Leicestershire Partnership NHS Trust

Physical assessment and examination of service users admitted to Mental Health Unit Policy

Clinical Policy

Policy Reference Number: P085

Version Number: 4

Date Approved: 11/03/2026

Approving Group: CEG

Review Date: 1 September 2028

Expiry Date: 31 March 2029

Type of Policy Clinical

Keywords: Physical assessment, physical examination, admission

Contents

Policy On A Page

SUMMARY & AIM

Leicestershire Partnership Trust is dedicated to addressing the physical healthcare needs of all service users, regardless of their care setting or pathway. This policy establishes the minimum standards for physical assessment and examination for individuals accessing mental health and learning disability services. Clinicians are encouraged to conduct more detailed assessments as necessary, tailored to the specific needs of each service user. While the differing specialities which work within the in-patient setting and may require more comprehensive evaluations using their own examination formats, these must, at a minimum, adhere to the standards outlined in this policy.

KEY REQUIREMENTS

- To enhance the overall health and quality of life for service users with mental health conditions and learning disabilities.
- To empower service users by providing clear, accessible information, enabling them to make informed decisions about their physical health.
- To promote parity of esteem by giving equal importance to physical health alongside mental health, supporting a truly holistic approach to patient care.
- To offer clear direction and guidance for the planning and delivery of high-quality, comprehensive care within the Trust.
- To proactively identify physical health issues early, ensuring timely intervention and effective management.
- To reduce health inequalities by implementing a consistent and equitable approach to physical assessment and examination.

TARGET AUDIENCE:

All medical and nursing staff.

1. Introduction and Purpose

People with severe mental illness (SMI) experience significantly poorer physical health outcomes and face a reduced life expectancy of 15–20 years compared to the general population. This disparity is largely driven by preventable conditions such as cardiovascular disease, type 2 diabetes, respiratory illnesses, and obesity. An article published by the Royal College of Psychiatrists in October 2024 revealed that between 2020 and 2022, approximately 87,000 premature deaths in England among people with SMI were linked to such physical health conditions, equating to an average of 120 deaths every day.

Contributing factors include lifestyle risks such as smoking, twice as prevalent among individuals with SMI, along with poor diet, low levels of physical activity, and side effects from psychiatric medications. These risks highlight the urgent need for proactive, integrated physical healthcare amongst this population.

To address this, the NHS Long Term Plan set an ambitious target of delivering 390,000 annual physical health checks, referred to as the "Core 6", by March 2024. These checks include assessment of alcohol use, smoking status, HbA1c, blood pressure, BMI, and lipid profiles. By the end of March 2024, 66.5% of eligible individuals on the SMI register had received a full physical health check. While this represents meaningful progress, it also underscores the need for continued efforts to reach the remaining third of the population.

Updated NHS England guidance (January 2024, revised May 2025) outlines strategies to improve uptake of these checks, including trauma-informed and multidisciplinary approaches, targeted outreach, digital tracking tools, and structured follow-up care to support sustained engagement and long-term health improvements.

Leicestershire Partnership NHS Trust remains committed to delivering comprehensive physical health checks for people with SMI. This work is critical in helping to reduce the stark and preventable mortality gap faced by this high-risk group and aligns closely with national priorities to improve parity between physical and mental healthcare.

2. Policy Requirements and Objectives

All service users admitted to inpatient care must receive a **comprehensive physical health assessment and examination** within **24 hours** of admission.

3. Process

3.1 Pre-Examination Preparation

- Clinicians should, wherever possible, **review referral documentation and prior medical notes** before assessing the service user. Helpful information can often be found in the GP section of SystmOne.
- Helpful information may also be found in previous core assessments, where relevant

3.2 Consent

Consent should always be obtained for a physical examination. It is important that patients have a clear understanding of the importance and purpose of the physical assessment and examination and are kept informed of the outcomes.

If the patient does not give consent the clinician needs to revisit explaining to the patient the importance and purpose of the intended examination. The clinician needs to make reasonable attempt to support the patient in their decision making with regards to examination and discuss again at a later date.

This and every subsequent attempt should be clearly documented in the medical records along with any information relevant to the service user's capacity to make that decision.

Where service users are unable to provide consent the clinician should examine the patient where it is deemed to be in their best interest. This examination should be attempted with the help of nursing staff and should be clearly recorded. For further details related to consent please refer to Trust policy on Consent to Examination and Treatment.

3.3 Initial Physical Health Examination

- A full physical assessment must be completed and documented using the **Physical Health Assessment template on SystmOne** (*Appendix 2*).
- **Medical equipment** required is listed in *Appendix 3*.
- Document all vital signs using Trust observation charts and record a **baseline National Early Warning Score (NEWS2).**
- Action the NEWS2 score in line with the LPT Deteriorating Patient Policy

3.4 Adaptations for Individual Needs

- The examination should be conducted in a manner that respects the **dignity, safety, and preferences** of the service user.
- If the service user does not consent, lacks capacity, or is assessed to be **too high risk** (e.g., due to violence or severe distress), this must be:
    - Clearly documented in clinical records
    - Discussed with the **responsible consultant** at the earliest opportunity.
    - Accompanied by a risk assessment with respect to not performing the examination
- **Reasons for declining examination** (e.g., aggression, severe distress, refusal due to cultural or religious reasons) must be documented, and the **multidisciplinary team** should continue reviewing the need for assessment.
- The physical exam should be **offered again at the earliest safe opportunity.**

3.5 Cultural Competency and Communication

- Consider **protected characteristics** (Equality Act 2010), including:

  - Religious beliefs
  - Gender identity
  - Cultural preferences
  - Language needs
- Use Interpretation and Translation Services where appropriate.
- Involve adult carers with the service user's consent, where this supports communication and safety.

3.6 Non-Contact Observations

- If a full examination is not possible, complete non-contact physical observations (Appendix 4), and continue efforts to complete the full assessment when feasible.

3.7 Further Investigations

- The examining clinician must assess whether additional investigations (e.g., ECG, blood tests, urine tests) are required, based on the service user's clinical presentation and recommended monitoring standards for new admissions
- Duplication of investigations should be avoided. A patient transferred from ED may have already had appropriate bloods, for example. If this is the case they should be documented in the SystmOne notes.
- Any investigation which is deemed necessary should be discussed and documented with the responsible clinician. This should include an assessment as to whether the investigation itself and the outcome of that investigation is needed prior to the patient being discharged.
- Where this is not deemed necessary this should be clearly documented and communicated to the next responsible clinician or GP who takes over the service users care.
- The list of investigations that could be considered are listed in Appendix 5. This list is not comprehensive and other investigations can be considered for service users based on their individual needs.
- When an investigation is considered the service user should be fully informed and given information in an accessible format to help support them during that investigation.

3.8 Ward Rounds

- At each ward round, review and document:
  - Latest physical observations from the BRIGID records, fluid and hydration charts, weights and any diabetic monitoring
  - Any outstanding or ongoing physical health concerns
  - Any medication reviews.
  - Any changes in the patient's condition which require a discussion of the VTE risks
  - Pending or incomplete investigations
  - Planned next steps for physical health care
  - Consideration of the need for a ReSPECT form

- Ensure findings are documented under a **"Physical Health"** heading in clinical notes for clarity.

