Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document level: Trustwide (TW)
Code: CP35
Issue number: 6

Physical health pathway and policy

Lead executive	Medical Director - Compliance Quality and Assurance
Author and contact number	Associate Director of Nursing and Therapies (Physical Health) – 01244 397662

Type of document	Policy
Target audience	All clinical staff
Document purpose	The policy raises the profile of health assessment and promotion within CWP. Addressing issues of risk and the management of the risks in assessing patients with physical health problems. The policy sets out guidance for staff with regards to best practice in health promotion in physical assessment for patients.

Document consultation	Ward Managers, Modern Matrons, Senior nurses, clinians, Infection Prevention and Control Team, CAMH Services, Learning Disabilities Services, Medical Director, Clinical Governance Dept	
Approving meeting	Patient Safety and Effectiveness Sub Committee	18-Oct-12
Ratification	Document Quality Group (DQG)	13-Nov-12
Original issue date	Feb-06	
Implementation date	Nov-12	
Review date	Jul-17	

CWP documents to be read in conjunction with	HR6	Trust-wide learning and development requirements including the training needs analysis (TNA)
	CP1	Admission and discharge from hospital policy
	GR1	Incident reporting and management policy
	CP14	Prevention and management of slips, trips and falls
	CP24	Cardiopulmonary Resuscitation (CPR) policy
	CP30	Do not Attempt Resuscitation (DNAR policy)
	CP60	Handover / transfer of care policy
	CP55	SBAR (Situation-Background-Assessment-Recommendation) Handover / Communication Tool
	SOP3	Physical observations assessment and the management of altered levels of consciousness (including NEWS, PEWS, Pregnancy EWS, AVPU,GCS, Care and Management of the intoxicated Service User and ECG Recording

Training requirements	There **is** specific training requirements for this document.

Financial resource implications	Yes - Regarding the delivery of training

Equality Impact Assessment (EIA)

Initial assessment	Yes/No	Comments
Does this document affect one group less or more favourably than another on the basis of:		
• Race	No	
• Ethnic origins (including gypsies and travellers)	No	
• Nationality	No	
• Gender	No	
• Culture	No	
• Religion or belief	No	
• Sexual orientation including lesbian, gay and bisexual people	No	
• Age	No	
• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
N/A		
Is the impact of the document likely to be negative?	No	
• If so can the impact be avoided?	N/A	
• What alternatives are there to achieving the document without the impact?	N/A	
• Can we reduce the impact by taking different action?	N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted.		

If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact.

For advice in respect of answering the above questions, please contact the human resource department.

Was a full impact assessment required?	No	
What is the level of impact?	Low	

Document change history

Changes made with rationale and impact on practice
1. Review of document to support CareNotes Assist workflow launch of new assessment form (old appendix 4) and working forms.
2. Removal of appendix 4 – documents now in CareNotes Assist workflow in CareNotes;
3. Removal of appendix 5 – document now in SOP3;
4. Removal of appendix 6 -15 documents now in ……..
5. Addition of new appendix 3 – Care Pathway of Physical Health and Wellbeing (Learning Disability Specialist Health Respite)
6. Reordered appendices

External references

References
1. North Essex Mental Health Partnership NHS Trust, Physical Health Care Policy
2. Department of Health 2006 Choosing Health; Supporting the Physical Health Needs of People with Severe Mental Illness, London, Department of Health
3. Department of Health 2002 Mental Health Policy Implementation Guide- Acute Inpatient Care Provision, London, Department of Health
4. South Staffordshire and Shropshire Health Care NHS Foundation Trust

5. (2011) The Royal Marsden Hospital manual of Clinical Nursing Procedures

Monitoring compliance with the processes outlined within this document

Please state how this document will be monitored. If the document is linked to the NHSLA accreditation process, please complete the monitoring section below.				NHSLA standard 4.8 – The Deteriorating Patient		
Minimum requirement to be monitored NB the standards in bold below are assessed at level 2/3 NHSLA accreditation	Process for monitoring e.g. audit	Responsible individual / group	Frequency of monitoring	Responsible individual / group for review of results	Responsible individual / group / for development of action plan	Responsible individual / group for monitoring of action plan and Implementation
Requirement for a documented plan for vital signs monitoring that identifies which variables need to be measured, including the frequency of measurement (pilot)	Audit	Clinical Audit team	At least once per year	PSESC	PSESC	PSESC
Use of an early warning system within the organisation to recognise patients at risk of deterioration	**Audit**	**Clinical Audit team**	**At least once per year**	**PSESC**	**PSESC**	**PSESC**
Actions to be taken to minimise or prevent further deterioration in patients	Audit	Clinical Audit team	At least once per year	PSESC	PSESC	PSESC
How the organisation will monitor compliance with all of the above	As above	As above	As above	As above	As above	As above

Content

1. Introduction

Cheshire and Wirral Partnership NHS Foundation Trust (CWP) has a duty of care to all patients. CWP also has a duty of care to promote the overall physical wellbeing of patients.

This policy defines the responsibilities of CWP practitioners in promoting, identifying and meeting the physical health care needs of patients. It offers guidance on when to refer to primary and acute care Trusts. It also provides guidance to practitioners on the assessment of the health care needs of patients.

