Trust Standard Operating Procedure

Plymouth Hospitals NHS Trust

Managing the care needs of people with a learning disability in the Acute Hospital setting.

Issue Date	Review Date	Version
March 2017	March 2019	4

Purpose

This Standard Operating procedure (SOP) provides guidelines for clinical staff, managers and the Learning Disabilities Liaison team for the expected standards to manage the care of adult patients who have learning disabilities, as they attend or are admitted to hospital.

The joint working practices and procedures apply to all adult patients in hospital who have Learning Disabilities, irrespective of their place of residence. The philosophy of care is for equality of access to services, treatments and clinical care, taking into account the specific needs of individuals

Who should read this document?

All staff working in clinical areas and patient safety

Key Messages

The care of adult patients with learning disabilities must be well planned and co-ordinated and involve the patient, their family, carers, community services and care providers.

• The LD Liaison Team must be notified of all patients with learning disabilities and be involved in the facilitation of Treatment Escalation Plan discussions and the care planning of patients with complex needs.

• Information regarding the patient's needs should be gleaned before hospital admission/attendance and outpatient appointments wherever possible.

• Information from the Hospital Passport and reasonable risk assessment tool should be used to inform the patient's care plan in hospital.

• Transfers between wards should be kept to a minimum and only be considered where clinically necessary for the patient. Any such ward transfers must be carefully planned and not undertaken late at night.

• Planning for discharge should commence at pre-assessment for elective admissions and commence on admission for emergency admissions.

• For patients at the very end of life(EOL) in hospital, consideration will be given to the use of the EOL/last days Care Plan. Decisions must involve the Learning Disabilities Liaison team unless decisions are made urgently out-of-hours. For patients who lack Mental Capacity to consent to decisions must follow Best Interest principles and be fully documented.

Core accountabilities	
Owner	Learning Disabilities Liaison Team Leader
Review	Safeguarding Steering group
Ratification	Director of Nursing
Dissemination	Learning Disabilities Liaison team and Matrons
Compliance	Trust Wide

Links to other policies and procedures

- Joint protocol for the care and transfer for adults with mental health needs
- Adults at Risk Policy
- Consent to examination and treatment policy
- Guidance on the use of Restraining Therapies within the acute hospital setting
- Mental Capacity Act and Deprivation of Liberty Policy
- Clinical handover of care and internal transfer of adults Standing Operating procedure
- Procedure for Assessing and Managing Health and Safety Risks
- Tool for Assessing Risk in the Workplace.
- Incident Management Standard Operating Procedure
- Moving and Handling Standard Operating Procedure
- Workforce Induction and Training Policy
- Carers Policy
- Enhanced Observation Policy (Funding of 1:1 support)
- Emergency Patient Summary SOP
- Transitions Policy

Version History

1.0	December 2009	Developed joint protocol
2.0	July 2013	Revised SOP following internal and external review of original protocol
3.0	May/June 2016	Internal Review
4.0	March 2017	Reviewed and revised

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents on StaffNET. Larger text, Braille and Audio versions can be made available upon request.

Standard Operating Procedures are designed to promote consistency in delivery, to the required quality standards, across the Trust. They should be regarded as a key element of the training provision for staff to help them to deliver their roles and responsibilities

<u>Note for Document Authors</u>

Red text – Indicates assistance with content of the section.

Black text – Standard text that relates to all formal documents and can be left in situ.

Plymouth Hospitals NHS
NHS Trust

Standard Operating Procedure (SOP)

Managing the care needs of people with a learning disability in the Acute Hospital setting.

1 Summary Chart for Inpatient Admissions and Introduction

Alerting

All patients with LD to be altered on RAPA and IPMS once known by LDL team. LD team to check LD diagnosis if alerted by another service line with the relevant LD community team or GP and report back to ward, update systems accordingly.

Ward staff to inform LDL team of any patients who they think may have an LD but not alerted on IPMS or SALUS. LD team to check LD diagnosis with community team, arrange for LD nurse to review if not clear, record outcome on IPMS or RAPA and inform ward.

Staff to alert LDL team if issues arise and initial first visit is needed ASAP

Assess/ Review

LDL team to review all RAPA alert emails every morning and update SALUS LD and HP (Hospital Passport) attributes accordingly

LDL nurse to arrange to visit any new patients within agreed time frame of 24-48hrs after admission (however this is expected to be on the same day of admission) and prioritise in patients who need a review (Not all patients will need to be seen daily)

Ward staff to check LD and HP attribute status and call LDL team if a review is needed sooner or urgently, especially in regards to restraints, 1:1 supervision, MCA and Dols issues/policy implementation, SGA alerts or Non-compliance or distressed behaviours.

On review by LDL nurse LDL care plan (sticker) to be followed and sticker placed in nursing notes. Any additional notes to be put in medical or nursing notes depending on nature of information. Check location of HP this should be in bed notes. Check complex discharge referral has been sent. Attributes to be updated by LDL team accordingly.

Ward nurse must take time to read reasonable adjustment (RA) risk assessment tool, sign it and read HP then update the ward care plan accordingly. Inform senior nurse of any issues i.e. family staying/complaints, funding 1:1, concerns with compliance etc. Ensure all information including RA and HP is handed over on shift change or ward transfer.

Senior nurse to ensure bed moves are kept to a minimum based on clinical need only and before 10pm, and LD outliers are chased up daily with the bed manager and are reviewed by appropriate medical team

Medical team and LD team to liaise regularly with patients and families to support with understanding of investigation/treatment plans and capacity to gain consent to any plans. Easy read pictures and communication book to be used to aid understanding.

Discharge

Patient to be identified on admission with support from LD team if a complex discharge is likely.

Ward nurse should follow the complex discharge process and refer using the ‘Data Forms’ section on SALUS

Complex Discharge team to contact LD team to further discuss and plan for discharge needs. Regular contact/updates to ward and LD team must be maintained.

Capacity around discharge needs to be ascertained as early as possible so that pre discharge meetings or best interest meetings can be arranged in a timely way. LD team to be invited to any meetings concerning patient’s with LD.

For noncomplex discharges meetings may still be needed in terms of good handover of care and patient may need an easy read discharge plan. Ward staff must invite LD nurse to any meetings, or request them to review any patient’s being discharge if ward staff have or the patients families/cares express concerns about discharge.

1 Introduction

This Standard Operating procedure (SOP) provides guidance for all clinical staff, managers and the Learning Disabilities Liaison team for the expected standards to manage the care of adult patients who have learning disabilities, as they attend or are admitted to hospital. The joint working practices and procedures apply to all patients in hospital who have Learning Disabilities, irrespective of their place of residence. The philosophy of care is for equal and timely access to health services, treatments and clinical care, taking into account the specific needs of individuals.

