

<b>Reference Number:</b> <i>UHB 550</i> <b>Version Number:</b> 1	<b>Date of Next Review:</b> <i>02/05/2028</i> <b>Previous Trust/LHB Reference Number:</b> <i>n/a</i>
<b>Physical Health Monitoring Procedure for Adult Mental Health and MHSOP Inpatient Services</b>	
<p><b>Introduction and Aim</b></p> <p>People with mental health disorders die on average 15-20 years sooner than the general population. This can be attributed to preventable physical conditions such as respiratory and cardiovascular disease and poor access to physical health monitoring and assessment. They can also experience unnecessary health inequalities.</p> <p>Parity of esteem means giving equal priority and value to mental and physical health needs, so that people with mental health problems will have equal access to care and treatment, the same level of dignity and respect from health and social care and the same quality of physical health care as those without a mental health problem.</p> <p>The aim of this procedure is to provide clinical teams with support and guidance that will enable them to assess, monitor and manage patient’s physical healthcare needs within their level of competency.</p>	
<p><b>Objectives</b></p> <ul style="list-style-type: none"> <li>• <i>To ensure a standardised approach to physical healthcare is agreed and maintained within Mental Health Inpatient Services.</i></li> <li>• <i>Minimise the risk of harm to patients whilst in the care of or receiving services from Mental Health inpatient Services.</i></li> <li>• <i>To ensure equal priority and value to mental and physical health which strives to ensure that mental health patients have the same access to physical healthcare as those within the medical directorates, and other specialist areas within the UHB.</i></li> </ul>	
<p><b>Scope</b></p> <p>This procedure applies to all of our staff in all locations including those with honorary contracts.</p> <p>The Patient Group includes all wards in Hafan Y Coed and the Llanfair Unit. Inpatient MHSOP Wards Ash, East 10,12,14,16,18 –Some policies are slightly different for patients being nurses in the Inpatient Young Onset Dementia Setting –St Barruc’s Ward in Barry Community Hospital.</p>	
<b>Equality Health Impact Assessment</b>	<i>An Equality Health Impact Assessment (EHIA) has not been completed.</i>

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<b>Documents to read alongside this Procedure</b>	<p><i>NICE guideline ng181 Rehabilitation for adults with complex psychosis August 2020</i></p> <p><i>NICE guideline cg178 Psychosis and Schizophrenia in adults: prevention and management</i></p> <p><i>High Dose antipsychotic Therapy Guideline 2020</i></p> <p><i>Antipsychotic Monitoring Pathway 2021 MHC B</i></p> <p><i>Chaperone Policy UHB092 2016</i></p> <p>The Maudsley Prescribing Guidelines in Psychiatry (14<sup>th</sup> Edition)</p>
<b>Approved by</b>	<i>Controlled Document Oversight Group</i>

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<p><u><b>Disclaimer</b></u></p> <p><b>If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the <a href="#">Governance Directorate</a>.</b></p>	

<b>Summary of reviews/amendments</b>			
<b>Version Number</b>	<b>Date of Review Approved</b>	<b>Date Published</b>	<b>Summary of Amendments</b>
1	25/04/2028	TBA	<i>New document</i>

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## 1. Introduction

Evidence shows that people with serious mental illness (SMI) such as schizophrenia and bipolar disorder die on average between 15-20 years before the rest of the general population ([JRA Physical Health revised.pdf \(publishing.service.gov.uk\)](#)). There are many complex reasons for this, including discrimination and stigma, poor life chances, poor physical health and sedentary lifestyle choices and the use of long-term medication.

Specific factors leading to poor physical health include:

- **Lifestyle** – smoking; poor diet; lack of exercise; alcohol consumption; substance abuse; living conditions/homelessness.
- **Self-neglect** – people with SMI may not be able to look after themselves well due to negative symptoms associated with their

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illness. Individuals with a SMI may lack the social skills to effectively communicate a medical or physical health problem.

- **Psychotropic medication** – side effects of these medications include movement disorders; weight gain; toxicity issues; development of short- and long-term physical health conditions such as metabolic syndrome i.e. obesity, diabetes, cardiovascular disease.

Clinical staff also need to be aware of their bias toward interpreting physical symptoms as psychiatric in origin. This is a common problem called diagnostic overshadowing a process by which physical symptoms are misattributed to mental illness, or the clinical setting.

In 2016 the Welsh Government published the Together for Mental Health: Delivery plan which was a 10-year strategy to improve mental health and wellbeing. This delivery plan aims to ensure that there is Parity of Esteem between mental and physical health, in which people with mental health problems have access to appropriate and timely services, and that mental wellbeing should be given equal priority with physical wellbeing in the development and delivery of services.

People with mental illness should have the same access to preventative health promotion advice and support as the general population. A holistic approach to managing mental and physical health is needed. Physical and mental health are inextricably linked, and it is detrimental to a person's overall wellbeing to regard these as two separate entities. (Department of Health 2016).

In 2022 The National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD), published the Picture of Health report which reviewed the quality of physical healthcare provided to working and older adults admitted to mental health settings. This report describes the physical health disparities facing people living with mental health conditions who are less likely to receive preventative care, a diagnosis of a long-term disease or receive treatment for an identified condition.

The report addressed these issues and made recommendations to drive quality improvement initiatives for care provided within mental health inpatient settings. These recommendations will be incorporated within practice and form the foundation for the physical healthcare provided to all inpatients within the Cardiff & Vale Mental Health Inpatient Services.

A copy of the full Picture of Health report can be accessed via the following link:

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[A Picture of Health Full report.pdf \(ncepod.org.uk\)](#)

This document will assist in providing meaningful physical healthcare for our service users through appropriate standardised assessments, monitoring and management of the physical health risks which could be associated with mental illness and the side effects of medication prescribed. It will also signpost those who are identifying and managing acute onset of physical health problems appropriately to other care setting such as UHW or UHL. Lastly it will ensure that identification of early signs of chronic physical healthcare problems are addressed, as well as providing education to services users on these signs and preventing or minimising deterioration.

## 2. Physical Health Assessment and Ongoing Monitoring

Physical health deterioration can occur at any stage of a patient's pathway, there are certain periods when our patients may be more vulnerable such as:

- During the onset of infection or illness
- Administration of rapid tranquilisation
- During changes to their medication
- After a fall
- During a period of deterioration of their mental health
- During an exacerbation of a long-term physical health condition e.g. Diabetes, Chronic Obstructive Pulmonary Disease (COPD), cardiovascular disease (CVD)

Physical health assessment and monitoring is a multi-disciplinary and multi-professional responsibility. Any physical health problems must be included within the patient's intervention plan to ensure that these needs are being met, especially where the physical health condition is of a complex nature. Where possible these intervention plans must have a multidisciplinary approach to ensure consistency and accuracy in care. This information needs to be shared within handovers and ward rounds for continuity of care throughout the patient's admission.

There may be occasions where capacity assessments are required for patients whose mental state may compromise their ability to make decisions relating to their physical health. If the patient is found to lack capacity to make the decision themselves and there is no one else who can make the decision

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for them (I.e. Lasting Power of Attorney or Court Appointed Deputy), a decision will need to be made in their best interests to determine the most appropriate course of treatment and any ongoing monitoring of their physical health problems. This will need to be discussed with the Responsible Clinician and the MDT involved in the patient's care.

### **Physical Health Assessment on Admission to Inpatients Services.**

All patients admitted to Inpatient Services will be offered and encouraged to have a comprehensive physical health assessment within 24 hours of admission.