2. Definitions

For patients who are being cared for within inpatient or CWP West Physical Health settings, CWP staff have a duty of care to assess and act upon any identified physical health needs. For patients who are being cared for in a Community Mental Health (CMH) setting, although the responsibility for addressing physical health needs lies with primary care, CWP staff have a duty to facilitate and contribute to the assessment and ongoing review of physical health care, liaising with primary care colleagues. All CWP patients (excluding CWP West Physical Health) must have a physical health assessment at least annually.

3. Promotion of good physical health among patients

CWP clinical staff should promote good physical health amongst patients.

Practitioners with specialist knowledge and skills within the organisation will share those skills with patients and colleagues. Health promotion may be delivered through activity, education and awareness raising.

Practitioners working with patients have a responsibility to help and encourage individuals to maintain and improve their physical health and in many instances also have a role in facilitating patients accessing appropriate health care. CWP standards for managing the physical health and wellbeing (Mental Health) of patient's - guidance for CWP staff appendix 1.

3.1 General Principles of Consent

"Consent is the voluntary and continuing permission of the patient to receive a particular treatment based on an adequate knowledge of the purpose, nature, likely effects and risks of the treatment including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not 'consent'" *(Code of Practice for the Mental Capacity Act, Chapter 23.31)*.

It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical investigation, or providing personal care for a person. This principle reflects the right of patients to determine what happens to their own bodies, and is a fundamental part of good practice.

- For consent to be valid it must be voluntary and informed, and the person consenting must have the capacity to make the decision.
- If an adult has the capacity to make a voluntary and informed decision to consent to or refuse a particular treatment, their decision must be respected.
- Consent should be sought for each aspect of the person's care and treatment.

For guidance on the Consent to Treatment under the MHA, see trust policy MH13 Consent to Treatment.

3.2 Principles of good practice regarding chaperones

All patients should have the right, if they wish, to have a chaperone present during an examination, procedure, treatment or any care. A chaperone provided by CWP can be a professionally qualified member of staff or the patient may choose to have a relative or friend present with them during any examination or procedure. A Chaperone poster for display is available as Appendix 11.

4. Physical assessment of patients when they are admitted to a service, including timeframes for all CWP inpatient services

Ward staff will request a duty doctor to carry out a physical examination. The joint assessment must be completed within 24hrs by nursing staff and 6hrs by medical staff using CareNotes Assist workflow. If the assessments are not completed within these times the reason must be documented in the relevant CareNotes Assist document e.g. the patient refuses to be examined. CWP Care pathway for the management of physical health and wellbeing for all CWP inpatients is detailed within appendix 2.

4.1 Inpatient Assessment for nurses using CareNotes Assist workflow and ongoing assessments

On every admission the Nurse Inpatient Assessment workflow will include the following assessments. This is not an exhaustive list:

- Physical observations, including level of consciousness assessment

Physical Health (PH) observations are recorded on admission, using the CWP physical observation chart (which incorporates National Early Warning Score (NEWS), Paediatric Early Warning Score (PEWS), Pregnancy Early Warning Score, AVPU (Alert, Voice, Pain, Unresponsive). and Glasgow Coma Scale (GCS). Detailed guidance in the assessment, recording, scoring and actions of physical observations is contained in SOP3 Physical observations assessment and the management of altered levels of consciousness (including NEWS, PEWS, Pregnancy EWS, AVPU, GCS, Care and Management of the intoxicated Service User and ECG Recording.

4.1.1 Continence

An initial continence assessment is made on admission and where continence care is indicated a further assessment care plan is formulated and referrals made where required. An Intake and Output chart maybe commenced to aid this assessment. Changes to any catheter or stoma products are made in conjunction with the patient's continence / stoma team. If a patient develops diarrhoea, the Bristol stool chart must be utilised (see Clostridium difficile policy.)

A fluid input / output chart must be commenced where there are concerns regarding a patient's urinary output or fluid intake. The total inputs and outputs must be calculated up at the end of every shift and recorded in the health records.

4.1.2 Nutrition

A Malnutrition Universal Screening Tool (MUST) / Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) is carried out on all patients within 24 hours of admission. This should be reviewed **weekly** along with the patient's weight and BMI score. Where nutritional risk issues are identified, a care plan must be formulated and reviewed weekly.

The MUST assessment tool and the CAMH services STAMP assessment tool can be downloaded from the intranet.

4.1.3 Mobility

A Falls Risk Assessment Tool (FRAT) is carried out where indicated within 24 hours. Any actions and referrals required from the assessments must be carried out and reviewed on a **weekly basis** and / or when a patient's condition changes in line with the prevention and management of slips, trips and falls policy and recorded in the health records.

4.1.4 Skin / tissue viability

A Waterlow risk assessment is carried out on every admission where indicated within 24 hours. Actions and referrals required from the assessments must be identified in the care plan and **reviewed on a weekly basis** and / or earlier if a patients condition changes.

4.1.5 Infection Prevention and Control (IPC)

An IPC assessment is carried out on every admission where indicated within 24 hours. Any actions and referrals required from the assessments must be incorporated in the care plan .If there is an IPC risk, the patient must be referred to the IPC team who will provide follow up.

Physical health needs will be reviewed and incorporated in the care plan (for ongoing assessment tools see appendix 6, appendix 7, appendix 8, appendix 9 and appendix 10).

