Appendix 3 - SOP for physical health assessments of service users receiving treatment and support from home treatment teams

Purpose and Objective:

There is clear evidence that people with severe mental illness experience higher rates some physical health problems and have a reduced life expectancy compared to the general population. With improvements in identification and treatment of physical health the mortality gap can be reduced.

The purpose of this SOP is to describe the approach to improving the physical health of service users receiving care from home treatment teams in Sheffield Health and Social Care NHS Foundation Trust. The SOP is based on standards set out in the Royal College of Psychiatrists Home Treatment Accreditation Scheme.

Working with physical health services

Joint working and good communication between staff working in SHSC home treatment teams and physical health services is essential.

SHSC home treatment teams have a responsibility to

1) seek information from primary care about a service users physical health.
2) complete medicines reconciliation.
3) undertake physical health investigations and monitoring when initiating antipsychotics and mood stabilisers.
4) include physical health assessments and treatment in care plans.
5) share relevant information with primary care and other SHSC services.

Scope:

This SOP applies to service users receiving care from the home treatment teams. The standards have been taken from the Royal College of Psychiatrists accreditation standards.

Initial assessment

Clinical staff undertaking initial assessments should document an assessment of the service users physical health in their initial assessment. The assessment includes but is not limited to: Details of past medical history; Current physical health medication, including side effects and compliance with medication regime; Lifestyle factors e.g., sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use. If the assessment has been documented by another SHSC team e.g. SPA/EWS, recovery team, a ward team, etc prior to the service user being taken on by the home treatment team it does not need to be repeated.

Timescale – At the time of initial assessment

Responsibility – Clinical staff member completing the assessment

Physical health monitoring for service users commenced on a new antipsychotic or mood stabiliser

Timescale – at the time of prescription, monitored weekly for the first 6 weeks and repeated at 12 weeks.

Responsibility – Clinical staff.

Baseline investigations are completed before antipsychotics or mood stabilisers are prescribed. If not possible before prescription the investigations should be completed as soon as possible.

Baseline investigations are

ECG if required in the summary of product characteristics or if the service user has a personal history of cardiovascular disease.

Weight

Waist circumference

Pulse and blood pressure (NEWS2 to be completed if out of normal range and observation and escalation policy to be followed)

Glucose and lipid levels

Diet

Physical activity

Monitoring

The service user should be advised to monitor their weight weekly for the first six weeks and report weight gain to the team. At 12 weeks if the service user is still receiving treatment and support from the home treatment team the baseline investigations should be repeated.

Actions to be taken if the service user is found to be gaining weight or developing metabolic disturbance include advice about diet and activity, referral to community services that provide support with health behaviours and signposting to the service users GP.