POLICY TITLE:	**Monitoring Physical Health of Inpatients**
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Policy Owner:	Rachael Jackson, Associate Director of Nursing and Quality
Ratified by:	Colin Quick, Chief Quality Officer
Responsible Signatory:	David Watts, Director of Risk Management
Outcome:	This policy: • Aims to ensure that the physical wellbeing of all patients is routinely monitored. • Provides tables for minimum standards and frequency of testing.
Cross Reference:	H02 Admission, Transfer & Discharge H22 Medicine Management in Hospitals H26 Prevention of Falls H100.2 Promotion of Continence OP05 Mental Capacity OP39 Supporting Patients with Diabetes OP55 Promotion and Management of Tissue Viability OP55.1 Wound Management OP38 Supporting Service Users with Epilepsy OP47 Supporting Service Users with Swallowing Difficulties (Dysphagia) FS01 Food Safety in Commercial Kitchens Physical Healthcare Strategy

EQUALITY AND DIVERSITY STATEMENT

Priory is committed to the fair treatment of all in line with the Equality Act 2010. An equality impact assessment has been completed on this policy to ensure that it can be implemented consistently regardless of any protected characteristics and all will be treated with dignity and respect.

In order to ensure that this policy is relevant and up to date, comments and suggestions for additions or amendments are sought from users of this document. To contribute towards the process of review, email LegalandComplianceHelpdesk@priorygroup.com

MONITORING PHYSICAL HEALTH OF INPATIENTS

1 INTRODUCTION

1.1 The physical wellbeing of all patients will be routinely monitored by the care staff, with Practice Nurses, GPs and ward based Doctors taking a lead with this.

1.2 People with mental health problems may also require physical health care monitoring, either as a direct result of an eating disorder, cognitive impairment or longer term use of medication or because they have a co-morbid physical health long term condition.

1.3 There is a need to implement the latest guidelines from the National Institute for Health and Care Excellence (NICE) in order to meet the physical health needs of all patients.

1.4 Metabolic Syndrome and Type 2 Diabetes are common in mental health patients, and routine physical health checks and investigations for people receiving psychotropic medication will be carried out on a regular basis. The physical health of learning disabilities, eating disorders and elderly patients are also more at risk of developing physical healthcare conditions.

1.5 Prescribers have a responsibility to ensure appropriate monitoring of patients physical health takes place. They may delegate the responsibility for testing and follow-up to another appropriately trained professional (such as the patient's GP). Should they do so the prescriber still retains responsibility for ensuring appropriate tests are done in a timely fashion and the results are acted upon promptly whilst responsible for their care.

1.6 Medication management good practice requires services to provide information and assist understanding of medication effects and side effects, including any concerns about physical health side effects.

2 MINIMUM STANDARD FOR INPATIENTS

2.1 **Initial assessment** - A recording of the following parameters will be made on first admission for all patients. It must completed as soon as practicable, ideally within 72 hours of admission:

(a) Patient measurements and tests to be completed: Blood Pressure (BP), pulse, weight/height/BMI, temperature, respiratory rate and NEWS2 baseline implemented, or MARSI Mews within ED services.
(b) Blood profile: FBC, U&Es, LFTs, GGT, TFTs, HbA1C, full lipid profile and any other blood tests relevant to physical conditions or prescribed medication.
(c) ECG to be carried out, either digital 6 lead ECG or standard 12 lead ECG, where there is cardiac history.
(d) Vitamin D advised by SACN (Scientific Advisory Committee on Nutrition 2016).

2.1.1 The frequency and type of physical observations to be completed will be prescribed by the admitting doctor with reference to the patient's physical health history and in response to the results of the initial assessment.

2.2 The date of the investigations should be recorded in the patient's Health Record together with a copy of the results. The admission template in Care notes must be completed within 72 hours of admission and the Keeping Healthy Care plan. Tests and measurements should be repeated as outlined below.

2.3 All refusals to have blood tests or monitoring should be documented in the patient's Health Record. A Mental Capacity Assessment in relation to this should also be completed (see OP05 Mental Capacity) to ascertain if the person has capacity to consent. If they do not, then the Best Interest Process should be followed.
NB: However, the requirements of the Mental Health Act 1983 will always override the requirements of the Mental Capacity Act 2005 for treatment of mental disorders, but not necessarily physical disorders.