3.9 Chaperones

Anything more than an examination of appearance, pulse or blood pressure should be conducted with a chaperone subject to the service user's consent. The service user should be given the opportunity to state their preferences in relation to the sex of the chaperone.

This must be documented in their health records in accordance with the Chaperone policy. If either the staff member or the service user does not wish the examination to proceed without the presence of a chaperone it can be delayed to a later date when one (or an alternative chaperone) will be available.

Any discussions about chaperones (including if one is present) should be documented, including the identity of who is present. If the service user declines the offer of a chaperone this should be documented.

3.10 Communication of Results and Follow Up

It is the duty of the responsible clinician to ensure that any identified physical health problems are appropriately addressed and that treatment plans are implemented and followed through in a timely and effective manner.

In line with best practice and national guidance, this includes assessing whether:

- The physical health issue and its investigation outcomes need to be resolved prior to discharge.
- Ongoing care can be safely transferred to the GP or next responsible clinician.

Where it is determined that further investigations or treatment are not required prior to discharge, this must be:

- Clearly documented in the clinical record
- Communicated explicitly to the GP or receiving clinician.

The responsible clinician is accountable for ensuring that any management plans arising from ward rounds or specialist input are acted upon. This may include, but is not limited to:

- Initiating or amending medication
- Referring to services such as physiotherapy, dietetics, or smoking cessation
- Requesting additional investigations
- Making referrals to relevant medical or surgical specialties

In most cases it is appropriate for the ordering clinician to review investigation results and discuss the results with advice and comments with the responsible clinician. It is important for ward teams to have a clear understanding relating to the review of results

and any subsequent actions. Accountability will ultimately lie with the responsible clinician for the patients' care.

A clear documentation trail should be available within the electronic patient record (EPR) on SystmOne in order to ensure this information is not lost should the ordering clinician be unavailable for any reason.

Ward teams should check results of any pending investigations every day and take necessary action at the earliest opportunity. If a result is still pending at the end of the normal working day this should be clearly handed over to the duty clinician covering out of hours.

Nursing staff are responsible for informing the ward doctors or duty doctor about any abnormal investigation reports that they receive which are phoned through to the wards.

If a service user stays in the hospital for longer than a year the physical examination and assessment should be repeated at least annually, however, service users should be examined physically whenever clinically indicated.

A physical examination should be considered after a period of leave or if the patient has been admitted to another setting, such as an acute hospital, within 24 hours of their return to the in-patient setting.

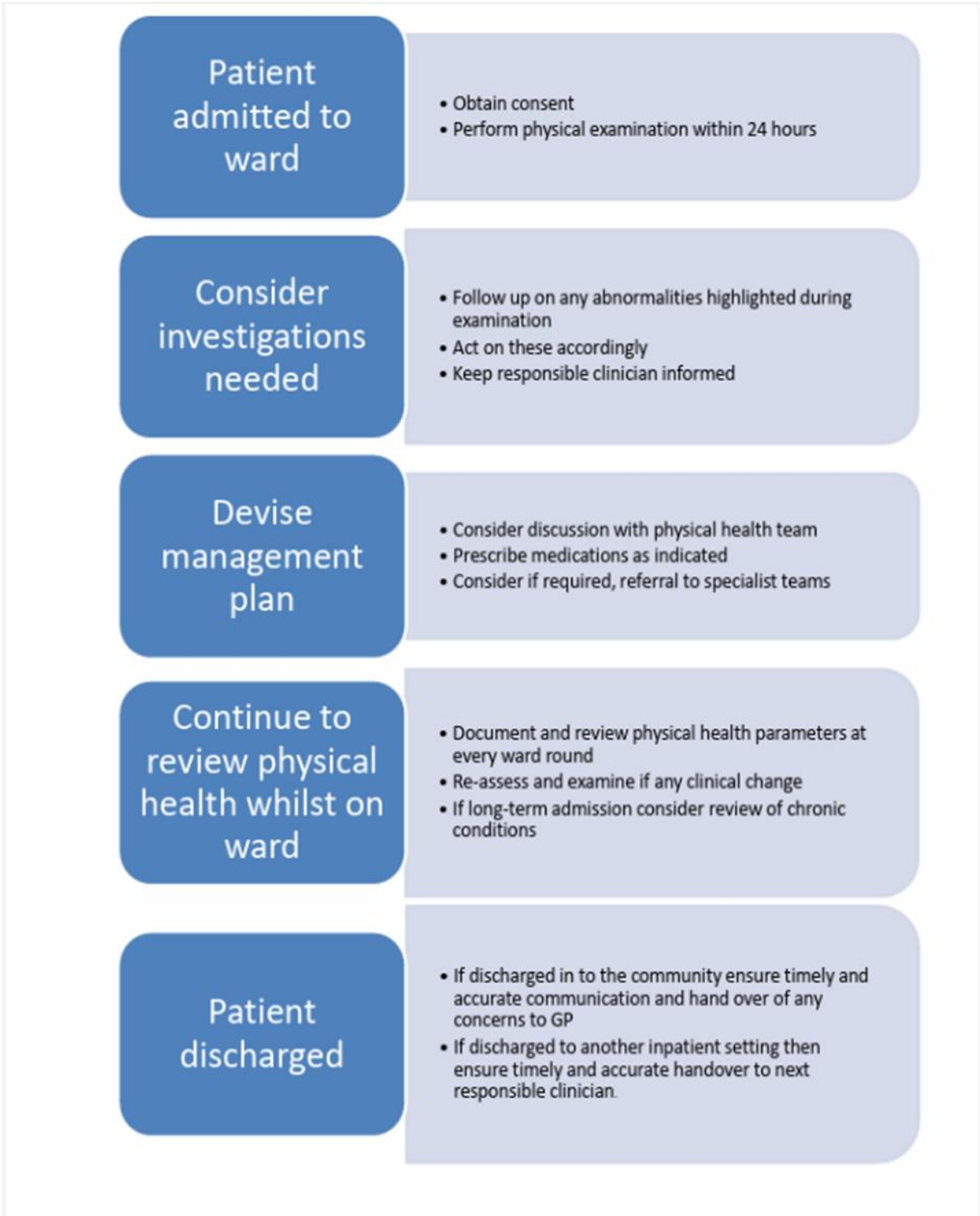
Some patients with long terms physical health conditions such as diabetes, COPD, etc may need more regular monitoring and intervention. Advice and support from the physical health team or specialist opinion should be sought if needed.

Upon discharge to the community, a comprehensive and timely discharge summary must be sent to the GP. This should include:

- A clear summary of all physical health concerns identified during admission.
- Investigations completed or outstanding.
- Any actions required by primary care.
- Planned follow-up arrangements.

Similarly, if the service user is transferred to another inpatient facility, a formal handover of physical health status and management plans must be provided to ensure continuity of care.

3.11 Summary Flow Chart



4. Roles and Responsibilities

Roles and responsibilities including duties of relevant individuals and groups.

Lead Executive Director

The Medical Director has overall responsibility for ensuring that:

- Staff are aware of this policy and adhere to its requirements.
- Appropriate resources exist to meet the requirements of the policy.

