PHYSICAL HEALTHCARE POLICY

1. INTRODUCTION

This policy establishes minimum standards for the physical healthcare of patients across all hospitals within PiC.

The physical healthcare of residents within PiC care homes will be under the direction of a local GP and local protocols will be in place to reflect these arrangements.

2. POLICY STATEMENT

PiC recognises the importance of providing a holistic care package to patients addressing their physical and mental healthcare needs through individual care planning.

All patients will have a physical assessment at point of admission to PiC services and at intervals determined by the policy; and will have access to resources and facilities that support their physical wellbeing so as to ensure that their physical healthcare needs are not compromised by their stay within PiC services.

3. SCOPE

This policy applies to all PiC hospitals and all patients regardless of their length of stay.

This policy should be read in conjunction with:

- PiC Operational Policy – *The Care Programme Approach*
- PiC Operational Policy – *Risk Management Policy & Strategy*
- PiC Operational Policy – *Clinical Audit*
- PiC Operational Policy – *Health Record Content & Management*
- PiC Operational Policy – *Dealing with a Medical Emergency*
- PiC Operational Policy – *Infection Control Policy Manual*

This policy should be implemented within the context of the PiC Values:

- Valuing people – respecting our staff, patients, their families and communities
- Caring safely – for ourselves, our patients, our customers and communities
- Working together with everyone
- Uncompromising integrity, respect and honesty
- Taking quality to the highest level

4. DUTIES & RESPONSIBILITIES

Lead for Physical Healthcare

Each Region's Clinical Director will be accountable for the standards of patient physical healthcare. The lead for Physical Healthcare is responsible for ensuring high standards of physical healthcare within the Region / Services and to ensure adherence to PiCs physical healthcare policy and strategy.

The Clinical Director will ensure the collation of evidence or liaise with training leads to ensure that all staff involved in physical healthcare attend relevant training programmes.

It will be the responsibility of the Clinical Director to disseminate areas of good practice within PiC to encourage a culture of learning from good practice.

The Clinical Director will ensure prioritisation of health promotion within their Region / Services, focusing on smoking cessation, diet and nutrition, sexual health, weight management and lifestyle choices. Patients should have easy access to appropriate health promotion information in a format which is accessible for all patients.

The Clinical Director will ensure that the necessary authorisation is given enabling the GP to make entries into CAREnotes irrespective of whether the GP maintains their own records.

Responsible Clinician (RC)

The Responsible Clinician has the responsibility of ensuring the completion of a full physical examination as soon as possible after admission within 7 days. Such examinations will always be undertaken by the General Practitioner.

The RC will ensure that patient care planning takes proper account of their physical needs and wellbeing. In the event of a patient refusing any medical treatment, the RC must ensure that there is an assessment carried out on the patient's capacity.

Admitting Doctor

The admitting doctor is responsible for ensuring the completion of an initial brief physical assessment within the first 24 hours. The full assessment will be carried out by the GP. Any factors preventing a physical assessment, e.g. patient refusal, should be clearly recorded in CAREnotes. The admitting doctor should record basic observable physical signs pending the full physical examination that should be undertaken as soon as possible by the GP. The Responsible Clinician is accountable for ensuring that the physical examination has been performed.

5. ENVIRONMENT / FACILITIES

Appropriate medical equipment must be available within hospitals, readily accessible and maintained in all hospitals ***(see Appendix A – Recommended Medical Equipment for Hospitals).***

Equipment should be maintained in good working order, checked regularly and replaced as necessary.

Emergency resuscitation equipment must be available within hospitals, maintained and readily accessible.

Regions / Hospitals should secure an appropriate physical care environment that should include a designated area or room for physical examinations.

Patients should be provided with appropriate food and drink to meet their nutritional, health related (e.g. Diabetes) therapeutic and cultural needs.

Patients should have access to appropriate, clean, washing / toilet facilities, which should be maintained at all times.

Patients should have access to fresh air and exercise space.