The physical health assessment will be combined with the necessary investigations e.g. bloods, urinalysis and electrocardiogram (ECG). The results of physical investigations must be reviewed and documented in the patient's PARIS case notes. Please note there is a module on PARIS for physical health where these results can be recorded. (Appendix 10 illustrates the Physical Health Assessment Template)

Junior Doctors or nursing staff with advanced skills can undertake a physical health assessment on patients. The assessment should include the following:

#### **Medications**

- Regular medications – Most will be prescribed by the GP, and recent medication can be accessed through the WGPR (Welsh GP Records) on WCP (Welsh Clinical Portal). It may also be necessary to contact the GP practices for this information. Mental health prescribed medication should be available via the COPPS (Computerised Outpatient Prescribing Printing System) and PARIS, it is important to ensure IM depot medication is identified. These sources should be checked prior to prescribing regular medication.
- Supplementary charts are required for the prescribing of insulin or warfarin.
- Adherence to medication should be documented, families and carers can be useful sources of information when considering this.
- Allergies
- **PMH (past medical history)**
- **Any current physical health conditions or acute changes/symptoms – including details of recent medical reviews and pending appointments.**

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- **Lifestyle factors (smoking status, sexual health, drug and alcohol use and risk of withdrawal, nutrition, activity level and sleep)**
- **Physical examination**
  - Physical observations (NEWS)
  - Cardiovascular
  - Respiratory
  - Abdominal/GI
  - Neurological
  - Skin
- **Bloods – these are the minimum required, other investigations may be necessary depending on the patient’s presentation:**
  - FBC, LFTs, U/E, TFT, B12 and Folate, random Glucose or HbA1c, bone profile, Vitamin D and CRP
  - If patient is on antipsychotic or likely to start, consider Lipids, Prolactin and CPK (See Appendix 4)
  - GGT if significant alcohol history
  - Plasma levels (Lithium, Na valproate, Clozapine) if indicated. **The timing of trough levels is important to ensure accurate levels are acquired, this is usually 12 hours after the last dose.**
  - BBV screening if indicated.

### 3. Rapid tranquilisation

When prescribing rapid tranquilisation for patients it is important to adhere to the Summary Guide for the Management of Acutely Disturbed Behaviour in Mental Health Inpatients 18-64 years. This is available on the Pharmacy SharePoint page under the Medicines treatment

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pathways and guidelines for Mental health ([Medicines treatment pathways and guidelines](#)). Guidance for treating patients over 64 years will vary and should be discussed with the Consultant and Pharmacist involved in the patients care.

On admission to hospital, it is necessary to assess if patients have any pre-existing physical health conditions that can increase the risks associated with the administration of rapid tranquilisation. If so, appropriate actions should be taken to ensure that these risks are addressed, documented and communicated with the Multidisciplinary Team. This information must be included in the admission clerking.

#### 4. ECG - Timing/frequency of electrocardiography

- ECG should be done on initial admission to serve as baseline (pre-treatment) and as part of physical health evaluation.
- ECG results must be recorded within the Physical Health Module on PARIS so that they are easily obtained when required. We are currently not connected to MUSE, therefore ECG's must be stored in the patient's clinical notes. Where possible a copy of the ECG should be scanned and uploaded to the attached documents module on the PARIS system.
- ECG should also be carried out in the presence of symptoms, especially chest pain, dyspnoea, palpitations and pre-syncope/syncope (collapse.)
- ECG may also be required when medication is being commenced (antipsychotics) increased or changed as part of inpatient treatment. i.e. A patient px Clozapine requires an ECG before the start of treatment, at the end of the titration dose and any subsequent increase in treatment. Yearly thereafter.
- ECG may be required to be carried out more frequently if risk factors are identified. These may include cardiovascular disease or where a patient is on High Dose Antipsychotics. Further ECGs are required after each dose increase. Please refer to the High Dose Antipsychotic Therapy Guidance (**This document is available on "S" drive – MHC B QSE & Lessons Learned- Archived Folder/Policies and Porcedures**).

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It is essential that physical assessments and examinations are conducted in a timely manner and environment that protects people's privacy, dignity and safety. They should be carried out in the treatment rooms where equipment is maintained for this purpose. In addition, a chaperone should be available and utilised when necessary (please refer to **Chaperone Policy UHB092** which is available on the SharePoint [Controlled Document Library - Home \(sharepoint.com\)](https://sharepoint.com)).

If a patient declines or does not give consent to a physical assessment or examination, then this should be clearly documented within their PARIS case notes and discussed within the MDT. Further attempts to offer this to the patient must be given and documented if repeatedly refused. If there are concerns about the patient's health, then this must be discussed within the MDT and a plan made on how this will be managed whilst the patient remains within the service especially if there are concerns raised in relation to any physical health or medical condition that is detrimental to that patient's wellbeing.

## 5. Discharge Summaries

Discharge summaries are the responsibility of the Medical Staff, and it is important to ensure that information about any physical health issues identified during the patient's admission, are included within this and shared with the patients GP in a timely manner.

## 6. Nursing Staff responsibilities

The nursing staff on the wards and clinical areas re responsible for the following:

- Obtaining consent from the individual to carry out physical monitoring.
- Baseline observations on admission and on-going monitoring of NEWS score to include Respiratory Rate, SpO<sub>2</sub> (SATs), Temperature, Blood pressure, AVPU.
- Urinalysis/DSU
- Pregnancy Test – not routine unless clinically indicated
- Blood glucose monitoring/ketone monitoring where necessary.
- Height, weight and BMI (also document on Drug Administration Chart)

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- Dietary/fluid intake
- Skin condition
- Mobility
- Personal hygiene
- Continence, bladder & bowel function
- Dental hygiene
- Medication compliance and side effects (GASS and Lunsers scales to be used where indicated)
- Ensuring ECG's have been completed.

- **All patients must have a National Early Warning Score (NEWS) recorded on admission. This is to be continuously monitored at least every 12 hours or twice daily, or as indicated according to score and escalation requirement.**
- **Escalation of sick patients to be followed as per the NEWS process, including referrals to P@RT (Patient at Risk Team) and the Medical Assessment Unit (MEAU).**
- **Patient mobility must be assessed by a doctor using the Venous Thromboembolism (VTE) Risk Assessment on PARIS and signed on the patient Drug Administration Chart. (Appendix 2) The VTE score must be updated if there is a physical health concern where the patient's mobility is directly affected, and prophylaxis is required.**

Other assessments that are required to be completed on admission are:

- Pressure sore risk assessment including the PAT-E-BAC and Purpose T assessments. These are required to be done within 6 hours of admission. **Please note that when completing the pressure sore risk assessment, the Waterlow assessment does not have to be completed as this has been replaced by the Purpose T assessment.**

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- WASSP Nutritional Assessment.
- Falls Risk Assessment including Bed Rails Assessment (Bed Rail assessment only required in Hafan y Coed where the patient is in a medical bed).

## 7. Care and Treatment Plans

Nursing staff must ensure that within 24 hours of admission a physical healthcare plan is developed with every patient. Where possible this should be done collaboratively with the patient and be based on their initial physical health assessment and examination. The plan must include the following:

- Frequency of physical observations
- Recognition of acute or chronic conditions
- Physical health support that is required
- Escalation of care in the event of deterioration
- Any gaps in clinical information and how these will be obtained.

Individual care and treatment plans must be developed with patients who have pre-existing medical conditions. These must include current treatment and support required to manage the condition and who to contact in the event of escalation of care. Where possible and with the patients consent, family and carers should be involved in formulating these plans to ensure accurate and up to date information is obtained.

Depending on the patient's physical health condition and its complexities, care plans to address and manage these conditions will require input from the MDT to ensure treatment plans are accurate and in line with best practice.

## 8. Medication reconciliation

Pharmacy will access the patients GP records to clarify current and up to date prescribed medication for individual patients. This can then be prescribed correctly on the patients All Wales Medication Chart. This is usually done within 24 hours of the patient being admitted. Other sources of information about regular medication include IHR, WCP, COPPS and PARIS, these sources should be checked prior to prescribing regular medication.

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## 9. Referrals

Referrals to Diabetic Nurse Specialist, Wound Healing, Podiatry and Smoking Cessation Practitioners can be made through the e-Advice & Communications module which is under the Clinical Systems tab on the CAVUHB SharePoint. Staff need to complete the e-learning to have access to this referral system. Referrals to Physiotherapy, Occupational Therapy, Speech and Language Therapy can all be done through the PARIS system.

