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## **Vulnerable Groups**

Draft Good Practice  
Framework for people  
with a learning disability  
requiring planned  
secondary care

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A special acknowledgement goes to Mr Crispin Hebron for giving permission for Public Health Wales to make full use of the document 'Working together; easy steps to improving how people with a learning disability are supported when in hospital – guidance for hospitals, families and paid support staff' (2009) Gloucestershire and Worcestershire NHS.

## 1. Summary

- People with learning disabilities (LD) have poorer and more complex health needs than the general population and have difficulties in communicating their needs and wishes.
- All hospital staff should not assume that certain behaviours are part of having a LD and should **listen** to people who know the individual well and describe their behaviour as unusual or indicative of being in pain.
- Under the Disability Discrimination Act reasonable adjustments, such as taking more time with a person with LD and ensuring all patient documentation is in an easy read/accessible format, have to be made by all health care staff to ensure people with LD can access and receive the same high standards of healthcare as anyone else.
- Each person with LD will have different needs and require different levels of support (including access to advocates) to help them cope and get the best health outcomes from their stay in hospital.
- Every hospital in Wales should have a **care pathway** in place which details good practice at each stage of the admission process and individual responsibilities in ensuring patients with learning disabilities have appropriate care (model attached in section 5).
- With regards to secondary care it is important to recognise that responsibility for providing medical and nursing care to people with a LD will remain with the hospital at **all** times during their inpatient stay.
- It is essential to complete an individualised assessment for each persons need for support and who is best placed to provide it. This is called a **Risk, Dependency and Support Assessment**. It is good practice to undertake this before the patient has entered hospital in order to ensure the correct level of support can established.
- It is the hospitals responsibility to fund any extra support over and above the individually funded support ordinarily available to the person in their own home. Any additional support has to be negotiated with the LHB before admission.
- In order to improve communication and care within a hospital environment between health care staff and people with LD, there must be a **hospital information system** for recording key information about what hospital staff need to know about a person. A good example is the traffic light hospital information system in Appendix 2.

- Health care staff should ensure that the well being of carers and paid staff providing support to people with LD whilst they are in hospital is considered. This includes providing them with security 'carer' passes.

## **2. Purpose of document**

This report aims to define best practice and improve health outcomes for people with LD when they access secondary health care for a planned hospital stay. It is primarily targeted at hospitals and for people with LD, their families, carers and paid support staff. It will also have relevance for other key stakeholders and service user organisations.

The work has been commissioned from Public Health Wales by the Welsh Assembly Government (WAG) as part of their service level agreement.

## **3. Policy Context**

There have been a number of recently published documents in the UK highlighting suboptimal health care received by people with learning disabilities (LD). The Welsh Assembly Government have responded by setting policies that ensure that:

“Welsh citizens with a learning disability have the same right of access to primary, secondary and specialist health care services and routine national health screening programmes as any other citizen” (Statement on Policy and Practice for Adults with a Learning Disability, WAG, 2007).

The same statement goes on to say that:

“All people with a learning disability are full citizens, equal in status and value to other citizens of the same age. They have the same rights to:

- Live healthy, productive and independent lives with appropriate and responsive treatment and support to develop to their maximum potential.
- Be individuals and decide everyday issues and life-defining matters for themselves joining in all decision-making which affects their lives, with appropriate and responsive advice and support where necessary.
- Live their lives within their community, maintaining social and family ties and connections which are important to them.
- Have the support of the communities of which they are a part and access to general and specialist services that are responsive to their individual needs, circumstances and preferences.”

The Department of Health (DoH) and WAG specify that ‘reasonable adjustments’ have to be made by health services so that people with LD can access and receive the same high standards of healthcare as anyone else. By ‘reasonable adjustments’ they mean that this healthcare must be responsive and flexible so that any diagnosis

or treatment takes into full account the LD needs of the person so that the best possible health outcome can be achieved.

Any hospital policies must also be set in the context of the disability and Human Rights legislation and should uphold people's human rights.

All arrangements for the employment of staff have to take place under Vulnerable Adult Protection procedures.