Executive Management Board

The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

Governance Group level 1 and 2

Level 1 Quality and Safety Committee
Level 2 Quality Forum
Level 3 CEG

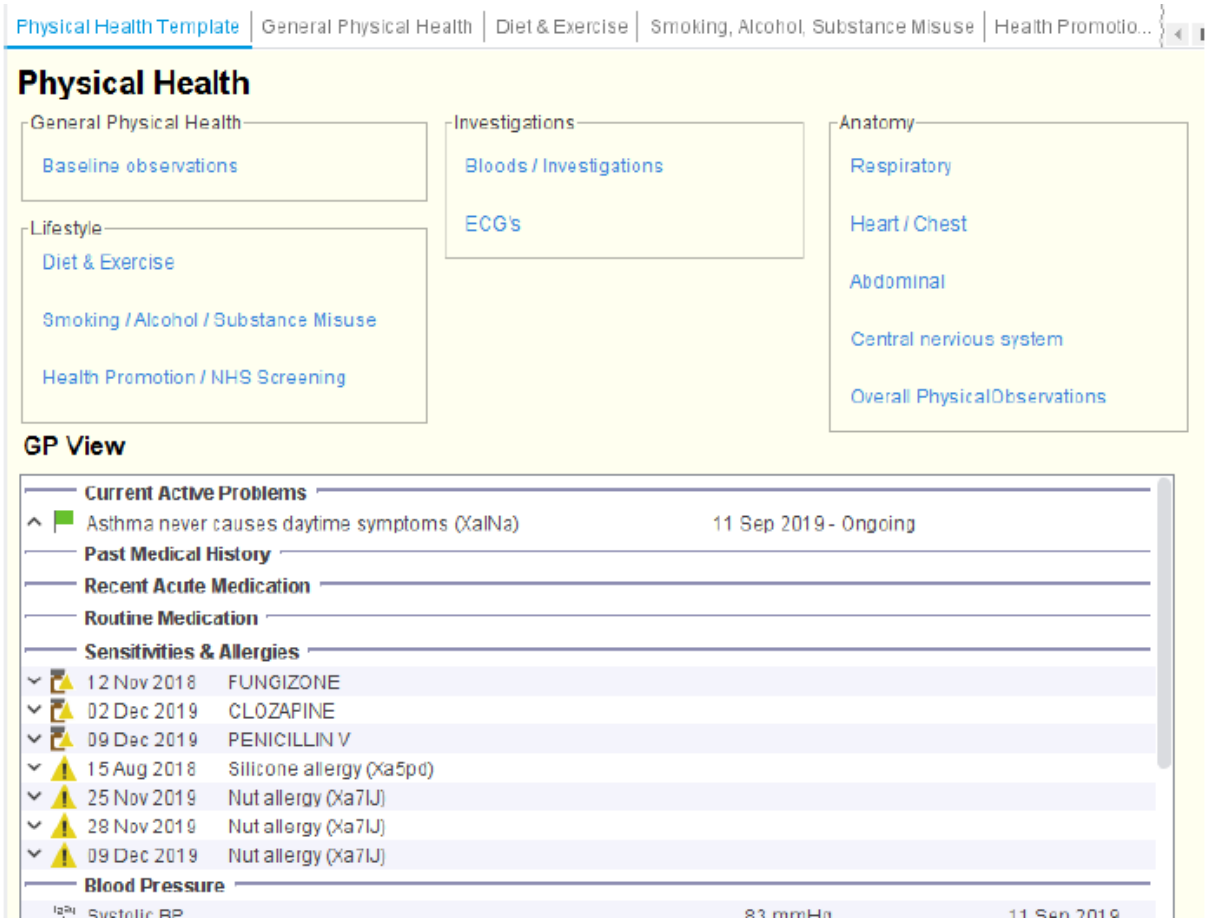
Staff

Consultants are responsible for ensuring all medical staff under their supervision carry out the physical examination of their patients in accordance with this policy.

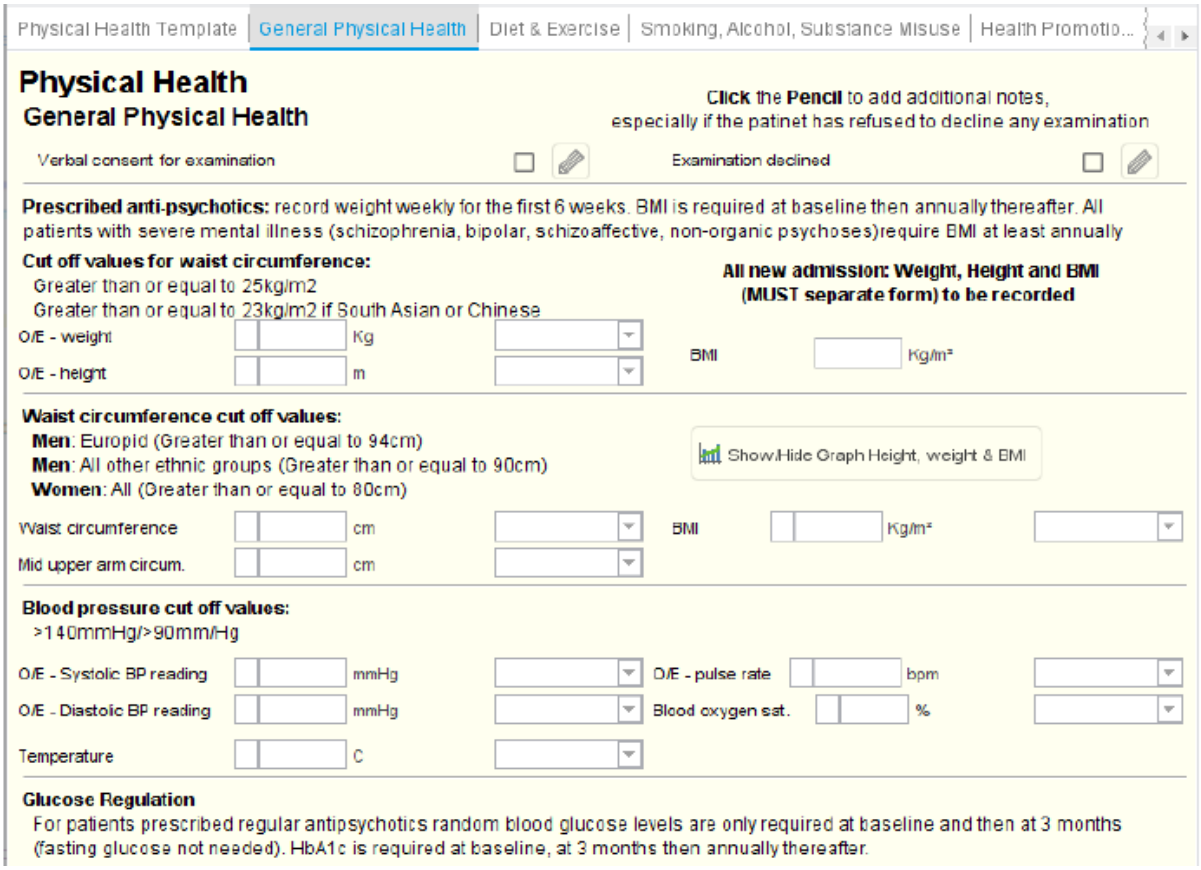
5. Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered.

