Humber Teaching
NHS Foundation Trust

Protocol for Physical Health Monitoring: Mental Health and Learning Disability Inpatient Services

Document Reference	Prot529
Version Number	1.3
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Consultation (Date and nature of contact)	Physical Health and Medical Devices Group LD Clinical Network/Practice Network meeting (MH) Jenny Croft – Epilepsy Nurse Specialist
Date of Last Changes (This Version)	14 June 2023
Date of Next Review	October 2025 (3 years from last full review).
Name of approving group/Committee **Date of approval**	Physical Health and Medical Devices group 12th October 2022 (full review) 14 June 2023 (minor amendment)

VALIDITY – Policies should be accessed via the Trust intranet to ensure the current version is used.

CHANGE RECORD

Version	Date	Change details
1.0	*July 2019*	*New protocol – supersedes Physical Health and Care of the Deteriorating Patient Policy. This protocol is a supporting document of the Deteriorating Patient Policy.*
1.1	*December 2019*	*Amendments made in relation to the timings in section 2.1.*
1.2	*October 2022*	*Reviewed. Added in links to SUDEP, NICE NG217, added PAWS for under 16s, Removed appendix 2. Added clarity re risk assessments on admission including MUST, VTE, falls and Waterlow. Added reference to Medicines Management Tool for Antipsychotics Guidelines G368. Added in reference to UTI guidelines for over >65s. Changes to wording relating to perinatal care and a caveat re overnight admissions as approved by MH practice network group. Approved at PHMD group (12/10/22).*
1.3	*June 2023*	*Minor amends. Changed wording relating to MUST assessment to align with the tissue viability policy i.e. completion in 6 hours of admission. "Ideally The Malnutrition Universal Screening Tool (MUST) within 6 hours of admission and repeated as indicated as per the Nutrition and Hydration guidelines. however if this is not clinically appropriate every effort should be taken to ensure it is completed within the first 24 hours, and if this is not achievable the reason why and a plan of how this will be actioned should be clearly documented". Lorenzo changed to electronic patient record (EPR). Approved at PHMD group (14 June 2023).*

Contents

1. INTRODUCTION

Good physical health is a fundamental part of our health and wellbeing for all. NHS providers of services need to be cognisant of the leading global risk factors for morbidity; high blood pressure, tobacco use, high blood glucose, high cholesterol, physical inactivity, low fruit and vegetable intake and obesity. These risks are responsible for raising the risk of chronic diseases such as heart disease, diabetes and cancers and it is known that 30% of people with a long-term condition suffer with a mental health problem. It is important therefore that physical health is considered as part of the initial assessment and subsequent reviews of people using services within Humber Teaching NHS Foundation Trust.

"The health inequalities faced by people living with severe mental illnesses (SMI) and people with a learning disability are stark. The life expectancy gap for people with SMI continues to deteriorate, with recent data from 2018-20 highlighting that people with SMI are five-and-a-half times more likely to die prematurely than those without an SMI, due to preventable physical health conditions. Likewise, people with a learning disability are three times more likely to die from an avoidable medical cause of death than the general population." (NHSI/E, 2022).

This protocol describes the minimum standard of physical health assessment that should be undertaken within Humber Teaching NHS Foundation Trust Mental Health and Learning Disability Inpatient Services.

2. MENTAL HEALTH AND LEARNING DISABILITY INPATIENT SERVICES (including CAMHS, adult and older age mental health units, learning disability and forensic inpatients units)

2.1. Assessment of Physical Health on Admission

All patients admitted to the Trust's Inpatient Services, as described above, will have a full physical examination, ideally **within six hours** of admission (**four hours** for unplanned care within the Mental Health Division). If the patient initially refuses, staff should try to complete this within the first 24 hours of admission. If a patient continues to refuse to be examined or to have basic observations undertaken beyond the 24-hour period, this must be clearly documented in the notes, with a management plan and review date. If a patient is admitted overnight, the on-call medic should discuss with the nursing staff and the patient (if capacitous) as to whether the examination, blood tests and ECG can be postponed until the next day, taking into account the patient's personal and family medical history, medications and current physical health presentation. If the examination, blood tests and ECG are to be postponed then the reasons for this must be clearly documented and the tasks to be handed over to the day medic by the on-call medic. All patients will be offered a chaperone during a physical examination or procedure as outlined in the Chaperone Policy.