Patients with learning disabilities are likely to have additional needs, sometimes complex, which may impact on their clinical condition and access to investigations or treatment. These may include communication needs, consent to treatment issues, need for specialist equipment, need for specialist assessments (eg. Speech & language, dietetics), complex discharge needs and/or challenging behaviours.

Use of this SOP should always take account of the requirements of the Equality Duty Act (2010). The basic principle of health services is equal access for all according to need. Healthcare is provided to a range of ‘groups’ who have different needs, and will use services differently, but need to be able to access the same level of care as the general population.

2 Definitions

Learning disabilities are defined as lifelong conditions, with an onset before adulthood, which are neither illness nor disease. Learning disability is defined as;

- Significant reduced ability to understand new or complex information, to learn new skills (impairment of intelligence, usually within IQ of less than 70)

WITH

- Reduced ability to cope independently (impaired social functioning)

(Valuing people, A new Strategy for learning Disability in the 21st Century, Department of Health 2001)

3 Regulatory Background

People with learning disabilities often have specific health needs, in addition to the general health needs which the rest of the population face throughout life. However, for various reasons, they often struggle to access the same level of healthcare services – both in terms of primary and secondary care. The range of specific needs people with Learning Disabilities have include:

- Communication – abilities to read and write, verbal communication, sensory needs
- Memory – ability to tell the time, remember everyday facts, medication compliance
- Social – ability to forge relationships, deal with people, organise themselves, manage financial and domestic affairs, risk awareness, unemployment
- Physical needs may be linked to their learning disabilities eg mobility, obesity, swallowing, continence
- Challenging behaviours in a small number of cases

- Medical/health conditions often related to learning disabilities eg dental care, diabetes, epilepsy, coronary heart disease, respiratory disease, hypothyroidism, Gastro-Intestinal conditions and cancers, mental health issues.

(Royal College of Nursing 2006 – Meeting the health needs of people with learning disabilities)

The Death by Indifference report by Mencap (2007) highlighted the fact that people with learning disabilities receive poor care and treatment from healthcare services. The report concluded that:

- People with learning disabilities are seen to be a low priority
- Many healthcare professionals understand little about learning disabilities.
- Many healthcare professionals do not properly consult and involve the families and carers of people with learning disabilities
- Many healthcare professionals do not understand the law around capacity and consent to treatment.
- Health professionals rely inappropriately on their own estimates of a person's quality of life.
- The complaints system within NHS services is often ineffectual, time-consuming and inaccessible for people with learning disabilities.

(Death by Indifference, Mencap March 2007.)

The report claimed that many people with learning disabilities die in hospital due to the widespread ignorance and indifference throughout healthcare services, towards their needs and those of their families and *carer's*. Mencap claim that the inequitable service afforded to those with learning disabilities by hospitals and other healthcare services amounts to institutional discrimination.

Following '*Death by Indifference'* reports from Mencap (2007 and 2010), a two year investigation of deaths in hospital, was commissioned. The report *'Confidential Inquiry into the deaths of people with a Learning Disability'* was published in March 2013. In total, the Inquiry examined the factors leading up to the deaths of 247 people with a learning disability aged four or older, who died between 1 June 2010 and 31 May 2012 in the South West of England. Overall it found that 37% of deaths would have been potentially avoidable if good quality healthcare had been given.

Key findings of the inquiry include:

- The median age of death for men with LD was 65 years, 13 years earlier than men in the general population: for women it was 63 years, 20 years earlier
- 25.5% of people with LD had 4 or more treatable medical conditions including constipation, pressure sores and sleeping problems.
- Almost all (96.8%) of the people with LD had one or more long-term treatable health condition, most commonly epilepsy, cardiovascular disease or dementia.
- 97% of people with LD admitted to hospitals were on some sort of medication
- More than half the cohort was described as having behavioural or emotional problems.
- Health action plans and hospital passports were not found not to be used consistently.
- 38% of the deaths investigated by the Inquiry were reported to the coroner; however, the Confidential Inquiry team felt that there were a number of additional cases that had not been reported to the corner which they felt should have been
- More than a third of people with LD had difficulty identifying or communicating their pain, yet only 4 people had any sort of pain assessment that could help carers unfamiliar to them, recognise that they might be in pain.

Consequently, this report has made a number of recommendations (18 in total) which they feel will help improve the healthcare of people with LD and reduce the number of premature deaths.

Hospitals are now required to regularly review compliance towards the National Monitor framework Standards (Updated August 2015) '*S.* ***Learning disability access****: meeting the six criteria for meeting the needs of people with a learning disability*, based on recommendations in *Healthcare for all* (DH 2008)'. These include –

1. Mechanisms to 'flag' patients with a learning disability and have protocols to ensure reasonable adjustments to pathways of care
2. Readily available and comprehensive information for people with a learning disability
3. Protocols ensuring support for family carers
4. Training available for all staff
5. Protocols to encourage representation of people with a learning disability and their family carers
6. Regular audits in place, with findings reported in public

4 Key Duties

4.1 Trust Board

- Board Members are required to agree the strategy for managing patients with Learning Disabilities in hospital – ensuring that policies, procedures and services are compliant with legislation, national guidance and standards

- Overall responsibility for the standards of patient care in hospital

- Overall responsibility for the safe clinical environment in which care is delivered.

4.2 Matrons/Heads of Service

- Are overall responsible for ensuring that all staff in their wards/departments are aware of this SOP and the necessary joint working required to appropriately support people with Learning Disabilities in hospital

- On request review any patient in their service who has Learning Disabilities and has formally complained to the ward manager without good effect– to ensure that appropriate risk assessment, care planning and communications have been put in place to promote optimum care and support for individuals and their carers

- Ensure all ward/department managers fulfil responsibilities for patient care, risk assessment and staff mandatory training

- On request review with ward/department managers/clinical teams the care of any individual with Learning Disabilities - ensuring that patients are not moved around the hospital unless there is a clinical need to do so; any ward transfers must be carefully planned with carer or LDL team input and not undertaken after nine pm.

4.3 Ward/Department Managers

- Responsible for ensuring the care of people with Learning Disabilities is appropriate in terms of mental capacity assessments, care planning, reasonable adjustments and communication.

- Ensure that patients with Learning Disabilities are identified within the clinical team via the SALUS PCM attribute system and alerted to the Learning Disabilities Liaison team on admission.

- Ensure that staff are aware of this protocol, the Hospital Communication book and the Hospital Passport for people with Learning Disabilities, both are available for download from the PHNT website.

- Ensure staff are aware of LDL nursing care plan sticker and reasonable adjustment risk assessment tool which must be used to inform the ward core care plans.

- Maintain high standards of patient care for people with Learning Disabilities, their carer's and families. Undertake regular audit of patient care to gain assurance of standards within clinical team.

- Be available and open to receive formal verbal complaints, Datix complaints and try to resolve issues in the first instance, involve LDL team leader or nurse when needed.