4.2 Inpatient Assessment for Doctors using CareNotes Assist workflow and ongoing assessments

On every admission the Doctor Inpatient Assessment workflow will include the following assessments; this is not an exhaustive list:

- Patient physical history;
- Blood tests;
- VTE screening;
- General examination of condition and appearance;
- ECG where clinically indicated;
- CXR where clinically indicated.

Following assessment, a care plan will be developed and documented in care notes to address physical health needs and the management of such. Any condition which may increase the risk of injury or collapse will be documented, e.g. cardio-pulmonary function, muscle or joint impairments, with the appropriate treatment and management plan.

5. Medication and side effect of medication monitoring

Medicines reconciliation will take place as soon as possible after admission. A medicines review will take place **weekly as a minimum** by a pharmacist and or the Multi-Disciplinary Team (MDT). Where required a LUNSERS or GASS assessment can be downloaded from the website.

6. Practitioners' responsibility in meeting the ongoing physical health care needs of patients

Physical observations will be completed weekly as a minimum.

6.1 Use of an early warning system within the organisation to recognise patients at risk of deterioration including level of consciousness assessment (vital signs)

Physical Health (PH) observations including respiratory rate, oxygen saturation, blood pressure, pulse and heart rate, temperature and neuro response (AVPU) must be recorded on admission, using the CWP physical observation chart (which incorporates National Early Warning Score (NEWS), Paediatric Early Warning Score (PEWS), Pregnancy Early Warning Score, AVPU and Glasgow Coma Scale (GCS) as part of the physical assessment. The frequency of ongoing physical observations will be directed by clinical need and care plan, but must be done **once a week as a minimum.**

Recording of physical observations should also be undertaken if:

- The patient appears to be physically unwell;
- The patient has fallen (do not move patient if there is a suspicion of neck / head injury or fracture);
- The patient has altered level of consciousness e.g. head injury;
- The patient is intoxicated with alcohol or drugs;
- The patient not responding to requests as expected;
- The patient is commencing new medication that may affect physical health;
- A report from patient or witness regarding any of the above.

6.2 Actions to be taken to minimise or prevent further deterioration in patients

In addition to the initial admission assessments the following will apply:

- Nursing staff will commence physical observations should the patient complain of feeling unwell, has fallen etc;
- The duty doctor will ensure that all appropriate physical investigations are undertaken;
- Should the patient complain of a minor medical problem and the examining doctor feels competent to treat the patient, then they may do so;
- If it appears the patient is suffering from a medical problem that the examining doctor feels cannot be treated adequately within the Trust, the doctor must either refer the patient to the

local Accident and Emergency (A&E) department or to the appropriate acute hospital department;
- It is the responsibility of the nurse in charge (or deputy) to call an ambulance to ensure a patient is transferred to the appropriate department where required;
- In an Emergency situation ring 2222 (main hospital switch board) to request an emergency ambulance within the main hospital sites or (9)999 for standalone units outside the main hospital sites

Staff and services based on the main inpatient sites must:

- Dial 2222 or (9)999
- Inform the switch board of your exact location, that there is a cardiac arrest and a paramedic response is required urgently;
- Commence and maintain appropriate life support in accordance with CWP policy until emergency services have arrived.
- If there are any difficulties or delay in response being experienced by staff then staff must dial 999 and again request paramedic/ambulance assistance.

The main inpatient sites are:

- Clatterbridge Hospital (Springview);
- Countess of Chester Health Park (Bowmere);
- Macclesfield District General hospital. (Millbrook)

6.2.1 National Early Warning Score (NEWS), Paediatric Early Warning Score (PEWS) and Pregnancy Early Warning Score – CWP physical observations charts

MEWS enables staff to recognise patients who are deteriorating and need to have an urgent medical review. The algorithm ensures immediate management is started and the need for medical expertise considered at an early stage. For detailed guidance in the assessment, recording, scoring and actions of physical observations refer to SOP3 Physical observations assessment and the management of altered levels of consciousness (including NEWS, PEWS, Pregnancy EWS, AVPU, GCS, Care and Management of the intoxicated Service User and ECG Recording.

7. CWP learning disability specialist health respite services

Patients admitted to CWP learning disability specialist health respite services will have a physical health assessment as part of their admission process; this will be done by the nurse contacting GP and / or next of kin to obtain physical health assessment information prior to every admission (appendix 3). This information will be held in the patient health record.

On at least an annual basis the named nurse will complete the **Nurse Physical Health Assessment Form** and relevant assessments using CareNotes Assist workflow within 24 hours of admission and incorporate into the care plan. This must be done annually unless there are changes in needs. If the assessments are not completed within these times the reason must be documented in the relevant CareNotes Assist document. The nurses' physical health assessment form and relevant assessments can be completed on every admission if required, dependant on the patient's physical conditions. –

In any circumstance where the professional identifies a physical health concern or deterioration in the patient, immediate advice will be sought from the medical staff, general practitioner (GP) or emergency services (Call 999), and this will be documented in the patients' health records.

8. Trust community mental health / outpatient services

For patients being cared for by community mental health teams the responsibility for a formal physical assessment lies with primary care services (GP). When trust staff identify a potential physical health problem, they will liaise with the relevant primary care professional, to ensure follow up and further assessment of any physical symptoms (appendix 4). In a medical emergency staff will call 999.

