

MHAIDS

Comprehensive Plan

NHI: SMF4820
Patient First Names: MICHAEL JONATHAN
Patient Surname: MOUSE
Date of Birth: 08 May 1989

Comprehensive Plan

Team

Name of primary contact for client

Minnie Mouse

Primary contact designation

Psychiatrist/SMO/RMO name

Other team members, NGOs or community services involved

Formulation

Treatment Goals

Clinical team actions

Whanau/family/others actions

g
g
g
g
g

g
g

gg

gg

MDT progress summary

Wellness Plan

Has an advance directive been lodged with MHAIDS?

What am I like when I'm well?

Things I do that keep me well

Early warning signs

What can I do to help myself?

What can others do to help me?

Triggers

What can I do to help myself?

What can others do to help me?

When more is needed

Things that don't help

People I don't want involved

People or groups that support me

Name	Relationship	Phone Number	Address

How my family, friends and I have been involved in putting this plan together

MHAIDS staff assisting preparation of plan

Date of Wellness Plan

Client given copies

MHAIDS

Comprehensive Plan

NHI: HAF0511
Patient First Names: Debbie Louise
Patient Surname: ORION
Date of Birth: 22 Apr 1977

Team:

Name of primary contact for client:

Primary contact designation:

Psychiatrist/SMO/RMO name:

Other team members, NGOs or community services involved

Formulation

Provide a hypothesis of the cause and nature of presenting problems, current clinical risks and prognosis. Construct a meaningful story, placing the person's current presentation within the context of his or her life. Have it aim to answer the following questions:

- *Why this person?*
- *Why this problem?*
- *Why at this time?*

Treatment goals

Goals for service intervention, of the person, whānau, and service which are Specific, Measurable, Achievable, Realistic, Time-bound (SMART). "What matters to you?" across domains of wellbeing)

Clinical Team Actions

Clinical team actions for the person or whānau

Client/whānau/family/others actions

MDT progress summary

Updated at each MDT review: what are we doing to contribute to a person's wellbeing?

Wellness Plan

Has an Advance Directive been lodged with MHAIDS?

What am I like when I'm well?

Things I do that keep me well

Early warning signs

What can I do to help myself?

What can others do to help me?

Triggers

What can I do to help myself?

What can others do to help me?

When more is needed

Things that don't help

People I don't want involved

People or groups that support me

How my family, friends and I have been involved in putting this plan together

MHAIDS staff assisting preparation of plan

Date of Wellness Plan:

Client given copies:

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Positive Behaviour Support Plan

for

XXXX YYYY

[Place photo here]

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Layout of this Plan

Part A	Introduction	Page 3
Part B	A Bit About Me <ul style="list-style-type: none">• Who am I?• My skills and talents• My goals for the future• Understanding me and my behaviour• My wellbeing	Pages X – Y
Part C	My Good Life <ul style="list-style-type: none">• My quality of life• My daily routine• Proactive strategies for working with me	Pages X – Y
Part D	When the Going Gets Tough <ul style="list-style-type: none">• Non-restrictive de-escalation strategies• Planned reactive strategies• Last resort restrictive reactive strategies and post-event management	Pages X – Y

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Part A - Introduction

Please note, this document is written in the first person

This plan provides you, the staff who work with me, guidance around how best to support me through a shift. The approaches described in this document are informed by our service's Model of Care, in particular the principles of Positive Behaviour Support. Emphasis is placed on promoting my quality of life, because that has been shown to be the most effective way of improving my wellbeing and reducing the likelihood of me displaying behaviours of concern. The use of proactive strategies are included, as well as ways to respond - in the least restrictive manner - to any behaviours of concern that I may present with.

This plan is based on following sources of information:

- What I have told health professionals directly involved in the creation of this plan
- What the health professionals know of my personal preferences and goals
- Information the direct care staff I have worked alongside know about me
- My psychological formulation

This plan was created in partnership on [insert date] by my keyworker [insert name], clinical psychologist [insert name], and care manager [insert name] with feedback from other members of my multidisciplinary team. I met with [insert name] on [insert dates] to work on and review this plan.

This is a living plan, meaning it is added to and changed over time.