- Facilitate appropriate multi-disciplinary/multi-agency case conference/meetings, to fully plan care for people with Learning Disabilities with high complex needs; following principles of Mental Capacity act with Best Interest decisions for those who lack mental capacity.

- Ensure that ward staff complete a thorough discharge process and a plan is put in place for all patients with Learning Disabilities and communication regarding the discharge is clearly recorded and communicated with the individual, care providers, community teams and family carers

- Support Link staff with Learning Disabilities role - to attend link meetings, promote and raise awareness of needs of people with Learning Disabilities and ensure appropriate, inclusive care is offered at all times; that the Liaison team are fully involved and their expertise included in the care plan for individuals

- Responsible for ensuring that the Liaison team are informed about any patient who is potentially being placed on an end of life care plan. .

- Responsible for liaison with care providers and agreeing extra 1:1 support needed and funding or invoicing arrangements as per Trust enhanced observation Policy and Nursing Safer Staffing Escalation Standard Operating Procedure .

4.5 All Clinical Staff

- Identify LD attribute from Salus PCM screens and ask patient for hospital passport, if a patient is not alerted but LD is stated or suspected please contact the LDL team

- If a person has a hospital passport turn the HP Attribute to Green, if not leave it red.

- Ensure appropriate care plans are in place for any patient with Learning Disabilities – making reasonable adjustments based on the reasonable adjustment risk assessment tool to standardised care plans, care pathways or clinical protocols, to meet the complex needs of individuals.

- Undertake timely and regular risk assessments/reviews of patients – ensuring complete and timely records of all care.
- Consider the needs of individuals as presented through the Hospital Passport and information from formal Carers or family carers. This must be evidenced in the care plan or nursing record. Identify and agree any care more appropriate to be delivered by known carers/family whilst patient in hospital
- Support carers and/or family in the delivery of care - ensuring that they are given regular breaks, information, feedback from clinical investigations and care decisions - as per the Trust Carers carer's policy
- Ensure patients and relatives are made aware of any risks in hospital, plans for investigation/treatment and discharge.
- Work in a multi-professional way to promote patient independence and maintain abilities with activities of daily living
- Be aware of and actively use the principles of the Mental Capacity Act (MCA) in decision making
- If a person needs 1:1 supervision consider a urgent Deprivation of Liberty Safeguard (Dols) request as per Trust policy. Doctors need to complete this.
- Use appropriate patient preference of equipment/communication aids to support care, record this and share to promote patient safety and communication
- Escalate any concerns regarding patient care to Learning Disabilities Liaison team and/or Matron
- Ensure any incidents including Dols and safeguarding are reported via the Datix system ticking the learning disability option in the patient information section.
- Ensure appropriate people are involved or advised of discharge plans at the earliest convenience
- Ensure robust handover of care for people with LD returning to ward transfers or residential or home environment and record this
- Ensure patients dignity on discharge in that they are appropriately presented and clothed

The clinical team should hold regular meetings with the family/carers to ensure effective mutual understanding through involvement in care planning. The agreements in these meetings must be comprehensively documented in the patient record. Regular contact with the patient's family must be maintained, so that they can be involved and informed of decisions for treatment and discharge. Where necessary, for long-distant family members, a Password should be agreed to allow telephone discussions.

4.4 The Learning Disabilities Liaison (LDL) team

The role of the Learning Disabilities Liaison (LDL) team is to facilitate and co-ordinate the meeting of individual healthcare needs for people with LD; supporting clinical teams to best meet the needs of individuals with complex needs. This involves liaising with the community learning disability teams, community providers, families and acute hospital clinical services. To co-ordinate support, planning and treatment delivery for referrals of people with LD, who may require help to access acute services.

The Learning Disabilities Liaison team will review every patient with LD admitted to hospital using LDL care plan sticker (see Appendix 1) to:

- Check and ensure people with a Learning disability are appropriately alerted on IPMS, RAPA caseload, so that any attendance, admission or transfer in hospital will be alerted to the LDL team via electronic messaging and can be seen on Salus Patient Care Management system on the wards via automated attributes: LD (learning disability) and HP (hospital passport) and in their medical notes using the LDL alert sticker
- Complete the Reasonable Adjustment Risk assessment tool (See Annex 2) – and inclusion of Hospital Passport information to enable personalised care, patient choice, effective and safe care
- Identification of and planning for complex needs – the team will prioritise their workload on those individuals with the most complex needs
- Support with or advise with clinical decision-making – including use of Mental Capacity act where necessary; and co-ordination of Best Interest meetings or other consent issues
- Support with agreeing appropriate use of the Supervisions Policy, Restraining Therapies care plan and/or application for Deprivation of Liberty Safeguards, where the care plan severely restricts a patient's freedom
- Check Reasonable adjustments are made and reviewed to best meet patient's individual needs
- Support wards staff to involve carers and families in this process and identifying their needs in their caring role whilst in hospital as per carers Trust Policy.
- Have regular contact and communication with the family and/or formal carers to discuss needs and check understanding/knowledge of care/investigations needed and treatment plans in place.
- Promote appropriate involvement of family/carers/providers in agreeing and provision of 1:1 support as per Trust enhanced observation Policy and Nursing Safer Staffing Escalation Standard Operating Procedure .
- Promote and co-ordinate early discharge planning – with involvement of community teams as needed.
- Provide support and give advice regarding Safeguarding issues/concerns specifically for Learning Disability patients; ensure appropriate Alerts are made to Social Services where necessary
- Where necessary arrange for appropriate advocate for users with Learning Disabilities, advise on need for a referral to Independent Mental Capacity advocates for those individuals who lack mental capacity who have no next of kin or who are befriended.

<u>Development of effective working relationships, including communication/information</u>

- Raise the profile of the health care needs of people with a Learning Disabilities across the acute hospital services; bridging the gap between acute clinical care areas, community services and primary care to enable better communications and access to healthcare.

- Promote the Learning Disabilities Liaison team role within all clinical areas across Acute/PHT, networking with other healthcare settings, community hospitals within Plymouth/Cornwall/Devon.

- Actively promote the Acute Learning Disabilities Liaison Team role to service users (easy read information leaflet for the team to be available), families and carers and other professionals and developing and maintaining networks with partners in primary, community and learning disability services.

- Contribute to the development of healthcare information and resources in accessible formats for service users and their families / carers.

- Develop constructive relationships by attending and contributing specialist knowledge to case conferences / clinical meetings and discharge planning meetings as appropriate, and to make referrals direct to social services / other agencies as required.

- Liaise with relevant voluntary services within the community.

- To assist clinical specialities and others in providing information so that the health needs of people with Learning Disabilities are reflected within Acute/PHNT priorities, ensuring that the delivery on National Service Frameworks, Monitors national Framework and CQC standards, local implementation strategies, local care pathways, are inclusive of their needs.

- Identify existing / potential barriers in accessing acute services for people with a learning disability and promote initiatives to overcome these barriers including developing specific care pathways.