9. CWP West Physical Health service

For patients referred to CWP West Physical Health services the responsibility for a comprehensive physical health assessment lies with the GP. However specific physical health assessments will be completed on first contact with the patient and a care plan will be developed and evaluated on each contact. Should the patient deteriorate or have a medical emergency, staff will ring 999.

10. Harm reduction services

For patients being referred to the harm reduction service the responsibility for a formal physical assessment and referral to GP accordingly. The harm reduction nurse will complete a physical health assessment on the first contact with the patient and develop a plan of care that is evaluated at each contact with the patient, follow appendix 4. Health concerns will be referred to the GP and in an emergency staff will ring 999.

11. Situation – Background – Assessment – Recommendation (SBAR)

To support communication between nursing and medical staff a SBAR technique will be used. This will be used when communicating MEWS scores and Glasgow Coma Scale (GCS). For detailed guidance in SBAR please refer to SBAR (Situation-background-Assessment-Recommendation) Handover Tool.

12. Education and training for staff

Training will be available on physical health issues via learning and development department. This will include both in-service training and academic training via Higher Education Institutions (HEIs) and is detailed on MEL.

13. Duties and Responsibilities

13.1 Chief Executive

As accountable officer, the Chief Executive must ensure that responsibility for clinical standards, including appropriate systems regarding physical healthcare, is delegated to an appropriate executive lead, as outlined in the executive portfolios.

13.2 Medical Director (Compliance Quality and Assurance)

The Medical Director has responsibility to ensure there is an appropriate and effective clinical governance system in place with regard to provision of adequate training, assessment and review of physical health needs within the Trust.

Also as chair of the Patient Safety and Effectiveness Sub Committee (PSESC), specific duties for the Medical Director include:

- Approval of this policy and review of the inpatient physical health assessment tools;
- Working with primary care, including CWP West Physical Health services regarding ongoing physical health assessments of those individuals who are treated within trust community services.

13.3 Medical Staff

- All medical staff in inpatient areas will ensure that physical assessment is completed within 6 hrs of admission, and examinations are undertaken as part of their interventions with all patients and that patients are referred to the appropriate health professionals where appropriate.
- The duty doctor will ensure that all appropriate physical investigations are undertaken and, if applicable, refer the patient to the appropriate department.

13.4 Nurse in charge

- It is the responsibility of the nurse in charge (or deputy) to call an ambulance to ensure a patient is transferred to the appropriate department where required.

13.5 Nursing Staff

- For patients who are being cared for within an inpatient or Community setting, trust staff have a duty of care to assess, monitor, evaluate, and act upon any identified physical health needs;
- Nursing staff will commence physical observations should the patient complain of feeling unwell, has fallen etc

13.6 Learning and Development Department

- Learning and development department are responsible for providing training on physical health issues, this will include both in-service training and academic training via higher education institutions (HEIs). Training is delivered in accordance in line with mandatory employee learning policy.

13.7 Patient Safety and Effectiveness Sub Committee (PSESC)

- PSESC is responsible for approval, ongoing review (including review of duties) and receiving reports on the monitoring of this policy, through receipt of reports, work plans and action plans as detailed in this policy.

Appendix 1 – CWP standards for managing the physical health and wellbeing (Mental Health) of patient's - guidance for CWP staff

The life expectancy of people with learning disabilities and mental health problems is considerably worse than an average person in the UK. CWP is committed to improving the standard of physical health that is provided to its patients.

- All patients should be offered support for their physical health;
- Where and when physical health support is delivered should be determined by the needs and preferences of the individual patient;
- Patients who are receiving services from CWP should have their physical health needs included in their care plan;
- All care co-ordinators (lead professional) will ensure that information regarding the physical health checks are disseminated to the patient and the care team;
- The care co-ordinator should be informed, or seek to be informed of any current or outstanding physical health monitoring / outcomes;
- **The on-going responsibility of the physical health care of the patient in the community remains with the GP. However, all staff are to support patients in accessing physical health care and document the outcomes. During in-patient stays the responsibility lies with CWP and on admission the patient will follow CWP's physical health pathway.**

