved where appropriate.
- Staff will communicate effectively to provide support that promotes health.

2.2 Mental Capacity Act

Healthcare professionals must proceed in accordance with the Mental Capacity Act 2005 (DCA, 2005) before taking treatment decisions (including physical examination) on behalf of those who lack capacity. Advice on the Act is contained within the Code of Practice and a series of guides produced by the Department for Constitutional Affairs (DCA). Any queries on how the Act should be applied in particular circumstances may be directed to the Mental Health Law Office for advice. If advice is required out of hours it should be sought via an on call manager and/or on call Consultant Psychiatrist. Reference must be made to the Trust's policy on Consent to Examination and Treatment (CL2).

3. ROLES AND RESPONSIBILITIES

3.1 Medical Director

The Medical Director is the Trust's Board Lead for Physical Healthcare, with the responsibility for ensuring that appropriate policies are in place and any risks regarding physical healthcare management are monitored and reported to the Board accordingly.

3.2 Service Directors

Service Directors are responsible for ensuring high standards of physical healthcare within the service for which they have overall responsibility and ensuring adherence to the Trust's Physical Health Policy.

3.3 Service Managers and Ward/Team Managers

Service Managers and Ward/Team Managers are responsible for ensuring that high standards of physical health care are maintained within their areas of responsibility and for ensuring adherence to the Trust's Physical Health Policy.

Managers also have responsibility for identifying and appropriately communicating the training needs of staff, and for ensuring that appropriate equipment is available for relevant aspects of physical health care and maintained (Management of Medical Devices Policy C016).

Managers should ensure that good practice is shared across their service and with other services to help ensure a learning culture where good quality evidence based practice is continually strived for.

Managers are responsible for ensuring that their clinical area(s) participate in physical health related clinical audit as required in relation to the Trust's Clinical Audit Programme.

3.4 Service Improvement Modern Matrons

Physical health is a key work stream for the Matrons, who will support the service and ward managers to meet all their responsibilities; provide consultation and/or advice to inpatient services where appropriate; assist in the identification of training needs, commission training or design/deliver in-house, training as appropriate; support the design and implementation of physical health audits; produce resources to support quality care delivery; research and source equipment to meet particular needs and liaise with procurement services; facilitate the sharing of good practice and the dissemination of evidence based information.

The Matrons will sit on the Physical Health Steering Group and will develop and review the physical Health policy as directed by the group. The Physical Health Steering Group will oversee the implementation of the policy, promote the policy across the Trust, and will liaise with the Learning and Development Department to develop training in relation to physical healthcare.

3.5 Learning and Development Department

The Learning and Development Department are responsible for providing support to the service line and corporate Learning Associates to assist in the provision of appropriate training for clinical staff.

3.6 All Clinical Staff

All staff working with service users are required to assess and manage physical healthcare in accordance with this policy and within their professional limitations and competence.

4. GENERAL PRINCIPLES OF PHYSICAL HEALTHCARE

4.1 Health care environment

All services must ensure that an appropriate environment is provided for individuals receiving physical health assessment, care or treatment, which protects confidentiality, privacy and dignity. This may be a designated area or room for physical checks or examinations or a single bedroom in in-patient services.

4.2 Chaperoning

Any physical health assessments involving a service user undressing and/or intimate examinations should be undertaken in the presence of a chaperone. This protects both the service user and the member of staff from inappropriate actions or allegations of inappropriate behaviours or actions.

Gender, religious and cultural sensitivities should be considered when undertaking a physical examination.

4.3 Health Promotion

Ward Managers and Team Leaders, supported by Service Managers and Modern Matrons, should ensure prioritisation of health promotion within their service areas. This will include (but is not exclusive to) advice and activities to support smoking cessation, healthy diet, exercise and weight management, and sexual health. Service users in all care settings should have easy access to appropriate written health promotion information. Inpatients should have access to appropriate, well maintained, good quality facilities to enable them to attend to personal hygiene needs, and should be able to access fresh air and exercise space. Each ward must demonstrate that they are holding health promotion groups or other health promotion activities regularly.

4.4 Obesity and weight management

Obesity and weight management should be considered part of effective physical health care, particularly where prescribed medication may be adversely effecting weight. The in-patient service user's care plan should include intervention according to Trust policy 'Identification and Management of Obesity in Adult and Older People's Services' (CL28). The guidance in this document may also be useful in informing intervention for out-patients plans of care. Where service users do not wish to address their weight management issues consideration should be given to their capacity to make this decision and this should be clearly documented in the clinical notes.

4.5 Smoking Cessation

Pennine Care NHS Foundation Trust has an important health promotion role to play in relation to smoking cessation as there are very high rates of smoking by those with mental health problems (DoH 2016: 33% compared to 19% of the general adult population). One of the most important aspects of this role is to provide a smoke free environment. Each clinical area should provide posters, leaflets, and other forms of information, advising on the dangers of smoking to health and signposting for smokers to sources of help. The harmful effects of smoking should underpin the health promotion philosophy of all clinical teams on the wards/units and in the community.

All staff must follow Trust guidance as outlined in the Smoke Free NHS Trust Policy (CO39) and the Nicotine Replacement Therapy (NRT) Guidelines for Patients of Pennine Care NHS Foundation Trust (MM036). The smoking status of all patients (in-patients and out-patients) must be recorded. Service users who smoke should be offered encouragement and support to cease smoking as part of the clinical care plan.

All health professionals (in primary and secondary mental health care) should routinely ask about smoking and advise smokers to stop. All smokers who wish to attempt to stop smoking should be referred to a trained advisor for specialist support. This referral may be to the local Borough Stop Smoking Service, which will offer further support and advice to service users and staff (the Trust's Health and Wellbeing Strategy provides further support and information for staff who wish to stop smoking), or to an appropriately trained advisor within the team who can provide individually tailored advice or counselling in relation to the most appropriate forms of NRT. Where appropriate, access to NRT should be facilitated by a member of the team trained to deliver Level 2 smoking intervention or by medical staff. There is a rolling programme of training in brief intervention work and Level 2 smoking cessation training.

Any referral for smoking cessation should be recorded and should include the contact details of relevant healthcare professionals working with the service user, who need to be notified about a quit attempt, and details of any current psychotropic medication. Stopping smoking can reduce the metabolism of some medication resulting in higher, sometimes toxic, blood levels over a few days. It is therefore recommended that the advice of a pharmacist is sought prior to smoking cessation and that the quit attempt is monitored closely when the smoker is on psychotropic

medication. There may be an exacerbation of medication side effects, the dose of neuroleptic medication may need to be altered and the service user may need additional help with withdrawal symptoms and urges to smoke.