## **4. Methodology**

The work has been undertaken by reviewing all relevant policy documents and existing models of good practice in the UK. The key conclusions of the review are documented below.

This is then followed by a suggested care pathway framework which is a summary of best practice within the UK. The inclusive style of care pathway has been selected because it was formulated in close consultation between people with LD, their families and carers and other key stakeholders. It is designed to improve communication at every step of the pathway by use of check lists and forms which over a period of time have evolved as best practice. There are check lists for both the person with LD, their family and carers and for health care staff to follow which help prevent any adverse outcomes.

In this context the definition of a care pathway is "... a locally agreed multidisciplinary practice based on evidence and best practice guidelines ... It forms all or part of the clinical record, documents the care given and facilitates the evaluation of outcomes for continuous quality improvement" (Riley, 1998).

## **5. Overview of Health Issue for Individuals with a Learning disability**

### **5.1 Epidemiology**

Mencap (2004) reported that the general standard of health is lower in people with LD than the general population. This is summarised below.

#### **Increased risks**

People with LD have shorter life expectancies and different leading causes of death than the general population. They are three times more likely to die from respiratory disease, have a higher risk of coronary heart disease (second most common cause of death) and higher rates of gastrointestinal cancer and stomach disorders.

#### **Higher prevalence of certain medical conditions**

People with LD have a greater risk of poorer health because they experience greater variety, complexity and range of health problems compared with the general population. For example:

*Mental health problems* – 34% of people with LD have mental health problems.

*Epilepsy* – 22% of people with LD have epilepsy compared with 1% of general population.

*Dementia* – 22% of people with LD develop dementia compared with 6% of the general population (people with Down's syndrome are at a higher risk of developing it earlier).

*Schizophrenia* – 3% of people with LD have schizophrenia as compared to 1% of general population.

*Thyroid disease* – people with LD, particularly those with Down's syndrome, have a greater risk of thyroid disease.

*Hearing problems* – 40% of people with LD have hearing problems.

*Sight problems* – people with LD are more likely to have sight problems.

*Poor dental health* – 37% of people with LD and 80% of people with Down's syndrome have unhealthy gums and teeth.

*Osteoporosis* – people with LD have osteoporosis younger and have more fractures.

*Under or over weight* – people with LD are more likely than the general population to be under or overweight.

## **5.2 Access to Services**

It is common to find that service users have difficulties in:

- understanding and using information;
- making choices and decisions;
- learning and using symbolic forms of communication;
- dealing with social situations and getting around a busy and complicated building such as a hospital.

(Statement on Policy and Practice for Adults with a Learning Disability, WAG, 2007.)

This will inevitably lead to situations where people with a LD sometimes have difficulty in communicating symptoms and understanding what they are told. It is the health care provider's responsibility to find a way to ensure a high standard of health care and provide additional support to ensure the best health outcomes.

Some service users will require further support as they have complex health needs such as physical/sensory impairments, psychological difficulties, mental illness, neurological conditions (such as epilepsy, cerebral palsy) and behavioural difficulties

(such as challenging behaviour, autism, offending). These will vary in severity and degree of social impact.

## **NHS Professionals Response**

The Disability Right Commission undertook a formal investigation into the health inequalities suffered by people with learning disabilities. Amongst the conclusions the DRC identified in 'Closing the Gap' were "diagnostic overshadowing" as a key barrier to people with a LD getting equal treatment. This reflects an overall lack of training and skills in understanding LD and the consequent incorrect assumption that the presenting symptom is that of LD. In other words health care professionals should not make assumptions about people with LD and fall into the trap of diagnostic overshadowing, for example, assuming that certain behaviours are part of having a LD. This is crucial when people who know the person well describe their behaviour as unusual or indicative of being in pain.

Mencap (2007) additionally reported that professionals often didn't understand:

- the signs and behaviours expressed by people with LD in particular the clues that indicate distress in an individual;
- the key role that carers play in interpreting distress cues;
- the need to be more suspicious that the patient may have a serious illness, and be more proactive in intervening and assessing the needs of a person with LD;
- the issues around consent and capacity;
- the difference between a professionals opinion of a patients quality of life and a patients opinion of their own quality of life;
- the professional requirement to ask for help and/or refer on when faced with a novel or puzzling clinical situation;
- the dangers of delaying or deferring action.