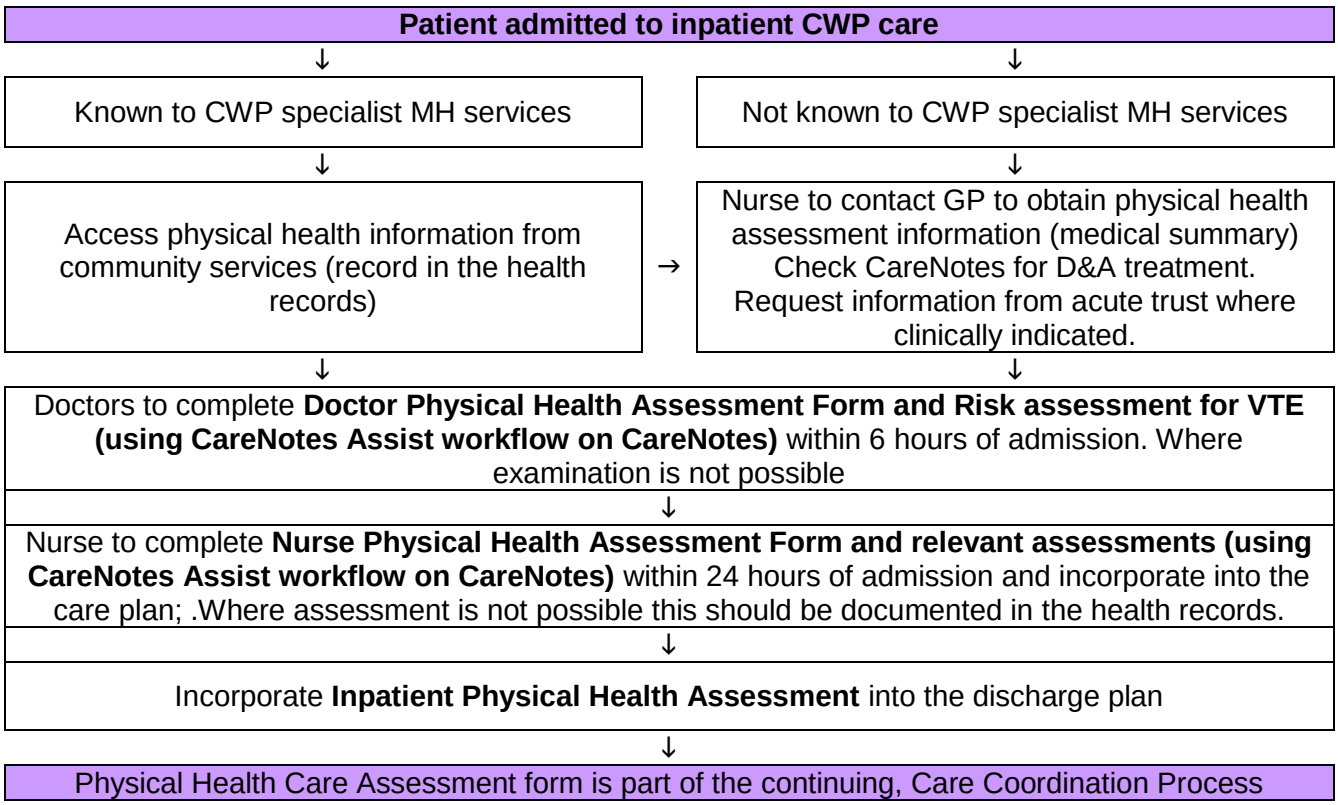
All Patients	
Promote Healthy Lifestyle	▶ Advise on diet, exercise, smoking cessation, alcohol consumption, dental health, and optician assessment.
Promote Mental Health Wellbeing	▶ Monitor for breakthrough symptoms. Encourage attendance at outpatient / CPN appointments.
Facilitate routine physical health checks provided by GP	▶ Physical health checks should pay particular attention to endocrine disorders, cardiovascular risk factors, side effects of medication, lifestyle factors, national screening programmes and immunisation programme.
	▶ Ensure baseline measurements are taken where appropriate to allow comparison and track trends over time

Assess / monitor lifestyle	**Assess / review / monitor physical health at least annually**	**Assess / monitor medication management / mental health wellbeing**
▼	▼	▼
Consider the following lifestyle factors and referrals **Smoking status** – Establish and record in the health records; – Request NRT is prescribed – Refer to smoking cessation service'; – Provide contact information for NHS groups. **Alcohol** – Complete AUDIT tool on CareNotes, if trigger other brief interventions.	**Review of past medical history and family history** – Consider patient's perception of their health needs; – Consider other chronic disease reviews e.g. asthma, arthritis, osteoporosis, diabetes; **Metabolic and endocrine** – Consider routine urine, blood/urine screen for diabetes; – Selective screen for other endocrine disorders e.g. hyperlipidaemia, HBA1C and	**Medication review** Check to ensure that the patient is taking what is prescribed and this is documented in the health records. Monitor uptake of prescriptions and check patient understands of medication. Offer patient information leaflets on medication from the Trust intranet-see medicines management page. Check for interactions between currently prescribed medications and any over the counter medicines as well as herbal /