4.6 Management of Alcohol Withdrawal

Staff responsible for managing assisted alcohol withdrawal should be competent in the diagnosis and assessment of alcohol dependence and withdrawal symptoms and the use of pharmacological interventions, whether as an inpatient or within the community setting. Local Drug and Alcohol Services should be contacted for more specialist advice and prescribing guidance can be found in the Guidelines for the Management of Alcohol Withdrawal and Prevention of Wernicke-Korsakoff Syndrome (MM018, v.3).

4.7 Medication specific physical health monitoring

Service users on certain medication will require medication specific monitoring, these include:

4.7.1 Antipsychotic Medication

Refer to:

- Initiation and monitoring of high dose antipsychotics (MM037)
- Guideline for the Prescribing and Monitoring of Antipsychotics in the Treatment of Schizophrenia (MM039)
- Guidelines for the use of antipsychotic long acting injections (MM014)
- Shared Care Guideline for Antipsychotics - prescribing and monitoring

4.7.2 Lithium

Refer to:

- Lithium Therapeutic Drug Monitoring (MM062)
- Shared Care Guideline for Lithium Treatment in Adults aged 18 – 65 years old
- Shared Care Guideline for Lithium Treatment in Adults aged 65 years and over

4.7.3 Clozapine

Refer to:

- Guidelines for the Monitoring of Physical Health for Service Users taking Clozapine (MM042)
- Guidelines for Clozapine Therapeutic Monitoring (MM089)
- Guidelines for Dealing with Clozapine Treatment Amber and Red Results (MM090)

5. PHYSICAL HEALTH CARE IN INPATIENT MENTAL HEALTH SERVICES

5.1 Assessment

Any factors that prevent completion of a physical health assessment or examination should be clearly recorded in the service user's hospital notes (e.g. service user's refusal or a clinical rational for delaying the assessment). The assessment must be offered or considered daily until it has been completed, and this must be clearly documented in the service user's notes. If the service user continues to refuse assessment a multi-disciplinary discussion needs to take place to ensure that appropriate action is taken. This discussion must be documented.

5.1.1 Initial Assessment

This refers to the general assessment conducted at the initial point of contact with the service at the start of the assessment process. The format of the initial assessment may be different in different specialities, but should take in to account past medical history and any current medical problems, and physical examination/investigation information available from Pennine Care NHS Foundation Trust, the patient's General Practitioner and/or other sources. An example of an initial assessment proforma used in the acute areas can be seen in **appendix 1.** Those patients who are on the Care Programme Approach (CPA) should be asked when they last had an Annual Health Check with their GP. If the check is due or overdue, the GP should be notified.

5.1.2 Physical Health Monitoring

This refers to a comprehensive screening using the 'In-patient Physical Health Screening, Assessment Summary and Overarching MDT Intervention Plan' ('The Physical Health Monitoring Form') **(appendix 2),** which is conducted where possible in the first 24 hours of admission by a Registered Nurse or, as agreed by the ward/unit manager, by a suitably qualified and competent Assistant Practitioner.

The 'Physical Health Monitoring' assessment ensures that base line measures of basic physical observations, for example blood pressure, temperature, pulse, and respiration, are recorded in an easily accessible place. The baseline measures should also be recorded on a MEWS chart **(appendix 5)**, with a score calculated, for continued monitoring at a frequency determined by the patients overall physical presentation or by local policy and to enable rapid comparison and appropriate response should the service user's physical health deteriorate.

Monitoring also includes baseline measures of waist circumference, height, weight and a calculation of Body Mass Index (BMI). All adult and older adult patients should have an 'Assessing Alcohol Intake Screen' if they take any amount of alcohol, and a further more detailed assessment of intake if indicated, both of which can be seen in **appendix 6** (Recording of Alcohol Intake/Reduction Monitoring Form).

In addition to these specific measures, screening questions are asked about the following physical health indicators:

- Smoking status
- Alcohol use
- Fluid intake
- Caffeine intake
- Elimination (bladder, bowel and continence issues)
- Diet and exercise
- Sleep
- Hygiene, oral health and sensory
- Sexual Health
- Pain
- Substance misuse
- Foot health
- Wounds
- Infections
- Mobility including risk of falls
- Venous Thromboembolism (VTE) risk screen
- Chronic conditions (other)

Any abnormal results, concerns or potential problems highlighted will require either further assessment by ward/unit staff to gather more information to define the problem and inform care, or immediate referral to a Doctor or Specialist Practitioner. Further assessment of some elements within the monitoring tool may be required regardless of whether issues were apparent from the initial screening questions and where this is the case it will be indicated on the form or by local agreement. This may be to ensure that the needs of particular client groups are met, for example all Older People's service users will require fluid intake monitoring for several days, or to meet requirements of national guidance, as in the case of cardiometabolic monitoring.

5.1.3 Physical Health Examination

This refers to a full, systematic physical examination of the service user, carried out by a Doctor or Advanced Practitioner within 24 hours of admission. A documentation template, **appendix 3**, is available for those wishing to use it. Those preferring to document the examination in the on-going record must adhere to the guidance and standards outlined in the 'Physical Examination and Assessment on Admission Policy' (CL20).

Investigations requested will largely depend on the presentation of the service user, but should include ECG and blood tests required for cardiometabolic and specific medication monitoring (see section 4.7).

5.1.4 Annual Physical Health Check

This refers to a full range of tests taking a broad overview of an individual's physical wellbeing where the service user is on a General Practitioner Severe Mental Illness (SMI) register as part of the Quality Outcomes Framework (QOF). Responsibility for

annual health checks for those on GP SMI registers will be identified in local Service Level Agreements for the longer stay services. Where a service user is unable or unwilling to see their GP for an annual physical health check, the service user's key worker should offer to arrange for the checks to be completed by the ward medical team, in consultation with the Consultant Psychiatrist, using the agreed physical health check proforma in **appendix 4.** In these circumstances, a copy of the Annual Physical Health Check should be given to the GP.

5.1.5 Assessment on transfer between wards/units within the organisation

Where a service user is transferred between wards within the Trust, physical health monitoring and physical health examination information should be reviewed as part of the new ward's admission process. The review and outcome must be clearly documented and assessment repeated if necessary.