Where a patient's capacity to consent to examination is doubted, a capacity assessment will be completed. Decisions relating to physical examination, were the patient lacks capacity, will be made as part of a best interest decision. See Consent Policy.

The following physical assessments will be carried as part of the admission process when a patient is admitted to either Mental Health or Learning Disability Unit:

- The National Early Warning Score (NEWS2) (or PAWS with CAMHS for under 16s) will be undertaken within **one hour** of admission where practicable, with the consent of the person
- If the baseline NEWS2/PAWS score is 0, the NEWS2/PAWS should continue 12-hourly for a minimum of three days and should only be discontinued thereafter with sound clinical reason having been determined by the MDT.

- If the NEWS2/PAWS score is 1 or above, follow the Deteriorating Patient Policy and Protocol to determine frequency of monitoring and escalation.
- Blood tests should be carried out as clinically indicated as a baseline on admission, usually to include full blood count, urea and electrolytes, liver function tests, blood glucose, thyroid function tests and lipids. Consider the physical health monitoring of patients prescribed antipsychotics.
- A VTE risk assessment will be conducted on admission and if prophylaxis anti-coagulation is required then this will be commenced within 14 hours as per the VTE procedure
- Assess family history of premature cardiovascular disease or diabetes
- Electrocardiograms should be carried out on all patients considered to be at significant risk of cardiovascular disease (or on antipsychotics), including arrhythmias.
- Other investigations should be arranged as appropriate, and on an ongoing basis in conjunction with the National and Trust guidelines for medication related monitoring. (See product literature at www.medicines.org.uk).
- Urine analysis/urine drug screen as clinically indicated. NB Do not use routine urinalysis in >65-year-old patients due to the prevalence of asymptomatic bacteriuria and the risk of harmful antibiotic use. See Public Health England guidelines PHE UTI guideline
- Records should be kept in accordance with the essential elements of defensible documentation (add link to page on intranet).
- Basic body check, as appropriate, observing and examining for physical injuries
- Visual skin assessment and Waterlow score within six hours and repeated as indicated. Appropriate plan of care devised
- Ideally The Malnutrition Universal Screening Tool (MUST) within 6 hours of admission and repeated as indicated as per the Nutrition and Hydration guidelines. however if this is not clinically appropriate every effort should be taken to ensure it is completed within the first 24 hours, and if this is not achievable the reason why and a plan of how this will be actioned should be clearly documented
- There are exceptions for mental health and learning disability units in respect of Waterlow and MUST assessments. If it is clinically unsafe or not appropriate to undertake on admission, then this can be postponed to a more clinically appropriate time. This may be due to the patient being distressed, showing disturbed behaviour or is end of life and/or not consenting.
- Height and weight (BMI) and weight repeated monthly (or more frequently if indicated within nutrition screening tool)
- A lying and standing blood pressure and the bedside vision check as part of the falls prevention programme. See Falls Policy (Inpatients)
- Patients may require a falls risk assessment. See Falls Policy (Inpatients)
- Medicines reconciliation must be completed within 24 hours from the time of admission. This must also include a check of any drug allergies and the appropriate documentation of this.
- All current medication, side effects and allergies including any home remedies or alternative therapies
- personal history of, or exposure to, infectious diseases, including blood-borne viruses
- For patients with known epilepsy or a history of non-epilepsy seizures conduct an assessment of risk as per section 2.4.3 or for LD setting consult the patient's management, medication and emergency plan.

The Infection Prevention and Control (IPC) Initial Risk Assessment must be completed within 48 hours of admission. Patients who meet the MRSA screening criteria are to be screened within 48 hours of admission and staff to document on the IPC initial risk assessment the date screen was obtained. If staff are unable to obtain an MRSA screen the reason must be documented on the IPC risk assessment.