6. PHYSICAL HEALTH ASSESSMENT

Admission

All patients will have a physical assessment on admission. This should be immediate but in any case within 24 hours to ensure the immediate wellbeing of the patient.

The comprehensive physical assessment should then follow as soon as is practicable but in any case within seven days of admission as directed by the Responsible Clinician.

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

The standard pro-forma for physical examination is contained within CAREnotes

Routine blood testing includes FBC, U&E's, LFT's, Lipids, TFT's and HbA1C. Of the blood tests may be needed dependent on the known physical history of the patient and current prescribed medication. Routine bloods should be taken as soon as possible after admission and the frequency agreed by the Responsible Clinician and the GP.

Ongoing Physical Healthcare

Assessments

Assessment of physical healthcare should be undertaken as required and, at a minimum, annually during the period of admission.

Baseline observations should be taken once per month. This will include BMI, waist measurement, weight (Kg), BP, and smoking status.

At the point of admission all patients will be offered Hepatitis B screening. Hepatitis C screening will also be offered dependent upon illegal drug history.

Patients who have been admitted for more than one year should have an annual physical to the level of detail that the GP feels appropriate for the individual patient.

Physical Health Reviews

A full physical health review should be completed at the first care programme approach (CPA) review following admission and reviewed at every CPA thereafter.

This review should include:

- details of past and present illnesses
- a comprehensive symptom review
- health promotion history (including smoking, diet and exercise)
- details of health screening (e.g. dental care, cervical screening)
- a record of all forms of medication and allergies.

An action plan with respect to physical healthcare should be agreed with the patient and incorporated into the CPA care plan. This will include action agreed with the patient in relation to lifestyle factors, using the patient Cardiometabolic chart to set their own goals for improving their physical health.

Every patient within PiC should have and an appropriate malnutrition screening tool:

- ‘Malnutrition Universal Screening Tool’ (‘MUST’) , (MUST Guidance)
- Eating well: children and adults with learning disabilities, Nutritional and practical guidelines (appendix 3)

The MDT will conduct a monthly review of the patient’s physical health care plan.

Specialist Services

To ensure patients are supported in accessing dental health care, all units should adhere to the following;
A dental service will be offered to all patients within 12 weeks of admission.

- Where appropriate, the clinical teams will review any dental care plans and assessments bi-annually, in line with the CPA process.
- Each unit will ensure a local protocol is in place that describes how urgent cases will receive treatment in a timely manner.

Expert advice should be sought from specialist services as required e.g. Physiotherapist, Well Women Clinics and Diabetes Management. All Services should have access to GP’s input over and above the initial full physical examination.

Chronic Health Conditions

For patients with identified chronic physical health conditions, care plans should include management of their physical healthcare and follow NICE guidelines

Emergency Care

The National Early Warning system is an algorithm that is built into CAREnotes. It uses the information entered when physical observations are taken of a patient to alert clinicians to a potential physical healthcare crisis.
Patients requiring transfer to acute hospitals must be accompanied by an up to date care plan, prescription card and medication (if necessary).

Health Promotion

Patients should have access to health promotion, including smoking cessation support, exercise and dietary advice and advice on sexual health.

Discharge

When a patient is discharged into the community a discharge summary outlining physical healthcare will be sent to the patient's General Practitioner within 7 days. For patients who are being transferred as inpatients the physical healthcare summary will be included in the discharge summary by the Responsible Clinician.

7. MONITORING AND REVIEW

The Group Medical Director has ownership of the Physical Healthcare Policy and will, in association with the Directors of Nursing, monitor the implementation and effectiveness of the policy and formally review the policy every three years or sooner if demanded by circumstances.

8. SUPPORTIVE READING

1. Cormac, I, Martin, D & Ferrier, M: Improving the physical health of long stay psychiatry inpatients: Advances in Psychiatric Treatment (2004) 10, 107-115

2. Clinical Negligence Scheme for Trusts – Mental Health and Learning Disability Clinical Risk Management Standards, National Health Service Litigation Authority 2005

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

4. Department of Health (2000b) National Service Framework for Coronary Heart Disease. Main Report. London: Stationery Office.