(include the following information for subsequent plan reviews)

Last review date:

Key worker:

Clinical psychologist:

Care manager:

It is important that my plans are regularly reviewed. This plan should be formally reviewed every six months, as part of the Good Lives Formulation process. My keyworker and clinical psychologist are jointly responsible for this.

Part B - A Bit About Me

Who am I?

-

My skills and talents





-

My goals - what my team and I are working on at the moment and aiming for in the future

-

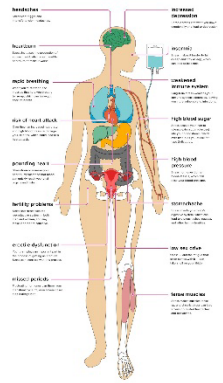

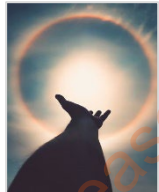

Understanding my behaviour

- This table describes the common behaviours of concern I can resort to when I have been unable to meet my needs in helpful ways.
- The behaviours of concern are listed in order of the frequency they occur (top of table = most common; bottom of table = least common).
- Remember - I am less likely to engage in these behaviours if you work with me in proactive ways to promote my quality of life. **My proactive strategies are outlined on pages x – y.**

The behaviour of concern 	What it looks like for me 	Why it happens 	Triggers 

Pages X – Y outline my early warning signs and ways to de-escalate me, as well as how to respond to the above behaviours so to maintain mine and others’ safety.

My wellbeing

My wellbeing includes	What it looks like for me	How it affects me	Plan
<p>Taha Tinana (Physical Wellbeing)</p> 			
<p>Taha Hinengaro (Mental and Emotional Wellbeing)</p> 			
<p>Taha Wairua (Spiritual Wellbeing)</p> 			
<p>Taha Whānau (Family Wellbeing)</p> 			

Part C - My Good Life

My quality of life

- My good life table is filled with activities and experiences that increase my quality of life and the quality of life of those around me.
- If you are able to work with me *each day* to promote the points in this table I will feel good, busy and satisfied. I will also be less likely to engage in any unhelpful behaviours of concern (see page 4) to meet my needs.


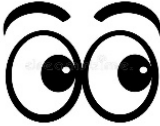

My quality of life will be best when...

-

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My daily routine

- My day-to-day routine is important to me. There are aspects of my adaptive functioning that I can do independently and others that I require support from you to complete.
- Active support is about you working with me at the right level of support for the given task. It is important for my goal of moving into the community that I am able to continue to practice the tasks and skills I can do independently, and learn to develop new skills.
- It is important that you know the tasks I require support to complete and how I need this support to look.

Activities of daily living that I require support to complete 	What the support looks like 	Activities of daily living that I can complete myself 
Morning Routine		
Evening Routine		
Budgeting and Personal Shopping		
Use of Transport		
Self-Occupation		
My Leave		

Proactive strategies for working with me


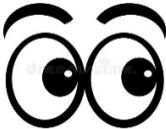
- Proactive strategies are important to use consistently and in the first instance when working with me to reduce the likelihood of harm to myself or other people.
- There are two types of proactive strategies: proactive *preventative* and proactive *developmental*.

Proactive preventative strategies These strategies are focused on managing my environment, reducing my stress and increasing my wellbeing.	
The Strategy	What you need to do
	

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Proactive developmental strategies

These strategies are skills, behaviours, and methods of coping that you can reinforce when working with me. They are more helpful ways of meeting my needs of safety, security, personal choice and positive emotion. It would be great if you could also help me to practice these skills in different situations.

The Strategy 	What you need to do 

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Part D – When the Going Gets Tough

Reactive strategies are planned interventions you use with me when my early warning signs are present or when I am engaging in a behaviour of concern. Early warning signs are changes in my mood and behaviour to look out for.

My early warning signs

-



Non-restrictive de-escalation strategies to use when I display my early warning signs

-

When the above de-escalation strategies have not worked, proceed as outlined on page X

**When my de-escalation strategies have not worked,
proceed as outlined below**

**When I am being verbally
aggressive**



You should:

-

**When I engage in acts of
property damage**



You should:

-

**When I engage in acts of
physical aggression**



You should:

-

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As a last resort...