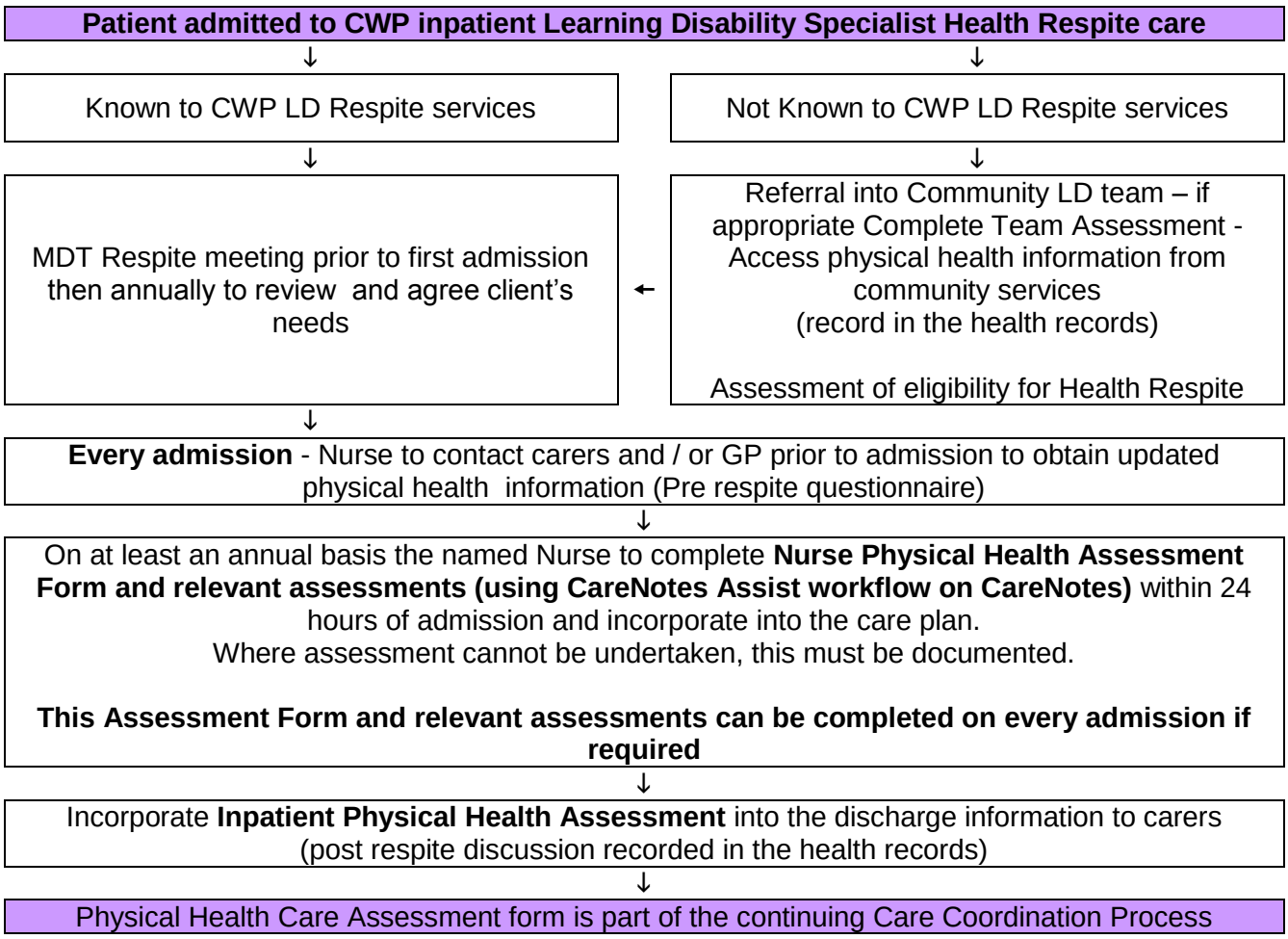
Assess / monitor lifestyle	Assess / review / monitor physical health at least annually	Assess / monitor medication management / mental health wellbeing
Use of illicit drugs – Establish illicit drug taking status and document in the health records. Signpost or facilitate access to appropriate service. **Dental, eyesight, hearing and sexual health** – Ask if having regular checks; – Re optical health needs further exploration if family has a history of glaucoma or if the patient is diabetic; – Raise awareness of recommended frequency of checks; **Male and female screening for sexual health**: – **Female** – breast, cervical and contraceptive screening; – **Male** – Testicular and prostate. **Diet / nutrition** – BMI calculation – waist measurement (complete MUST); – BMI <19 - Significantly under weight consider further assessment (different for adolescents and young people; – BMI >30 - Offer appropriate dietary advice if patient is morbidly obese; – BMI ≥25 in people diagnosed with an SMI (NICE CG43) - and / or weight gain of >5Kg over a 3 month period - Offer appropriate advice. – Consider referral to a dietician; – Consider referral to a local weight management group, either in primary or	hyperprolactinaemia, thyroid disease; – Ensure communication with Care Coordinator **Cardiovascular** Monitor increased risk of cardiovascular disease Consider: – Primary prevention (use standard scoring systems); – Secondary prevention in those with established heart disease; – Specific monitoring in relation to certain antipsychotic drugs (see BNF \ ESCA \ LUNSERS \ GASS); – Advice on heart disease, including history suggestive of arrhythmias; – Blood pressure and anaemia. – ECG base line on admission and annually if on antipsychotic (information from GP – share health records) **Blood tests** – Consider other blood tests as appropriate e.g. FBC, U & E's, LFTs; **Infection control** – Blood borne viruses (BBVs), esp Hep C identified and documented; – D&V (admission) – Alert organisms – MRSA status (admission) Identify areas that are prone to certain physical health checks.	homeopathic remedies they may be self-medicating with. Indications for considering involvement of specialist services: – Persistent symptoms; – Persistent side effects; – Polypharmacy; – Poor concordance e.g. attendance for injectable antipsychotic medication; – Consultant review (minimum annually); – Long term use of anticholinergic medication; – Long term use of benzodiazepine medication – Illicit drug and alcohol use. **Lithium** – Serum lithium, U&Es, creatinine and thyroid function tests for those people taking Lithium (U & E's). – Ensure that lithium levels are within therapeutic range **Depakote/sodium valproate** – LFTs and contraception – Contraception and pregnancy risks discussed with all female patients taking a mood stabiliser. **Clozapine** - Regular FBCs as per blood and prescription schedule; - Consider Plasma clozapine levels if poor concordance/increased side effects / ineffective treatment; - Advice on treatment / side effect monitoring.