### GP referrals

The Mental Heal Clinical Board employs three GP's. This service offers clinic appointments and ward visits Monday-Friday for patients within Hafan y Coed and MHSOP wards in UHL. Referrals to the GP's must be send via the following email [CAV\\_Mental.GpClinic@wales.nhs.uk](mailto:CAV_Mental.GpClinic@wales.nhs.uk). (Appendix 8 GP referral Form & SOP)

The GP can also be contacted by telephone ext 25758 or ext 25759

Physical health concerns should initially be referred to the psychiatric SHO. If a GP appointment is required, please email referral forms as above. The SHO's can ring the GPs for advice on the above numbers. All GP referrals need to be specific and clear to what is being asked of the GP.

All GP referrals need to be specific and clear to what is being asked of the GP. The referrals should also be made by the ward SHO. All follow-up from recommendations made by the GP is the responsibility of the ward SHO's.

**Dental referrals** are a paper document which should be available on the wards. These are completed and sent to the OSCAR Dental Department via the internal mail (Appendix 6). The referrals address all aspects of dental issues and will be triaged according to the need of the patient. Appointments will be made directly with the ward following the triage of the referral.

## 10. Sexual Health and Blood Borne Virus Screening (BBV)

Department of Sexual Health is an outpatient clinic providing advice and treatment for people who are:

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- Worried about infections which can be spread by sexual contact
- Have other conditions affecting the genital/urinary tract
- Any other sexual health issues
- Pre /post-test counselling for HIV
- Coordination of care for people living with HIV
- Provide coil training clinics
- Implant Clinic
- Contraception clinics in the Cardiff and Vale community

Patients who are admitted to Mental Health Inpatient Services can be referred to Sexual Health Clinic via a referral process, details of the referral process and clinic times and destinations are available on the SharePoint.

BBV screening for Hepatitis and HIV can be offered to all inpatients if indicated, as long as the patient is consenting. Information and advice on BBV screening can be requested from the BBV Team based at UHW. If a patient does require this screening, please refer to the Senior Nurse for Physical Health who will liaise directly with the BBV Team regarding the referral required. The BBV Team will liaise directly with the ward if treatment and further investigations are required for the patient.

## **11. Medical Emergency Assessment Unit (MEAU)**

This is 24-hour service based in UHL that is accessible via a referral process either through the Medical Registrar or direct contact with the Triage Nurse via the 'Red Phone'.

MEAU in UHL is not an Accident and Emergency Department and therefore has an exclusion criterion which includes all trauma. Patients with trauma injuries will require transfer to UHW A&E in these cases. Appendix 1 provides details of the SOP for MEAU and includes the referral process, the exclusion criteria and information on specific clinical situations and how to deal with these.

## **12. Out of Hours UHL Site Practitioner**

A Site Nurse Practitioner remains present overnight, and they have a dual role. Clinically the Site Practitioners are called upon to provide cover for jobs such as falls, routine cannulas, urinary catheters, verification of death or any other of the extended roles that affect other patients that are not clinically deteriorating or causing clinical concern.

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Managerially the Site Practitioners are the senior operational on-site presence. They manage and facilitate flow through the acute areas, respond to staffing, estates and professional issues and when required escalate to colleagues at UHW.

### **13. Patient at Risk Team (P@RT)**

P@RT are a team of Critical Care Practitioners based on the UHL site. They are available 24hrs per day, 7 days a week. They will assess all patients with a NEWS score of >3 or where concerns have been raised by nursing staff. P@RT will discuss and agree a clinical management plan with the primary medical team and document this in the patient's notes. P@RT require input from the primary medical team responsible for the patient. The primary medical team could be the Psychiatric SHO or the Inpatient GP team, it may also be the Medical Team or sometimes the out of hours GP. Appropriate clinical management may include escalation to high care areas such as ICU, setting treatment limitations or instigating palliation.

P@RT can be contacted via bleep no.4892 (Appendix 5).

### **14. Management of Falls**

The Management of Falls procedure is included in the appendix. This policy currently being reviewed but at present these are the guidelines we use. P@RT do not manage falls although will come and assist if the patient is scoring above a 3.

#### **In Hours**

First Point of call is:

Adult & MHSOP Inpatients - Ward SHO

Barry St Barruc's – if Dr available on site (Psychiatric SHO or GP). Phone MHSOP GP for advice or 999 if concerned.

#### **Out of Hours**

First Point of Call is:

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Adult & MHSOP - Inpatient SHO  
Site Manager for advice

Falls that require a CT scan (Have/cannot rule out a head injury and on an anticoagulant need to be scanned within 8 hours). Ring on call Psychiatric team who will review the patient and request and subsequently review the CT head scan. An onsite review by the OOH Psychiatric SHO will usually prevent the patient being transferred to UHW for a CT scan.

### **15. Management of Long-Term Conditions and Chronic Illness.**

A long-term condition is one that cannot be cured but can be controlled with the use of medication and/or other therapies. If there are significant changes to a patient's physical and mental health which impacts on their long-term condition, it is essential that advice is sought from Specialist Services within Cardiff & Vale ULHB.

This could include referral to the GP Service or the Special Departments that deal with the specific illness. It is essential that all efforts are made to ensure that patients attend outpatient appointments, and receive appropriate screening associated with their long-term conditions during their admission within Inpatient Services.

NICE has produced Clinical Knowledge Summaries (CKS) that provide current evidence base and practical guidance on best practice in the prevention and management of long-term physical conditions. These can be used to assist in the development of interventions plans detailing the frequency of monitoring treatment and the procedure to follow if there is a deterioration of the patient's long-term condition.

### **16. Patients on Steroid Therapy**

Steroids, also called corticosteroids, are anti-inflammatory medicines used to treat a range of conditions. They are a version of hormones normally produced by the adrenal glands to fight stress associated with illnesses and injuries. Some patients are physically dependent on daily steroid therapy as a critical medicine. Patients with conditions such as Addison's Disease are at risk of adrenal insufficiency which can lead to adrenal crisis, a medical emergency which untreated can be fatal.

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NICE guidelines published in August 2024 on the identification and management of Adrenal insufficiency can be accessed via this link: [Adrenal insufficiency: identification and management | Search results | NICE](#). These recommendations also include the management of adrenal insufficiency during times of psychological distress which will be more pertinent to our patient group.

Any patient admitted to Mental Health Services with known steroid insufficiency must have rescue medication protocols in place. Communication with Endocrinology Services must be established as it is likely that the patient will need a specialist review by this team. Endocrinology can provide an NHS Wales Emergency Steroid Therapy Card, advice on signs and symptoms of adrenal insufficiency and crisis and care plan for the management of adrenal insufficiency during inter-current illness. Please refer to Patient Safety Notice PSN057/June 2021 which can be found on the following link: [Patient Safety Solutions \(sharepoint.com\)](#).

### **17. Long term physical health monitoring for patients on antipsychotic medication and Bipolar disorder.**

All patients receiving long term treatment with antipsychotic medication should be monitored routinely and regularly. (NICE guidelines on Bipolar disorder: assessment and management (CG185) and Psychosis and schizophrenia in adults: prevention and management (CG178) are useful documents to refer to). In addition to the physical monitoring all patients should be offered the opportunity to complete a GASS or LUNSER at regular intervals to measure the impact of side effects.

Considerable thought should be given to the ongoing monitoring arrangements for patients on long-term therapy. A clear medication care plan advising what monitoring arrangements are necessary and how often they will be conducted should be completed in consultation with the patient and included in their Care and Treatment Plan (Please refer to the *High Dose antipsychotic Therapy Guideline 2020, Antipsychotic Monitoring Pathway 2021 MHC B*).

It is recommended that all patients prescribed antipsychotics be medically reviewed on an annual basis. It is expected that monitoring should be undertaken for at least the first year by the secondary health services commencing the medication, or until stability is achieved. **(Please refer to**

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## **monitoring tables for antipsychotic medications and Bipolar disorder as per Maudsley Prescribing Guidelines in Appendix 3&4)**

### **18. Prescribing, Administration and monitoring of Clozapine**

There is a Clozapine Policy which can be accessed via the search bar through the following the link: [Medicines treatment pathways and guidelines \(sharepoint.com\)](#) under the Mental Health tab. This aim of this document is to enable the safe and effective use of clozapine in CAVUHB for the treatment of mental illness. This involves the standardisation of practice to enhance patient care, reduce the potential for error, and improve patient safety.