The NHS Centre for Equality and Human Rights (Equal Treatment: Closing the Gap Second Audit of Local Health Boards and NHS Trusts 2009) whilst acknowledging progress made in delivering healthcare to this client group makes the recommendation that:

"The issues highlighted in the FI should be used to inform equality impact assessment of mental health and learning disability strategy, policy and service development, to ensure that the *physical health* needs of people with learning disabilities and/or mental health problems are fully considered."

## **Wider Societal issues**

People with LD are more likely to be disadvantaged in society, have low incomes and become socially isolated. Many people with LD live fully independent lives whilst others live in care homes, supported living, or with their families where they are dependant on others to provide them with healthy and active lifestyle. As a result

many have a limited diet, a sedentary lifestyle and are more likely to be overweight than the general population (less than 10% eat a balanced diet and 80% do less physical exercise than is recommended).

In 2004, Mencap published *Treat me right!* This contained key findings and recommendations about the health and healthcare services for people with LD. They reported that people with LD have poorer health than the general population which is partly due to:

- conditions related to their disability – (such as epilepsy, thyroid problems, sight and hearing problems);
- socio-economic factors – people with LD generally have low incomes and more likely to have unhealthy lifestyles;
- a poor standard of healthcare often from ignorance and prejudice among healthcare professionals.

## **6. Good Practice Framework for a Care Pathway**

This section specifies good practice in relation to the process for patients with a learning disability accessing secondary care. It is based around work undertaken in Gloucestershire and identifies key actions for hospitals and service users and carers.

### **6.1 Key Principles**

- The responsibility for providing medical and nursing care (including the administration of medicines) to people with LD will remain with the hospital at **all** times during their inpatient stay. Any additional identified health related support needs must be funded by the hospital in negotiation with the Health Board (HB).
- It is the hospitals responsibility to fund any extra health related support over and above the individually funded support ordinarily available to the person in their own home. As a principal, local authorities should continue to fund social support (as appropriate) if required in a hospital setting. This is important in accessing someone known to the person with LD and who knows their needs and wants.
- However, if the person receives paid support shared with other people, then this can't be transferred and additional support will have to be funded by the hospital to meet any identified additional needs so that the health outcomes for the person with LD will be equal to those of the general population.
- Each person with LD will have different needs/levels of support to help them cope and get the best health outcomes for their stay in hospital. It is crucial to carefully assess each persons need for support and who is best placed to provide it.



- Communication is key to good health outcomes and healthcare professionals should listen to the families and support staff as they will know the person with LD and what support they need. Information should be provided to people with LD in an easy read/accessible format.
- Healthcare staff should pay attention to the well being of carers and paid staff of people with LD whilst they are supporting the person with LD in hospital. This means that consideration must be given to their needs, for example, for meal breaks and rest periods.
- It is also good practice to provide the main carers with security passes which clearly indicates that they are carers.

## 6.2 Capacity to Consent

- Under the Mental Capacity Act (2005) it is assumed that the individual has the capacity to make decisions for themselves and be able to give consent to medical investigations and treatment unless deemed unfit to do so.
- There should be clear recorded evidence about what has been done by the hospital, family, carers and paid support staff to help the individual understand what is required and enable them to give consent.
- If the person is thought not to have capacity to consent, a Decision Maker will make a Best Interest Decision in accordance with the Mental Capacity Act and can give consent to medical treatment on the person's behalf. The Decision Maker is the person who will be carrying out the procedure or treatment.
- Best interests decisions need to be formally recorded in a meeting with all parties involved. If there is no family member then an Independent Mental Capacity Advocate (IMCA) needs to be appointed and a referral made by the Decision Maker. Once the best interest decision has been made it needs to be clearly recorded.