Assess / monitor lifestyle	Assess / review / monitor physical health at least annually	Assess / monitor medication management / mental health wellbeing
secondary care; – Consider referral to a well man / woman clinic if available, give health promotion advice or refer on; **Exercise** – Consider exercise on prescription if available – Encourage '"Move more" age appropriate; – **Falls / mobility – assessment and establish plan;** – **Health history status, allergies identified and documented;** **Care Plan** Check to ensure care plan has been agreed; follow assessment in the community / inpatient.		**Side effect management for antipsychotics** Using a side effect rating scale e.g. LUNSERS \ GASS to uncover side effects such as: EPSE, akathisia, hyperprolactinaemia, sexual dysfunction, weight change etc. Consider reducing dose of antipsychotic or change of antipsychotic medication if side effects are persistent and uncontrolled. Treat side effects.

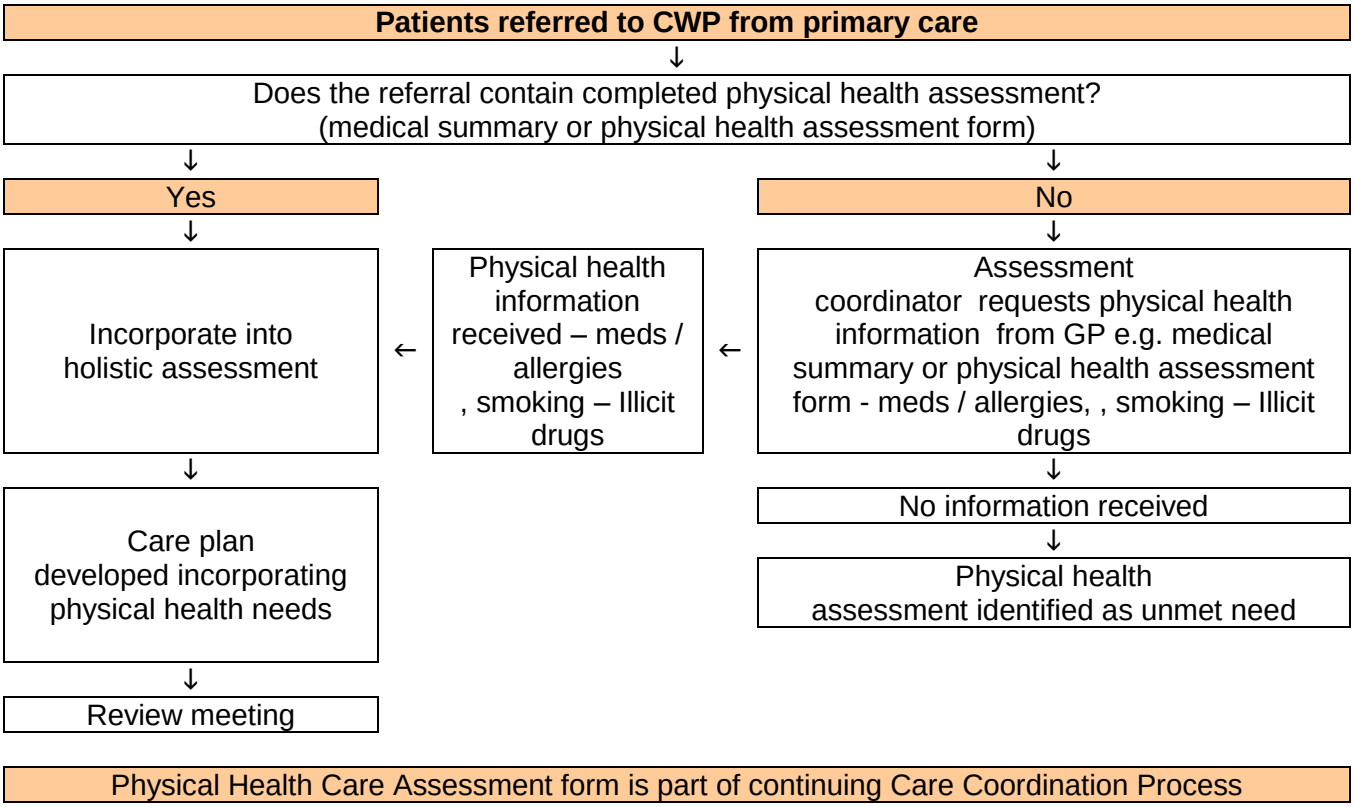
Appendix 2 - CWP Care pathway for the management of physical health and wellbeing for all CWP inpatients