5. Department of Health (2000c) National Service Framework and Strategies: Improving outcomes: a strategy for cancer

6. Department of Health (2001a) National Service Framework for Diabetes. London: Stationery Office

7. Department of Health (2001b) National Service Framework for Older People. London: Stationery Office

8. Harris, E. C., & Barraclough, B. (1998) Excess mortality of mental disorder. British Journal of Psychiatry, 173, 11-53.

9. National Institute for Health and Care Excellence (2002) Core Interventions

10. Mental Health Act (Amended 2007)

11. NHS CONTRACT

12. No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages (Department of Health 2011)

13. Mental Health in Scotland: Improving the Physical Health and Well Being of those experiencing Mental Illness (2008)

14. Physical health in mental health - Final report of a scoping group: Royal College of Psychiatrists (2009)

15. Addressing long-term physical healthcare needs in a forensic mental health inpatient population using the UK primary care Quality and Outcomes Framework (QOF): an audit (GO Ivbijaro, LA Kolkiewicz, LSF McGee and M Gikunoo) (2008)

16. The Abandoned Illness - Schizophrenia Commission (2012)

APPENDIX A

RECOMMENDED MEDICAL EQUIPMENT FOR HOSPITALS

Ward / House: _____

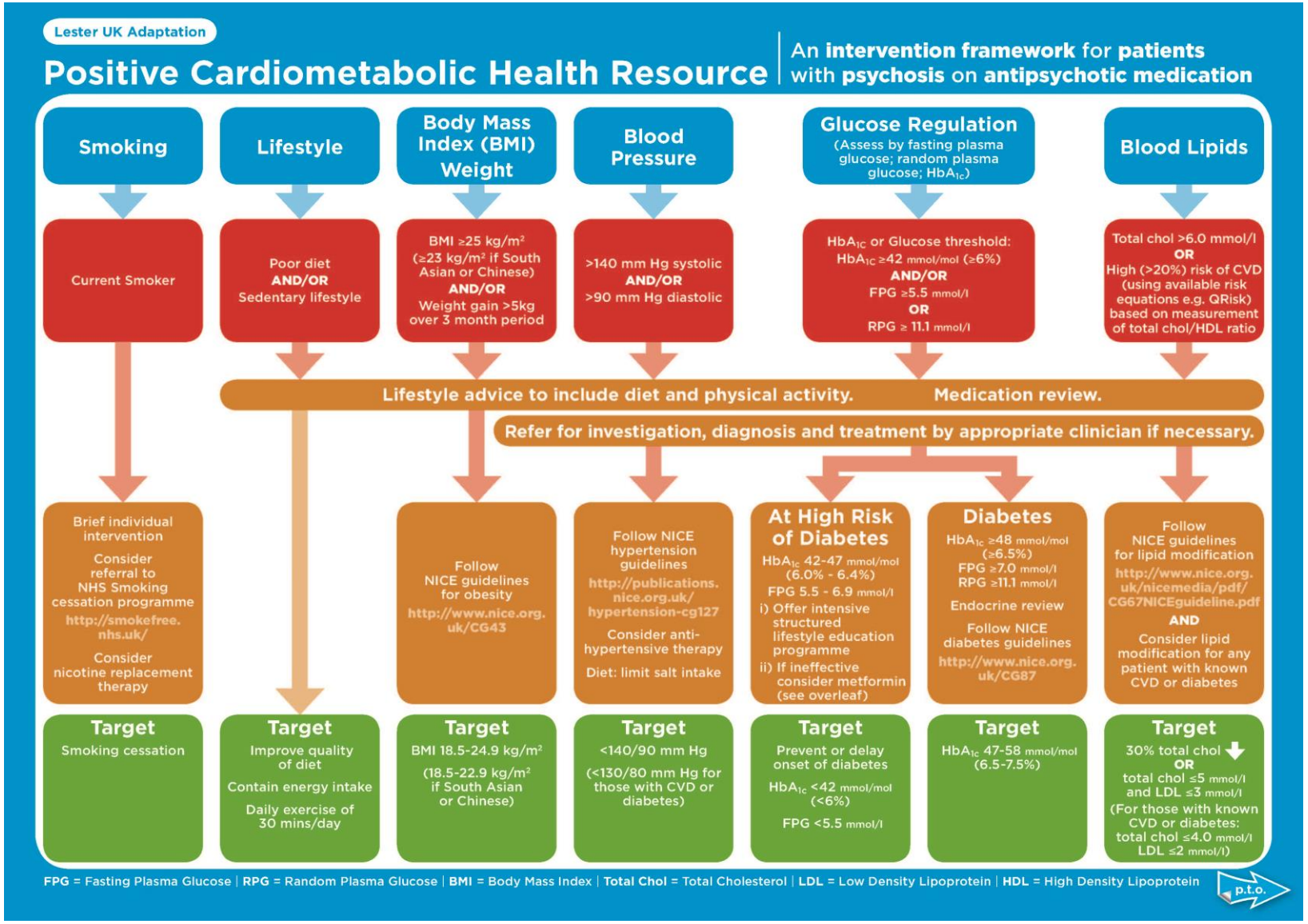
When completing this checklist, check that the item:

- is in good working order, and
- is within the expiry date if applicable.

Item	✓	Action needed	By When
Examination couch			
Hand wash basins			
Stethoscope			
Sphygmomanometer			
Thermometer (non-mercury)			
Tendon hammer			
Tuning fork (265 HZ)			
Patella hammer			
Ophthalmoscope / Auroscope			
Pulse Oximeter			
Neurological testing pins			
Snellen Chart			
Height measure			
Waist measure (tape measure)			
Disposable gloves			
Urinalysis sticks			
Tourniquet			
Syringes with retractable needles			
Sharps boxes as appropriate to clinical area			
Torches and adequate examination lights			

Item	✓	Action needed	By When
Copy of Glasgow coma scale			
Peak flow meter			
Information on blood tests			
i.e. what forms / bottles to be used			
Tape and plasters			
All equipment drawers labelled			
Blood bottles / urinalysis bottles / specimen containers			
Specimen forms			
ECG machine available			
CPR equipment			
Defibrillator			
Weighing scales			
Hypoglycaemic tray or locally agreed alternative			
Alcometer			
First Aid Kit			

Reviewed by: _____ (Name) _____ (Date)


Lester UK Adaptation
Positive Cardiometabolic Health Resource
An intervention framework for patients with psychosis on antipsychotic medication
Smoking
Lifestyle
Body Mass Index (BMI) Weight
Blood Pressure
Glucose Regulation
(Assess by fasting plasma glucose; random plasma glucose; HbA1c)
Blood Lipids
Current Smoker
Poor diet AND/OR Sedentary lifestyle
BMI ≥25 kg/m² (≥23 kg/m² if South Asian or Chinese) AND/OR Weight gain >5kg over 3 month period
>140 mm Hg systolic AND/OR >90 mm Hg diastolic
HbA1C or Glucose threshold: HbA1C ≥42 mmol/mol (≥6%) AND/OR FPG ≥5.5 mmol/l OR RPG ≥ 11.1 mmol/l
Total chol >6.0 mmol/l OR High (>20%) risk of CVD (using available risk equations e.g. QRisk) based on measurement of total chol/HDL ratio
Lifestyle advice to include diet and physical activity. Medication review.
Refer for investigation, diagnosis and treatment by appropriate clinician if necessary.
Brief individual intervention
Consider referral to NHS Smoking cessation programme
http://smokefree.nhs.uk/
Consider nicotine replacement therapy
Follow NICE guidelines for obesity
http://www.nice.org.uk/CG43
Follow NICE hypertension guidelines
http://publications.nice.org.uk/hypertension-cg127
Consider anti-hypertensive therapy
Diet: limit salt intake
At High Risk of Diabetes
HbA1c 42-47 mmol/mol (6.0% - 6.4%)
FPG 5.5 - 6.9 mmol/l
i) Offer intensive structured lifestyle education programme
ii) If ineffective consider metformin (see overleaf)
Diabetes
HbA1c ≥48 mmol/mol (≥6.5%)
FPG ≥7.0 mmol/l
RPG ≥11.1 mmol/l
Endocrine review
Follow NICE diabetes guidelines
http://www.nice.org.uk/CG87
Follow NICE guidelines for lipid modification
http://www.nice.org.uk/nicemedia/pdf/CG67NICEguideline.pdf
AND
Consider lipid modification for any patient with known CVD or diabetes
Target
Smoking cessation
Target
Improve quality of diet
Contain energy intake
Daily exercise of 30 mins/day
Target
BMI 18.5-24.9 kg/m²