If the strategies specified in the blue boxes do not contain or reduce the behaviour I am exhibiting *and* you have safety concerns for myself or others you can consider the below restrictive practices:

- Environmental restraint
- Personal restraint
- Prevent me (in the short term) from accessing planned activities or outings

If there is an imminent and/or lethal threat to my or someone else's safety, phone 111

Post-event management

- Complete an incident report with a full behavioural description of my behaviour, the context and environment around me at the time. Please use A-B-C format.
- Once safety is re-established, continue moving forward with my shift as planned. Re-focus on my quality of life, as that is the most effective way of preventing another incident.
- Offer me the chance to speak about my feelings or give me the time and space to express any residual fears or worries I have.
- Offer me the opportunity to talk with members of my care team.
- Offer me the opportunity to complete a chain analysis sheet with staff.

I was actively supported to read through this plan in its entirety by [insert staff name] on [date].

I signed this plan to acknowledge the above and to confirm I have received a hard copy of my plan.

Signature _____

Thank you for reading and working with me in the way this plan outlines.

HUIHUI

6 week initial assessment and 3-monthly multidisciplinary team review

Person's name:

DOB:

NHI:

Date of admission:

Legal status (and court date if relevant):

Victim notification register:

Responsible Clinician:

Care Manager/Key Worker:

Date of last Huihui: Click or tap to enter a date.

Date of this Huihui: Click or tap to enter a date.

Date of last SPR, (if relevant): Click or tap to enter a date.

Date of this SPR, (if relevant): Click or tap to enter a date.

Record all attendees and their relationship to the person:

Did the person attend the Huihui? Yes / No

If not, state reason:

Current medication:

Diagnosis (to be completed by Responsible Clinician)

Psychiatric:

Medical:

Name:

Designation:

Date: Click or tap to enter a date.

Current pathway (to be completed by Responsible Clinician with input from others)

Name:

Designation:

Date: Click or tap to enter a date.

Summary of key presenting issues (to be completed by Responsible Clinician with input from others)

Summary of presentation:

Key issues to be discussed at Huihui:

Name:

Designation:

Date: Click or tap to enter a date.

Issues for special patient review panel (must be completed if this report is to be used for the Special Patient Reviews)

Any recommendations for change in leave status:

Any recommendations for change in legal status:

Last SPR recommendations and outcomes:

Other key issues for discussion:

Name:

Designation:

Date: Click or tap to enter a date.

Last SPR recommendations & outcomes:

Risk summary, to be read with forensic history (to be completed by Responsible Clinician, attach HCR-20/FAM as an appendix for all people in the Forensic Service for 3 months or longer. Consider person-specific risks in formulation, including flight risk)

Risk summary and formulation:

Current level of risk to; Self: Choose an item. Others: Choose an item.

Current risk of absconding: Choose an item.

Flight risk assessment

Dual citizenship: Yes / No

Relatives or connections overseas: Yes / No

Access to financial resources to fund travel: Yes / No

Expressed desire to travel: Yes / No

Other incentives to travel: Yes / No

Possession of valid/current passport: Yes / No

Additional information:

For people in medium secure care only (if not relevant, write N/A):

Is this person under night safety order: Yes / No

If so, does night safety order need to continue: Yes / No

If yes, record reasons:

Expiry date of night safety order, (if relevant): Click or tap to enter a date.

Name:

Designation:

Date: Click or tap to enter a date.

Leave (to be completed by Care manager/Keyworker)

Current leave:

Ground access/community leave	Escorted/unescorted	Staff ratio

Name:

Designation:

Date: Click or tap to enter a date.
Summary of Progress Since Last Review of Admission
<p>Consent to treatment</p> <p>Is the person still consenting to current medication: <input type="checkbox"/> Yes / <input type="checkbox"/> No</p> <p>Date Signed: Click or tap to enter a date.</p>
<p>Persons own report (to be facilitated by the keyworker. The person may, with you, write their own report, or have the keyworker write it based on their input. Include comments on the person's view of their own progress and any key successes or challenges, their values, goals and long term aspirations and any requests for the Huihui)</p> <p>Date: Click or tap to enter a date.</p>
<p>Keyworker, Care manager and/or associates</p> <p>Clinical report: Current mental state examination: Summary of any incident reports since last Huihui: Key nursing issues:</p> <p>Name: Designation: Date: Click or tap to enter a date.</p>
<p>Psychiatric (to be completed by Responsible Clinician. Include progress, medication issues, physical issues, current mental state, plan and recommendations and issues for the review)</p> <p>Name: Designation: Date: Click or tap to enter a date.</p>
<p>Psychology</p> <p>Name: Designation: Date: Click or tap to enter a date.</p>
<p>Social Work</p> <p>Name: Designation: Date: Click or tap to enter a date.</p>
<p>Occupational Therapist</p> <p>Name: Designation: Date: Click or tap to enter a date.</p>
<p>Employment/education/training/activities update (to be completed by Care Manager/Occupational Therapist)</p> <p>Name: Designation: Date: Click or tap to enter a date.</p>
<p>Cultural and spiritual (eg: cultural and spiritual workers such as chaplain)</p> <p>Name: Designation:</p>

