Appendix 4 – SOP for physical health assessments of patients admitted to SHSC wards

Purpose and Objective:

The Physical Health Policy requires a SOP for the assessment and monitoring of the physical health of Service Users. This is to ensure all people admitted to an in-patient ward receive a range of investigations. Consideration should be taken dependent where service users are in their care pathway and whether in depth physical examination is clinically indicated.

Scope:

This SOP applies to all SHSC inpatient wards.

Initial physical health assessment following admission

a. An Early Warning Score assessment will be completed as soon as possible after admission, within 4 hours An urgent physical review will be undertaken if indicated by the National Early Warning Score (NEWS2)
b. The patients past medical history will be documented as soon as possible after admission.
c. A physical examination will be completed by a doctor, physician's associate or advanced clinical practitioner within 24 hours of admission. The examination completed will be based on the patient's past medical history and current presentation and will be documented in the patient record.
d. An ECG and screening tools (smoking form, falls assessment, MRSA screening, VTE screening) will be completed within 24 hours of admission.
e. Routine blood tests will be completed within 24 hours of admission.
    - FBC (full blood count)
    - U&E (Urea and electrolytes)
    - LFT (Liver function test)
    - HbA1C
    - Random Glucose
    - Lipid Profile
    - Prolactin level (if likely to receive an antipsychotic)
f. Additional investigations will be requested if clinically indicated.
g. The "physical health assessment" document will be commenced within 24 hours of admission and completed within 7 days.
h. A clinical management plan will be developed to meet the patient's known physical health needs and documented in their care plan. In the event of any abnormal findings in screening and examination undertaken after admission an individualised management plan will be documented in the patient's care plan.
i. If specialist medical/surgical assessment or treatment is required the patient will be referred to the appropriate medical specialist and supported to attend any appointments. Recommended treatment will be delivered on return to the ward and documented in the care plan.
j. On discharge from the ward the discharge summary will include relevant information about physical health investigations and treatment and will be sent to the patients GP and available in the patient record for SHSC community teams to access.

Physical health monitoring for service users commenced on a new antipsychotic or mood stabiliser during an inpatient admission

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 weighed weekly for the first six weeks. At 12 weeks if the service user is still an inpatient the baseline investigations should be repeated. If the patient is discharged before 12 weeks the community team should be informed of the date the investigations should be completed.

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.