2.2. Following initial admission onto a Mental Health or Learning Disability Inpatient Unit

2.2.1. Following initial admission to and Mental Health or Forensic inpatient unit:

- the Health Improvement Profile (HIP) for mental health should ideally be completed within 72 hours but where this is not clinically appropriate within 1 week of admission.
- If this has been completed as part of a previous admission within the past 12 months this does not need repeating.
- Where the HIP assessment identifies red flags this requires escalating as appropriate i.e. refer to primary care, MDT, consultant
- Patients should receive education/advice/support in relation to smoking cessation
- Patients should receive education/advice/support as part of their care plan in order to make healthy lifestyle choices i.e. exercise, weight management, alcohol consumption.
- Patients must be supported to attend for routine and emergency health screening where required (e.g., dental care, cervical screening, breast screening etc).
- concerns arising from assessments should be documented and any action should be agreed with the patient within the care plan
- Electrocardiograms should be carried out on all patients considered to be at significant risk of cardiovascular disease (or on antipsychotics), including arrhythmias. (on-going monitoring)
- The VTE risk assessment needs to be repeated by the consultant or appropriate other as per the VTE procedure.

2.2.2. Following initial admission to a Learning Disability inpatient unit:

- On admission practitioner to check that the Annual Health check has been completed in the past 12 months.
- If Annual Health check has not been completed in previous 12 months, this should be arranged with the GP
- Review/complete the patient Health Action Plan
- Complete a Hospital Passport on admission
- Electrocardiograms should be carried out on all patients considered to be at significant risk of cardiovascular disease (or on antipsychotics), including arrhythmias. (on-going monitoring)
- The VTE risk assessment needs to be repeated by the consultant or appropriate other as per the VTE procedure.

2.3. Physical health care of patients who will be in-patients for over one year

- All patients should have a documented review of their physical health at 6 months following their admission and thereafter on an annual basis which includes a full physical examination by a medic responsible for the ward or service with input from specialist teams where required. A person may need to be seen earlier if this is clinically indicated from their initial physical examinations.
- Chronic disease monitoring (e.g. diabetes, asthma, COPD, cardiovascular disease) should be reviewed (by a GP/district nurse), and actions taken as required.
- A full medication review must also be carried out and documented.
- Weight should be monitored monthly (or more frequently if indicated within nutrition screening tool).
- Patients should have access to smoking cessation and alcohol/substance misuse advice and support, dental care, chiropody, dietician, physiotherapy, sexual health care, and an optician, along with improving physical activity levels. Access to these services should be offered regularly and at least every six months when the physical

health review is undertaken. Action taken, or a record of services being declined, should be documented.
- Patients on High Dose Antipsychotic Therapy should be reviewed, and their monitoring carried out as guided by Pharmacy and Trust policy guidelines.
- Support to access routine age and gender appropriate physical health screening and vaccinations with access to annual flu jab for those at risk, support to attend cervical, breast or bowel screening,
- Annual health check for people with learning disability with a review of the health action plan
- Support to access routine and emergency dental care: dental care must be part of every patients care plan. Patients will be supported to attend for dental appointments if needed

2.4. Special Considerations

2.4.1. Patients requiring palliative or end of life care

Palliative care is for people living with a terminal illness where a cure is no longer possible and care aims to treat or manage pain and other physical symptoms.

People receiving care within mental health (adult and older age), forensic or learning disability inpatient services may require palliative or end of life care. They have the right to receive high-quality care that effectively manages physical symptoms such as pain, breathlessness, nausea, and fatigue in addition to addressing psychological, social and spiritual concerns.

Patients being cared for at the end of life should be supported to live as well as possible and to die with dignity.

The care of the patient should be discussed with the patient, family, and the wider multidisciplinary team this may include GP, community nurses or palliative care specialist.

It is important that the care planned for the patient, with the patient, focuses upon their individual needs, agreeing a person-centred approach and were appropriate takes into account their preferred place of care and personal preferences.

Meeting the physical needs of a patient remains an important part of nursing and medical care throughout the end-of-life pathway. Physical health interventions and assessments should be undertaken with the best interest of the patient being or paramount concern. It may or may not be appropriate to carry out vital signs monitoring. This should be determined on an individual patient basis by the MDT.