## 6.3 Communication – Hospital information systems

- In order to improve communication within a hospital environment, there should be a **hospital information system** providing a clear and universally recognised mechanism for recording key information about what hospital staff need to know about a person with LD. (A useful example is the traffic light hospital information system shown in Appendix 2).
- Using this tool in a clinical environment ensures that key information to improve communication, diagnosis and treatment can travel with the person around the hospital so that any health care professional can access it, for example, in radiology departments.

## 6.4 Risk, Dependency and Support Assessment

- In addition to a hospital information system, communication and care can be improved by undertaking a **Risk, Dependency and Support Assessment**.
- This Risk, Dependency and Support Assessment will provide an in depth framework to identify risks to both the physical needs and to the standard of health care received during the hospital stay and what support may be required to address the risks. (Example in Appendix 3).
- The assessment has to be undertaken before the patient has been admitted to hospital. Discharge planning can then be put in place to enable the patient to have the same standard of care and support received before admission to hospital or if needs change as a result of their inpatient stay, additional home support post-discharge arranged.
- It is the hospital's responsibility to provide all medical and nursing care to the patient whilst they are an in-patient. This assessment provides a framework to assist in the negotiation for any additional support to reduce risks by identifying who is best able to provide that support and how much of this support is required.
- This framework then provides information of where further funding is required. The risk, dependency and support assessment should be used by the pre assessment nurse (where available) or the nurse in charge of the ward together with the patient and people who have the best knowledge about their needs.

## 7. Key Stages

### 7.1 Key Stage – Pre-admission

#### 7.1.1 Responsibilities of Patients Carers and Families

- Before admission to hospital it is important to gather together any information about the support and care currently being given, any previous experiences of ill health or inpatient stays, reactions to medicines or pain etc.
- In order that all hospital staff can understand and know important information about the patient a blank copy of a hospital information sheet should be completed. This asks questions about their likes, dislikes and anything else important for their stay in hospital and can improve the quality and health outcomes of a persons experience during their admission. This document will stay with the patient at all times during their stay in hospital in order for health care staff to understand the patient's needs and improve the quality of their stay in hospital.
- It is important to work closely with the ward to complete the Risk, Dependency and Support Assessment to agree what additional support may be required and who is best to provide it.

- Any concerns about what equipment might be required on discharge, for example, hoists, wheelchairs or changes in support needs should be discussed with the ward Team before admission to hospital so that support can be in place before the patient returns home.

### **7.1.2 Responsibilities of the Hospital**

- The senior nurse in charge of the ward should ensure that the community LD team know about the planned admission and that relevant paperwork containing a hospital information system such as the Traffic Light System and easy to understand information about the hospital has been sent to the patient.
- Ideally a Risk, Dependency and Support Assessment should be undertaken before the patient is admitted so that arrangements can be made for funding to pay for additional support from those who know the individuals and their needs rather than use agency nurses.
- It is also good practice to organise a visit to the ward before admission so that the ward team and other healthcare staff can meet the individual and discuss any anxieties or access difficulties.
- Where possible a pre-admission meeting should be arranged whilst the person with LD is visiting the ward so they can be included. It is good practice to use a systematic check list during this meeting and there is a sample one in Appendix 1.
- The discussion in the admission meeting should include such issues as consent and best interests (Mental Capacity Act, 2005), and issues of confidentiality amongst others.
- Where available the hospital Learning Disability Liaison Nurse or LD Nurse Consultant should be aware of the admission and be available to attend a pre-admission meeting. They will be key members of the ward Team providing LD knowledge, LD nursing expertise and support.
- The senior nurse in charge should ensure that there is a LD ward policy on the medical treatment and nursing care and that all staff are aware of this policy and are trained to use the Risk, Dependency and Support Assessment.
- An experienced member of health care staff should be identified on each ward or department to take a lead on support for people with LD in their clinical areas.
- It is good practice to ensure that staff are aware of the Mental Capacity Act (2005) and informed decision making, consent, best interests meetings etc.
- For paid staff who will be providing additional support to the person with LD, the senior nurse should agree practical arrangements such as timing of breaks, access to refreshments, car parking and arrange security support staff identification.