Appendix One: Physical Examination Template

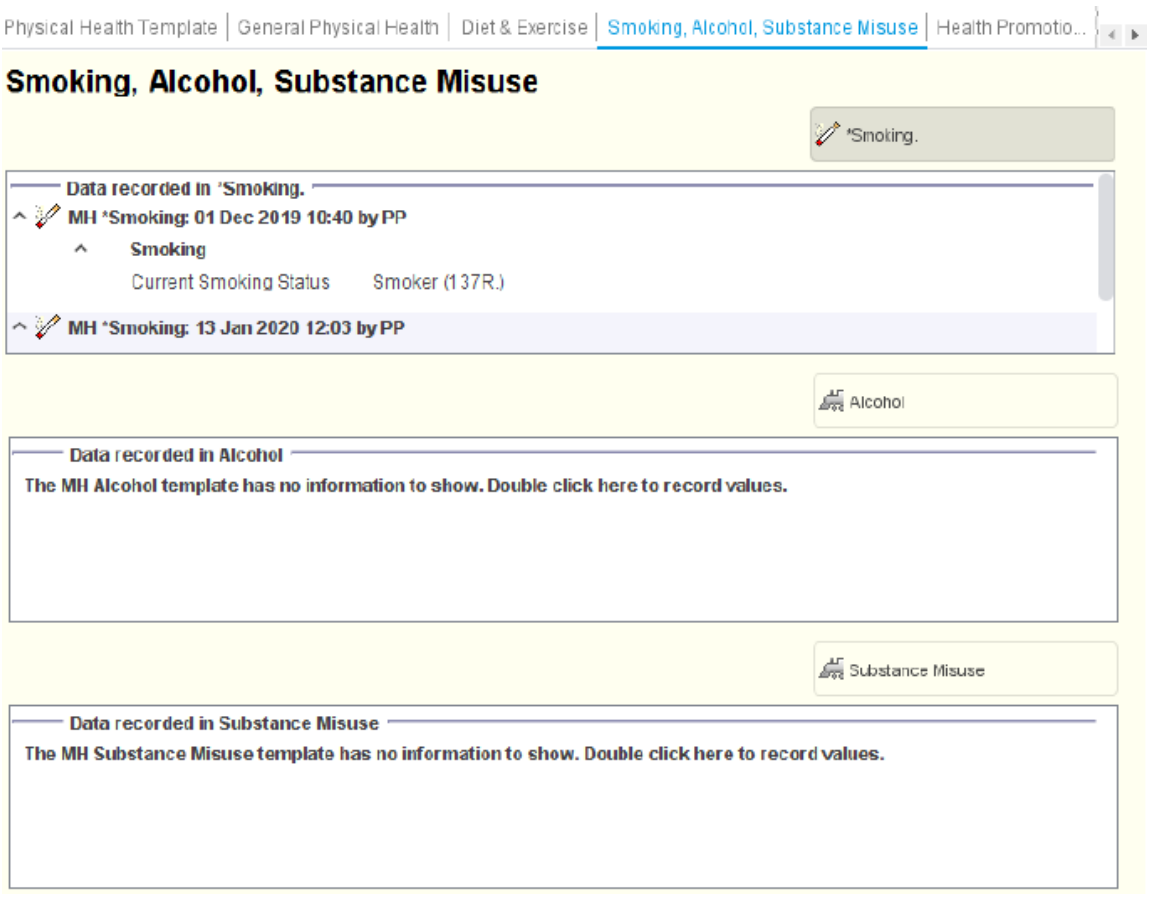


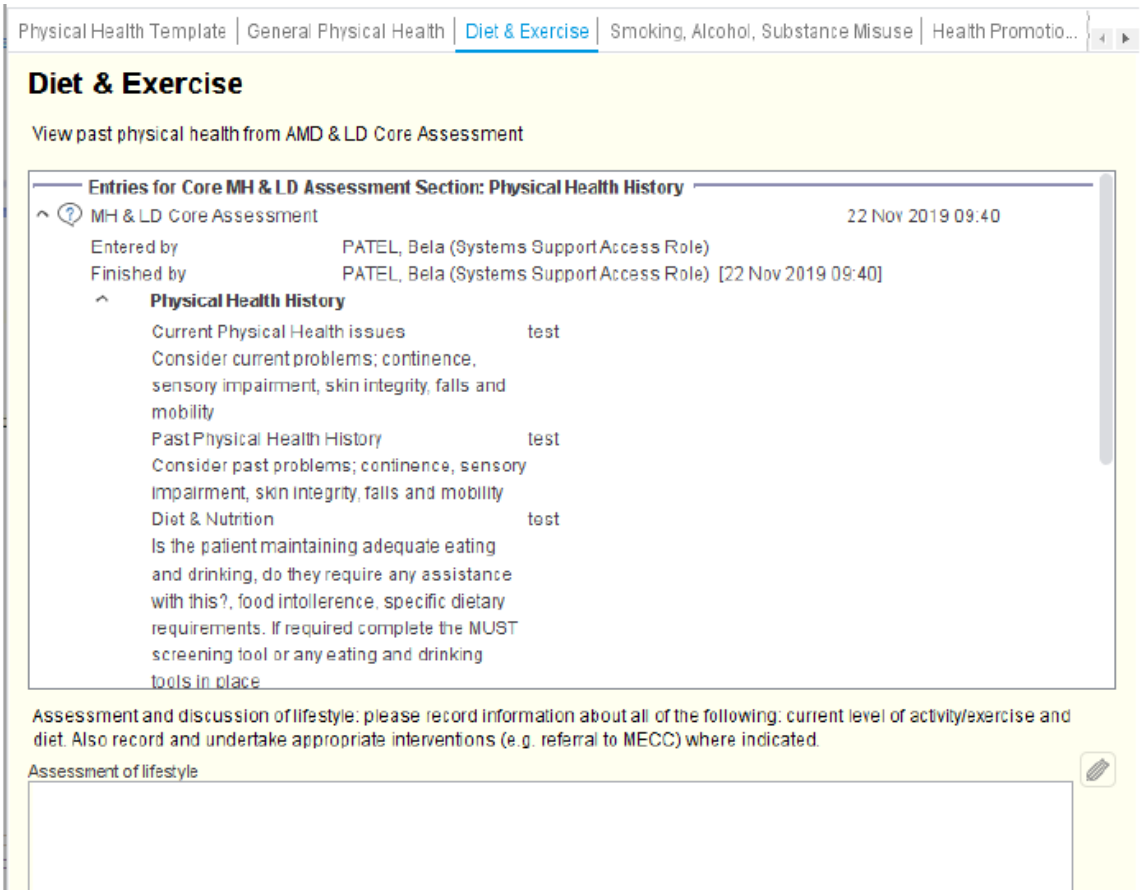
This front page of the template will give you the GP summary of the records if the patient has a GP on SystmOne. It will provide you with a brief view of any of any conditions the patient has that have been coded by the practice as well as current medications. Please be aware this will not necessarily reflect if there have been any recent admissions or changes so always double check.