Adults in the last days of life who are likely to need symptom control will be prescribed anticipatory medicines with individualised indications for use, dosage and route of administration.

2.4.2. Disability Distress Assessment Tool

Within a learning disability setting staff should consider the use of DisDAT (Disability Distress Assessment Tool) to understand the person’s presentation of pain and the development of a hospital passport with the person and or their carer, to aid understanding of the persons needs if an admission to an acute hospital is required. The Hospital Passport is a requirement.

2.4.3. Support for people with epilepsy to stay safe

Epilepsy is associated with an increased risk of premature death, including a risk of sudden unexpected death in epilepsy (SUDEP) NICE NG217 April 2022

Patients may be admitted to an inpatient unit who have a known diagnosis of epilepsy or have experienced non-epileptic seizures. In consultation with the patient and their family, a patient centred care plan should be developed to ensure areas of risk have been assessed. Consideration should be given to the following risks:

- Bathing and showering
- Sleeping
- Falls
- Preparing food
- Using electrical equipment
- Managing prolonged or serial seizures
- Managing seizures in social settings
- Adherence to medication
- Alcohol/substance misuse

Useful tools and a seizure safety checklist can be found at SUDEP and Seizure Safety Checklist | SUDEP Action

In the Learning Disability setting all patients with epilepsy are considered at risk of SUDEP and their management, medication and emergency plans are developed with SUDEP in mind. This is a carried out by the Learning Disability Epilepsy Service and is available on admission. The plan will be reviewed on admission in collaboration with the specialist team and will include requests for any specialist equipment needed during the patient's in-patient stay. This review will inform the care plan and risk assessments. Any patient not known to services will be referred to the Epilepsy Specialist Team who will develop the plan after review with Specialist Consultant/GP and this should take place ideally within 24 hours.

For information on intervention and management of epilepsy please see Epilepsies in children, young people and adults (nice.org.uk)

For general advice and support relating to patients experiencing seizures the LD epilepsy service can be contacted at **hnf-tr.ldepilepsy@nhs.net**

2.4.4. Admission of a young person – under the age of 18 years

A young person admitted into an adult inpatient bed will be an exceptional circumstance

Where a child is admitted to an adult inpatient bed, the team will liaise with the appropriate CAMHS service who will work closely with the admitting clinician, liaising with the wider medical and nursing team. All physical examinations of a child or young person will be chaperoned.

2.4.5. Transgender

The physical health care needs of a transgender person will be considered.

All service users will be offered a full physical health assessment on admission to mental health and learning disability services. For transgender, non-binary and gender diverse persons there may be some additional physical health considerations for the health care team, such as any pre or post-operative care or follow up that may be required. Wherever

possible, appointments for specialist care and treatment should be enabled Supporting Transgender Patients Policy.

2.4.6. Care of the pregnant, postnatal and/or breastfeeding woman

There may be times when a pregnant women or new mother may be admitted into services. The inpatient service will work closely with midwifery services and the perinatal mental health team when required. The mental health team and maternity practitioners will work closely together for the benefit of the mother and baby. A risk assessment will be undertaken to monitor the risks to both the mother and baby.

2.4.7. Substance misuse/detoxification support/assisted withdrawal

Patients who are admitted who experience substance misuse and/or are undergoing detoxification/assisted withdrawal will be provided with care and treatment for physical symptoms during this process, along with care and support for longer term physical health complications. This will be led by the consultant psychiatrist and agreed with the patient within their person-centred plan.

2.4.8. People with existing long-term conditions who are admitted into services

People who are admitted with an existing long-term condition will have their physical observations undertaken for the first three days of their admission in order to understand their physical presentation, the results will be discussed in the MDT to ensure that the treatment and monitoring of their condition is in line with best practice and will continue uninterrupted during their stay in our mental health (adult and older age), forensic or learning disability services.