5.1.6 Urgent assessment and medical emergencies

If there is indication that physical health is deteriorating or a service user is complaining of feeling physically unwell, nursing staff should ensure where possible that observations of temperature, pulse, respiratory rate and blood pressure are recorded and that a Modified Early Warning Score (MEWS) is calculated. Other tests may be carried out depending on the patient's presentation, for example ward urinalysis or finger prick blood glucose, and all relevant information should be relayed to a doctor when requesting an unplanned medical assessment. Remedial action should be taken where appropriate while awaiting the Doctor's attendance. Further observations should be recorded and reported as agreed with the Doctor to ensure effective on-going monitoring. The observations and communication with the Doctor must be recorded in the service user's hospital notes.

In cases of medical emergency, staff should use crash teams and 999 as appropriate to their location. All staff should be familiar with the emergency contact procedures for their area of work.

5.2 Intervention

Appropriate intervention must be provided for all physical health needs identified in the assessment process, including chronic conditions, and this must be documented in the service user's notes. For some minor issues advice or information may be sufficient and a note can be made on the monitoring form or in the medical notes when this has been offered. The 'In-patient Physical Health Screening, Assessment Summary and Overarching MDT Intervention Plan' **(appendix 2)** should be used to ensure that an overview is taken of the relationship between symptoms in order to plan an holistic care/treatment package. The roles and responsibilities of the members of the multi-disciplinary team in the delivery of physical health care and treatment should be clearly identified in the MDT plan. More detailed care/treatment plans should be provided by the assigned members of the team using profession specific documentation or formats.

Where physical symptoms have been identified that require more specialised assessment/treatment, or pre-existing conditions require follow-up appointments, referral should be made to specialists by the medical or nursing team as appropriate and this should be documented in the MDT intervention plan. The outcome of any physical health investigations carried out should be documented in the notes and passed on by the referrer to the specialist concerned. Advice or instruction from specialists should be incorporated in to the service users care/treatment plans as appropriate or, where possible, joint care planning should take place.

5.3 Review

Response to planned intervention will be monitored through the general multi-disciplinary review process, for example at ward rounds, CTMs, CPAs and GP meetings. Re-assessment of physical health should be undertaken whenever there is deterioration in physical health status. Along with medical examination, repeating the physical health monitoring assessment may help to establish the wider impact of the deterioration. Where the service user has an extended stay in hospital, the physical health monitoring assessment should be repeated after 6 months and 6 monthly thereafter until discharge.

5.4 Nutrition

Adequate nutrition and hydration are an essential part of physical wellbeing. All service users should be provided with appropriate food and drink to meet their nutritional, therapeutic and cultural needs whilst on inpatient units.

The Health and Social Care Act 2008 (Regulations 2014) Regulation 14: Meeting nutritional and hydration needs, states that

- People who use services should have adequate nutrition and hydration to sustain life and good health and reduce the risks of malnutrition and dehydration while they receive care and treatment.
- Where it is part of their role, providers must make sure that people have enough to eat and drink to meet their nutrition and hydration needs and receive the support they need to do so.
- People must have their nutritional needs assessed and food must be provided to meet those needs. This includes where people are prescribed nutritional supplements. People's preferences, religious and cultural backgrounds must be taken into account when providing food and drink.'

The Trust's Nutrition and Hydration Policy (CL85), details the requirements for assessment, including the use of the Malnutrition Universal Screening Tool (MUST), care planning and intervention.

5.5 Interagency transfer to another service

The minimum information provided when a service user is transferred to another service must include the following:

- Name
- Gender
- Date of Birth
- Address
- Unique identification number, where one exists
- Emergency contact details
- Details of any persons acting on behalf of the service user
- Records of care
- Treatment and support provided up to the point of transfer
- Assessed needs
- Known preference and any relevant diverse needs
- Previous medical history that is relevant to the service users current needs including General Practitioner's contact details
- Any medication the service user needs to take
- Any Allergies/Adverse Drug Reactions
- A key contact in the service the service user is leaving
- The reason for the transfer and any Advance Decisions
- Any assessment risk of suicide, homicide, harm to self and/or others and any infection that needs to be managed

In an emergency situation, some of this information may be given verbally in the first instance by a member of staff who knows the patient well, but written information must be sent on as soon as possible after the patient has been transferred.

Service users should be assessed to establish whether they meet the criteria for Methicillin-Resistant Staphylococcus Aureus (MRSA) screening on admission to the service and this should be checked in terms of changes to status prior to transfer to another in-patient area ('The Prevention and Management of Meticillin Resistant Staphylococcus Aureus Policy' (CL70). In an emergency situation where it has not been possible to screen a patient who meets the criteria, staff should inform the new service that the MRSA screen has not been undertaken. In cases where a service user is identified as being MRSA positive, or has another known infection, an interagency transfer form should be completed and sent with the information outlined above to the receiving in-patient area ('Infection Prevention and Control Policy' CL4).

5.7 Discharge from inpatients services

In addition to the information outlined above, it is the responsibility of the Doctor to ensure that the service user's GP is made aware of the physical healthcare needs that arose during the service user's admission. It is the Psychiatrists responsibility to ensure that the service user's GP receives a full discharge summary that includes all physical investigations undertaken, including copies of results, and any medication that has been prescribed. When the service user is being discharged to the Community Mental Health Team (CMHT), a handover must take place which includes details of the physical health assessment and any on-going needs. The discharge planning process

must include details of the arrangements required to support service users in any follow up arrangements required. This must be clearly documented on the service users care plan, which will be given to the service user and the service user's GP.

6. PHYSICAL HEALTHCARE IN THE COMMUNITY MENTAL HEALTH SERVICES

6.1 The role of Primary Care

Primary care has a responsibility for the physical healthcare of community mental health service users (Choosing Health, Department of Health 2006). However, Community Mental Health Services must include up-to-date assessment of the physical health care needs of service users as part of the Care programme Approach (CPA) process or as part of the individual's overall care plan if the service user is not included within the CPA process.

6.2 The role of Community Mental Health Teams

The importance of supporting service users with their physical health needs, as part of a holistic package of care, is recognised in Mental Health Community Services. However, it is also recognised that different approaches will be appropriate according to individual service user need. Some service users who experience severe and enduring mental illness are likely to neglect their physical health and there is evidence of a significantly increased risk of early death for this group. Service users prescribed Clozapine, a depot injection, and/or other mental health medication, are also at an increased risk of physical health complications and premature death. An assertive approach may therefore be required for some service users, whereas an approach that promotes self-responsibility and recovery may be more appropriate for others.

Service users under secondary care community mental health services will be allocated a Care Co-ordinator, if they are being cared for under the Care Programme Approach (CPA), or otherwise a key worker.