- Support and enable Acute/PHNT services to make ‘reasonable adjustments’ within their care delivery for people with learning disabilities.

- Develop suitable information systems to monitor and report on clinical activity and of the LD Liaison team – to ensure compliance with national standards and local action plans.

<u>Ensure the service adheres to legislation requirements and national standards</u>

- Undertake benchmarking, audit and monitoring against recognised national standards.

- Promote active participation of service users and their families / carers in the healthcare process, working within the Public and Patient Engagement agenda.

- Assist in the development of monitoring of local standards in partnership with people with learning disabilities; through Essence of Care audits, Patient and Liaison Service (PALS), User feedback (Derriford User Group), Local Patient Easy read, Friends and Family Surveys and complaints

- Work in partnership with people with Learning Disabilities, self-advocacy groups, PALS and carers' groups in the development, implementation and maintenance of service provision

- Provide leadership and co-ordination of the Derriford LD user group, annual work plan and feedback to appropriate hospital department leads, PHNT patient experience committee, local health action sub groups and LD partnership boards.

- Assess the impact of local and national initiatives and provide feedback on Trust initiatives relating to skills competency of its workforce in respect of Learning Disabilities.

- Make recommendations and participate in the formulation of new working practice policies.

- Contribute to the Risk and Health & Safety Agendas in the Trust.

- Promote the early resolution of issues and complaints working closely with appropriate Matrons and Clinical Leads.

<u>Work with the appropriate users, healthcare professionals, support staff and external agencies to support professional development and practice.</u>

- Work in partnership with multi-professional / clinical education staff to provide a comprehensive, innovative clinical skills and competency education framework.

- Assist Workforce Development Team to identify training needs in relation to learning disabilities and assisting with the development of teaching materials / training packages and the mandatory e-learning.

- Monitor and report on staff numbers completing LD awareness e-learning training and other direct training

- Co-ordinate and assist in the delivery of training to meet identified needs specifically to ensure that colleagues in acute hospitals are aware of and able to meet the needs of people with a learning disability. This should include adults at risk awareness, MCA and Dols.

- Contribute or deliver educational sessions to all staff groups, liaising with other agencies and users in order to gain their participation in the education delivery.

- Develop and deliver multi-professional education opportunities, including shadowing/working with the Learning Disabilities liaison team

5 Procedure to Follow

Information regarding the patient's needs etc. should be gleaned before hospital admission/attendance, wherever possible. All known patients will be added to the Learning

Disabilities Liaison team RAPA caseload - so that attendance to the Accident and Emergency department or admission to hospital is alerted to the Liaison team.

5.1. Hospital attendance to Out Patients or Day Treatments/investigation (see Appendix 3)

It is expected that Learning Disabilities Community services/Primary care Liaison services will liaise with The Acute Liaison Team for patients attending Outpatients appointments. This contact should be with sufficient time before the appointment to enable appropriate planning for the necessary support to individuals – across community and hospital staff.

The role of the specialist LD healthcare assistant within the LDL team will mainly support people attending for outpatient appointments. They will in advance pull an outpatients list from RAPA. They will aim to contact people to confirm and provide additional information in regards to their appointment if required. Confirm and arrange any reasonable adjustments needed. When required they will book and support people at their appointments, notifying the LDL nurses of any concerns or complex issues.

The client's specific needs for a hospital admission/attendance should be incorporated into the individual's Health Action Plan and Hospital Passport. Information from the Hospital Passport should be used to inform the patient's care plan in hospital - identifying specific needs of the individual: in particular any complex needs which may require reasonable adjustments to be made when planning investigations, assessments or treatments.

Individuals attending as a Day patient may need to be supported with the following:

- Pre-hospital planning, acclimatisation, reasonable adjustments to meet the needs of the individual and management of anxiety or phobias
- Clear communication with individual and carers
- Medication to reduce anxiety and/or agitation in hospital
- Management of behaviours which may challenge or disrupt - may require increased observation, carers known to the individual, sedation
- Hoists or other manual handling equipment – to move or be moved
- Support with activities of daily living – using toilet, eating/drinking. Maintaining dignity and respect of the individual
- Support/help from community services/carers/family/community liaison staff – to provide continuity of care and help from carers known to the individual

Did Not Attend (DNA)

The LD Liaison team will monitor DNA's for people with a learning disability. If a person DNA's more than once for an appointment departments should let the LD Liaison team know. The LD Liaison team will pull fortnightly reports on DNA's. A member of the team will do a follow up call to the patient to try resolving any issues and offering support. They will when required liaise with the community LD team for further support for individuals and contact the community safe guarding services if they have concerns.

5.2 Elective Admissions (see Appendix 4)

Pre-assessment – a reasonable adjustment summary (where available) and Hospital Passport (where available) will be used in the assessment of patient needs to identify any special requirements either whilst in hospital or following treatment. Anticipated needs on discharge should be assessed and planned for at pre-operative assessment

Care Pathways – will normally define the patient care needs according to the condition or treatment provided. However, consideration will need to be taken as to the specific needs of a patient with learning disabilities – so that Reasonable adjustments can be made to take the specific/complex needs of the patient into consideration. These should be discussed with the patient and their carer, or the Community Learning Disabilities/Primary Care Liaison Nurse at pre-assessment

Examples of Reasonable adjustments may include – General Anaesthetic (see Appendix 5 for specific LD GA clinic held once a month) may be required over Local; 'Day case' procedures may well require overnight stay; Day of surgery admission may be inappropriate; Patients may need carer support up until sedation for procedure has taken effect.

The LDL team will actively manage and coordinate the LD general anaesthetic clinics held one morning a month. The LDL team will accept open referrals and liaise with other departments, community clinical staff, GPs, family members/providers of care and the patient to ensure the mental capacity act is followed, reasonable adjustments are made, correct clinical procedures are booked and the most effective use of this service is made for the person on the day.

Day of Surgery Admissions – Most patients admitted to hospital for surgery will not know which ward they will be on post-operatively. Bed mangers are to be made aware of planned overnight stays 48hrs in advance. In times of bed shortages any cancellation of a persons with LD procedure on the day must be consulted with the LDL nurse at earliest opportunity. For patients with learning disabilities, careful planning will be required at pre-admission clinic and on the day of surgery, to ensure reasonable adjustments are assessed, agreed and communicated. If at all possible this should include visiting the post-op ward prior to surgery.