(18.5-22.9 kg/m² if South Asian or Chinese)
Target
<140/90 mm Hg
(<130/80 mm Hg for those with CVD or diabetes)
Target
Prevent or delay onset of diabetes
HbA1c <42 mmol/mol (<6%)
FPG <5.5 mmol/l
Target
HbA1c 47-58 mmol/mol (6.5-7.5%)
Target
30% total chol ↓ OR total chol ≤5 mmol/l and LDL ≤3 mmol/l
(For those with known CVD or diabetes: total chol ≤4.0 mmol/l LDL ≤2 mmol/l)
FPG = Fasting Plasma Glucose | RPG = Random Plasma Glucose | BMI = Body Mass Index | Total Chol = Total Cholesterol | LDL = Low Density Lipoprotein | HDL = High Density Lipoprotein
p.t.o.

Although this clinical resource tool targets antipsychotic medication, many of the principles apply to other psychotropic medicines given to people with long term mental disorders.

The general practitioner and psychiatrist will work together to ensure appropriate monitoring and interventions are provided and communicated. The general practitioner will usually lead on supervising the provision of physical health interventions. The psychiatrist will usually lead on decisions to significantly change antipsychotic medicines.

Primary care's **Quality and Outcomes Framework (QOF)** includes four physical health indicators in the mental health domain: BMI (MH12); blood pressure (MH13); total to HDL cholesterol ratio (MH14); Blood glucose (MH15). Currently MH14 and MH15 are only for those aged over 40yrs.

History and examination following initiation or change of antipsychotic medication

Frequency: as a minimum review those prescribed a new antipsychotic at baseline and at least once after 3 months.

Ideally weight should be assessed 1-2 weekly in the first 8 weeks of taking a new antipsychotic as rapid early weight gain may predict severe weight gain in the longer term.

Subsequent review should take place annually unless an abnormality of physical health emerges, which should then prompt appropriate action and/or continuing review at least every 3 months.

At review

History: Seek history of substantial weight gain (e.g. 5kg) and particularly where this has been rapid (e.g. within 3 months). Also review smoking, exercise and diet. Ask about family history (diabetes, obesity, CVD in first degree relatives <60 yrs) and gestational diabetes. Note ethnicity.

Examination: Weight, BMI, BP.

Investigations: Fasting estimates of plasma glucose (FPG), HbA_{1c}, and lipids (total cholesterol, LDL, HDL, triglycerides). If fasting samples are impractical then non-fasting samples are satisfactory for most measurements except for LDL or triglycerides.

ECG: Include if history of CVD, family history of CVD, or if patient taking certain antipsychotics (see Summary of Product Characteristics) or other drugs known to cause ECG abnormalities (eg erythromycin, tricyclic anti-depressants, anti-arrythmics – see British National Formulary for further information).

Interventions

Nutritional counselling: reduce take away and "junk" food, reduce energy intake to prevent weight gain, stop soft drinks and juices, increase fibre intake.