- It is also good practice that arrangements are made so that someone who knows the individual and their communication well be present during ward rounds.
- In order to evaluate the care that people with LD experience whilst an in-patient it is useful to develop an audit mechanism to monitor how many LD patients are admitted, record how well the admission went and what support was required.

## **7.2 Key Stage – during admission**

### **7.2.1 Responsibilities of Carers**

- Paid support staff must ensure that they provide the support agreed in the Risk, Dependency and Support Assessment and contribute to any re-assessment of Risk, Dependency and Support Assessment needs, for example, after surgery. This may involve changes in discharge planning where additional needs of the patient when they return home have to be planned for. It is good practice to notify support agencies of any needs which may be higher after the hospital stay.
- Family carers and paid support staff participate to provide information about how the patient is responding to pain control, medication, treatment etc during nurse handover meetings.

### **7.2.2 Responsibilities of Hospital Staff**

Hospital staff should provide emotional support and continually check that their explanations about procedures, medication, changes in condition or treatment are fully understood by the patient and carers giving them plenty of opportunity and time to ask questions.

- Wherever possible family carers and/or paid support staff should be included in the nursing handover and if not possible seek current information from them for inclusion in the handover.
- Whenever there is an indication that the patient requires more or less support a reassessment of Risk, Dependency and Support needs must be undertaken.
- Ward staff must ensure that any actions suggested at pre-admission meeting are being undertaken, for example, checking whether the Occupational Therapy assessment has been booked to ensure that vital equipment will be available on discharge.
- Any concerns around paid staff providing the additional support identified in the Risk, Dependency and Support Assessment should be directed to the paid supporters employing organisation.

## **7.3 Key Stage – Discharge**

### **7.3.1 Responsibilities of Patients Carers and Families**

- When its time for the person with LD to leave hospital, consideration should be given to see if any of their needs have changed since their admission e.g. as a consequence of surgery. If they have, then the Local Authority Care Manager or Hospital Social Worker can be asked to carry out an assessment of changed needs. This will ensure that the allocation of any additional funding for additional support will be agreed in plenty of time before the patient is discharged home.
- A discharge planning meeting should be requested between the family and carers, the ward staff and the Local Authority Care Manager. During this discharge meeting discussions can take place on what will be needed at home and the Care Manager will be able to confirm who will be doing what and when including any changes in paid staff support. Carers and families should use this session to inform the hospital about how the in-patient stay went, what worked well etc.
- If hospital transport is needed people with LD may not be able to make arrangements themselves and will need extra support to ensure a safe journey home.
- Everyone who needs to know when the person will be leaving hospital should be informed and who to contact in the hospital if there are any concerns about the person's health after they have been discharged home.

### **7.3.2 Responsibilities of the Hospital**

- A formal discharge meeting should be organised with the patient, family, carers and paid support staff. A clear discussion should include any future requirements following the hospital stay such as bed rest or no lifting, any possible side effects of new medication and explain clearly what to do and who to contact if any complications arise.
- Ensure arrangements have been put in place for any outstanding specialist assessments such as Occupational Therapy.
- The Community LD Team should be informed when the person will be leaving hospital and any transport home should be organised if needed.
- The patient, their family and paid support staff should be encouraged to give feedback on the whole hospital experience for audit purposes.

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## Appendix 1

# ● Checklist for admission meeting

The purpose of an admission or pre-admission meeting is to agree all of the arrangements for admission. To achieve this the agenda for the meeting will probably need to include:

- **Introductions and clarifying of roles.**
- **Consent:** before this meeting it is helpful if the decision on whether the individual has the capacity to consent to this treatment has been made and recorded according to the Mental Capacity Act. If not, see the **Where to find further information** section and **Do you know about consent?** for carers, in **Section 1: What you can be doing now**, as well as **Points on consent to consider before any admission meeting** on page 19, and establish who will undertake the necessary work.
- **Confidentiality:** record how information will be shared and with whom. Record key people who will need to be consulted throughout the process along with their contact details.
- **Key contacts within the hospital:** identify and record.
- **Recorded information** provided by the person themselves, their family and /or paid support staff – including any assessments, care plans and traffic light assessment: should be shared.
- **The current medical need:** share and discuss:
  - The presenting medical need, including treatment required and how will this be carried out.
  - Expected outcome and possible areas of risk.
  - Communication aids or communication patterns should be explained to hospital staff so they become aware of the ways the patient expresses themselves.
  - The person's likely reactions to the hospital environment and procedures – may restraint be necessary, if so how is this best delivered?
  - Whether or not the patient should be resuscitated if a cardiac arrest occurs.
- **Information and support needs of relatives and paid support staff** involved with the individual's hospital stay (*see list of possible questions below*).
- **What additional support may be required** to ensure the best outcome is reached. The **Risk, Dependency and Support Assessment** should be completed and signed with all present.
- **Further tasks**, such as ward based and risk assessments, along with practical arrangements of who will take what actions: to be listed.
- **Likely timing of other multi-agency meetings**, such as discharge meeting.



## Note for family and/or paid carers

Below we give a list of possible questions suggested by family members. Mark those you would like to ask and add to the list if you are intending to take this sheet to the hospital meeting.

- Are drinks offered to relatives/non hospital staff when they are beside patients or should they take their own refreshments?  
\_\_\_\_\_
- Should you take special cups, spoons etc with you or does the ward always have them?  
\_\_\_\_\_
- Will relatives and members of support staff need to be provided with passes to leave and enter the ward during the night?  
\_\_\_\_\_
- If the person needs incontinence pads (perhaps temporarily because of the treatment) will the correct type be available?  
\_\_\_\_\_
- Does the hospital provide accommodation for carers providing additional support? If not, will a mattress be available or a comfortable chair for night support?  
\_\_\_\_\_
- What and where are bathroom facilities for carers?  
\_\_\_\_\_
- Specialist equipment needs, eg hoists, accessible baths etc – does hospital have them and where?  
\_\_\_\_\_
- Will drinks be provided during the night?  
\_\_\_\_\_
- How will I as family carer or paid support staff get necessary breaks in MY support role?  
\_\_\_\_\_
- Travel practicalities – bus, car, taxi, parking, costs etc  
\_\_\_\_\_

*(continued)*

*Additional questions:*

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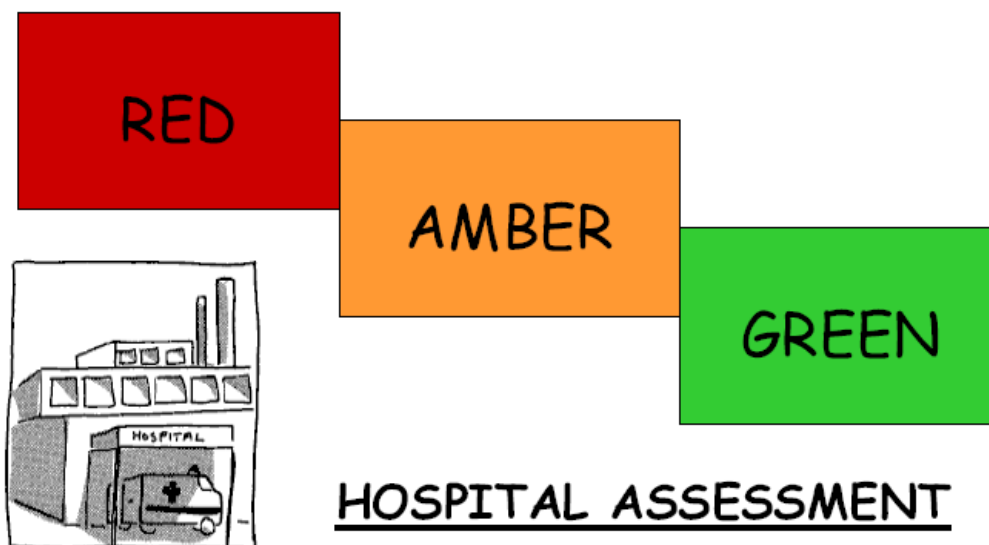
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## Appendix 2

# The Traffic Light Hospital Assessment

Gloucestershire **NHS**  
Primary Care Trust

In partnership with the 2gether Foundation NHS Trust & the Gloucestershire Hospitals NHS Foundation Trust



This assessment gives hospital staff important information about you.