This policy provides information on prescribing standards, healthcare professionals duties, initiation of treatment including baseline assessment and monitoring required. Information on the mandatory registration with ZTAS is also available within the policy.

The Clozapine Causing Constipation – Prophylaxis and Treatment Guideline is also available via the same link. It is important to note that CAVUHB recommend the use of prophylactic laxatives when commencing clozapine treatment. This guideline provides the treatment pathway to follow for this.

### **19. Screening for Life -**

As Health Professionals we all have a responsibility to ensure that our patients have access to information regarding Public Health Wales screening programmes. These include Cervical, Bowel, Breast and Abdominal Aortic Aneurysm (AAA) screening.

**Cervical Screening** – Women aged 25-64 are invited every three to five years.

**Bowel Screening** – Offered to Men and Women aged 50-74

**Breast Screening** – Offered to women aged 50

**Abdominal Aortic Aneurysm (AAA)** – offered to men aged 65 and over.

Screening information should be displayed within clinical areas and patients should be asked (where appropriate) if they have engaged in any screening

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as part of their assessment process. If the patient expresses that they wish to participate in screening during their admission, staff can assist to signpost patients to the screening available. Nursing and the clinical team can support the patient to attend any appointment required.

Information on screening can be accessed through the following link:

[Screening - Public Health Wales \(nhs.wales\)](https://nhs.uk/health-wales/screening)

## **20. Smoking Cessation**

Cardiff & Vale UHB operates a No Smoking Policy across all sites, this includes Mental Health Inpatient Services. Currently inpatients are permitted to use disposable vapes within the designated outside areas within Hafan y Coed and on specific MHSOP wards. The use of vapes is subject to strict monitoring and patients are not permitted to keep vapes on their person whilst in hospital. Information about the use and storage of vapes will be provided to patients on admission to hospital.

Smoking Cessation support and advice is available to access within the Health Board and within Mental Health Services. There is a specific protocol that can be followed if patients within Mental Health Inpatients Services wish to consider nicotine replacement therapy during their admission. Nursing staff will be able to offer support and advice to patients on Smoking Cessation and nicotine replacement therapy on and during their admission.

Smoking Cessation training is available for all staff and can be accessed through e-learning on the ESR system.

The Smoking Cessation Service is accessible and details of this are available on the CAVWeb. Other services that are available to assist patients who wish to consider quitting smoking include Stop Smoking Wales on freephone 0800 085 2219 or visit [www.stopsmokingwales.com](http://www.stopsmokingwales.com).

It is important to discuss smoking cessation with patients on admission and offer the help and advice to them should they wish to consider it.

## **21. Role and Responsibilities of the Senior Nurse for Physical Health**

**There is a Senior Nurse for Physical Health covering both the Adult and Mental Health Services for Older People (MHSOP) inpatients wards**

**The Senior Nurse for Physical Health remit covers the following:**

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- 90% Clinical to meet service demand, be highly visible in clinical areas.
- Assess complex clinical presentations in liaison with medical colleagues.
- Manage own caseload of patients who present with physical health problems within the Mental Health Inpatient Services (Adult and MHSOP).
- To ensure that acutely unwell or injured patients are cared for safely and effectively following set protocols and procedures.
- Request clinical investigations and be responsible for the interpretation of results, to enable the autonomous management of a patient caseload.
- Support the wider team to maintain and improve upon the quality of care and treatment planning, specifically in relation to physical healthcare.
- Communicate and liaise with the MDT and the wider UHB regarding patient care.
- Identify the priorities, themes and risk concerning physical healthcare that may arise from serious incidents and work with clinical staff, Directorate and Clinical Board to develop systems to minimise potential harm to patients.
- Review complaints concerning physical healthcare and make recommendations to improve patient experience.
- Develop strategies and guidance arising from NICE and other national/professional guidance related to physical healthcare.
- Work with the Professional and Practice Development Team to ensure that educational, training and competence around physical healthcare is relevant and up to date for the service.
- Lead specific work streams relating to the physical health strategy.
- Support services on the complex clinical management of physical health with the Adult Mental Health Directorate.
- Undertake Audit, service improvement and research - to initiate and lead or collaborate on audit, service improvement and research projects relating to mental health and physical health.
- 

## 22. Training

All Clinical staff are required to complete mandatory training and must undertake further skills training in relation to some aspects of this procedure i.e. BLS, AED and NEWS training (Mandatory), ILS, venepuncture and ECG. For full details of additional skills training please refer to the UHB's prospectus

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of training courses or speak with the Professional and Practice Development Team.

### **23. Monitoring**

Fulfilling our clinical responsibilities for physical health monitoring and interventions will be monitored through performance reports, audits and quality improvement initiatives. These improvement plans will be uploaded onto AMat and will always be available for Patient Safety Review. Other Audit processes used will include Tendable.

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## Appendix 1 – MEAU SOPs and Referral Process

### Mental Health Standard Operating Procedures (SOPs) - University Hospital of Llandough:

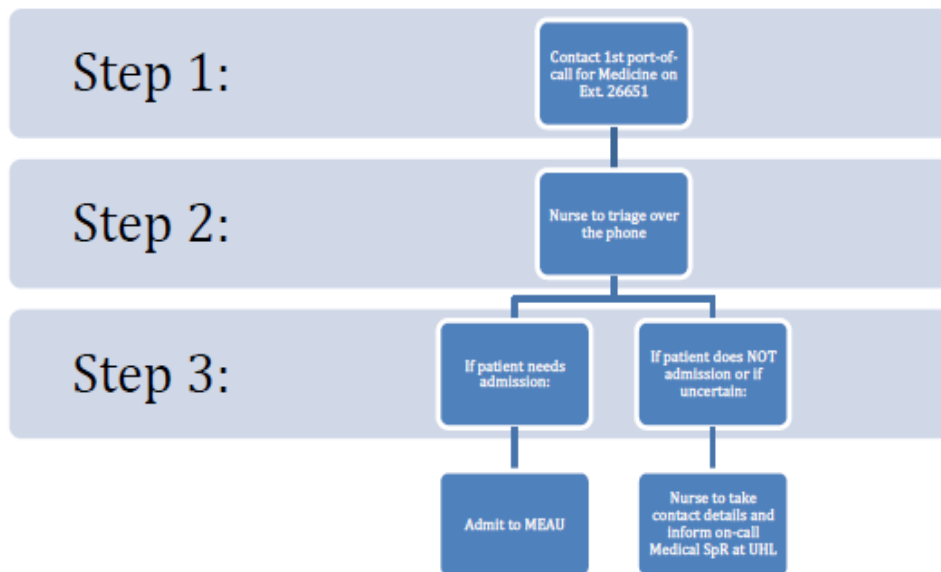
NEWS score	0-2	3-5	6-8	≥ 9 or, Seizures / Collapse / Airway emergency:
In-hours :	Managed by ward	Contact Psychiatry SHO/ Salaried GP	If needed, psychiatry SHO / Salaried GP to discuss with the 1st port-of-call for medicine on Extn: 26651	Call 2222
Out-of-hours (OOH)	Managed by ward	Days: shift coordinator to contact OOH GP Nights: MH night site manager to call OOH GP	Ward to contact the 1st port-of-call for medicine on Extn: 26651	Call 2222

An elevated NEWS score does NOT provide a diagnosis but helps identify a sick patient who requires an urgent clinical review in a standardised way. **Concern about a patient's clinical condition should ALWAYS override the NEWS score if the attending healthcare professional considers it necessary to escalate care.**

Specific clinical situations:	How to deal with:
1. Urinary catheter issues e.g., 'blocked' catheter, 'pulled-out' catheter	Contact surgical / urology SHO on bleep 4551
2. Renal impairment & electrolyte disturbance	Ensure bloods are up-to-date before contacting extension: 26651
3. For MEAU exclusion criteria (see below)	Contact UHW
4. If high NEWS score ≥ 6 (i.e., an acutely unwell patient)	Escalate as per protocol and take bloods, ECG, CXR and Urine dipstick, if appropriate to avoid delays in care: Bloods - FBC, U+E, CRP, LFT, Coagulations
5. For antibiotic advice	Consult Micro guide viewer on CAVWEB and for further advice contact Microbiology SpR on bleep 5216