5.3 Emergency Admissions

Patients known to Learning Disabilities services will be identified with an alert on Patient Information Management System (iPMS) and the Hospital Administration System (HAS) used in the Emergency Dept. Patients admitted will be alerted to the Learning Disabilities Liaison Team via the RAPA system

- Where a patient who has an identified learning disability is admitted through the Emergency units, nursing staff will contact the Learning Disabilities Liaison team, at the earliest opportunity, to find out known information regarding the patient's specialist needs and to alert the team of the admission via ED, MAU and SAU.
- Those patients who repeatedly attend Emergency Department or have complex needs may have individualised Emergency Summary Plans (ESP), developed by and with the Learning Disabilities services, so that information regarding the specific needs of these patients can be readily accessed by Emergency Department staff. Please ensure they are printed off and transferred in patient confidential notes that essential information is verbally handed over.
- The Care Provider will provide a patient profile or Hospital Passport for those admitted under emergency conditions known to their service – including list of regular medication and identification of known risks to patient

- All patients who have known Learning Disabilities will be viewed as an adult at risk- particular attention will be made to ensure that complex needs relating to the Learning Disabilities, are considered and included as part of the hospital care plan.
- Patients not previously known to the Learning Disabilities teams (community and hospital), may require a formal referral to Liaison teams in the hospital, community or primary care for any ongoing health needs on discharge.
- People with Learning Disabilities are at high risk of being abused/self-neglectful - any concerns regarding the condition of an individual on admission, the care plan reported to be in place in the community or any disclosures made by the patient or carers will be referred for multi-agency investigation doing a Datix and making a Safeguarding Alert as per Trust policy.
- Transfers of people with Learning Disabilities must be carefully planned. The Bed manager must be advised that the person has Learning Disabilities. Transfer to other wards may cause increased anxiety or risk breakdown in communication between teams and compromise continuity of care and carers.
- When the patient is transferred to an appropriate ward the Nurse-in-charge on the transferring ward <u>must</u> inform the Nurse-in-charge on the receiving ward of the patients specialist/complex needs relating to their Learning Disabilities; this includes the involvement of any formal or family carers.
- The Matron of the area should also be notified that a person with Learning Disabilities has been transferred onto the ward

5.4 Bed Transfers

Transfers of people with Learning Disabilities must be carefully planned. The bed manager must be advised that the person has Learning Disabilities. Transfer to other wards may cause increased anxiety, risk breakdown in communication between teams and break continuity of care and carers. Therefore transfers between wards should be kept to a minimum – and only be considered where clinically necessary for the individual. Any such ward transfers must be carefully planned and not undertaken late at night.

Any transfers after 10pm even if clinically necessary are to be a Datix so this can be monitored by the LDL team leader.

On transfer to a new ward please ensure patient’s personal documents for example hospital passport, seizure protocol or any other guidelines are verbally handed over to senior nurse in charge and this is recorded on the yellow transfer sheet.

On transfer the patient’s hospital reasonable risk assessment tool must be verbally handed over and signed on the back by receiving ward/nurse.

Any plans in regards to discharge must be handed over and recorded

If 1:1 is in place this must be reviewed and agreed by accepting ward as needed with the family or provider and method of funding (see section 5) agreed

Poor handovers are to be a Datix so this can be monitored by the LDL Team leader

Patient with LD must not be “out-lied” to other wards to allow admission of another patient.

5.5 End of Life care

Any patient who is deemed to be within the last twelve months of life, should be identified for End of Life care. This must include:

- Completed Treatment Escalation Plan (TEP) – which must be discussed with the patient and family; such discussions can be facilitated by the LD Liaison team unless the clinical condition of the patient deteriorates so rapidly that TEP discussions are made out of hours.
- Advanced Care plan – identifying patient choices/preferred place of care
- Record of any advance decisions to refuse treatment
- Details of Enduring Power of attorney (where necessary)
- Details added to Electronic Palliative Care Co-ordination system

The Learning Disabilities Liaison team will work closely with community teams to ensure appropriate EOL care is planned

5.6 Review of Treatment plans by Medics:

The patient's hospital treatment/care plan should be reviewed daily; arrangements for weekend review will need to be made by the medical team. Appropriate involvement of the Learning Disabilities Liaison team must be maintained throughout the patient's admission; Revision of treatment plans should involve the Learning Disabilities Liaison team, who will where necessary include Community services

All reviews of care planned should include the patient as a partner in care. Even for those patients who lack mental capacity, every effort should be made to include the patient in decision-making and care planned. Encouraging development of any routine to care and treatment, which the patient can understand and be part of, will reduce the patient's anxiety and fears of being in hospital.

5.7 Discharge Planning

Senior in charge should ensure that all potential complex admissions are flagged on the SALUS as a complex discharge at the point the decision to admit is made, or at the next available opportunity. Where a ward has a discharge case manager they must follow the complex discharge pathway. This is to allow early planning of discharge and regular communication with community services/providers.

Elective admissions –

Planning for discharge should commence at pre-assessment, needs should be discussed and identified with both the patient and their carer's and appropriate referrals made at this point.

Emergency admissions –

Discharge planning should commence on admission, for all LD patients this will include the referral to the Discharge Case Manager and using the complex discharge pathway. Development/finalisation of the discharge plan will be based on a multi-agency approach which is an ongoing process throughout the admission and may include a case conference.

The clinical team on the ward should follow up referral to discharge team with a phone call to ensure early involvement of the appropriate discharge team(s) member. The learning disability liaison team will liaise with the Community Learning Disabilities services for patients with known complex needs or who are already known to community services as appropriate or make onward referrals as needed.

Full involvement and discussion of discharge plans with the patient and family should be held, at ward level. For patients with complex needs – a full health needs assessment may be required and discharge care plan devised in hospital, with involvement of community teams. This process must include the Learning Disabilities Liaison Nurse when they have requested it.

Any patient identified as a vulnerable adult and for whom Safeguarding adult concerns are identified, will need to have a multi-agency Vulnerable Adults Risk Management plan (VARM) for appropriate support and follow-up on discharge lead by local authority/community teams. .

Good communication will be maintained with the LDL team and discharge team via email, fortnightly briefings and regular meetings in the year to resolve any issues.

5.8 Staff Training and development

The importance of training in relation to the management of patients with Learning Disabilities is recognised by the Trust. The Learning Disabilities Liaison team will be involved in planning, delivery and review of training.

Training will be delivered as part of the Trust's induction and mandatory update training programme. Compliance with mandatory training completion is monitored at Directorate level through Performance management.

Face-to-face training re Learning Disabilities awareness is included in the Healthcare Assistance programmes, Preceptorship programme and F1 and F2 junior doctor programmes.

Through the identification, training and regular support of Learning Disabilities Link practitioners (see Appendix 5 for Job description) , awareness training and standards of care for people with Learning Disabilities will be improved and promoted including non-clinical staff.

Staff within Emergency Department and Acute Assessment units will receive training from the Learning Disabilities Liaison team in addition to their eLearning, to ensure that they are confident and competent in caring for patients with Learning Disabilities.

6 Document Ratification Process

The design and process of review and revision of this procedural document will comply with The Development and Management of Formal Documents.

The review period for this document is set as default of two years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be reviewed by the Safeguarding Steering Group and ratified by the Director of Nursing.