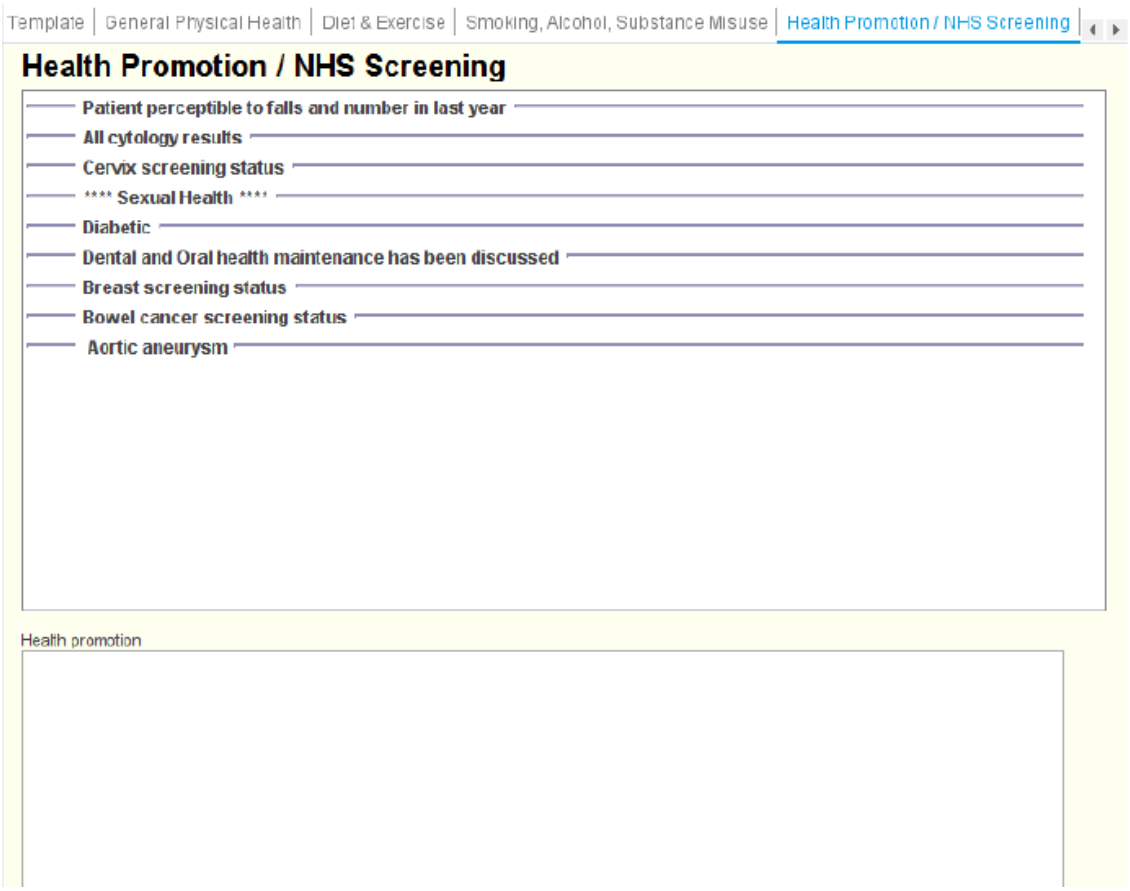
You can record any values which are obtained in to this template, this then allows them to be coded and seen across the EPR in order to monitor for any trends or patterns.

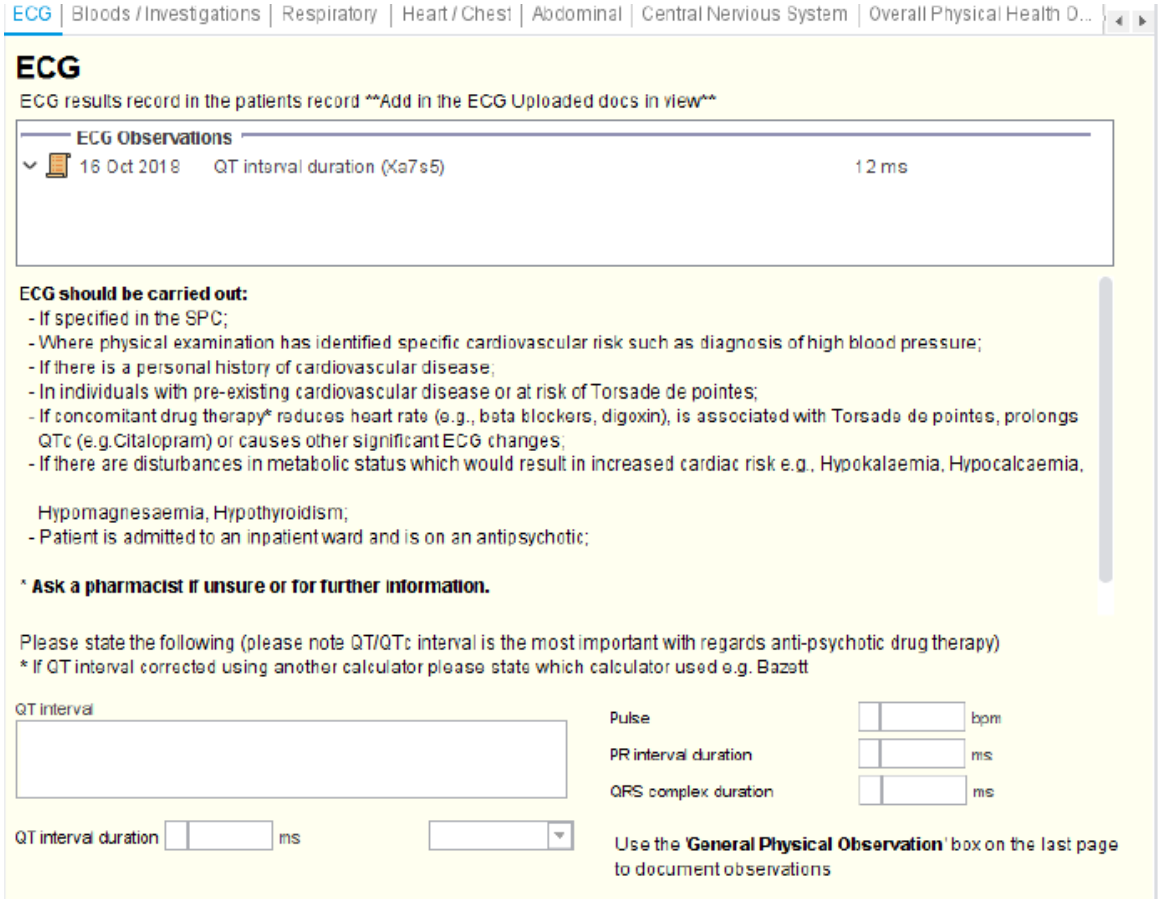
Please note the small boxes at the top for if the patient declines examination. If a patient does decline examination click the box with the pencil on the side to document who you have handed over to that this is a task which remains outstanding.