Date: Click or tap to enter a date.		
Other (include any reports from key others involved in supporting the person. Eg: AOD clinician, mental health support workers, family comments)		
Name:		
Designation:		
Date: Click or tap to enter a date.		
Person's History		
Summary of psychiatric history (to be completed by Responsible Clinician)		
Name:		
Designation:		
Date: Click or tap to enter a date.		
Forensic history (to be completed by Responsible Clinician. Describe index offence in detail)		
Name:		
Designation:		
Date: Click or tap to enter a date.		
Summary of alcohol and drug history (to be completed by Responsible Clinician or designated other. Eg: AOD clinician)		
Name:		
Designation:		
Date: Click or tap to enter a date.		
Family history and personal history (to be completed by Responsible Clinician/Social Worker. Include family psychiatric history if applicable)		
Name:		
Designation:		
Date: Click or tap to enter a date.		
Medical History* See appendix 3 for guide to completion		
Relevant medical issues and update on management:		
Diagnoses and past medical history:		
Medical issues this admission:		
Side effect and physical health monitoring:		
Date Completed: Click or tap to enter a date.		
Designation:		
Smoker? <input type="checkbox"/> Yes / <input type="checkbox"/> No Smoking cessation (include current pattern of use):	Physical exam- CHAPS (To be done annually on all inpatients) Date completed: Click or tap to enter a date. Results:	Weight, BMI, girth: Date completed: Click or tap to enter a date. Results:
Blood pressure, pulse: Date completed: Click or tap to enter a date. Results:	HbA1c: Date completed: Click or tap to enter a date. Results:	Lipids: Date completed: Click or tap to enter a date. Results:
LFTs:	Electrolytes and Creatinine:	FBC:

Date completed: Click or tap to enter a date. Results:	Date completed: Click or tap to enter a date. Results:	Date completed: Click or tap to enter a date. Results:
TFTs: Date completed: Click or tap to enter a date. Results:	Prolactin: Date completed: Click or tap to enter a date. Results:	Clozapine level: Date completed: Click or tap to enter a date. Results:
Monitoring of cardiac enzymes, (<i>if on Clozapine</i>): Date completed: Click or tap to enter a date. Results:	EPS or side effects: Date completed: Click or tap to enter a date. Results:	Constipation: Date completed: Click or tap to enter a date. Results:
Date of last ECG: Date completed: Click or tap to enter a date. Results:	Dental check: Date completed: Click or tap to enter a date. Results:	CT or MRI (<i>if relevant</i>): Date completed: Click or tap to enter a date. Results:
EEG (<i>if relevant</i>): Date completed: Click or tap to enter a date. Results:	CVD risk: Date completed: Click or tap to enter a date. Results: Next Due: Click or tap to enter a date.	Sexual health screening: Date completed: Click or tap to enter a date. Results: Next due: Click or tap to enter a date.
Cervical smear: Date completed: Click or tap to enter a date. Results: Next due: Click or tap to enter a date.	Breast screening: Date completed: Click or tap to enter a date. Results: Next due: Click or tap to enter a date.	Immunisations: Date completed: Click or tap to enter a date. Results: Next due: Click or tap to enter a date.
Serology status: Date Completed: Click or tap to enter a date. Results:	Diabetic patient HbA1C: Date completed: Click or tap to enter a date. Results: Next due: Click or tap to enter a date.	Retinal screen: Date completed: Click or tap to enter a date. Results: Next due: Click or tap to enter a date.
Diabetic foot exam: Date completed: Click or tap to enter a date. Results:	Patient on Metformin – B12/Folate blood test: Date completed: Click or tap to enter a date. Results: Next due: Click or tap to enter a date.	Routine bloods due on: Date completed: Click or tap to enter a date. Results:
Past and Present Huihui Recommendations		
Previous Huihui recommendations (<i>if previous Huihui has occurred</i>)		

Recommendations:

1. Was this recommendation completed? Yes / No
2. Was this recommendation completed? Yes / No
3. Was this recommendation completed? Yes / No
4. Was this recommendation completed? Yes / No
5. Was this recommendation completed? Yes / No

Current Huihui recommendations and outcomes (what is the planned pathway? What leaves are supported and will be requested? What do the team and the person need to do in order for progression to occur?)

