

Guidance notes for completion of Patient Passport

To be completed by someone who knows the person really well

The Patient Passport provides crucial information about a person's everyday needs and wishes. It also specifies the person's primary diagnosis, if known, for example: learning disability, dementia or other condition. **[Please write this in the space at the top of the Patient Passport].** The Passport is not designed to hold all the available information about the person but it should contain enough detail to enable others to understand the person's needs at first contact and help them to feel safe, comfortable and understood.

The Patient Passport is not expected to last for 10 years like a British passport as it is recognised that people's needs change. The Passport should therefore be reviewed at every health and social care review and updated, if necessary.

Complete as fully as possible: involve the person's family and friends as appropriate. Family and friends may also need to remind health and social care staff of the existence and importance of the person's Passport, for example: if the person is admitted into hospital or enters into a care home or respite care or attends an out-patient appointment.

Complete in full: first name, surname, telephone (with area code), date of birth, NHS number (this can be found on the letter from the hospital or from your doctor, or if not, don't worry; the hospital staff or other people can find this).

Lasting Power of Attorney (LPA): identify if the person has a Lasting Power of Attorney. Give the name of the person and provide details of what the power relates to: health, welfare and treatment or finances, or both.

NB: This is not the same as Enduring Power of Attorney (EPA).



In partnership with:

Advance decision: identify if the person has an advance decision in place. If so, check what this applies to.

Allergies: please give details of any known allergies.

Medical conditions: include all known medical conditions the person may have, for example diabetes, epilepsy etc.

GP details: please give details of the person's current GP.

Religion: please give details and how this may impact on current care delivery.

Next of kin: please give details of the name of the person's next of kin and identify their relationship to the person.

Contact name: please give details of someone who knows the person really well.

Medicines: please bring a copy of person's MAR chart (Medication Administration Record) or prescription card or bring in the person's current medication. **Always contact their doctor to verify medications.**

I need help with: these are the important things that health and social care staff need to be aware of. These things will help the staff to care for the person and to be able to write and implement a care plan during the person's stay, or understand their needs at out-patients appointments. Think as diversely as possible; it is often the little things that can make a difference, the things that staff who have not met the person before need to know to care for a person in a sensitive and person-centred way.

Personal care: any help the person may need with washing and/or dressing.

Mobility and falls: please give details of any problems or issues in this area.

Communication: how the person normally communicates, for example gestures, use of pictures or symbols, Makaton etc.

Keeping safe: this can include anything the person may need to help keep them safe such as use of aids and specialist equipment. For example, does the person need cushioned bed sides?

Eating and drinking: this can include details of how the person normally eats and drinks, how food is prepared and any assistance that may need to be given with food and drinks. Does the person need their food to be chopped up small or liquidised, do the person's fluids need to be thickened? Highlight any issues with eating and drinking. Does the person have dentures?

Behaviour: please give details of any behaviours that can be challenging or cause a risk to the person and or others.

Going to the toilet: please give details of how the person currently uses the toilet and manages their continence or incontinence. Include details of the management of constipation if applicable. Does the person require any aids or equipment to use the toilet?

Seeing and hearing: identify any problems the person may have with their sight and/or hearing. Does the person wear glasses or have a hearing aid?

Epilepsy: identify the type and severity of seizures the person normally experiences and any details of any epilepsy management plan in operation. How can you recognise their seizure activity?

Pain: please give details of how the person normally manages pain and shows signs of distress. Consider use of a non-verbal pain tool for example DisDAT.

Positioning: please give details of how the person needs to be positioned safely during the day and night. Are any positions dangerous? Does the person have a postural management plan?

Taking of medications: please give details of how the person normally takes his or her medicines, for example in liquid form, and the importance of taking medicines at the prescribed times. Remember: medications cannot be administered covertly when a person lacks capacity to consent, unless this has been discussed and documented in a best interests meeting and within the person's care plan.

Things I like: these could be food and drink choices, things that make the person happy and feel good, lifestyle choices or leisure activities. These things are important to help health and social care staff meet the needs of the person and not just treat the illness or health problem.

Things I don't like: these are the things that the person does not like, and again could be food or drink or lifestyle choices; things that may upset the person and make them unhappy or distressed.

Other people who help me: try to identify relevant people who work with or are involved in the person's life. These might be hospital or other staff who could be contacted to seek advice and support.

Identification of needs: try to identify as many areas of need as possible to help the health and social care staff care for the person. Use the Patient Passport to signpost the hospital staff to more detailed information if necessary, for example *"please see my epilepsy management plan"*.

Consent: The Mental Capacity Act (2005) provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It makes it clear who can make decisions and in which situations, and how they should go about this. It enables people to plan ahead for a time when they may lose capacity. Does the person have a Lasting Power of Attorney (LPA) or have they made an advance decision?

The Act is underpinned by a set of five key principles which must be taken into account.

- A person must be assumed to have capacity unless it is established otherwise
- A person is not to be treated as unable to make a decision for themselves unless all practicable steps have been taken to help the person without success
- A person is not to be treated as unable to make a decision merely because they make an unwise decision
- An act done, or decision made, for a person who lacks the capacity to consent, must be undertaken in the person's best interests
- Anything done for, or decided on behalf of a person without capacity should be the least restrictive of their basic rights and freedoms

Decision Making and Best Interest pathways have been developed locally to guide staff through the process of consent.

Preferred priorities for care:

End of life care planning needs to take place early whilst the person has sufficient mental capacity. There are a number of critical decisions that need to be addressed, not least the person's preferred place for care whilst they are poorly and their preferred place of death.

Discussions need to be held about the person's wishes regarding care and treatment, for example their willingness to undergo diagnostic investigations, active treatments, resuscitation and palliation such as artificial nutrition and hydration. Particular attention needs to be made to the recognition of symptoms such as pain and how these are communicated. It is crucial that carers are involved in these areas of discussion.

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