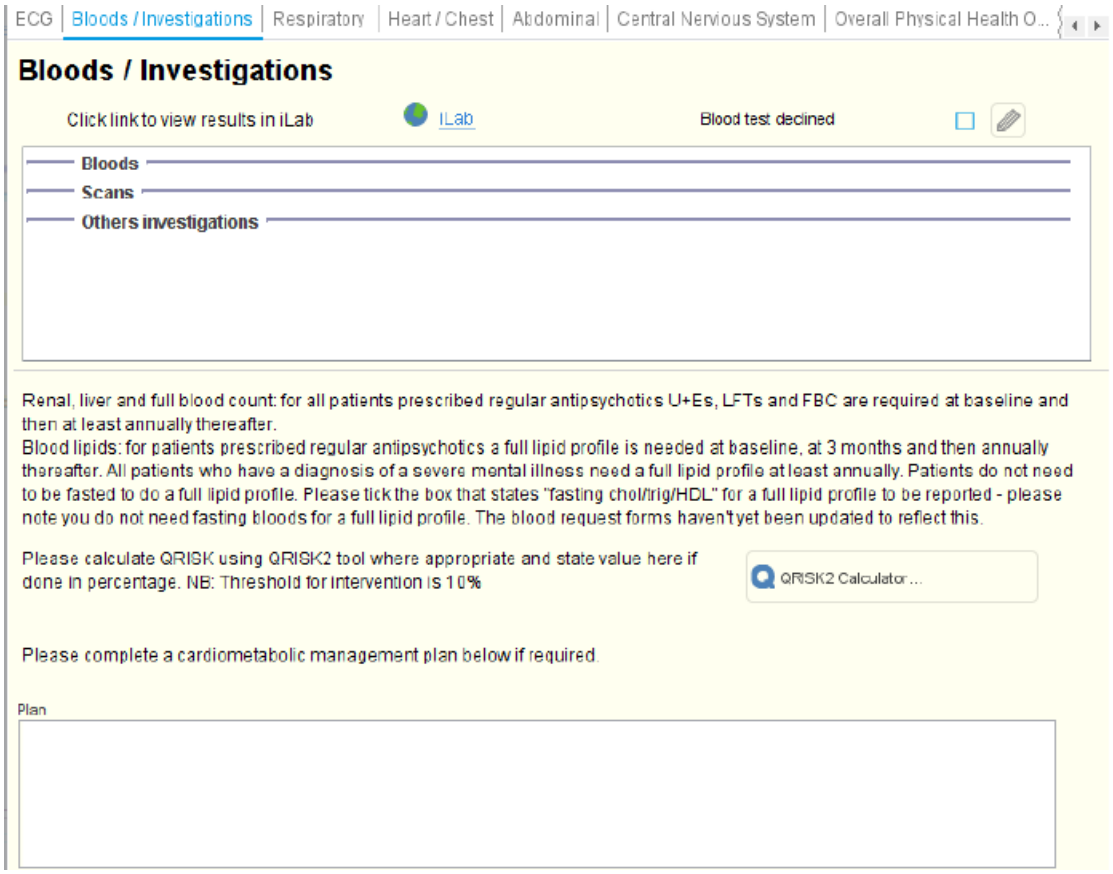

Physical Health Template | General Physical Health | Diet & Exercise | Smoking, Alcohol, Substance Misuse | Health Promotio...
Smoking, Alcohol, Substance Misuse
*Smoking.
Data recorded in *Smoking.
MH *Smoking: 01 Dec 2019 10:40 by PP
Smoking
Current Smoking Status Smoker (137R.)
MH *Smoking: 13 Jan 2020 12:03 by PP
Alcohol
Data recorded in Alcohol
The MH Alcohol template has no information to show. Double click here to record values.
Substance Misuse
Data recorded in Substance Misuse
The MH Substance Misuse template has no information to show. Double click here to record values.