2.4 For patients who are physically frail who may be at high risk of poor nutrition, pressure sores, falls, incontinence, etc. a full suite of physical health baseline monitoring using validated assessment tools should be undertaken.

2.5 **Care planning** - Where there is an identified physical health issue, there must be a physical health care plan in the core care plan Keeping Healthy. This should be linked to the Keeping Health Care plan should be reviewed monthly as a minimum and updated before then if there is a change.

2.6 Where there is a sudden change in the physical presentation of a patient for example they become more confused, disorientated, start to have seizures, complain of pain etc. then an immediate physical health assessment including NEWS2 must be undertaken and a plan for further care agreed by the Multidisciplinary Team (MDT).

2.7 If significant physical health changes are noted then the hospital medical emergency procedure should be initiated and the local emergency services called dialling 999 immediately.

2.8 In the event that the patient subsequently has to be admitted (due to a physical health condition) to an Acute Medical Hospital (Accident and emergency department / ward), it is essential that a sufficiently detailed physical health handover is provided to the hospital upon referral/admission and received from the acute hospital, following the discharge of the patient. This ideally should be a written or a telephone conversation that is transcribed in CareNotes.

2.9 Where this is not possible, the patient's physical health observations should be taken and recorded upon their return to the Priory ward using NEWS2 and their Keeping Healthy Care Plan must be updated and an entry made in CareNotes

3 MINIMUM STANDARD FOR ALL PATIENTS

3.1 **Psychotropic medication** - Anyone, inpatient or outpatient, prescribed psychotropic medication must have baseline tests on commencement of psychotropic medication and further monitoring as per Tees, Esk and Wear Valleys NHS Foundation Trust, Psychotropic Medication Monitoring Guide.

3.1.1 Pregnancy testing to be provided if there is any risk that the medication they are being prescribed is a particular drug that is contraindicated in pregnancy and the patient has concerns. This is not to advocate blanket pregnancy testing of women and must only be done for those women where there has been a risk of unprotected sex.

3.2 **Cardiovascular review** - It is good practice every six months for those inpatients with identifiable cardiovascular risk factors e.g. raised BP, male, over 55, smoke, overweight, poor diet, sedentary life style, dyslipidaemia etc. to have a cardiovascular review as part of a physical health review. However, the minimum frequency, this should be completed is once a year at the annual physical health review. This list is not exhaustive and clinical judgement should be used.

3.3 **Health Promotion** - The following issues should be addressed in line with the Priory Physical Healthcare Strategy for any patient.

3.3.1 Hospitals should plan health awareness groups which are available to all patients on a regular basis. Access to gender specific health screening such as cancer screening should be offered for patients who are in our care longer term. Access to a flu vaccination for high-risk groups and age specific (pneumoccal and shingles) should also be facilitated.

3.4 CAMHS units need to ensure that young people are up to date with immunisations and that these are arranged when indicated, particularly for longer stay patients who may not have access to them elsewhere. Assess on admission and check they are up to date and where gaps facilitate planned immunisation with their local GP Surgery or the hospital GP surgery if required.

3.5 People with eating disorders, in particular those with anorexia nervosa are at high risk in terms of their own health and safety. They have the highest mortality of any psychiatric illness. Both their physical state and suicidal behaviours contribute to this risk. It is recommended that physical health monitoring is guided by nationally agreed guidance which sits outside of this policy, e.g. MaRSiPAN (Management of Really Sick Patients with Anorexia Nervosa (2014) currently under review since 2019).

3.6 **On-going monitoring** – As per **Appendix 1**, BMI (Body Mass Index), blood pressure, pulse, full lipid profile, and HbA1C should be done as part of annual cardiovascular risk assessment or more frequently as clinically indicated and recorded in the physical health section of CareNotes for those sites with the electronic health record.

3.7 Blood pressure and pulse should be checked a maximum of two weeks following a change or commencement in any anti psychotics, including depot, as per Tees, Esk and Wear Valleys NHS Foundation Trust, Psychotropic Medication Monitoring Guide.

3.8 An ECG is desirable, or as soon as practically possible, on admission and six monthly if a patient is on antipsychotics or has pre-existing cardiac disease (see Physical Examination Record and on Carenotes Physical Health Check).

