CTPLD Health Assessment Hospital Liaison Pathway

This base line assessment is intended to be carried by Wiltshire PCT specialist in learning disabilities. It is recommended that a nurse/allied health professional should assess any person with a learning disability admitted to hospital as soon as is reasonably possible following admission. CTPLD managers agree that this may mean re-prioritising case work.

The aim of this assessment is to ensure that the patient with learning disabilities has her/her needs met while in hospital and is assisted towards timely, safe outcomes. It is a comprehensive assessment covering both the nature of the learning disability and the current reason for admission. It is to compliment the medical and nursing assessments that are carried out in hospital. There are tools to support the person in hospital such as the “communication book” and information sheets such as the Dis-Dat tool.

This assessment can be shared with the hospital staff and the patient/ family to enable communication and promote equitable health care.

Please access the hospital notes and key medical/nursing staff to assist with accurate information gathering for this assessment.

Name		**Date of assessment**
Home Address		**DOB**
Date of Admission:		**CTPLD Staff**
Hospital and Ward:		
Ward Contact Name and Number:		
Reason for Admission:		
Treatments since admission:		
Domain of care	Indicators/prompts	Notes

Feeding and hydration	• Have needs changed since hospital admission? • Have needs changed due to health condition? • Is there clear information about the persons individual needs including pre-hospital admission base line? • If the person is unable to take food/fluids orally what is the plan? Has artificial feeding been considered? • S&LT referral • Is this likely to be a terminal/palliative event? • Are the nutritional needs being met? • Do the family/carers have any concerns about nutrition?	
Personal care/ dignity	• Are the person s needs being met? • Is there a good understanding of the persons usual base line? • Is the person having their usual needs met in terms of manual handling and physiotherapy? • Do they need their own equipment such as wheelchair? • Access toilet facilities? • TV/Phone? • Is the hospital reliant on carers to meet the individuals person care needs? • Are the family comfortable? Consider night time and the Tariff for paid carers.	
Communication	• Do hospital staff have access to information to individual communication? • What does the individual say about why they are in hospital? • What does the individual say about being in hospital? • What do the family say about why the person is in hospital? • Do they match the notes? • What are family/cares saying about the experience of being in hospital?	

	• Is there any challenging or complex health needs acting as barriers to providing medical care? • **Is the consultant communicating with the patient and family?**	
Pain	• Are there concerns about pain from anyone? • Are you concerned about pain? • How is pain being assessed and treated? • Think about hidden pain such as being in bed. • Are there signs of distress? • Introduce Dis-Dat	
Elimination	• Have problems been identified? • Is it being monitored? • Is there likely to be a long term change affecting life at home • What plans are in place	
Medication	• What's new? • Consider interactions • Compliance and consent • Plan if best interest decisions made • Route of medication to ease discharge	
Postural care	• Consider need for own equipment and care plan • Need for CTPLD physio and/or OT to assess and liaise with hospital staff • Need to prevent deterioration through own physio programme	
Pressure care	• Has this been assessed? • Has pressure area care plan been put in place? • Consider flexion in hands or waist causing sores	
Known Epilepsy	• Is the care plan in place with full seizure descriptions and risks outlined? • Are hospital staff aware of seizure descriptions and recording	

	them? • If Epilepsy was the reason for admission is there clear information regarding the person's usual seizure presentation?	
Challenging behaviour	• Usual baseline and management guidelines • Need BNS input? • Is mental health a factor? • Additional assessment such a continence, Pass-add, CHC1	
Decision making process	• Is the person aware of the reasons for admission? • If the person is not aware how can this be facilitated? • If the person is deemed to lack capacity what evidence is there to support this? • If decisions are being made in the persons best interests what procedures have been followed or will be followed? • Does the person have close family who can advocate for the persons best interests? • Does the person need referring to the IMCA services? • Do have concerns about diagnostic overshadowing? • Are there syndrome specific issues that are concerning you?	
Discharge planning.	• If the person has a long term health condition what is the disease trajectory likely to be? • What is the Prognosis according to the medical staff? • What will the person need to be able to manage at home? • Consider weekend care if late discharge is planned on the Friday evening. • Equipment needed for home care? • Referral to neighbourhood team? • Physio/OT community referral?	

Further Continuation notes

Date	Contact details	Name