**Please note that bleep numbers advised above are not always accurate. Contact switchboard directly or access RotaWatch via Sharepoint ([On Call Listing Options](#)) for accurate information.**

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#### Medical Emergency Assessment Unit (MEAU) Exclusion Criteria:

- Paediatrics (age 16 years and under)
- Trauma (including a head injury such as a patient their head if the patient has collapsed)
- Surgical patients (abdominal pain that could be surgical in nature / any recent surgery with ongoing complications)
- Acute pr bleeding (bleed via back passage)
- Intoxicated patients
- Patients on or needing haemodialysis
- ST elevation MI or new Left Bundle Branch Block (LBBB) on ECG (if unsure try <http://cvweb.uhw> to access old ECGs)
- Stroke (cerebrovascular accident)
- Pregnancy over 20 weeks
- Orthopaedic problems
- Painless jaundice
- ? DVT's between 9:00 - 16:00 Monday - Friday unless contraindicated to DVT clinical in UHW
- Cardiac and respiratory arrest including life threatening cardiac arrhythmias

This list is just a guide and all calls should be asked for as much history as possible including recent hospital admissions and why to ensure correct placement of patient.

If in doubt please ask the senior nurse / Acute Care Physician / Medical SpR

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## Medical Emergency Assessment Unit

### 999 EXCLUSION CRITERIA

- Very low O2 Sats 90% or below potentially needing NIV/CPAP excluding COPD patients (accept 88%-92% on air)
- **Type 2 respiratory failure on home NIV has been removed**
- Learning disability with complex needs
- **Wording changes from severe learning disabilities**
- Paediatrics 16 years old and under
- Trauma including head injury (such as a patient hitting their head if the patient has collapsed) Unwitnessed fall-on anticoagulant
- **Unwitnessed fall-on anticoagulant added**
- Surgical patients/Abdominal pain that could be surgical in nature/ recent surgery with ongoing complications.
- Acute PR bleeding/ Active hematemesis
- **Active hematemesis added**
- Intoxicated patients/ ODs/ suicidal tendencies
- **ODs/suicidal tendencies added**
- Patients on haemodialysis or history of recent transplant
- **Or history of recent transplant added**
- ST elevation MI/New left bundle branch block (if unsure try <http://cvweb.uhw> to access old ECG's)
- CVA or crescendo TIA
- **Or crescendo TIA added**
- Pregnancy 20 weeks & above
- Trauma and Orthopaedic problems
- Painless jaundice
- ? DVTs between 09.00 - 16.00 Monday-Friday unless contraindicated to DVT clinic
- Cardiac and respiratory arrest including life threatening cardiac arrhythmias, airway compromise.
- **Airway compromise added**
- ENT and Tracheostomy patients
- **ENT and Tracheostomy patients added**
- Urology problems
- **Urology problems added**
- Low GCS (less than 8) possible requiring intubation

This list is a guide and all calls should be asked for as much history as possible including recent hospital admissions and why to ensure correct placement of patient. If in doubt ask ACP/ Registrar / site manager.

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## Appendix 2 VTE Risk Assessment

**VTE Risk Assessment**

**REDUCING THE RISK OF VENOUS THROMBOEMBOLISM (VTE) IN MENTAL HEALTH IN-PATIENTS**

Assess Mobility:

Does the patient have reduced mobility relative to normal state?  YES  NO

Prescribe pharmacological thromboprophylaxis for all patients who become non-ambulant with an acute medical illness whilst an in-patient on a mental health unit who have >1 risk factor for VTE.

Mechanical thromboprophylaxis is not routinely used in this setting.

Patient weight (kg)

**DOES THE PATIENT HAVE RISK FACTORS FOR VENOUS THROMBOEMBOLISM? (VTE)**

Age over 60 years <input type="checkbox"/>	Obesity (BMI >30kg/m <sup>2</sup> ) <input type="checkbox"/>
Acute medical/critical care admission <input type="checkbox"/>	Dehydration <input type="checkbox"/>
Pregnancy or < 12 weeks post-partum <input type="checkbox"/>	Varicose veins or active phlebitis <input type="checkbox"/>
Active cancer or cancer treatment <input type="checkbox"/>	Use of oestrogen containing contraceptive therapy or HRT <input type="checkbox"/>
Personal or 1st degree relative with history of VTE <input type="checkbox"/>	Known thrombophilia <input type="checkbox"/>

**Mental health risk factors (to consider)**

Anti-psychotic medication including clozapine <input type="checkbox"/>	Catatonia <input type="checkbox"/>
Poor Oral intake <input type="checkbox"/>	NMS <input type="checkbox"/>
SIMA (restraint) <input type="checkbox"/>	ECT (anaesthetic risk) <input type="checkbox"/>

**DOES THE PATIENT HAVE CONTRAINDICATIONS TO PHARMACOLOGICAL THROMBOPROPHYLAXIS?**

Active bleeding or at risk of bleeding <input type="checkbox"/>	Thrombocytopenia: platelet count <75x10 <sup>9</sup> /l <input type="checkbox"/>
Severe renal disease (CrCl less than 30ml/min) <input type="checkbox"/>	Currently receiving therapeutic anticoagulation <input type="checkbox"/>
Previous heparin induced thrombocytopenia or allergy <input type="checkbox"/>	Acute Stroke/ICH/SAH <input type="checkbox"/>
Neuraxial procedure (e.g. LP) within the past 4h or due in the next 12h <input type="checkbox"/>	Known bleeding disorder, severe liver disease <input type="checkbox"/>

**Have any contraindications been identified?**

If NO prescribe pharmacological thromboprophylaxis on the 'VTE prophylaxis' section of the drug chart, dosing advice is provided below

If YES, document in the notes (and on the drug chart) - consider anti-embolic stockings (AES) if no contraindications

Reassess risk of bleeding and venous thromboembolism regularly and if clinical situation changes

Weight & CrCl based dosing of enoxaparin thromboprophylaxis	Weight ≤50kg	Weight >50-100kg	Weight 101-150kg	Weight >150kg
CrCl >30 mL/min	20mg ONCE daily	40mg ONCE daily	40mg TWICE daily	60mg TWICE daily
CrCl 15-30 mL/min	Consult Renal	20mg ONCE daily	40mg ONCE daily	40mg ONCE daily

**If mechanical thromboprophylaxis is indicated, ensure that there are no contraindications**

Known/Suspected arterial insufficiency <input type="checkbox"/>	Patient on noradrenaline (seek advice) <input type="checkbox"/>
Absent/Weak foot pulses on palpitation <input type="checkbox"/>	Severe peripheral oedema/Pulmonary oedema <input type="checkbox"/>
Peripheral neuropathy/sensory impairment <input type="checkbox"/>	Major limb deformity (affecting correct fit) <input type="checkbox"/>
New onset stroke <input type="checkbox"/>	Skin conditions with associated risk of harm e.g. tissue paper skin pressure ulcers <input type="checkbox"/>
Known allergy to AES material <input type="checkbox"/>	

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### Appendix 3 - Physical Monitoring for People with bipolar disorder (based on NICE Guidelines and NPSA advice)

#### Monitoring for all patients

#### Additional monitoring for specific drugs

Test or measurement	Initial health check	Annual health check	Antipsychotics	Lithium	Valproate	Carbamazepine
Thyroid function	Yes	Yes	-	At start and every 6 months; more often if evidence of deterioration		
Liver function	Yes	Yes	-		At start and periodically during treatment if clinically indicated	At start and periodically during treatment if clinically indicated
Renal function (eGFR)	Yes	Yes	-	At start and every 6 months; more often if there is evidence of deterioration or the patient starts taking interacting drugs		
Urea and electrolytes	Yes	Yes	-	At start and then every 6 months (include serum calcium)		Every 6 months. More often if clinically indicated
Full blood count	Yes	Yes	-	Only if clinically indicated	At start and at 6 months	At start and at 6 months