Please take it with you if you have to go into hospital. Ask the hospital staff to hang it on the end of your bed.

Please note: **Value judgements** about quality of life including decisions on resuscitation must be made in consultation with you, your family, carers and other professionals. This is necessary to comply with the Mental Capacity Act 2005.

**Make sure that all the staff who look after you read this assessment.**

**RED-ALERT**

Things you must know about me

Name - NHS number -  
Likes to be known as -  
Address - Tel no-  
Date of Birth -  
GP - Address:  
Next of Kin - relationship - Tel no -  
Key worker/main carer - relationship - Tel no -  
Professionals involved - Tel no -  
Religion - Religious requests -

Current medication -

Current medical conditions - e.g. epilepsy, allergies, heart problems, breathing problems, eating & drinking issues.

Brief medical history -

Medical Interventions - how to take my blood, give injections, take temperature, medication, BP etc.

Behaviours that may be challenging or cause risk -

Level of comprehension/ capacity to consent -

Completed by: ..... Date:.....

**AMBER**

## Things that are really important to me

**Communication** -

How to communicate with me.

**Information sharing** -

How to help me understand things.

**Seeing/hearing** -

Problems with sight or hearing

**Eating (swallowing)** -

Food cut up, choking, help with feeding.

**Drinking (swallowing)** -

Small amounts, choking

**Going to toilet** -

Continence aids, help to get to toilet.

**Moving around** -

Posture in bed, walking aids.

**Taking medication** -

Crushed tablets, injections, syrup

**Pain** -

How you know I am in pain

**Sleeping** -

Sleep pattern, sleep routine

**Keeping safe** -

Bed rails, controlling behaviour, absconding

**Personal care** -

Dressing, washing etc.

**Level of support** -

Who needs to stay and how often.

Completed by: ..... Date:.....

**GREEN**

Things I would like to happen

Likes/dislikes

THINGS I LIKE Please do this:		THINGS I DON'T LIKE Don't do this:	
Think about - what upsets you, what makes you happy, things you like to do i.e. watching TV, reading, music. How you want people to talk to you (don't shout). Food likes, dislikes, physical touch/restraint, special needs, routines, things that keep you safe.			

Completed by: ..... Date:.....

Review of Traffic Light Hospital Assessment form : March 2010  
Produced by the Learning Disability Health Facilitation Team

## Appendix 3

# Risk, Dependency and Support Assessment for Patients with a Learning Disability

Patient name \_\_\_\_\_

Date of birth \_\_\_\_\_ Hospital number \_\_\_\_\_

Assessment completed by: Ward staff \_\_\_\_\_  
(*print names*)

Family member(s) \_\_\_\_\_

Paid support staff \_\_\_\_\_

Date \_\_\_\_\_

This assessment is designed to be completed at the earliest opportunity for any patient with a learning disability being admitted to hospital. It is essential that the assessment is completed by hospital staff **and** those who know the patient well; this may be family members, paid support staff or both. It is only in this way that likely areas of vulnerability and risk can be effectively identified and appropriately responded to.

The purpose of the assessment is:

- To identify any areas where the patient may be at risk
- To identify how much additional support may be required to reduce that risk
- To identify who can most effectively provide such support

## Key

### Risk levels

- Low** Unlikely to impact on equality of outcome – Additional support not indicated.
- Medium** Likely to impact on equality of outcome – Additional support should be considered.
- High** High likelihood of impact on equality of outcome – Additional support essential.

### Required level of additional support and best person to provide it

When additional support needs are identified the assessment uses a number system to identify who can most effectively provide any required additional support as follows:

- Level 1** Appropriate additional support can be provided from existing ward.
- Level 2** Appropriate additional support can be provided with family or existing paid support staff input.
- Level 3** Additional ward support required.
- Level 4** Additional support from paid support staff is required.