2.5. Management of Abnormal Blood Results

- Medical staff, requesting physical and blood investigations should proactively follow-up the receipt of results via the electronic systems to ensure that any abnormal or out of range results are acted upon in a timely manner.
- Liaise with the patient's GP in respect of monitoring long term conditions.
- Electronic Patient Record (EPR)– medical staff can request access to Hull University Teaching Hospitals NHS Trust (HUTH) EPR to view results which have been performed by the HUTH labs, for tests performed elsewhere this would be the paper copy.
- Nurse in charge of the shift will triage the blood results received via a paper copy, (outlining that the results appear to be normal/abnormal or out of range if known) and clearly documents the actions taken to evidence the management of the results.
- The nurse in charge will alert the medical staff to the blood results received via paper within 24 hours of receipt or earlier if possible or the results are of concern.
- Out of hours – the nurse in charge alerts the on-call doctor if results are of abnormal or out of range and a concern for the health of the patient.
- The medical staff who requested the blood will ensure that the results are followed up and reviewed within a timely manner with a clearly documented plan for escalation for urgent medical review within an acute hospital setting where needed.

3. DOCUMENTATION

Contemporaneous clinical records will be maintained on the electronic patient record. Vital signs will be recorded on the NEWS2 form on the electronic patient record.

4. EFFECTIVE COMMUNICATION MODEL FOR ESCALATION: SBARD

Humber Teaching NHS Foundation Trust supports the use of the SBARD communication tool. For further details see the Deteriorating Patient Policy.

5. TRAINING, SUPERVISION AND COMPETENCY ASSESSMENT

All registered and unregistered health care professionals undertaking vital signs and physical health monitoring and assessment of patients must demonstrate competence, skills and knowledge in relation to the specific task to be undertaken.

The Nursing and Midwifery Code (updated 2018) places specific responsibilities on nurses to maintain professional knowledge and competence. Appropriately trained healthcare professionals are asked to recognise and work within the limits of their competence and professional registration this includes but is not limited to doctors, nurses, advanced nurse practitioners, associate practitioners, occupational therapists, physiotherapists and speech and language therapists. Registered practitioners have a duty of care and a legal liability to their patients. When delegating an activity, for example to an RN, HCA or AP, the registered practitioner must ensure that it has been appropriately delegated.

6. RELEVANT POLICIES/PROCEDURES AND GUIDANCE

Protocol for Physical Health Monitoring: Mental Health and Learning Disabilities Inpatient Services Prot529
Protocol for Physical Health Monitoring: Learning Disabilities Community Services Prot528
Deteriorating Patient Policy N-062
Deteriorating Patient Procedure Prot527
Consent to assessment, examination, and treatment Policy N-052
Chaperone Policy N-059
Consent for treatment for patient detained under MCA SOP21-05
Medicines Management Tool for Antipsychotics Guidelines G368
National Early Warning Score (NEWS) 2 | RCP London
Epilepsies in children, young people and adults (nice.org.uk)
NG217 Evidence review 19 (nice.org.uk)
NG217 Evidence review 17 (nice.org.uk)
PHE UTI guideline

Appendix 1: Recommended Equipment for all Inpatient Units and Confirmation of Usage

Minimum:

- Stethoscope – for measurement/listening to heart rate and breath sounds
- Sphygmomanometer (manual) for recording blood pressure; with a choice of cuff sizes
- Tympanic thermometer
- Digital weighing scales – there should be arrangements in place for people who cannot access standard scales, for example, due to obesity or wheelchair use
- Pulse Oximeter – adult or child and ear and finger probes available for measurement of oxygen saturation levels
- Urinalysis dipsticks – urine testing to look for glucose, protein, ketones etc.
- Height measure – special arrangements maybe needed to obtain the height of people who cannot stand up to be measured, e.g. measuring in bed if height not known
- Disposable gloves – personal protective equipment
- Tape measure – for waist circumference
- Phlebotomy equipment (including safer sharps) – taking of bloods
- Blood monitoring (BM) machine – for testing blood sugar levels
- Ophthalmoscope/Auroscope – handheld scope for looking into eyes and ears
- Tendon hammer
- Pen torch
- Charcoal transport swab i.e. for MRSA screening, wound swabs
- Body Mass Index (BMI)
- Nebuliser
- Venturi masks (24% and 28%)
- Smokelyzer

Additional items dependent on needs of the inpatient unit:

- Examination couch
- Alcometer
- Drug testing kits and oral swabs
- ECG machine