Physical activity: structured education-lifestyle intervention. Advise physical activity: e.g. Advise a minimum of 150 minutes of 'moderate-intensity' physical activity per week (http://bit.ly/Oe7DeS).

If unsuccessful after 3 months in reaching targets, then consider specific pharmacological interventions (see below).

Specific Pharmacological Interventions

Anti-hypertensive therapy: Normally GP supervised. Follow NICE recommendations http://publications.nice.org.uk/hypertension-cg127.

Lipid lowering therapy: Normally GP supervised. Follow NICE recommendations http://www.nice.org.uk/nicemedia/pdf/CG67NICEguideline.pdf.

Treatment of Diabetes: Normally GP supervised. Follow NICE recommendations http://www.nice.org.uk/CG87.

Treatment of those at high risk of diabetes: FPG 5.5-6.9 mmol/l; HbA_{1c} 42-47 mmol/mol (6.0-6.4%) Follow NICE guideline PH 38 *Preventing type 2 diabetes: risk identification and interventions for individuals at high risk* (recommendation 19) – http://guidance.nice.org.uk/PH38.

- Where intensive lifestyle intervention has failed **consider metformin trial** (this would normally be GP supervised).
- Please be advised that **off-label** use requires documented informed consent as described in the GMC guidelines, http://www.gmc-uk.org/static/documents/content/Good_Practice_in_Prescribing_Medicines_0911.pdf. These GMC guidelines are recommended by the MPS and MDU, and the use of metformin in this context has been agreed as a relevant example by the Defence Unions.
- Adhere to British National Formulary guidance on safe use (in particular ensure renal function is adequate). Start with a low dose e.g 500 mg once daily and build up, as tolerated, to 1500–2000 mg daily.

Review of antipsychotic medication: Normally psychiatrist supervised. Should be a priority if there is:

- Rapid weight gain (e.g. 5kg <3 months) following antipsychotic initiation.
- Rapid development (<3 months) of abnormal lipids, BP, or glucose.

The psychiatrist should consider whether the antipsychotic drug regimen has played a causative role in these abnormalities and, if so, whether an alternative regimen could be expected to offer less adverse effect:

- As a first step prescribed dosages should follow BNF recommendations; rationalise any polypharmacy.
- Changing antipsychotic requires careful clinical judgment to weigh benefits against risk of relapse of the psychosis.
- Benefit from changing antipsychotic for those on the drug for a long time (>1 year) is likely to be minimal.
- If clinical judgment and patient preference support continuing with the same treatment then ensure appropriate further monitoring and clinical considerations.

Don't just SCREEN – INTERVENE for all patients in the "red zone"

RC PSYCH Royal College of Psychiatrists · RC GP Royal College of General Practitioners · Royal College of Nursing · NAS CCQI · Rethink Mental Illness · HQIP · Royal College of Physicians · DIABETES UK CARE. CONNECT. CAMPAIGN.