6.3 Assessment responsibilities of the Care Co-ordinator/Key Worker

In completing physical health related assessment documentation, the care co-ordinator/key worker must consider:

- The approach being taken with the service user's mental health. If it is an assertive one, the service user is more likely to need an assertive approach to their physical health, which would mean arranging appointments, checking attendance and supporting attendance
- Whether the service user has the capacity to maintain their own wellbeing and make choices about the services they engage with
- The team to which the service user is allocated. For example, within a recovery team, self-responsibility and management are the focus and it would be expected this would be the same for their physical health

- The medication the service user is on. The requirements for monitoring physical health need to be clear in the care plan regardless of the approach being taken

6.4 Care planning responsibilities of the Care Co-ordinator/Key Worker

Whatever the approach the Care Coordinator/Key Worker implements, it is vital that the care plan contains:

- Information about medication and its monitoring
- Advice about physical health annual check with the GP
- Detail of any significant physical health needs the service user has and the care agreed to meet those needs
- Detail of any support that will be offered by Mental Health Services
- Information about the services responsible for ensuring that systems are in place to carry out the required physical health assessment and review of the service users on-going needs

6.5 Intervention responsibilities of the Care Co-ordinator/Key Worker

Physical health care needs must be included within the individual care plan for the service user, ensuring that they are able to access appropriate primary care based provision or secondary health care provision within acute NHS Trusts. Care Coordinators are responsible for encouraging and supporting service users to engage with physical health care services as appropriate to follow up symptoms. When a service user with a severe mental health illness chooses not to receive physical care from primary care services, they will be monitored by teams in secondary care (NICE, 2002). Service users should have information about access to appropriate community groups in relation to health promotion in accordance with the availability within each local service.

6.6 Review responsibilities of the Care Co-ordinator/Key Worker

Care Coordinators must ensure that community CPA reviews take place every 12 months as a minimum, and that a review of the service user's physical healthcare needs is included. Those on a recovery pathway and service users who only attend Treatment Support Services only, will have a review every twelve months at which physical health needs should be considered.

6.7 Annual Physical Health Check

Care Coordinators/Key Workers in community settings should advocate, and support where necessary, an annual physical healthcare assessment for service users. The Annual Physical Health Check refers to a full range of tests looking at the broad overview of an individual's physical wellbeing, including blood tests, blood pressure, temperature, pulse, Body Mass Index and so on, which should be undertaken on an annual basis for those service users who are on a General Practitioner (GP) Severe Mental Illness (SMI) register as part of the Quality Outcomes Framework (QOF). The Annual Physical Health Check should be completed by the service user's GP, but the Care Co-ordinator/Key Worker has responsibility for checking and documenting in the clinical notes whether or not the check has been carried out. If the service user is

unable, or unwilling, to attend their GP for this health check, the service user's Care Coordinator/key Worker should offer encouragement and practical support to facilitate attendance at the GP surgery where appropriate, or if need be arrange for the checks to be completed within the Community Mental Health Service, enlisting the services of the wider multi-disciplinary team, using the proforma in **appendix 4**. If the service user refuses this intervention it must be documented in their clinical notes.

7. TRAINING

All physical health assessments and interventions will be undertaken by appropriate members of the care team. Training needs will be identified by the Physical Health Steering Group and its service representatives in conjunction with the Learning Associate for the service area. A member of the Service Improvement team who sits on the Physical Health Steering Group will liaise with the Organisational Learning and Development Department as Learning Associate to negotiate training to meet identified needs.

8. TARGETS AND OUTCOMES

The aim of this policy is to ensure that the physical health care needs of the Trust's service users are identified and that appropriate action is taken. By ensuring holistic, individualised, patient centred care the Trust will contribute to the national objective of improving the physical health of those with mental health problems. Specific targets and outcomes are identified in section 2.1.

9. CLINICAL AUDIT AND MONITORING

To monitor adherence to this policy, periodic clinical audit of the physical health documentation in a random sample of clinical case files across mental health inpatient services and community mental health services will take place, supported where appropriate by the Clinical Audit and Effectiveness Department. Audit may include:

- The completion of appropriate physical health assessments on admission to in-patient services or on referral to community teams
- The follow up and intervention planning for any identified physical health symptoms
- The on-going assessment and review of conditions and any physical health needs that have been identified

Audit results will be presented at the Physical Health Steering Group and taken back to local Quality and Governance groups by the service representatives. Service and Ward/Unit/Team Managers, with support from the Modern Matrons, will have responsibility for ensuring that any necessary action plans are devised and

implemented. Governance Managers will have responsibility for monitoring the completion of action plans. The Physical Health Steering Group will ensure that information about lessons learned is disseminated to enable cascade through team meetings.

10. EQUIPMENT

Appropriate medical equipment must be available, readily accessible, maintained and functional at all Trust sites offering physical health assessment, care or treatment in accordance with the Medical Devices Policy (CO16). Ward Managers, with support from Modern Matrons, must ensure that staff have the relevant training to use the equipment.

In in-patient areas, emergency resuscitation equipment must be available, easily accessible and checks recorded daily as per the Trust's Resuscitation Policy (CL9). The Trust Resuscitation Lead should be contacted for advice and support regarding resuscitation training and equipment.

11. REFERENCES

Care Quality Commission (2014) Intelligent Monitoring. Trusts that provide mental health services: Indicators and methodology

Care Quality Commission (2015) Guidance for providers on meeting the regulations

De Hert, M. et al (2011) Physical illness in patients with severe mental disorders: Prevalence, impact of medications and disparities in health care (World Psychiatry; 10:52-77)

Royal College of Psychiatrists (2013) Whole-person care: from rhetoric to reality. Achieving parity between mental and physical health

Department of Health (2008) Refocusing the Care Plan Approach

APPENDIX 1: INITIAL PHYSICAL HEALTH ASSESSMENT FORM

Pennine Care NHS
NHS Foundation Trust

Assessment Proforma.
Adult and Older People Mental Health Services.
Pennine Care NHS Foundation Trust.

The following is designed to provide an aide memoire for practitioners, including medical, nursing and other professional disciplines concerned with the assessment of an adult presenting with a mental health need.

The aide memoire should be used in conjunction with the best practice guidelines that accompany this document.

All documentation of the assessment should be completed on history sheets, individually completed with patient name, Date of Birth and NHS/RT2 number if known. The assessment should have clear headings identifying each question in the process.