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Blood (plasma) glucose	Yes	Yes, as part of a routine physical health check	At start and then every 4-6 months (and at 1 month if taking olanzapine); more often if evidence of elevated levels	-		
Lipid profile	Yes	Yes, as part of a routine physical health check	At start and at 3 months; more often initially if evidence of elevated levels	-		
Blood pressure	Yes	Yes, as part of a routine physical health check	During dosage titration if antipsychotic prescribed is associated with postural hypotension	-		
Prolactin	Children and adolescents only	-	At start and if symptoms of raised prolactin develop  Raised prolactin unlikely with quetiapine or aripiprazole. Very occasionally seen with olanzapine and asenapine. Very common with risperidone and FGA's	-		
ECG	If indicated by history or clinical picture	-	At start if there are risk factors for or existing cardiovascular disease (or haloperidol is prescribed). If relevant abnormalities are detected, as a minimum	At start if risk factors for or existing cardiovascular disease. If relevant abnormalities are detected, as a		At start if risk factors for or existing cardiovascular disease. If relevant abnormalities are

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#### Appendix 4 - Monitoring of physical parameters for patients receiving antipsychotic medications – The Maudsley Prescribing Guidelines in Psychiatry (13<sup>th</sup> Edition)

<b>Plasma glucose</b> (fasting sample, if possible)	Baseline, at 4-6 months, then yearly to detect antipsychotic-induced changes and generally monitor physical health	Offer lifestyle advice. Obtain fasting sample or non-fasting and HbA1c. Refer to GP or specialist	Clozapine, olanzapine, chlorpromazine – test at baseline, 1 month, then 4-6 monthly	Some antipsychotics not clearly associated with IFG but prevalence is high in this patient group
<b>ECG</b>	Baseline and when target dose is reached (ECG changes rare in practice) on admission to hospital and before discharge if drug regimen changed	Discuss with/refer to cardiologist if abnormality detected	Haloperidol, pimozide, sertindole – ECG mandatory Ziprasidone – ECG mandatory in some situations	Risk of sudden cardiac death increased with most antipsychotics. Ideally, all patients should be offered and ECG at least yearly
<b>Blood pressure</b>	Baseline, frequently during dose titration to detect antipsychotic-induced changes, and generally monitor physical health	If severe hypotension or hypertension (Clozapine) observed, slow rate of titration. Consider switching to another antipsychotic if symptomatic postural hypotension. Treat hypertension in line with NICE guidelines	Clozapine, chlorpromazine and quetiapine most likely to be associated with postural hypotension	Amisulpiride, aripiprazole, brexpiprazole, cariprazine, lurasidone, trifluoperazine, sulpiride
<b>Prolactin</b>	Baseline, then at 6 months, then yearly to detect antipsychotic-induced changes	Switch drugs if hyperprolactinaemia confirmed and symptomatic. Consider tests of bone mineral density (e.g. DEXA scanning) for those with chronically raised prolactin	Amisulpiride, sulpiride, risperidone and paliperidone particularly associated with hyperprolactinaemia	Asenapine, aripiprazole, brexpiprazole, cariprazine, clozapine, lurasidone. Quetiapine, olanzapine, (<20mg), ziprasidone usually do not elevate prolactin, but worth measuring if symptoms arise.
<b>Liver function tests (LFTs)</b>	Baseline, then yearly as part of a routine physical health check and to detect chronic antipsychotic-induced changes (rare)	Stop suspect drug if LFT's indicate hepatitis (transaminases x 3 normal) or functional	Clozapine and chlorpromazine associated with hepatic failure	Amisulpiride, sulpiride

		damage (PT/albumin change)		
<b>Creatinine phosphokinase (CPK)</b>	Baseline, then if NMS suspected	Refer to NMS guidelines	NMS more likely with first-generation antipsychotics	None

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## Appendix 5 – P@RT (Patient at Risk Team)



**P** Patient  
**a** at  
**R** Risk  
**T** Team

**GIG CYMRU NHS WALES** | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Cardiff and Vale University Health Board

- Does your patient have a NEWS  $\geq 3$  or are they causing concern?
- Bleep 5344 (UHW) 4892 (UHL) 7am-7.30pm, 7 days a week.
- We are a friendly team with many years of experience across multiple specialities.
- We will work with you & your team to facilitate a plan of action, including escalation of care if necessary.
- We follow up patients discharged from critical care.
- We are here to provide education, advice and support for all colleagues caring for acutely ill or deteriorating adult ward patients.

**PATIENT AT RISK TEAM**  
Cardiff and Vale University Health Board

**From 4th of October 2021**  
**Bleep: 5344 (UHW) or 4892 (UHL)**

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## Appendix 6 OSCAR Dental referral form

### IN-PATIENT DENTAL REFERRAL TO OSCAR DENTAL

V1.02/02/2016/MAC

Hospital: \_\_\_\_\_ Ward: \_\_\_\_\_ Date: \_\_\_\_\_

<p>(Affix patient label here)</p> <p>Name: _____ DOB: _____</p> <p>Address: _____</p> <p>Hospital number: _____</p> <p>PARIS ID (if applicable): _____</p>	<p>Can the patient transfer to dental chair? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do they need assistance to transfer? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, what manual handling aids are required:</p> <p>Assisted by staff <input type="checkbox"/> Steady / Frame <input type="checkbox"/></p> <p>Wheelchair standard <input type="checkbox"/> Wheelchair electric <input type="checkbox"/></p> <p>Hoist <input type="checkbox"/> Bedfast <input type="checkbox"/></p>
<p>Reason for admission: _____</p> <p>Consultant: _____</p> <p>Date admission: _____ Discharge: _____</p> <p>Does the patient have section 17 leave (if applicable)? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>How does the patient communicate? Verbal <input type="checkbox"/> Non verbal <input type="checkbox"/> Other _____</p> <p>Do they require a translator? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, which language? _____</p> <p>Do they have a sensory impairment? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If Yes, please specify _____</p>

Please note if not completed fully, referral may be returned

Reason for referral: (e.g. Description of the problem, area of mouth affected, duration of symptoms)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To help us effectively triage this patient, please tick all that apply:

<p><b>Urgent</b></p> <p>Visible facial swelling</p> <p>Uncontrolled bleeding</p> <p>Dental trauma</p> <p>Loose teeth and aspiration risk</p>	<p><b>Dental pain</b></p> <p>Unresponsive to pain killers</p> <p>Responsive to pain killers</p> <p>Interrupted sleep</p> <p>Difficulty eating</p>	<p><b>Teeth</b></p> <p>Sharp / broken tooth</p> <p>Lost filling</p> <p>Loose teeth and no aspiration risk</p>
<p><b>Soft tissues (includes gums)</b></p> <p>Bleeding</p> <p>Swelling or lump</p> <p>Bad breath / halitosis</p> <p>Dry mouth</p> <p>Ulcer</p>	<p><b>Dentures</b></p> <p>Does patient wear dentures currently? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Broken denture(s)</p> <p>Loose denture(s)</p> <p>Lost dentures(s)</p>	<p><b>Pre-op dental screening needed</b></p> <p>Intervention planned:</p> <p>_____</p> <p>Date of intervention:</p> <p>_____</p>

Medical History (Please tick and record details as applicable)			
Any current or history of diagnosed conditions	Yes	No	Further details
CHEST e.g. asthma, bronchitis			
BLOOD e.g. anaemia, prolonged bleeding			