General recommendations:

1. Timeframe Click or tap to enter a date.
2. Timeframe Click or tap to enter a date.
3. Timeframe Click or tap to enter a date.
4. Timeframe Click or tap to enter a date.
5. Timeframe Click or tap to enter a date.

Any recommended changes in leave status or pathway progression: Yes / No

If yes, specify:

Person's offered copy:

If yes: accepted / declined

If not, why?

Responsible Clinician's Signature _____ Date Click or tap to enter a date.

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Appendix 1: Dundrum

Dundrum 3 and 4 (complete by the MDT for all people in the Forensic Service for longer than three months. Refer to Dundrum manual)

Programme	Dundrum 3: Programme Completion Items	0	1	2	3	4
PC1	Physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PC2	Mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PC3	Drugs and alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PC4	Problem behaviours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PC5	Self-care and activities of daily living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PC6	Education, occupation and creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PC7	Family and social networks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Subtotal					
Recovery	Dundrum 4: Recovery Items	0	1	2	3	4
R1	Stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R2	Insight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R3	Rapport and working alliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R4	Leave	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R5	HCR-20 dynamic items	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R6	Victim sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R7	Hope	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Subtotal					

Date completed: Click or tap to enter a date.

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Appendix 2: Structured professional judgement risk assessment tool: HCR 20/FAM* Coding (for all clients in the Forensic Service for longer than three months. *FAM items to be filled in for females only)	
Step 1: Gather relevant information	
Sources of information:	
Summary of psychosocial history	
Family/childhood:	
Education:	
Employment:	
Relationships:	
Medical problems:	
Mental/emotion problems:	
Substance use:	
Legal problems:	
Other:	
History of violent behaviour; past and recent (describe incidents and pattern; when, nature of harm, directed at and relationship to person, why, where, personal reaction, chronicity, diversity, severity and escalation)	
History of violent ideation (describe incidents and pattern; when, nature of harm, directed at and relationship to person, why, where, personal reaction, chronicity, diversity, severity and escalation)	
Step 2 and 3: Determine the presence and relevance of risk factors (*fill in only if patient is female)	
historical factors – history of problems with:	
H1. Violence:	Presence: Choose an item. Relevance: Choose an item.
H2. Other antisocial behaviour:	Presence: Choose an item. Relevance: Choose an item.
H3. Relationship:	Presence: Choose an item. Relevance: Choose an item.
H4. Employment:	Presence: Choose an item. Relevance: Choose an item.
H5. Substance use:	Presence: Choose an item. Relevance: Choose an item.
H6. Major disorder definite/provisional extent, the most prominent and critical factor in index offense:	Presence: Choose an item. Relevance: Choose an item.
H7. Personality disorder definite/provisional:	Presence: Choose an item. Relevance: Choose an item.

H8. Traumatic experiences: victimisation/trauma: adverse childrearing experiences:	Presence: Choose an item. Relevance: Choose an item.
H9. Violent attitudes:	Presence: Choose an item. Relevance: Choose an item.
H10. Treatment or supervisor response:	Presence: Choose an item. Relevance: Choose an item.
H11. Prostitution*:	Presence: Choose an item. Relevance: Choose an item.
H12. Parenting*:	Presence: Choose an item. Relevance: Choose an item.
H13. Pregnancy at a young age*:	Presence: Choose an item. Relevance: Choose an item.
H14. Suicidality/self-harm*:	Presence: Choose an item. Relevance: Choose an item.
H15. Other historical risk factors:	Presence: Choose an item. Relevance: Choose an item.
Clinical factors – recent problems with:	
C1. Insight:	Presence: Choose an item. Relevance: Choose an item.
C2. Violent ideation or intent:	Presence: Choose an item. Relevance: Choose an item.
C3. Symptoms of major mental disorder definite/provisional:	Presence: Choose an item. Relevance: Choose an item.
C4. Instability:	Presence: Choose an item. Relevance: Choose an item.
C5. Treatment or supervision response:	Presence: Choose an item.