*Example below:* 6 hours of additional support from paid support staff (i.e. this will be required to be funded by the hospital)

Mental Health Needs		Level of risk	Required support level	Required number of additional hours
Is the patient likely to self harm?	Yes	Low	1	—
	Unknown	Medium	2	—
		No	High	3
				4



Please complete all the boxes in the assessment form working from left to right.

Communication and Comprehension Needs		Level of risk	Required support level	Required number of additional hours
Risk, Dependency and Support Assessment Scale	<i>Circle as appropriate</i>	<i>See key on p.28</i> <i>Circle as appropriate</i>	<i>See key on p.28</i> <i>Circle as appropriate</i>	<i>Insert number of hours alongside selected support level</i>
<b>Can the patient orientate themselves?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Can the patient communicate needs, including pain?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Can the patient maintain their personal dignity?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Can the patient understand simple explanation of procedures?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Can the patient maintain their safety within the ward environment?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Can the patient maintain their safety away from the ward environment?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Summary of additional support needs to be met with identified hours and notes:</b>				

Please complete all the boxes in the assessment form working from left to right.

Mental Health Needs		Level of risk	Required support level	Required number of additional hours
<b>Risk, Dependency and Support Assessment Scale</b>	<i>Circle as appropriate</i>	<i>See key on p.28</i> <i>Circle as appropriate</i>	<i>See key on p.28</i> <i>Circle as appropriate</i>	<i>Insert number of hours alongside selected support level</i>
<b>Is the patient likely to self harm?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Is there a risk of suicide?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Is the patient likely to present destructive behaviours?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Does the patient have epilepsy?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Is the patient likely to present violent behaviours?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Is the patient likely to present hyperactive behaviours?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Is the patient likely to present inappropriate behaviours?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	

(continued)

Please complete all the boxes in the assessment form working from left to right.

<b>Mental Health Needs</b> <i>(continued)</i>		<b>Level of risk</b>	<b>Required support level</b>	<b>Required number of additional hours</b>
<b>Risk, Dependency and Support Assessment Scale</b>	<i>Circle as appropriate</i>	<i>See key on p.28</i>  <i>Circle as appropriate</i>	<i>See key on p.28</i>  <i>Circle as appropriate</i>	<i>Insert number of hours alongside selected support level</i>
<b>Is the patient likely to experience anxiety?</b>	Yes  Unknown  No	Low  Medium  High	1  2  3  4	
<b>Summary of additional support needs to be met with identified hours and notes:</b>          				

Please complete all the boxes in the assessment form working from left to right.

Physical Health Needs		Level of risk	Required support level	Required number of additional hours
<b>Risk, Dependency and Support Assessment Scale</b>	<i>Circle as appropriate</i>	<i>See key on p.28</i> <i>Circle as appropriate</i>	<i>See key on p.28</i> <i>Circle as appropriate</i>	<i>Insert number of hours alongside selected support level</i>
<b>Can the patient maintain their own personal hygiene, including safe hand washing after toilet?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Can the patient maintain their own fluid intake?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Can the patient maintain their own nutrition?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Is the patient at risk of choking or dysphagia?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Can the patient manage their own toileting needs?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Can the patient maintain their own mobility?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Does the patient have a regular sleep pattern?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	

(continued)

Please complete all the boxes in the assessment form working from left to right.

Physical Health Needs <i>(continued)</i>		Level of risk	Required support level	Required number of additional hours
Risk, Dependency and Support Assessment Scale	<i>Circle as appropriate</i>	<i>See key on p.28</i>  <i>Circle as appropriate</i>	<i>See key on p.28</i>  <i>Circle as appropriate</i>	<i>Insert number of hours alongside selected support level</i>
<b>Is the patient at risk from pressure areas?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Does the patient require any special equipment?</b>	Yes	Low	1	
	Unknown	Medium	2	
	No	High	3	
			4	
<b>Summary of additional support needs to be met with identified hours and notes:</b>				