Non-significant amendments to this document may be made, under delegated authority from the Director of Nursing, by the nominated author. These must be ratified by the Director of Nursing and should be reported, retrospectively, to the Safeguarding Steering Group.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes.

7 Dissemination and Implementation

Following approval and ratification, this procedural document will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the Director of Nursing and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

8 Monitoring and Assurance

Ongoing review of standards of care and patient experiences for people with Learning Disabilities, will be undertaken via the following:

- Regular audit of care practice through the safeguarding teams annual audit plans
- Standards of care in hospital for people with LD are reviewed on a quarterly basis – through reports to the Trust quality assurance committee board. This considers the Trust's compliance with specific national standards.
- Ongoing review and reporting of the PHNT LD DASH board via the safe guarding board.
- Local Patient Surveys to be made easy read so to include patients with Learning Disabilities
- Regular meetings with Derriford Users Group (DUG) – facilitated by Highbury Trust and lead by the LDL team leader
- Ongoing Mortality Reviews - review of death of any patient with Learning Disabilities in hospital and report bi-annually to mortality review panel
- Review by the Learning Disabilities Liaison team of clinical incidents reported and flagged as involving individuals with Learning Disabilities
- Involvement of Learning Disabilities Liaison team in any complaint investigation required, regarding concerns with care of patient with Learning Disabilities; annual review of such complaints and PALS concerns
- Feedback from community services/providers/carers re patient experiences of hospital – to Learning Disabilities Liaison team
- Annual review of service specification and LD DASH board with clinical commissioners of Learning Disabilities Liaison service

All staff will endeavour to resolve any concerns or issues of dissatisfaction as they arise. If the issue cannot be resolved at a local level or with the assistance of the Patient Advice Liaison Service (PALS) and a written complaint is made, the trust will provide an open, fair and accessible complaints process in line with the National Health Service Complaints Procedure that encourages communication on all sides. Plymouth Hospitals NHS Trust is committed to using complaints from patients, their relatives or carers to continuously monitor and improve the services it provides. The Trust does not decide if a complaint should be upheld or not, but treats every complaint as an issue to be resolved.

For further guidance on making a complaint please refer to the Complaints procedure.

9 Reference Material/Contacts

Learning Disabilities Liaison Nurses	Tel: 31566 or bleep 85436
Specialist Nurse for Safeguarding in Emergency Directorate	Tel:31664 or bleep 89195
Lead for Safeguarding Adults	Tel 39497 or bleep 89557
Deputy Director of Nursing	Tel: 32088 or bleep 89323
Community Learning Disabilities teams	Plymouth 08451558077 Devon 01392 385103 Cornwall 01208 834455
Plymouth City Council Adult Social Care	01752 668000
Patient Services (PALS and Complaints)	57683
IMCA services	Plymouth 01752 753718
Plymouth Hospitals NHS Trust contracts team.	37046
Local Clinical Commissioners	NEW Devon CCG Cornwall CCG

Appendix	**Appendix 1-3**

1. Learning Disability Liaison Care Plan sticker

2. Draft LD Reasonable Adjustment risk assessment tool

3. Procedure for Patients attending Out Patient appointments at Derriford Hospital

4. Pre assessment for Day case Surgery Pathway.

5. General Anaesthetic LD clinic pathway

6. Roles & Responsibilities of the liaison practitioner

Appendix 1	**LDL care plan sticker**

Learning Disability Plan of Care

- Seen by the Learning Disability Team, Tel 31566, pager 85436 ☐
- Alert sticker in front of notes ☐
- Hospital Passport ☐
- Risk assessment/Reasonable adjustment tool ☐
- Patient given LDL team service information leaflet ☐

The above information must be used to inform the patient care plan.

Print name……………………………… Date…………………

Signed…………………………………… Time………………..

HRSG: 0736/1

Appendix 2	Reasonable Adjustment Risk Assessment tool

Plymouth Hospitals NHS
NHS Trust

Learning Disability Risk Assessment and Reasonable Adjustment Tool

Name:
Hospital no:
NHS no:
DOB:

Individual specific care information:

Learning Disability	**Epilepsy** ☐	**Mental health issues** ☐	**Visual Difficulties** ☐
Mild: ☐	**Asthma** ☐	**Dementia** ☐	**Wears Glasses** ☐
Moderate: ☐	**Diabetes** ☐	**Physical disability** ☐	**Hearing difficulties** ☐
Severe: ☐	**Cardiac** ☐	**Wheelchair user** ☐	**Uses hearing aid** ☐
PMLD: ☐	**Autism** ☐		**Wears dentures** ☐

Has had / been advised to have flu / pneumonia vaccine: ☐

Care involvement: Usual care package: Care provider:
1:1 required for ….. hours a day, CHC funding Social care funding
Care to be provided by family/carers/hospital (see information in Care Planning section)

Epilepsy: Seizure monitoring ☐ Rescue medications ☐
Community Guidelines in place ☐ See patient notes / prescription chart

Identified Reasonable Adjustments Required

Communication: Needs / Plans	Communication Preference:		**Hospital Passport:**		Interpreter:	
	Future wishes / EOL plan:		Hospital Communication Book:		Easy read information:	
Anxiety/Pain:	Support from person known to patient:		Prefers company(busy area):		Prefers solitude (quiet area):	
			TV/Music/Activity (Specify):			
	How pain is expressed / managed:					
Personal safety:	High supervision bed:		Bed rails:		Bumpers:	
	Extra support required:		Space required (wheelchair/hoist/guest bed):			
Medical interventions / medication:	Best interest decisions required:		Needle phobic:		Contact LD team:	
	Needs support to take medications:		Needs own support present for interventions:			
	Blister pack required for discharge:		Has tablets/syrup takes in drink/food:			
Swallowing / Nutrition / Hydration:	Red Tray:		Supervision/food cutting up:		Thickened fluids:	
	Soft diet:		Pureed diet:		Special diet – see notes	
	For all feeds/top up feeds and/or fluids/peg in place;					
Hygiene needs:	Independent:	Direction / prompting:	Assistance:		All care:	
Continence support:	Independent:		Ask regularly:		Support to access toilet:	
	Wears pads:		Wears conveen:		Catheter in situ:	
Specific positioning / mobility needs:	Fully mobile:		Walking stick / frame:		Hoist:	
	Wheelchair:		Sleep system:		Regular turning:	
Other:	Parking concessions:		Single room:		Guest bed supplied:	
	Drinks / meals for carers: (PHNT Carers Policy for guidance)					