- **Demographics** Should still be completed on recognised NCRS Front sheet)

- **Assessment**:

1. Presenting complaint (current symptoms and complaints)
2. History of presenting complaint (Chronological history of development of symptoms, including frequency, severity and associated psychological stressors and relevant negative findings (eg no auditory hallucinations))
3. Past psychiatric history
4. Past medical history and current medical problems
5. Present treatment (All current medications being taken and any therapy being received)
6. Treatment History (Past medicines tried and any therapy completed)
7. Family history (include family tree)

8. Personal history (Including childhood, relationships, occupational and social history)

9. Present social circumstances

10. Drugs/alcohol use (Past and current use)

11. Forensic history

12. Mental state examination (Appearance and behaviour, speech, mood (objective and subjective), thoughts (including suicidal ideation), perception, cognitive function and insight/capacity).

13. Physical examination and investigations (as appropriate)

14. Diagnosis/formulation/current risks identified

15. Management plan (Next steps for the patient i.e. Home Treatment, follow up, refer back to GP, medication, level of obs if admitted etc.)

This assessment must be accompanied by a completed cluster profile, child and adult safeguarding assessment and a completed Risk Assessment on Trust Approved Documentation.

CC/SD/13

APPENDIX 2: PHYSICAL HEALTH MONITORING FORM

In-patient Physical Health Screening, Assessment Summary and Overarching MDT Intervention Plan

Patients Name		Date of Birth		NHS No.		Ward	

Date screening completed		Consent		Chaperone	
*Document refusal below		*If no, document action in notes		*Give name or state NR (not required)	

Screening attempt 1		Screening attempt 2		Screening attempt 3		Date continued refusal discussed with MDT and documented in notes
Date:	Print:	Date:	Print:	Date:	Print:	
	Sig:		Sig:		Sig:	

Food Allergies *complete allergy form and document intervention under 'lifestyle'	

Cardiometabolic Intervention Framework	Indicator	Screen/Result		Red Zone	Assessment Summary (state if no further assessment required **NFAR**)	MDT Intervention Plan (Indicate MDT roles/ responsibilities)	
	Smoking	Yes	No	Current smoker TAD Smoking Status Record	See Smoking TAD	No intervention required	
						See TAD Intervention Plan	
	Lifestyle & Life Skills			Poor diet and/or sedentary Lifestyle See Weight/ lifestyle assessment pathway tools			
	BMI/ Weight **BMI 18.5 – 24.9** **Waist** **M** **F**	Height	Weight	BMI>25 (>23 South Asian/ Chinese + lower waist circumference) **AND/OR**			
		BMI	Waist				

	<94 <80			Weight gain >5kg over 3mth period MUST tool for all OP pts and for others with a BMI <20, unplanned weight loss or other concerns			
	Baseline Blood Pressure 100/60 – 140/90	Lying Standing Sitting		>140mm Hg systolic **AND/OR** >90mm Hg diastolic Document on MEWS chart. L&St, or Si, as indicated. Lying & standing where possible in OP services		On-going monitoring frequency	
	Glucose Regulation			HbA1c or Glucose threshold: HbA1c>42mmol/l (>6%) **AND/OR** FPG >5.5 mmol/l **OR** RPG>11.1 mmol/l			
	Blood Lipids			Total chol/HDL ratio to detect high risk of CVD based on QRISK-2 Tool			

Indicator	Screen/Result	Red Zone	Assessment Summary (state if no further assessment required **NFAR**)	MDT Intervention Plan (Indicate MDT roles/ responsibilities)	
Substance misuse		Include misuse of prescribed drugs			
Alcohol Units / M / F Day / 3-4 / 2-3 Week / 21 / 14		If any alcohol at all is taken, next stage assessment **MUST** be carried out.			

Venous Thromboembolism Risk (VTE)		All patients **MUST** have a level 1 assessment (box to left). Level 2 assessment & intervention if indicated.			
Ward blood glucose (finger prick)		As clinically indicated **OR** as part of the admission process if local guidance indicates			
Ward urinalysis		As clinically indicated OR as part of the admission process if local guidance indicates			

For following sections indicate **NIR** in first box if discussed with patient/carer and no concerns to note

Indicator	Screen/Result	Red Zone	Assessment Summary (state if no further assessment required **NFAR**)	MDT Intervention Plan (Indicate MDT roles/ responsibilities)	
Fluid intake M: 3 L; F: 2.2 L		*Note - intake lower for older and lighter people (seek advice if concerned). Monitor for 3 days in OP services or if outside range in other services			
Caffeine intake **Up to 300mg/day**		Can of coke = 34.5mg Cup of coffee = 54mg Withdrawal plan required if changing to decaffeinated drinks			

Sleep **7.5-9 hours**		If outside range monitor for 7 days/nights			
Pain		Select an appropriate tool if required. ABBEY **MUST** be used in OP services			
Elimination		Consider voiding problems (including constipation), continence and elimination aids e.g. catheters			
Sensory		Document any aids used in assessment summary as well as any particular needs			
Hygiene		Consider impact of hygiene on health. Include oral/dental care needs e.g. issues with dentures			
Mobility		**MUST** enquire about falls history - assess further (TAD) if fallen in last 12mths	See Falls TAD	No intervention required See TAD Intervention Plan	
Sexual Health		Consider need for referral for specialist assessment			
Foot Health		Further assessment **MUST** be carried out if the patient is diabetic or where indications			

		of potential difficulties noted			
Infection		Specimens to be sent for further investigation where indicated. Ward urinalysis for all patients on admission in OP services			
Wounds		Use wound TAD. Assess pressure damage in high risk pts. Incident report grade 2 + PUs. Waterlow as indicated.	See Wounds TAD	No intervention required	
				See TAD Intervention Plan	
Other		Long-term conditions or acute symptoms reported by patient or noted from referral information			

Base line TPR (Baseline BP in cardiometabolic framework)									
Temperature **36.8 – 37.5**		**Pulse** **60bpm** **>100bpm**		**Respirations** **12-20 per min** **SATs % if indicated**		**Monitoring Frequency**		**Intervention** (if required)	

Attendee	Designation	Attendee	Designation
	Patient		**Nurse**
	Carer		
	Doctor		

APPENDIX 3: Drs PH Examination on Admission Proforma

Physical Examination

Date / Time of admission:

Patient Name: **Hospital No:**

Date of Birth: **Name of Chaperone:**

Consent to examination:

☐Consent Granted? ☐Lacks capacity but not refusing? ☐Refused/could not be done (Document Reasons)

Physical Observations (to be done by nursing staff on admission)