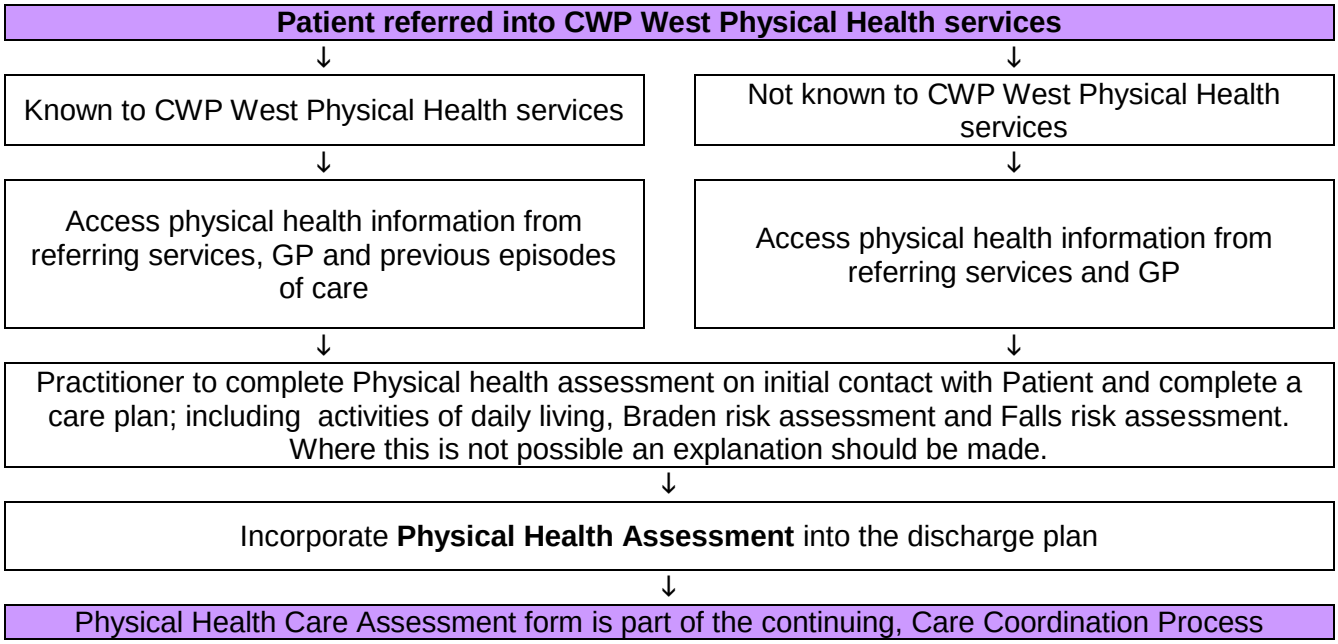
Appendix 3 - CWP Care pathway for the management of physical health and wellbeing for Learning Disability respite patients



Appendix 4 – CWP Care pathway for the management of physical health and well-being (community mental health and learning disabilities, and drug and alcohol services)



Appendix 5 - CWP Care pathway for the management of physical health and wellbeing (CWP West Physical Health)



Appendix 6 - Bowel movement / elimination record form

Month		**Patient label**	

Date and time Bowel action	**Pain / discomfort** In the bowel	**Colour of stool** Colour	**Bristol stool scale** Number	**Blood / mucus** Present	**Continent / incontinent**	**Laxatives or other relevant medications** E.g. antibiotics	**Antimotility given** E.g. Imodium

Appendix 7 - Sleep assessment and recording chart

Ward		NHS Number		Patient name label	

Times	Day 1 Date:		Day 2 Date:		Day 3 Date:		Day 4 Date:		Day 5 Date:		Day 6 Date:		Day 7 Date:	
	Awake	Reason	Awake	Reason	Awake	Reason	Awake	Reason	Awake	Reason	Awake	Reason	Awake	Reason
2000														
2100														
2200														
2300														
0000														
0100														
0200														
0300														
0400														
0500														
0600														
0700														
0800														

Reasons:	T	= Toilet	N	= Noise	S	= Spontaneous	+	= If agitated	-	= If not agitated

Day 1 Time of nap		Day 2 Time of nap		Day 3 Time of nap		Day 4 Time of nap		Day 5 Time of nap		Day 6 Time of nap		Day 7 Time of nap	
From	To	From	To	From	To	From	To	From	To	From	To	From	To

Appendix 8 – Input and output recording chart

Name		**Patient label**	
Consultant			
Date			

Time fluid taken	Oral or other (ml) i.e. PEG	Type of fluid	Input (ml)	Urine output (ml)	Output other (faeces, vomit) (ml)	Signature

Total Input of fluids		**Signature of nurse**	
Total Output of fluids			

Appendix 9 - MUST score recording

Patients name			NHS ID number		
Date of Birth			Height (m)		
Method of height assessment	☐ Actual	☐ Reported	☐ Ulna length	☐ Knee height	☐ Demispan

Date	Weight (kg)	Step 1		Step 2		Step 3	Step 4	Risk of Malnutrition 0 = Low / 1 = Medium / 2 = High Care plan commenced Yes or No?	Sign and print name
	Actual Reported Estimated Unable to weigh	BMI (kg/m2) Actual Estimated	BMI Score	% Weight loss	Weight loss score	Acute Disease Effect Score	Overall Risk of Malnutrition score (Steps 1+ 2 +3)		

Appendix 10 - MUST dietary intake chart

Patient label	

It is important that you state specifically what was eaten / drunk and the quantities in household measures to enable you to make decisions about the patient's dietary intake.

Date		
Meal time	**Actual food / drink**	**Quantity**
	e.g. porridge with full fat milk and sugar toast, butter and jam cup of tea with milk / sugar	e.g. 1 small bowl / cup milk / 1 sugar, 2 slices / tsp jam, 1 cup / 2 sugars
Breakfast		
Mid morning		
Lunch		
Mid afternoon		
Evening meal		
Bedtime		
Any other additional foods / drinks		

Appendix 11 – Chaperone poster

CHAPERONES

There are occasions when patients need to be assessed by a healthcare professional which might involve intimate examinations.

CWP is committed to putting patients at ease whenever possible, and if you wish a chaperone to be present during your examination please do not hesitate to ask a member of staff.