	Relevance: Choose an item.
C6. Covert, manipulative behaviour*:	Presence: Choose an item. Relevance: Choose an item.
C7. Low self-esteem*:	Presence: Choose an item. Relevance: Choose an item.
C8. Other clinical risk factors:	Presence: Choose an item. Relevance: Choose an item.
Risk Management Factors – Future Problems With (<i>specify context inpatient/community</i>)	
R1. Professional services:	Presence: Choose an item. Relevance: Choose an item.
R2. Living situation:	Presence: Choose an item. Relevance: Choose an item.
R3. Personal support:	Presence: Choose an item. Relevance: Choose an item.
R4. Treatment or supervision response:	Presence: Choose an item. Relevance: Choose an item.
R5. Stress or coping:	Presence: Choose an item. Relevance: Choose an item.
R6. Problematic childcare*:	Presence: Choose an item. Relevance: Choose an item.
R7. Problematic intimate relationships*:	Presence: Choose an item. Relevance: Choose an item.
R8. Other risk management:	Presence: Choose an item. Relevance: Choose an item.
Completed by: Designation: Date: Click or tap to enter a date.	

Appendix 3: Previous Psychiatric Huihui Reports

Completed by:

Designation:

Date: Click or tap to enter a date.

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Appendix 4: Guide for Medical History

- Physical Exam- CHAPS (To be done annually on all inpatients)
- Weight, BMI, girth (For mood stabiliser (carbamazepine, lithium, valproate, lamotrigine), baseline then at 3 and 6 months, more often if person gains weight rapidly. For antipsychotics, baseline then at least annually. For clozapine and olanzapine, more often for the 1st year (1-3monthly) then at least annually.
- Blood pressure, pulse (For mood stabiliser, baseline then annually. For all antipsychotics, baseline, during titration then annually)
- HbA1c (For antipsychotics, baseline, 3months then annually if no changes noted and no other risk factor. If person is high risk or on clozapine, olanzapine, monthly tests for first 3 months, then 3 monthly for the rest of the year, then annually)
- Lipids (For antipsychotics, baseline, 3months then annually. If person on clozapine, olanzapine, phenothiazines, quetiapine, 3 monthly for the 1st year, then annually)
- LFTs. (Baseline then every 3-6mths for the 1st year then annually. More often if abnormal LFT's, include prothrombin and albumin if abnormal.
- Electrolytes and creatinine (Baseline, then every 3-6 months for the 1st year then annually. More often if abnormal LFTs ,include prothrombin and albumin if abnormal)
- FBC (Baseline then every 6 months for antipsychotics. Annually for mood stabilisers. If on clozapine, follow clozapine schedule)
- TFTs (*Baseline*. Then every 6 months if on quetiapine, lithium or thyroid dysfunction)
- Prolactin (*Not required for mood stabilisers. For antipsychotics, baseline*, then if symptoms occur. If on amisulpiride, risperidone or typical antipsychotics, baseline, 6months then annually or symptoms occur)
- Clozapine level (3 monthly for inpatients on clozapine. Monthly if suspected non-compliance)
- Monitoring of cardiac enzymes if on clozapine (For patient on clozapine, baseline CK, CRP, trop T and pro BNP. Repeat CRP, trop T weekly for 1st 8 weeks. Be aware of myocarditis in 1st 1-2months of tx and for cardiomyopathy any time)
- EPS or side effects (Baseline then 6 monthly)
- Constipation (On-going monitoring)
- Date of last ECG (*Baseline ECG* in all patients. Annual ECG)
- Dental checking (Annual dental review for all long stay clients.)
- CT or MRI head (If relevant)
- EEG (If relevant)
- When next blood tests are due

GP/ House Surgeon to complete:

- CVD risk
- Sexual health screening:
- Cervical smear
- Breast screening
- Immunisations
- Serology status?
- Diabetic patient
- HBa1C
- Retinal screen
- Diabetic foot exam
- Patient on Metformin - B12/Folate blood test