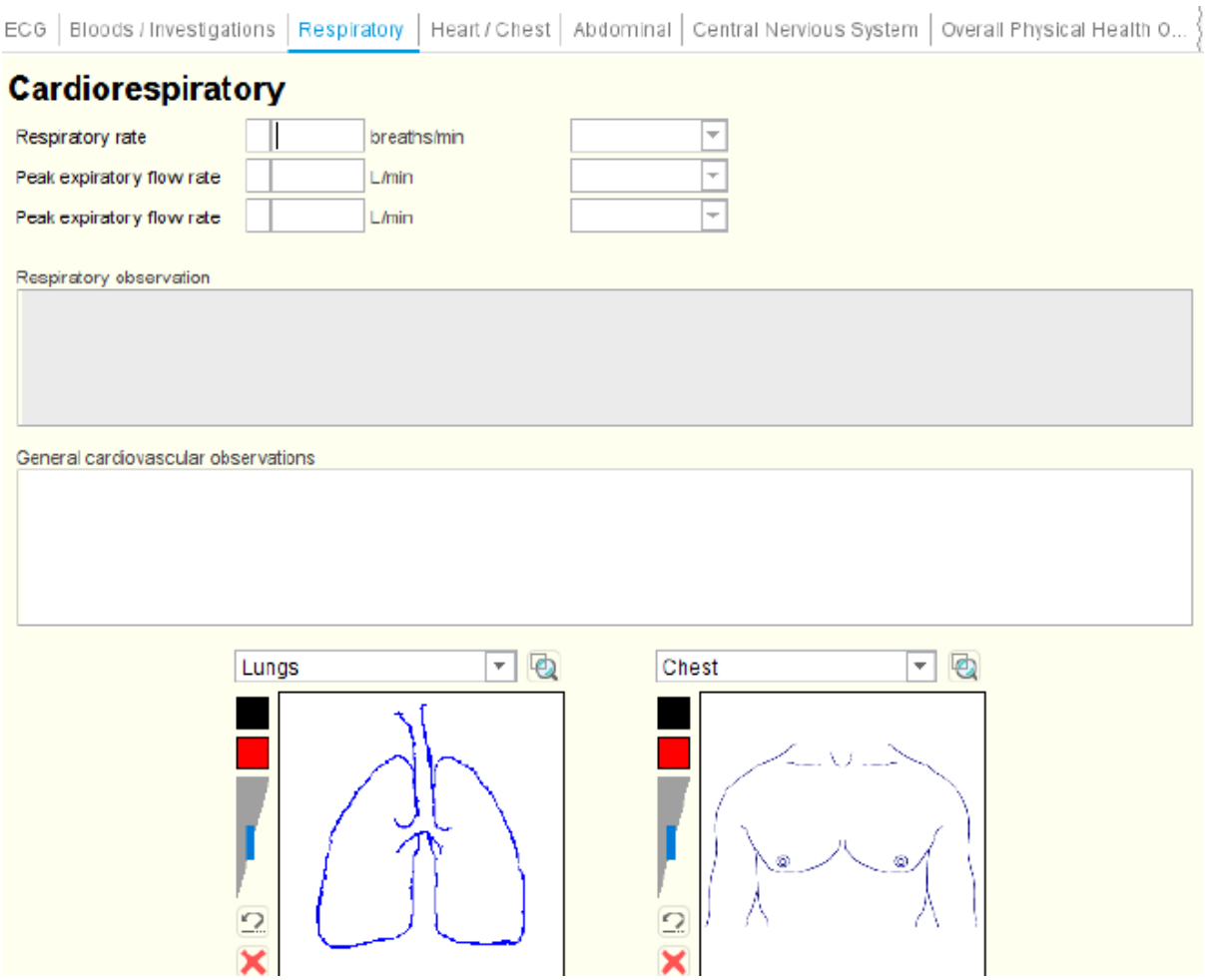

Physical Health Template | General Physical Health | Diet & Exercise | Smoking, Alcohol, Substance Misuse | Health Promotio...
Diet & Exercise
View past physical health from AMD & LD Core Assessment
Entries for Core MH & LD Assessment Section: Physical Health History
MH & LD Core Assessment 22 Nov 2019 09:40
Entered by PATEL, Bela (Systems Support Access Role)
Finished by PATEL, Bela (Systems Support Access Role) [22 Nov 2019 09:40]
Physical Health History
Current Physical Health issues test
Consider current problems; continence, sensory impairment, skin integrity, falls and mobility
Past Physical Health History test
Consider past problems; continence, sensory impairment, skin integrity, falls and mobility
Diet & Nutrition test
Is the patient maintaining adequate eating and drinking, do they require any assistance with this?, food intollerence, specific dietary requirements. If required complete the MUST screening tool or any eating and drinking tools in place
Assessment and discussion of lifestyle: please record information about all of the following: current level of activity/exercise and diet. Also record and undertake appropriate interventions (e.g. referral to MECC) where indicated.
Assessment of lifestyle

The following templates allow you to see any other part of the assessment which has been taken from elsewhere in the EPR.




ECG | Bloods / Investigations | Respiratory | Heart / Chest | Abdominal | Central Nervous System | Overall Physical Health O...
ECG
ECG results record in the patients record **Add in the ECG Uploaded docs in view**
ECG Observations
16 Oct 2018 QT interval duration (Xa7s5) 12 ms
ECG should be carried out:
- If specified in the SPC;
- Where physical examination has identified specific cardiovascular risk such as diagnosis of high blood pressure;
- If there is a personal history of cardiovascular disease;
- In individuals with pre-existing cardiovascular disease or at risk of Torsade de pointes;
- If concomitant drug therapy* reduces heart rate (e.g., beta blockers, digoxin), is associated with Torsade de pointes, prolongs QTc (e.g.Citalopram) or causes other significant ECG changes;
- If there are disturbances in metabolic status which would result in increased cardiac risk e.g., Hypokalaemia, Hypocalcaemia, Hypomagnesaemia, Hypothyroidism;
- Patient is admitted to an inpatient ward and is on an antipsychotic;
* Ask a pharmacist if unsure or for further information.
Please state the following (please note QT/QTc interval is the most important with regards anti-psychotic drug therapy)
* If QT interval corrected using another calculator please state which calculator used e.g. Bazett
QT interval
Pulse bpm
PR interval duration ms
QRS complex duration ms
QT interval duration ms
Use the 'General Physical Observation' box on the last page to document observations


ECG | Bloods / Investigations | Respiratory | Heart / Chest | Abdominal | Central Nervous System | Overall Physical Health O...
Bloods / Investigations
Click link to view results in iLab
iLab
Blood test declined
Bloods
Scans
Others investigations
Renal, liver and full blood count: for all patients prescribed regular antipsychotics U+Es, LFTs and FBC are required at baseline and then at least annually thereafter.
Blood lipids: for patients prescribed regular antipsychotics a full lipid profile is needed at baseline, at 3 months and then annually thereafter. All patients who have a diagnosis of a severe mental illness need a full lipid profile at least annually. Patients do not need to be fasted to do a full lipid profile. Please tick the box that states "fasting chol/trig/HDL" for a full lipid profile to be reported - please note you do not need fasting bloods for a full lipid profile. The blood request forms haven't yet been updated to reflect this.
Please calculate QRISK using QRISK2 tool where appropriate and state value here if done in percentage. NB: Threshold for intervention is 10%
QRISK2 Calculator...
Please complete a cardiometabolic management plan below if required.
Plan



The following templates allow you to clearly and easily document your examination findings.

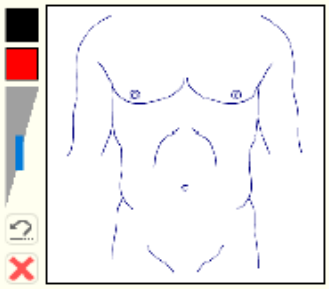
ECG | Bloods / Investigations | Respiratory | Heart / Chest | Abdominal | Central Nervious System | Overall Physical Health O...

Abdominal

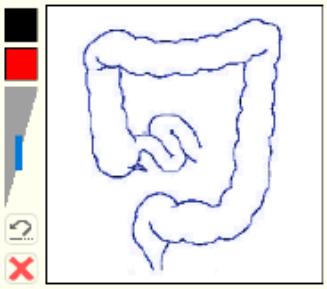
Abdomen examined - NAD	☐		Abdominal tenderness	☐	
Left inguinal hernia	☐		[D]Bowel sounds abnormal	☐	
Right inguinal hernia	☐		[D]Liver enlargement	☐	
Femoral hernia	☐		O/E - splenomegaly	☐	

Examination of abdomen

Abdomen



Bowel



Heart / Chest

Heart sounds normal	☐	O/E - ejection click heard	☐
Heart sounds exaggerated	☐	O/E - gallop rhythm present	☐
Heart sounds diminished	☐	O/E - heart sounds NOS	☐
O/E - 1st heart sound split	☐	O/E - third heart sound	☐
O/E - 2nd heart sound split	☐	O/E - cardiac murmur	☐
O/E - opening snap heard	☐		