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**IN-PATIENT DENTAL REFERRAL TO OSCAR DENTAL**

V1.030224MAC

Any current or history of diagnosed conditions	Yes	No	Further details
<b>HEART</b> e.g. valve replacement, pacemaker, hypertension, heart failure, acute coronary syndrome			
<b>STOMACH AND BOWEL</b> e.g. ulcers, reflux, colitis, previous surgery			
<b>LIVER AND KIDNEYS</b> e.g. hepatitis, cirrhosis, infections, chronic or acute kidney disease			
<b>NERVOUS SYSTEM</b> e.g. epilepsy, stroke, fits or faints, progressive neurological disorder, spinal cord injury, traumatic brain injury			
<b>MENTAL HEALTH</b> e.g. diagnosis, MHA status			
<b>CANCER HISTORY</b> e.g. surgery, chemotherapy, radiotherapy history			
<b>ENDOCRINE</b> e.g. diabetes, thyroid			
<b>BONES AND JOINTS</b> e.g. arthritis			
<b>SKIN</b> e.g. eczema, psoriasis			
<b>INFECTIOUS DISEASES</b> e.g. hepatitis, HIV, TB, CID			
<b>SUBSTANCE MISUSE</b> e.g. history of alcohol misuse, recreational drug use			
<b>DYSPHAGIA</b> (if yes, please write IDDSI levels for fluids and food)			
<b>PLANNED INTERVENTION</b> e.g. cranioplasty bisphosphonates, cardiac surgery, transplant			
<b>ALLERGIES</b> e.g. latex, penicillin, medications			
<b>MEDICATIONS (Please list)</b>			

Referral completed by:  
 Name (print) \_\_\_\_\_ Role \_\_\_\_\_ Date \_\_\_\_\_

Please forward completed referral to: OSCAR Dental, University Hospital Llandough via internal post or email  
[OscarDental.CMHT.Whitchurch@wales.nhs.uk](mailto:OscarDental.CMHT.Whitchurch@wales.nhs.uk)

For URGENT queries telephone 02921825165 (Ex 25165)

<b>FOR OFFICE USE BY DENTAL TEAM</b>		Received date: _____	
Urgent <input type="checkbox"/>	Routine <input type="checkbox"/>	Suitable for: DCT <input type="checkbox"/>	STR <input type="checkbox"/>
Comments:		Speciality Doctor <input type="checkbox"/>	Consultant <input type="checkbox"/>
Vetted by: _____		Date: _____	

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## Appendix 7

### SHO's Bleep numbers for Hafan y Coed during weekdays 9am- 5pm

Dial: **181**

*(wait until it asks "please enter user number")*

Enter: 4218 for Oak Ward

Enter: 4206 for Beech Ward

Enter: 4216 for Willow Ward

Enter: 4215 for Cedar Ward

*(then wait until it asks for a "message")*

Enter five-digit phone extension you are calling from, followed by the # key

*(It will then say "Your paging request has been accepted")*

If it is not answered within 5-10 minutes, please try again and take care not to make any typos.

If after another 5-10 minutes there is no response, please contact the Inreach SHO via switchboard/shift coordinator if urgent, or try again later if not urgent

Please note there will be NO RESPONSE to this bleep if before 9am or after 5pm weekdays, or if it is a weekend.

On Friday mornings there is teaching so please contact the Inreach SHO via switchboard/shift coordinator if urgent.

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## Appendix 8 GP Referral Form & SOP

<p><b>Mental Health Clinical Board GP Referral Form</b>  <b>Form for Urgent &amp; Routine Referrals Only</b>  Please e-mail form to: <a href="mailto:CAV_Mental.GpClinic@wales.nhs.uk">CAV_Mental.GpClinic@wales.nhs.uk</a>  Any queries please ring Victoria Hartley-Smith x25777/Alison Norris x25776  For urgent problems out of hours (18.30-08.00 Mon-Fri, all weekends and bank holidays) tel OOH GP on 01446 704666</p> <p style="color: red; text-align: center;"><b>Please note that only fully completed forms will be accepted.</b></p>					
Patient Surname:		Consultant:			
Patient First Name:		Ward:			
Gender:		Referring Doctor Name:			
PARIS ID:		Referring Doctors Email:			
DOB:		Contact Telephone No.:			
Psychiatric Diagnosis:					
Reason for Referral (please complete details and don't use 'Refer to PARIS'):					
Request : URGENT 48h <input type="checkbox"/> ROUTINE <input type="checkbox"/>					
-If this is more urgent than 48 hours please telephone _____					
What is required? (Please note that ward visits are only for patients physically unable to leave the ward)					
Clinic <input type="checkbox"/>		Ward Visit <input type="checkbox"/>		Phone Call <input type="checkbox"/>	
Routine Observations:					
BP	Pulse	Resp Rate	Temp	Sats	NEWS score
Relevant Previous Medical History					
GP's can be contacted for advice by phone or email: Phone: x25758 or x25759 Email: <a href="mailto:Caroline.Lai@wales.nhs.uk">Caroline.Lai@wales.nhs.uk</a> <a href="mailto:Claire.Benson@wales.nhs.uk">Claire.Benson@wales.nhs.uk</a> <a href="mailto:Sarah.Jones3625ab@wales.nhs.uk">Sarah.Jones3625ab@wales.nhs.uk</a>					
<p><b>*All patients coming to clinic must be accompanied by a nurse with their drug chart and physical observation (TPR) chart *</b></p>					

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SHOs should be required to cover the following medical tasks first line:

1. Treating simple UTIs/ review of MSU results
2. Constipation reviews and laxative prescribing
3. Falls
4. Management of simple skin conditions e.g. dry skin/fungal infections
5. Conjunctivitis
6. Requests for analgesia/simple pain medication reviews
7. Wound swab result reviews
8. Death certification
9. NEWS Parameters 3 and 4

The team (not GPs) are also responsible for DNACPR decisions

If SHO's feel unable to manage, they could then ask us for advice by speaking to us directly/referring to us via the existing GP referral pathway

If SHOs not contactable - should escalate up to registrar then consultant not to us

SHOs must have access to e-referral systems/radiology requesting - we cannot refer on their behalf

Later referrals (i.e. after 2pm) may not be actioned same day- they should come in earlier unless acute for same day completion or contact SHO

Referrals must have a good amount of detail on them and NEWS and PMH/current drugs present on the form

Do not phone routine referrals on the GP line – this is for emergency referrals only – otherwise send referral form. If the form is unable to be completed for any reason the ward must email over details to the secretary who can then add onto our list

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## Mental Health Clinical Board

### Inpatient GP Service: Standard Operating Practice

#### 1. Referrals

Please email GP referral forms to [CAVmental.GPclinic@wales.nhs.uk](mailto:CAVmental.GPclinic@wales.nhs.uk). These will be picked up by the MHSOP Admin team.

Forms must be completed in full. Please do not add 'refer to PARIS' for any answer, and please give as much detail as possible. Incomplete forms can cause delay and risk, and should be returned with a request for more detail.

For Adult MH wards, referrals are to be made by SHO/Senior Doctor.

For Phoenix and Park Road rehab units, referrals need to be from ward Doctor or Nurse in Charge.

Please do not use the form for emergency requests. All emergency requests for GP Support should be via telephone on 02921 825777 or 02921 825776 (internal ext 25777 or 25776).

Routine clinic requests will be booked into the next available clinic slots by the MHSOP Admin Team.

For 48-hour referrals: If there is no clinic during this time, these referrals will be handed to the working GP to assess (either for next available clinic appointment, review on ward or for a discussion with the referring SHO's).

GP clinics will run on Monday's to Friday mornings when there are 2 GP's present. When only 1 GP is present there will be no routine booked clinic.

SHO's and Consultants referring are to notify the ward of reason for referral before the appointment takes place (e.g. send a copy of the referral form to the ward).

#### 2. During and after Clinics

All patients coming to clinic must be accompanied by a nurse, with their drug chart and physical observation (TPR) chart. The nurse must be informed prior to the clinic of the reason for the appointment.

After the patient has been seen in clinic, the GP will record on PARIS and a summary/copy of notes emailed to the SHO/Consultant.