General Condition

Pulse/Rhythm:	Blood Pressure:	Sitting	Standing
Respitory Rate:	Temperature:	O2 Saturation:	
Weight (kg)	Height (cm)	BMI:	
BM:		Urine:	

Physical Examination (to be done by the admitting doctor)

General Examination:

Consciousness: e.g. Glasgow Coma Score (GCS) : /15

Best Motor Response: /6 Best verbal Response: /5 Best eye Response: /4

Appearance: Jaundice Anaemia Clubbing Cyanosis Oedema Lymphadenopathy

Warning Signs Smell of Alcohol Sweating Tremor

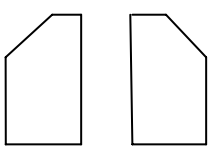
Cardiovascular System:

Peripheral Oedema: Y/N Peripheral Pulses:

Heart Sounds:

Additional Sounds:

Respiratory System

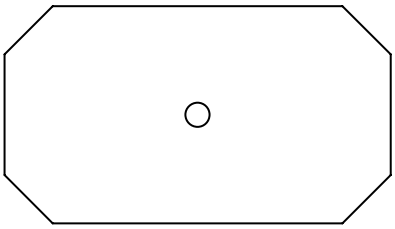


Respiration Rate: Breath Sounds:

Palpation/Trachea Additional Sounds:

Percussion:

Gastrointestinal System:



Oral Cavity Teeth Gums Hygiene

Palpation: Organomegaly:

Bowel Sounds: PR (if appropriate)

Hernia

Nervous System:

Neck Stiffness: Photophobia:

Pupils: Equal? Reactive to light? Accommodation? Fundi (if applicable)

Cranial Nerves

I: II: III/IV/VI: V:

VII: VIII: IX: X:

XI: XII:

Limbs:	Tone	Power	Reflex			Coordination	Sensation
UL			Triceps	Biceps	Supinator		
UR			Triceps	Biceps	Supinator		
LL			Knee	Ankle	Plantar		
LR			Knee	Ankle	Plantar		

Tremor / EPSE / Tardive dyskinesia

Gait: Other reflexes:

Locomotor System (e.g. evidence of fractures, walking aids etc.):

Observations / Other systems:

Body Maps: Is there evidence of an injury, bruising, scars, pressure sores, lacerations, lesions, IV needle marks etc.?

☐ No ☐ Yes – document on the body maps

Comments:

Signed: ---------- ***Grade:*** ----------

Name: ---------- ***Date/Time*** ----------

Glasgow Coma Score

The GCS is scored between 3 and 15, 3 being the worst and 15 the best. It is composed of three parameters: Best Eye Response, Best verbal response, Best Motor response, as given below:

Best eye Response. (4)

1. No eye opening.
2. Eye opening to pain.
3. Eye opening to verbal command.
4. Eyes open spontaneously

Best Verbal Response. (5)

1. No verbal response.
2. Incomprehensible sounds.
3. Inappropriate words.
4. Confused
5. Orientated

Best Motor Response. (6)

1. No motor response.
2. Extension to pain.
3. Flexion to pain.
4. Withdrawal from pain.
5. Localising pain.
6. Obeys Commands.

Note the phrase 'GCS of 11' is essentially meaningless, and it is important to break the figure down to its components, such as E3 V3 M5 = GCS 11.

A Coma Score of 13 or higher correlates with mild brain injury; 9 to 12 is a moderate injury and 8 or less, a severe brain injury.

Teasdale G., Jennett B., LANCET (ii) 81-83, 1974.