RISK ASSESSMENT

Personal safety	☐ No issues identified	**0**
	☐ Requires regular observation and reinforcement to maintain safety.	**1**
	☐ Level of learning or physical disability requires high observation to maintain safety. ☐ Mental health status affects ability to maintain safety. ☐ Additional sensory disability – blind or deaf.	**2**
	☐ Unable to maintain own safety due to level of learning disability / autism, may wander or remove medical devices such as cannulas or drains, needs 1:1 support. ☐ Complex physical disabilities require continuous observation and management of posture to maintain airway. ☐ High risk of pressure area breakdown (Braden). ☐ High risk of falls (Falls Assessment). ☐ Safeguarding issue identified.	**3**
Swallowing, nutrition and hydration	☐ No previous or current history of swallowing issues.	**0**
	☐ Previous history of swallowing issues, but has not been formally assessed. ☐ Requires support to ensure adequate food and fluid intake.	**1**
	☐ Requires safe position or additional support for eating/drinking/non-oral feeding. ☐ Long-term feeding via PEG or NGT and is NBM. ☐ History of recurrent chest infections or unintentional weight loss.	**2**
	☐ Assessment indicates high risk of dysphagia. ☐ On modified food / thickened fluids. ☐ Requires one-to-one support whilst eating / drinking for safe swallowing.	**3**
Communication	☐ Good verbal communication and understanding.	**0**
	☐ Some verbal communication; uses non-verbal systems to supplement. ☐ Requires additional time to process information and respond.	**1**
	☐ Uses some non-verbal signs, facial expressions, body language or behaviour to communicate. ☐ Requires extra time and/or information in alternative formats.	**2**
	☐ Extremely limited communication. ☐ Requires support from carers to interpret needs.	**3**
Mental capacity **(NB -general guidance only– each decision to be individually assessed)**	☐ Assessment indicates no capacity issues. ☐ Can make own decision and/or consent to treatment with clear explanation.	**0**
	☐ Understands simplified explanation of procedures. ☐ Requires reinforcement, extra time and accessible information to support decision making.	**1**
	☐ Has difficulties understanding complex treatments/interventions, but will consent with reinforcement and support.	**2**
	☐ Is unable to understand, retain, weigh up, communicate back and make decision related to treatment/interventions (lacks capacity). ☐ Very unlikely to comply with treatment/interventions.	**3**
Epilepsy	☐ No known seizure activity.	**0**
	☐ Seizures well controlled by medication or infrequent.	**1**
	☐ Poorly controlled or unpredictable ☐ Seizure activity increased by illness or anxiety.	**2**
	☐ Seizure activity is prolonged or difficult to recognise, leasing to loss of consciousness. ☐ High risk of airway obstruction or aspiration during seizures	**3**

Behaviours and anxieties	☐ No issues identified.	0
	☐ May become anxious in new environments, needs reassurance and extra time to reduce anxiety. ☐ May display inappropriate behaviour, needs clear boundaries and reinforcement.	1
	☐ Can display inappropriate behaviours ☐ Occasionally displays aggressive behaviours, not high risk of injury	2
	☐ Severe hospital phobia or unable to wait. ☐ Can display aggressive behaviours to self or others, high risk of injury. ☐ Requires own carers to manage needs.	3

Score 0-8 = low risk ★▲● ☐☐☐ **Score 9-12 Medium risk** ★▲● ☐☐☐ **Score 13-18= High risk** ★▲● ☐☐☐

Care Planning **To be initiated by ward nurse caring for patient** **(can be used on three separate admissions)**		★ **Date** **Initial in box**	▲ **Date** **Initial in box**	● **Date** **Initial in box**
Low Risk	Complete all Trust risk assessments, eg Moving and Handling, Bed Rails, Falls, Pressure Ulcer, Nutritional Screening			
	Implement basic nursing care monitoring charts, such as fluid charts, food charts and epilepsy charts.			
	Be aware of Trust learning disabilities policy – refer to if necessary			
	Ask to see Hospital Passport (KEEP WITH PATIENT, DO NOT FILE IN NOTES). Liaise with carers to identify usual support and communication needs, refer to PHNT Carers Policy.			
	Consider needs on discharge – Will a referral to discharge team be required? Record if completed.			
	Check TEP has been correctly completed			
Medium risk as for low risk plus:	Increase level of supervision and observation- Confirm level of support that can be offered by carers, document on care plan. Refer to PHNT Carers Policy. **Complete urgent DOLS if required**.			
	Use Trust Challenging behaviour, special needs and observation policies, under 'Policies and Guidelines' on the Trust intranet. Consider need for Restraints Policy implementation.			
	Use alternative methods to assess potential clinical issues, such as Abbey Pain Tool, Hospital Communication Book			
	Make referrals to appropriate healthcare professionals, such as SALT, physiotherapy, dietetics etc.			
	Assess for and agree funding for any additional support needs with senior nurse and Learning Disability Team if required			
	Funding agreed on admission by…………………………………………			
	Funding agreed on transfer to ward by…………………………………			
High risk as for low and medium risk, plus:	**Must liaise with LD team** to arrange an MDT meeting to support safe discharge planning and continuing care needs.			

<u>Document all actions clearly in the patient's medical record.</u>

<u>Admission 1</u>

Assessment completed (date) ………………………………………….(time)……………………..

LD nurse …………………………. Signature ……………………………. Initials: …………

Care plan completed (date)…………………………………………. (time)

Ward Nurse: ……………………. Signature ……………………………. Initials: …………

<u>Admission 2</u>

Assessment completed (date)…………………………………………….(time)…………………..

LD nurse …………………………. Signature …………………………. Initials………….

Care plan completed (date)…………………………………………. (time)

Ward Nurse……………………..Signature…………………………. Initials………….

<u>Admission 3</u>

Assessment completed (date)…………………………………………….(time)…………………..

LD nurse …………………………. Signature …………………………. Initials………….

Care plan completed (date)…………………………………………. (time)

Ward Nurse……………………..Signature…………………………. Initials …………..

Derriford Hospital Learning Disability Liaison team:
Saoirse Read, Kate Bamforth, Lesley Smith, Fiona Dilorenzo

Level 7 Derriford Hospital, Derriford Road, Plymouth, Devon, PL6 8DH
Tel no 01752 431566 Page: 85436

Email: plh-tr.learningdisabilityhospitalteam@nhs.net

Date issued: February 2014
Revised: April 2017
Date for review: January 2019

Appendix 3 — Procedure for Patients attending Out Patient appointments at Derriford Hospital for LDL HAC

LD team admin to print outpatient list 2 weeks prior, LD HCA to check to see if any patients known and need immediate attention.

↓

Ring patients at least 1 week prior to discuss needs. Priority need may be to change date, time or length of appointment etc.

↓

External referral: phone, email, letter.

↓

May need to do further information gathering prior to contacting patient. Contact Patient

↓

Arrange to support and put in LDL team diary, post out easy read version of appointment letter with directions if needed, and easy read leaflet of procedure and hospital passport. Meet and Greet in main entrance if written/verbal directions are not going to help. If it's a Best Interest or complex case refer to LDL Nurse.