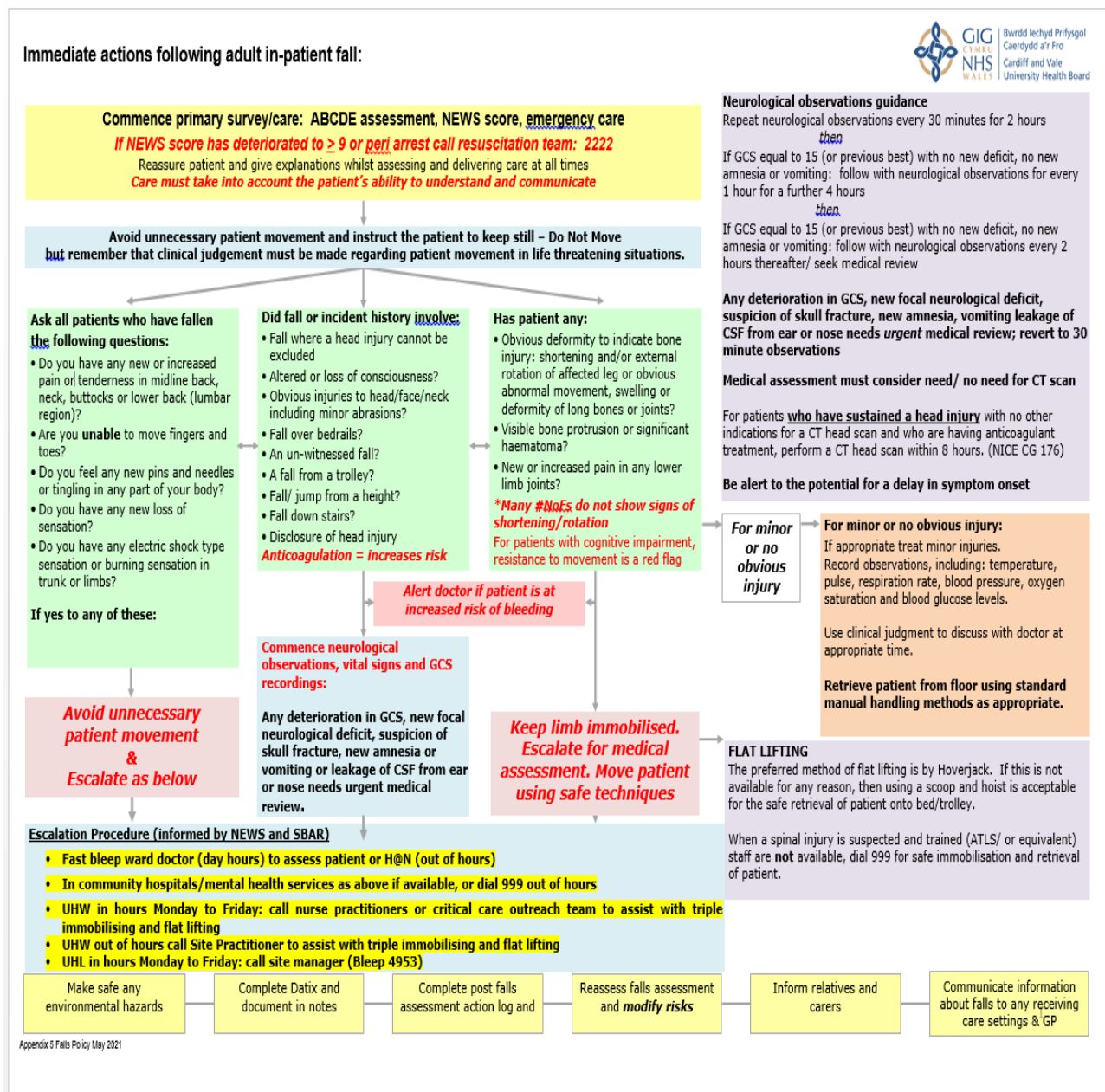
Initial investigations will be arranged by the GP and they will be responsible for checking the results.

Follow on care/investigations may then be handed over to the SHO Psych team.

If follow up with the GP is required in the next week or 2 this appointment can be booked by the GP but anything >2 weeks in advance will need to be arranged by the Psychiatric team, or added to the discharge letter if the patient is discharged.

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## Appendix 9 Management of Falls



## Appendix 10

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# OOH Physical Health Cover – HYC, Llanfair & MHSOP Inpatients



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## Medical Cover

Monday – Friday MH HYC inpatient wards	09.00 – 17.00	Ward Based Psychiatric SHO	Bleep via Ward
Monday – Friday MHSOP Inpatient wards	09.00 – 17.00	Salaried GP	East 18 Corridor office Ext 25758/25759 or email referral cav_mental.gpclinic@wales.nhs.uk
24/7	24/7	Medical Registrar on Call	Bleep 4803 or ext 26651 for triage nurse in MEAU
Out of Hours Evening Weekends and Bank Holidays	Out of Hours Evening Weekends and Bank Holidays	Psychiatric <u>On</u> Call SHO Psychiatric Registrar and Consultant Psychiatrist via switch To be contacted if SHO does not answer within 30 mins and you have tried to re bleep them	Via switch board or bleep 2122 (SHO) Registrar and Consultant via switch board.
Out of Hours GP	Psychiatric Team may advise you to call the GP Out of Hours		0300 102047 (PLEASE DO NOT CALL 111).

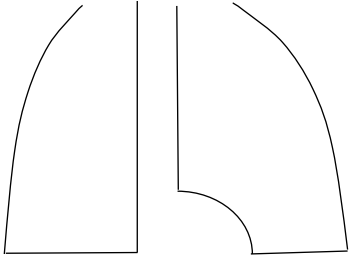
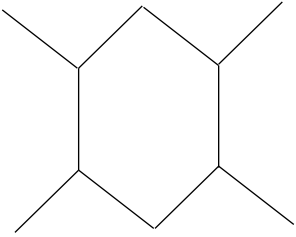
## Nursing Cover

Monday – Sunday	24/7	<b>PART Team Patient at Risk Team UHL</b> Bleep 4892. The PART Team work 24 hours a day, they are additional support for our wards and teams. The PART team will see all patients that are scoring a NEWS score of 3 or above or <u>patients you have concerns about</u> . PART can only review patients who have an overseeing Doctor to discuss the patient's treatment and escalation plan with. Monday – Friday 9 – 5 In Adult Mental Health Acute (Hafan Y Coed wards) this will be the Psychiatric SHO for the ward and <u>In</u> MHSOP, the GP. Out of hours this will always be the Psychiatric On-Call SHO. Please note The PART team cover the whole site and may not be able to attend.	
Monday - Sunday	19.00 – 07.00	<b>Site Practitioner Bleep 4980</b> For Advice in a Serious Incident. The Hospital Site Practitioner is not the MH Shift coordinator, they are a nurse that covers the whole of Llandough site and can advise in serious incidents. They will not usually be required to see sick patients as these will be seen by P@RT and the SHO on call. <u>However</u> they may be required to assist in falls management if the SHO is not available, or other unforeseeable serious events.	
Monday - Sunday	24/7 for MH HYC, Covers MHSOP 19.00 – 07.30	<b>AMH Shift Coordinator "Shifty"</b> via X 24691, Switch Board or <u>vocera</u> 5555	
Monday - Sunday	07.00 – 19.30	<b>MHSOP Shift Coordinator</b> via switch or <u>vocera</u>	
Monday - Friday	Various Hours	<b>Physical Health Nurse MHSOP</b> 25752 or <u>vocera</u>	
Monday - Friday	Various Hours	<b>Physical Health Nurse AMH</b> 24985 or <u>vocera</u>	

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**Appendix 11**

**PHYSICAL HEALTH ASSESSMENT**

<b>Medical Assessment</b> General appearance:	<b>Observations</b>				
	BP	HR			
	RR	Sats			
	Temp	BM			
	Weight	NEWS			
<b>Respiratory</b> 	<b>Cardiovascular</b>				
	BP	HS			
	CRT	Oedema			
<b>Abdomen</b> 	<b>CNS</b>				
	<ul style="list-style-type: none"> <li>GCS: E /4 V /5 M /6 = /15</li> <li>Pupils:</li> <li>Cranial nerves:</li> </ul>				
<b>General examination</b> (Skin/Endocrine/MSK):		RUL	LUL	RLL	LLL
	Tone				
	Power				
	Reflexes				
<b>Physical Health Condition(s):</b>	Sensation				

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	Co-ordination				
	Gait:				
<b>Physical health plan:</b>	<b>Urine dipstick:</b>				
	<b>ECG:</b>				

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