3.8.1 If the patient is on antipsychotics and has pre-existing cardiac disease and/or other physical risk factors, ECGs should be undertaken a minimum of every three months or more often if clinically indicated, as per Tees, Esk and Wear Valleys NHS Foundation Trust, Psychotropic Medication Monitoring Guide.

3.8.2 If the patient is on high dose antipsychotics, an ECG should be taken every three months; if on combination antipsychotics an ECG should be performed at a minimum every six months, as per Tees, Esk and Wear Valleys NHS Foundation Trust, Psychotropic Medication Monitoring Guide.

3.8.3 Prior to commencing a depot or clozapine, an ECG should be taken within eight weeks beforehand and repeated 4-8 weeks after starting treatment. As per Tees, Esk and Wear Valleys NHS Foundation Trust, Psychotropic Medication Monitoring Guide, the Ranges for QTc intervals are as follows:

(a) QTc should be less than 440 ms in men and less than 470 ms in women.
(b) QTc greater than 500 ms requires referral to a cardiologist and is associated with risk of sudden death.

3.9 As good practice a rating scale (approved locally by Clinical Governance) should be considered every six months for patients receiving antipsychotic medication, and every three months for patients on high dose antipsychotic medication.

3.10 For patients who are prescribed Clozapine the adherence to monitoring is required with particular reference made to the risk of constipation and the complications arising from this.

4 METABOLIC SYNDROMES

4.1 Diabetes is associated with significant morbidity and premature mortality. A high prevalence of diabetes and impaired glucose tolerance is seen in people with schizophrenia and other severe mental illness.

4.2 The Lester Tool is a guide to assess the cardiometabolic health of people experiencing psychosis and schizophrenia. It enabling colleagues to deliver safe and effective care to improve the physical health of mentally ill people.

5 PATIENTS PRESCRIBED ANTIPSYCHOTIC MEDICATION

5.1 As per Tees, Esk and Wear Valleys NHS Foundation Trust, Psychotropic Medication Monitoring Guide, the physical monitoring recommendations for patients with Serious Mental Illness and prescribed regular antipsychotics are as follows:

Criteria	Baseline for ALL patients	4 MONTHS after initiating or switching antipsychotics	Annually
Personal & Family History	✓		
Waist circumference	✓	✓	✓
Weight	✓	✓	✓
Height	✓	✓	✓
Blood pressure	✓	✓	✓

6 Recording Physical health monitoring

6.1 Physical health monitoring forms are standardised for healthcare services and should be used in conjunction with the relevant policy and guidelines for nutrition, tissue viability, mobility, infection control, wound care, epilepsy, and continence.

6.2 Where there are any physical health concerns identified through monitoring, the medical team must be informed to discuss and agree appropriate actions and interventions. This must be documented in the relevant section/s of CareNotes.

6.3 Physical Health monitoring must be up to date and available on patient discharge.

7 REFERENCES

7.1 The Maudsley Prescribing Guidelines in Psychiatry
International Diabetes Federation www.idf.org
NICE (2014) Psychosis and Schizophrenia in Adults: Treatment and management. Clinical Guideline CG178
NICE (2017) Eating Disorders: Recognition and Treatment. NICE Guideline NG69
Tees, Esk and Wear Valleys NHS Foundation Trust, Psychotropic Medication Monitoring Guide
The Lester Tool rcp17056-lester-uk-adaptation-4pp-a4-leaflet_4_updated.pdf (rcpsych.ac.uk)

Associated Forms:

H Form: 112 Fluid intake/Output Record and Urine Testing
H Form: 112A Food Intake Record
H Form: 112C Sleep Chart
OP Form: 24B Malnutrition Universal Screening Tool (MUST)
OP Form: 76 National Early Warning Score NEWS2

Appendix 1

Psychotropic Medication Baseline

Baseline for all patients	Then reviews
U&Es	Every six months
LFTs	Annually
FBC	Annually
TFTs (TSH and T4)	Annually
Full Lipid profile, Cholesterol, HDL/LDL ratio, triglycerides	Repeat after three months then yearly
Random blood sugars	Annually
ECG	As clinically indicated; minimum six monthly
Weight/BMI	As clinically needed; minimum three monthly
Blood pressure/pulse	Every six months or more often if clinically indicated
Prolactin	As clinically indicated