↓

Prior to appointment inform department of any reasonable adjustments needed, this may include a prior visit to department for desensitization, hoisting equipment, quite room. Source easy read or any other communication aids if not available to hand in department or on trust web site

↓

Support in appointment as required. Check patients understanding. Follow up as needed this could be to rearrange another appointment, an agreement to call care provider, GP, Family or local CTLD. If any urgent concerns arise or situation becomes more complex bleep LDL Nurse.

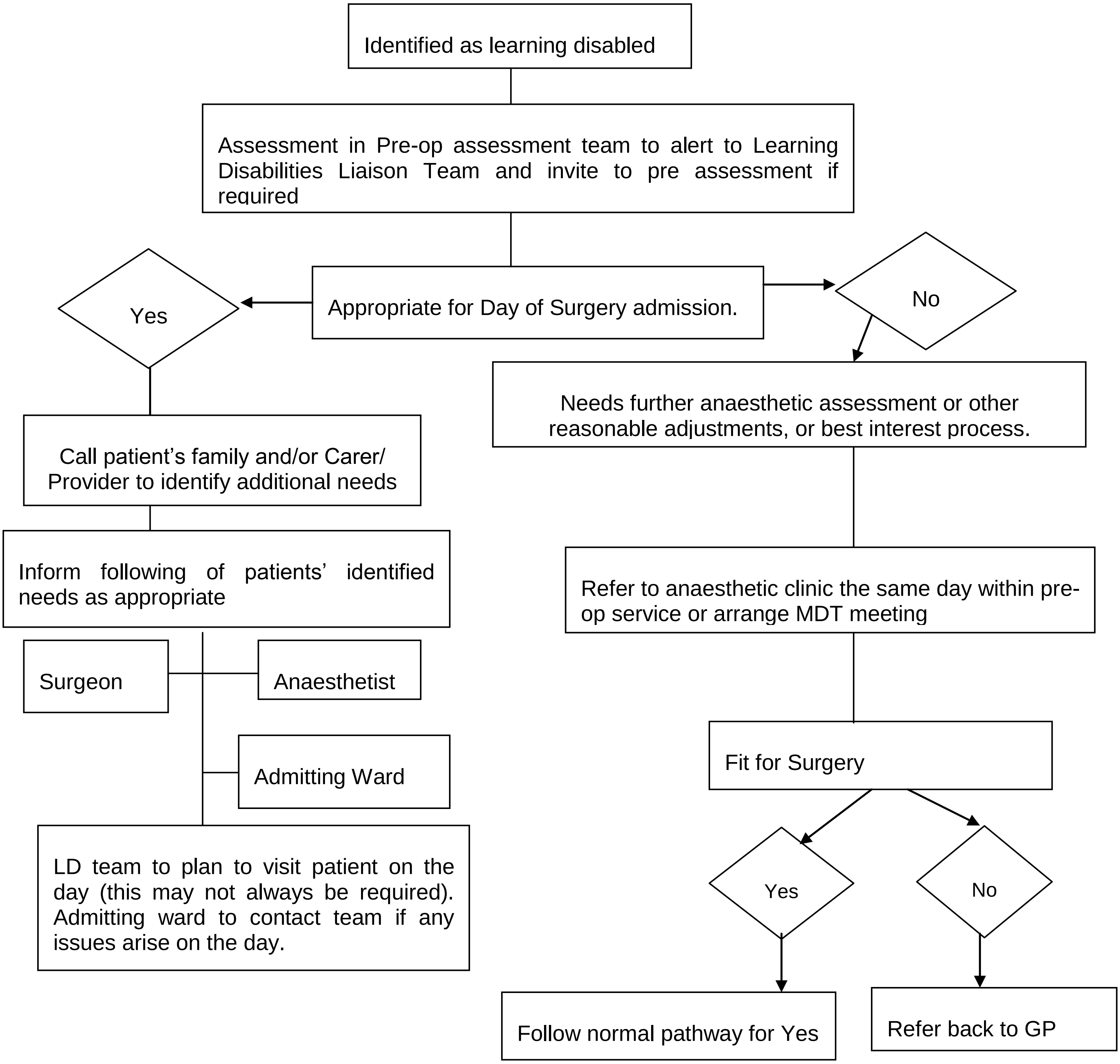
↓

LDL nurse to gather further information from referrer and contact key people in regards to complex needs and reasonable adjustments needed, capacity and Best Interest process.

↓

Ensure appointment time and length is suitable. Support in appointment as required. Arrange for key people to attend, agree and share plan. Check prior adjustments both in community and department are in place. Ensure notes and necessary paper work is available. Follow up as needed.

Appendix 4 Pre assessment for Day case Surgery Pathway.



Appendix 5: Learning Disability GA Pathway

Referral to be made to LDL team via letter, e-mail or telephone call. Ask for request forms and any capacity or best interest paperwork. Add patient to the waiting list database stating in the comments "This patient is on L.D GA List" Allocate date/time after booking appropriate procedures.

↓

Complete and send GA referral plan to Freedom Unit Lead & lead anaesthetist. Ensure any investigations have been booked .Complete and send easy read appointment letter (if required) and complete e-mail referral for pre assessment.

↓

1 week prior Complete GA list checklist, MRI CT questionnaires and call notes,. Ensure anaesthetist has GA referrals.

↓

2-3 days prior view check list and liaise with patient for any final matters, inform Freedom of any changes. Finalise the Theatre List through Corporate Services and confirm this by e-mail to the Theatre Co-ordinators and Freedom.

↓

Erme to do pre op assessment via a telephone slot for all patients. LD team to Collect notes from Erme once the pre assessment has been completed.

↓

Morning of procedure LDL nurse to attend 08:00am briefing to confirm plan. Bring patient notes, copy of GA referral forms, BI paperwork and any request forms. Have any on call or other consultant numbers ready. Any messages for the LDL nurse doing GA clinic need to go directly to them. Patient to bring own: razors, nail cutters, etc. as appropriate.

↓

Learning Disability Team will close the patient referrals the following day.

Appendix 6	Roles and responsibilities of the Learning Disability Link practitioner

The Learning Disability Link practitioner will promote the care and support for individuals and their families – ensuring that other staff is aware of the resources and support available at ward/department level. They will form a vital link between the ward team and Learning Disability Liaison team - specifically in respect of communicating learning disabilities issues and needs.

The Learning Disability Link Practitioner will:

1. Liaise with the ward / clinical area manager and the Learning Disability Liaison team for general awareness, resources and communications.

2. Promote and disseminate information of up to date practices / procedures to ALL healthcare staff in their team; alerting the LD liaison team of any training needs for members of the team

3. Ensure that patients with Learning Disabilities are alerted to the LD Liaison team.

4. Provide induction training for new staff or students, re the care of individuals with Learning Disabilities within the ward setting.

5. Maintain the Learning Disability resource folder and ensure staff is aware of this.

6. Attend Learning Disability Link practitioner training / meetings.

Information can be found: Q Drive – Learning Disability Resources

NHS Website – Learning Disability Link