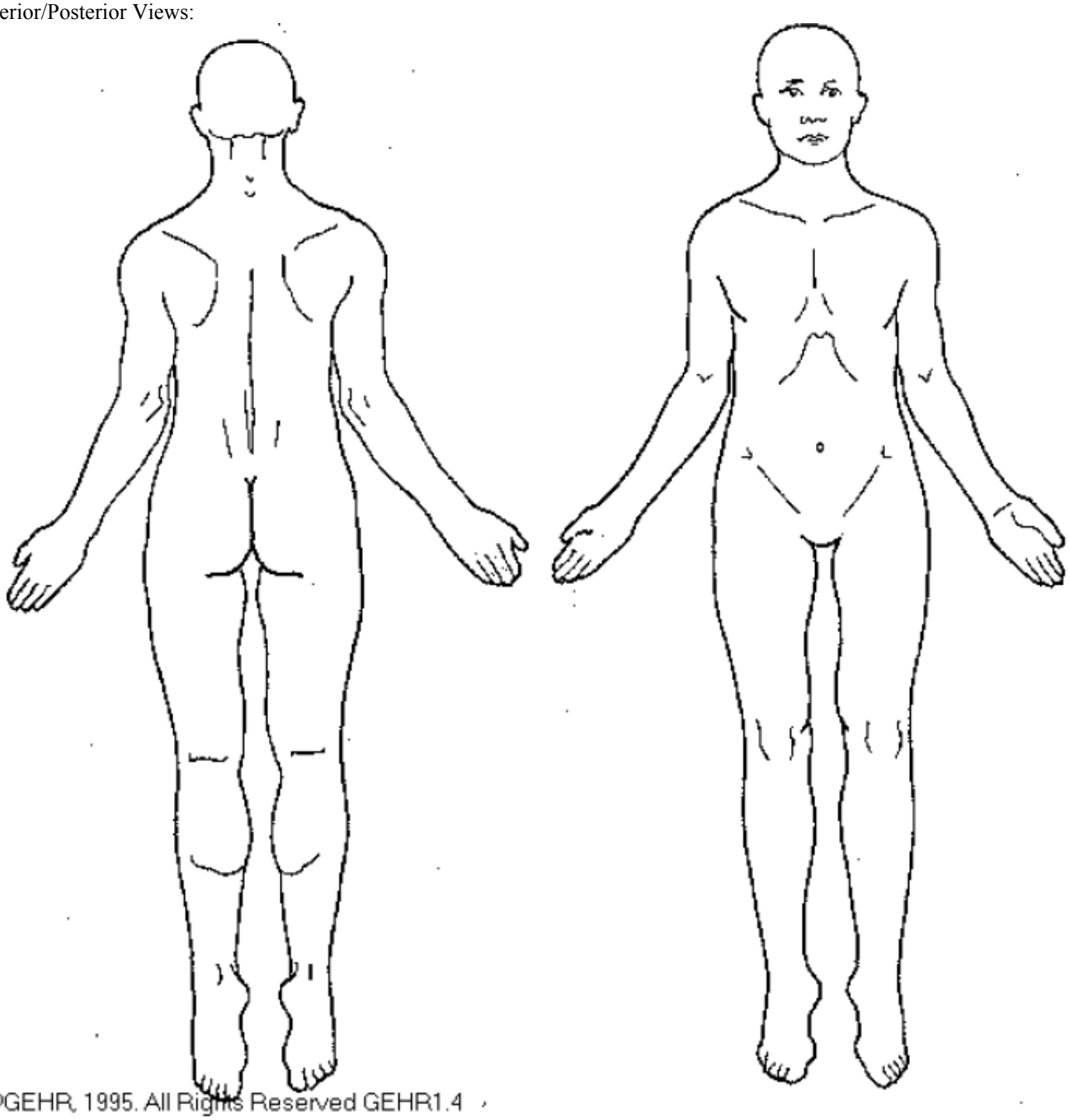
Body Maps Sheet

Patient Name: ***Hospital No:***

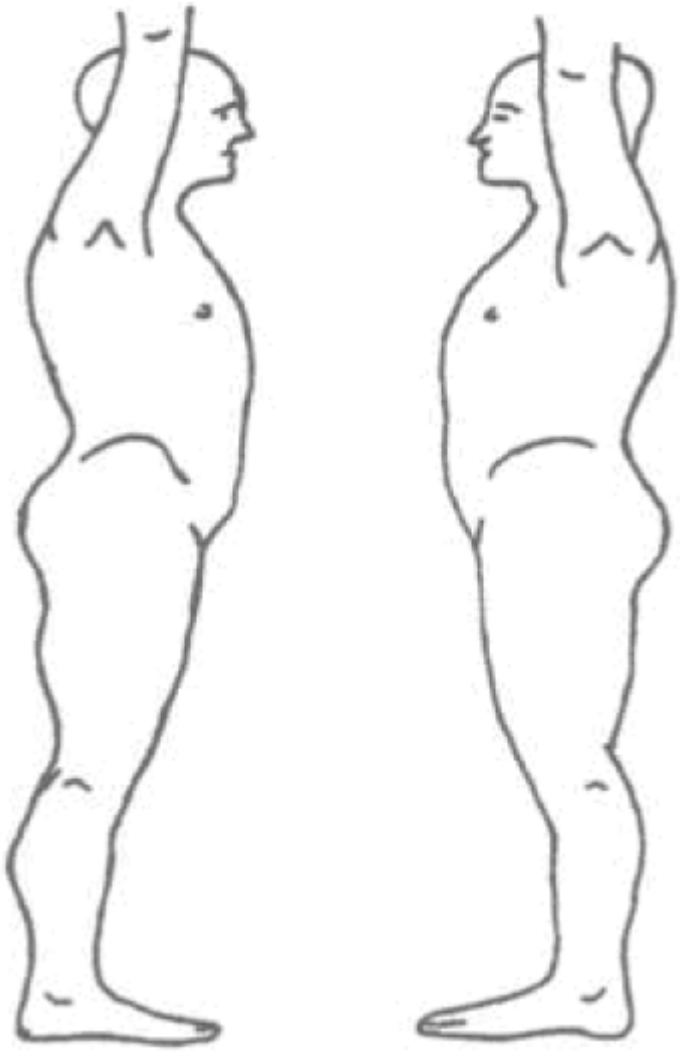
Date of Birth: ***Name of Chaperone:***

Document any injury, bruising, cars, pressure sores, lacerations, lesions, IV needle marks etc.

Anterior/Posterior Views:



Lateral Views:



Body Mass Index Chart

Height (cm) \ Weight (kg)	50	52	54	56	58	60	62	64	66	68	70	72	74	76	78	80	82	84	86	88	90
140	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
142	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45
144	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	43
146	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	38	39	40	41	42
148	23	24	25	26	26	27	28	29	30	31	32	33	34	35	36	37	37	38	39	40	41
150	22	23	24	25	26	27	28	28	29	30	31	32	33	34	35	36	36	37	38	39	40
152	22	23	23	24	25	26	27	28	29	29	30	31	32	33	34	35	35	36	37	38	39
154	21	22	23	24	24	25	26	27	28	29	30	30	31	32	33	34	35	35	36	37	38
156	21	21	22	23	24	25	25	26	27	28	29	30	30	31	32	33	34	35	35	36	37
158	20	21	22	22	23	24	25	26	26	27	28	29	30	30	31	32	33	34	34	35	36
160	20	20	21	22	23	23	24	25	26	27	27	28	29	30	30	31	32	33	34	34	35
162	19	20	21	21	22	23	24	24	25	26	27	27	28	29	30	30	31	32	33	34	34
164	19	19	20	21	22	22	23	24	25	25	26	27	28	28	29	30	30	31	32	33	33
166	18	19	20	20	21	22	22	23	24	25	25	26	27	28	28	29	30	30	31	32	33
168	18	18	19	20	21	21	22	23	23	24	25	26	26	27	28	28	29	30	30	31	32
170	17	18	19	19	20	21	21	22	23	24	24	25	26	26	27	28	28	29	30	30	31
172	17	18	18	19	20	20	21	22	22	23	24	24	25	26	26	27	28	28	29	30	30
174	17	17	18	18	19	20	20	21	22	22	23	24	24	25	26	26	27	28	28	29	30
176	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	26	27	28	28	29
178	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	27	27	28	28
180	15	16	17	17	18	19	19	20	20	21	22	22	23	23	24	25	25	26	27	27	28
182	15	16	16	17	18	18	19	19	20	21	21	22	22	23	24	24	25	25	26	27	27
184	15	15	16	17	17	18	18	19	19	20	21	21	22	22	23	24	24	25	25	26	27
186	14	15	16	16	17	17	18	18	19	20	20	21	21	22	23	23	24	24	25	25	26
188	14	15	15	16	16	17	18	18	19	19	20	20	21	22	22	23	23	24	24	25	25
190	14	14	15	16	16	17	17	18	18	19	19	20	20	21	22	22	23	23	24	24	25
192	14	14	15	15	16	16	17	17	18	18	19	20	20	21	21	22	22	23	23	24	24
194	13	14	14	15	15	16	16	17	18	18	19	19	20	20	21	21	22	22	23	23	24
196	13	14	14	15	15	16	16	17	17	18	18	19	19	20	20	21	21	22	22	23	23
198	13	13	14	14	15	15	16	16	17	17	18	18	19	19	20	20	21	21	22	22	23
200	13	13	14	14	15	15	16	16	17	17	18	18	19	19	20	20	21	21	22	22	23

Legend

- **Underweight**
- **Normal**
- **Overweight**
- **Obese**

Appendix 4: ANNUAL PHYSICAL HEALTH CHECK FORM

ANNUAL PHYSICAL HEALTH CHECK FORM – CARE COORDINATORS

Patient name.....Date.....