Heart rate EPM

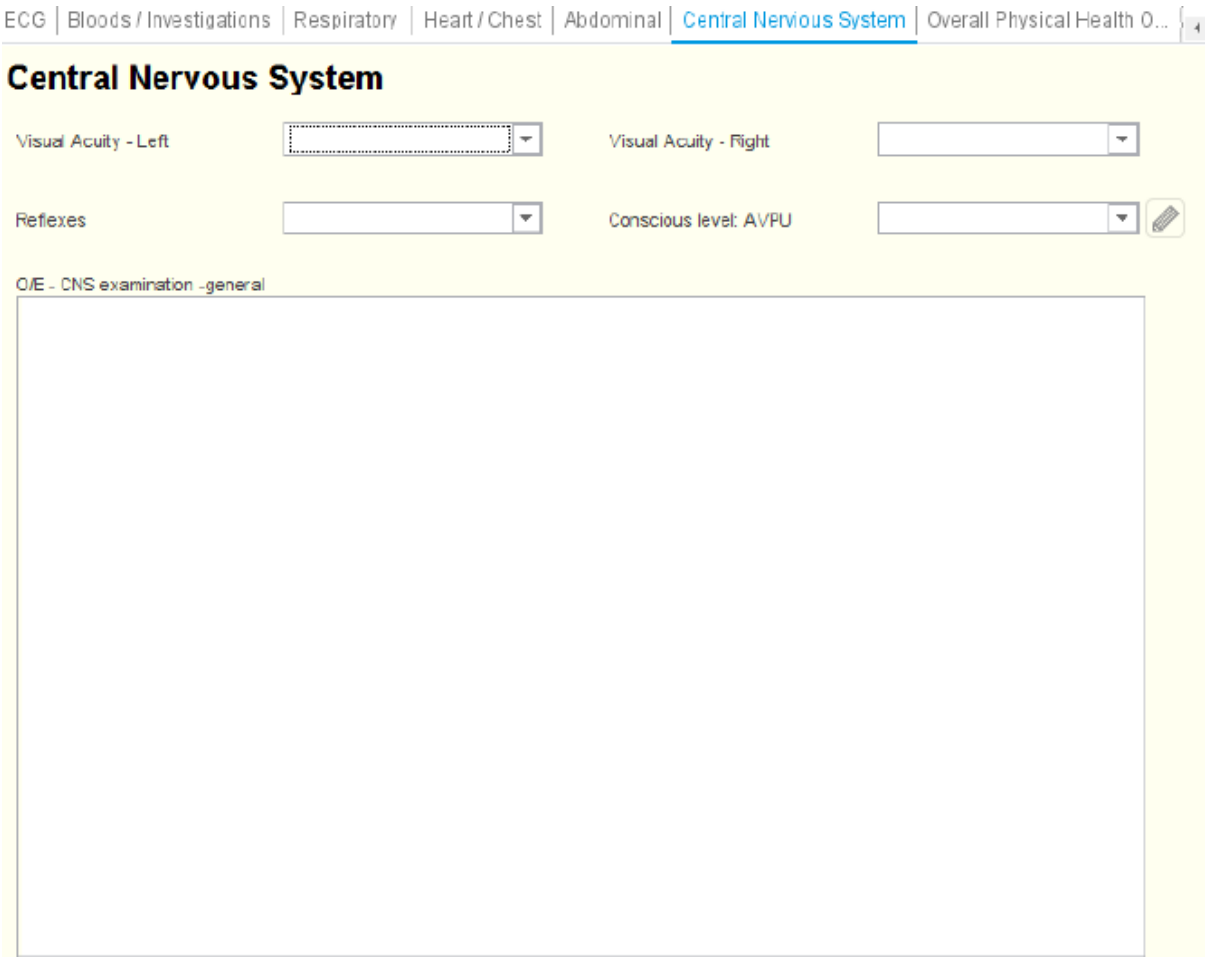
Pulse rate bpm

O/E - heart sounds

Observation of heart rhythm

O/E - chest examination normal	☐	O/E - expiratory wheeze	☐
O/E - coarse crepitations	☐		

O/E - chest findings


ECG
Bloods / Investigations
Respiratory
Heart / Chest
Abdominal
Central Nervous System
Overall Physical Health O...
Central Nervous System
Visual Acuity - Left
Visual Acuity - Right
Reflexes
Conscious level: AVPU
O/E - CNS examination -general

Appendix Two: Non-contact examination

Physical examination not possible

- Assessed not safe to approach the service user
- Approaching the service user may cause significant agitation and distress
- The service user does not consent to examination (clear explanation and assessment of capacity must be completed)

Use a non-contact approach

- Document what you can see and have assessed during your time with the patient
- Does not need specific equipment, just observation
- Should never be a substitute for a full examination if the patient is consenting

Record

- What does the patient look like – pale, sweating, skin blemishes, clammy, etc
- Count the respiratory rate – can they talk in sentences, any audible sounds (wheeze, etc)
- What is their consciousness level?
- Are they hydrated?
- Are they wearing any smart technology to give you some readings

Re-assess

- Continue to offer full examination at a regular interval

Appendix Three: Investigations

Initial Investigations for Adult and MHSOP Inpatients

Adult Inpatients – Initial Investigations (within 24 hours of admission)

Investigation Type	Details
Blood Tests	Full Blood Count, Urea & Electrolytes, Bone Profile, Liver Function Tests, Lipids, Haemoglobin A1c, Thyroid Function Tests, Haematinics, C-reactive protein, Gamma-glutamyl transferase, Vitamin D, Blood Borne Virus screen
Other Tests	Electrocardiogram, urinalysis for pregnancy and drug screen

Additional Tests – If Clinically Relevant and Appropriate

Chest X-Ray
Urinalysis
Lithium levels / other medication screening levels
International Normalized Ratio

MHSOP Inpatients – Initial Investigations (within 24 hours of admission)

Investigation Type	Details
Blood Tests	Full Blood Count, Urea & Electrolytes, Bone Profile, Liver Function Tests, Lipids, Haemoglobin A1c, Thyroid Function Tests, Haematinics, C-reactive protein, Vitamin D
Other Tests	Electrocardiogram

Additional Tests – If Clinically Relevant and Appropriate

Chest X-Ray
Urinalysis
Lithium levels / other medication screening levels
International Normalized Ratio
Blood Borne Virus screen
Urine drug test

Appendix Four: Essential Equipment for Inpatient Wards

The following equipment should be readily available on all inpatient wards to support effective clinical care and patient assessment.

Item	Usage
Blood Glucose Monitoring (BM) machine	Monitoring blood glucose levels
Blood Ketone Monitoring machine	Monitoring ketone levels
Disposable gloves	Personal protective equipment
Examination couch	Should be adjustable and weight appropriate
ECG machine	Recording the electrical activity of the heart
Neurological testing pins/Neuropen	Testing sensation
Ophthalmoscope	For eye examination
Otoscope	For ear examination
Pen torch	For pupil examination
Pregnancy test	Assessing pregnancy status
Pulse oximeter	Peripheral oxygen saturations
Sphygmomanometer	Blood pressure measurement
Stethoscope	Auscultation
Tendon hammer	Reflex assessment
Thermometer	Temperature measurement
Urinalysis sticks	Urine assessment
Weighing scales	Weight monitoring

Appendix Five: Governance

Version control and summary of changes

Version number	Date	Description of key change
4	12/01/2026	Updates

Responsibilities

Responsibility	Title
Executive Lead	*Medical Director*
Policy Author	*GP Mental Health Inpatient Lead*
Advisors	*Senior clinical staff attending CEG*
Policy Expert Group	*CEG*

Governance

Governance Level	Name
Level 1 Assurance Oversight	*Quality and Safety Committee*
Level 2 Delivery Group for policy approval and compliance monitoring	*Quality Forum/CEG*

Compliance Measures

KPI (only need 1-2 KPI's per policy)	Where will this be reported and how often
Physical examination of patients when they are admitted to the service, within timeframes	*Clinical Audit – "Physical assessment and investigation of patients on admission re-audit" completed by members of the Physical Health Steering Group and reviewed annually at CEG.* *Directorate to consider reporting via the Ward and Team Assessment on AMAT.*
Appropriate follow-up of physical symptoms	*Clinical Audit – "Physical assessment and investigation of patients on admission re-audit" completed by members of the Physical Health Steering Group and reviewed annually at CEG.* *Directorate to consider reporting via the Ward and Team Assessment on AMAT.*

Training Requirements

Training
There are no specific training needs identified within this policy. Training needs for specific investigations and procedures which may be needed during an in-patient stay can be found in the relevant guidelines for those investigations on the staff intranet. The competency of staff involved in the physical assessment and examination of

patients is assessed as follows on an on-going basis, this includes but is not exclusive to:

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• Through the discussion and review of patients care in clinical supervision and appraisal processes
• Clinical records audit
• Through the monitoring of any complaints which relate to the physical health care of a patient.
• Personal Development Reviews

References

References
LPT consent to examination and treatment policy