Download Lester UK Adaptation: www.rcpsych.ac.uk/quality/NAS/resources

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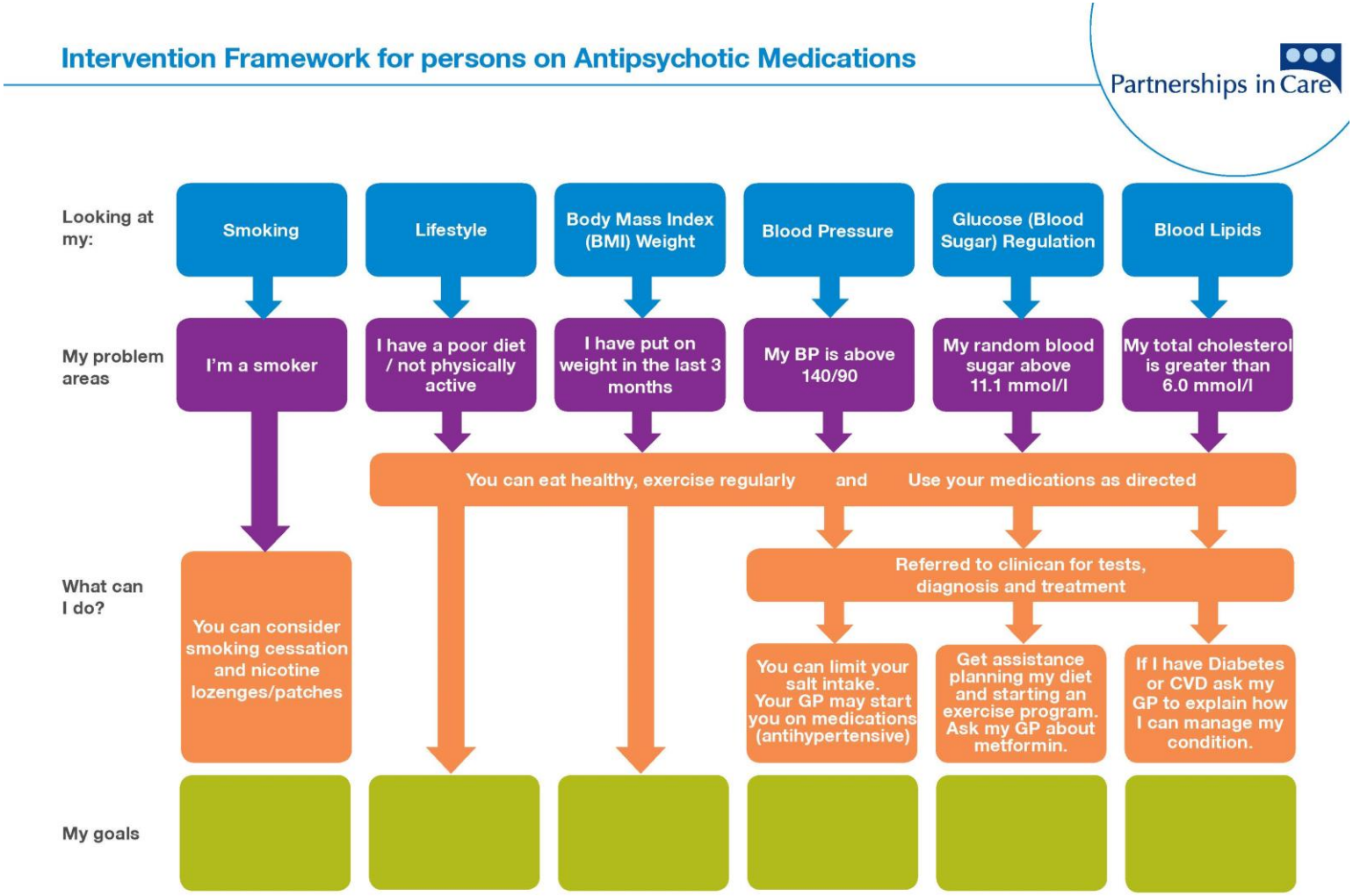
Intervention Framework for persons on Antipsychotic Medications
Partnerships in Care
Looking at my:
Smoking
Lifestyle
Body Mass Index (BMI) Weight
Blood Pressure
Glucose (Blood Sugar) Regulation
Blood Lipids
My problem areas
I'm a smoker
I have a poor diet / not physically active
I have put on weight in the last 3 months
My BP is above 140/90
My random blood sugar above 11.1 mmol/l
My total cholesterol is greater than 6.0 mmol/l
You can eat healthy, exercise regularly and Use your medications as directed
What can I do?
You can consider smoking cessation and nicotine lozenges/patches
Referred to clinican for tests, diagnosis and treatment
You can limit your salt intake. Your GP may start you on medications (antihypertensive)
Get assistance planning my diet and starting an exercise program. Ask my GP about metformin.
If I have Diabetes or CVD ask my GP to explain how I can manage my condition.
My goals