NHS number.....RT2 number.....Ward.....

***Please state actual results or where relevant, e.g. bloods, state "on file" when back from lab and filed in casenotes**

AREA	RESULT*	COMMENTS & ACTIONS
Bloods		
FBC inc B12 & Folate levels		
LFT		
Urea + electrolytes (U+E)		
Prolactin (if indicated ref MM039/ MM037)		
Fasting Lipids		
Glucose random and H6A1C		
Thyroid Function Test (TFT)		
Observations		
Physical Examination (see overleaf if appropriate)		
Blood Pressure sitting / standing		
Pulse (beats per minute)		
Weight (kg)		
Height (cm)		
Body Mass Index (BMI)		
Waist (cm)		
Others (condition specific)		
ECGnot all patients need this****		

Glossary:

FBC **Full blood count (including differential)**

LFT **Liver function test (including gamma glutamyl transferase)**

Care Coordinator:

Name..... **Signed.....**

This form may be used for service users who have an extended admission (greater than 6 months)

□ Copy to GP

Physical Examination;

Name:

Signed..... **Dated.....**

APPENDIX 5: MEWS CHART (Incorporating T.P.R. and BP chart)

Adults of Working Age and Older People
T.P.R., B.P. and MEWS Chart

Patient name..... NHS Number.....

Date of admission..... Ward..... Frequency of observations.....

Use for routine monitoring as indicated, or on onset of sudden illness, on medical advice and following rapid tranquilisation where

Date	**DD**													MEWS Score
	MM													
	YY													
Time	**(00:00) 24hr**	:	:	:	:	:	:	:	:	:	:	:	:	
Temperature enter numerical decimal value eg (.2)														
3	40													3
2	39													2
1	38													1
0	37													0
0	36													0
1	35													1
2	34													2
Blood pressure please indicate with arrows													enter dot **Heart Rate**	
3	230												230	3
3	220												220	3
2	210												210	3
2	200												200	3
1	190												190	3
1	180												180	3
0	170												170	3
0	160												160	3
0	150												150	3
0	140												140	3
0	130												130	3
0	120												120	2
0	110												110	2
0	100												100	1
1	90												90	0
1	80												80	0
2	70												70	0
3	60												60	0
3	50												50	0
3	40												40	1
3	30												30	3
3	20												20	3
3														3
Blood Pressure (use systolic reading for MEWS score)													**Heart Rate**	
Respiration rate Enter numeric value													If 21 or more consider short term oxygen use in line with ILS guidance	
3	Over 30													3
2	26-30													2
1	21-25													1
0	11-20													0
2	Less than 10													2
Oxygen Saturation Enter numerical value													Tick target saturation 88-92% ☐ 94-98% ☐	
0	94%-100%													0
1	90%- 93.9%													1
2	85%- 89.9%													2
3	0%- 84.9%													3
AVPU Tick which one patient responds to, or if new confusion present														
0	Alert													0
1	Voice													1
2	Pain													2
3	Unresponsive													3
1	New confusion													1
Total MEWS													**Total MEWS**	
Recorder Initials													**Recorder Initials**	
Counter initials when MEWS >1													Counter initials when MEWS >1	

MEWS is a tool and may not always reflect the severity of a patient's condition

Adults of Working Age and Older People
T.P.R., B.P. and MEWS Chart

Modified Early Warning Scores Actions

Score 0	1. Continue observations as before.
Score 1-3 (with no single parameter over 3)	1. Inform nurse in charge. 2. Increase frequency of observations to at least 2 hourly (or as requested by nurse in charge)
Score 4-5 (or any single parameter 3)	1. Inform nurse in charge. 2. Increase frequency of observations to every 30 minutes. 3. Inform medical staff to: a. Assess patient b. Initiate management plan c. Consider referral to acute trust. 4. Stay with patient.
Score 6 or more	1. Ensure patient is reviewed by nurse in charge 2. Ensure patient is reviewed by medical staff. 3. Maintain frequency of observations to at least every 30 minutes or as requested by medical staff. 4. Stay with patient If delay in accessing medic is over 30 minutes, call an ambulance or local crash team (see below). Failure to attend a MEWS call within this time period should be reported via Safeguard as a grade 4 incident.

Medical Emergency Contact

All staff must be aware of the emergency contact number for their area of work

Remember!

- MEWS is a tool that helps track and trigger a response in a medical emergency. It does not replace clinical judgement.
- Hypertension is defined as persistent raised blood pressure of systolic or diastolic or both are above 140/90 mmHg (NICE Guidance, CG34, 2006)

Adapted from Leeds Teaching Hospital Trust Policy for Recording and Acting Upon Physiological Observations in Adult In-patients 2010

APPENDIX 6: Recording of Alcohol Intake/Reduction Monitoring Form

RECORDING OF ALCOHOL INTAKE /REDUCTION MONITORING FORM

Patient full Name.....Date.....

NHS number.....Ward./ Community Team.....

Assessing Alcohol Intake

Questions	Scoring system					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 of drinking?	1-2	3-4	5-6	7-9	10+	
How often have you had 6or more units (if female) or 8 or more units (if male) on a single occasion in the last year?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
					Total	
If total score is 5 or more please complete alcohol assessment below						

Assessment

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you 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 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	Never	Less than Monthly	Monthly	Weekly	Daily or almost	

you had been drinking?					Daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during last year	
Has a relative of 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	
				Total Score		

Score	Risk	Intervention	Please indicate (tick)
0-7	Lower risk	In-patient team to provide verbal advice on safe alcohol consumption and effects of increased alcohol use on mental and physical health	
8-15	Increasing risk	In-patient team to provide verbal and written information to provide guidance on effects of alcohol consumption on mental and physical health	
16-19	Higher risk	Provide written information on harmful effects of alcohol in excess consumption. Provide brief alcohol intervention session Signpost to GP for continued physical health monitoring	
20+	Possible dependence	Signpost to local drug and alcohol service Refer to ward medical team for consideration for chemical interventions. Provide brief alcohol intervention	

Turn overleaf for interventions

RECORDING OF INTERVENTIONS FOR ALCOHOL INTAKE /REDUCTION

Risk Indicated	Intervention Provided	Date commenced	Date completed	Signed

Completed By:
Name: ……Signed: …… Date ……

Signature of Patient …… Date ……