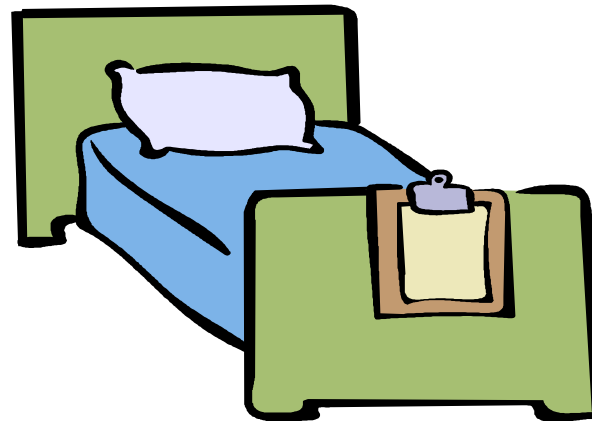


Blackpool Learning Disability Partnership
Blackpool PCT.
Blackpool Wyre & Fylde Hospitals NHS Trust



Information to Support

Name:.....


During A Stay In Hospital or Attending a Clinic



Level of support required whilst in hospital

 	<p>24 hr 1-1 <input type="checkbox"/></p> <p>A&E and Outpatients Appointments <input type="checkbox"/></p>	<p>Daytime 1-1 <input type="checkbox"/></p> <p>Daily Visits <input type="checkbox"/></p>	<p>Day & Evening 1-1 <input type="checkbox"/></p> <p>None <input type="checkbox"/></p>	<p>1-1 Supervision at certain times, eg mealtimes bathing etc. <input type="checkbox"/></p>
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Usual living Situation

	<p>Lives with Family Carers <input type="checkbox"/></p>	<p>Lives alone <input type="checkbox"/></p>	<p>Lives in a residential or other service with staff support <input type="checkbox"/></p>
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Risk Assessment



How does the person express pain? *Describe body language /gestures etc. if person is unable to speak, include methods used to reassure or comfort.*

Are there issues regarding challenging behaviour

What helps to reduce this ? *Provide details*

Are there any identified triggers? *List potential factors which could cause distress / anxiety*

Other Risk Factors

Does the person require a single room?




Is the person likely to wander or get lost?


Does the person have a tendency to choke?

If so how is this managed

Communication Skills






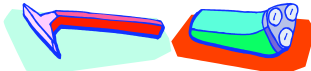

please tick all appropriate boxes

  	Can the person talk? <input type="checkbox"/>	Is English their first language? <input type="checkbox"/>
	Does the person require any specific aids to enable them to communicate? <input type="checkbox"/>	
	If so, provide details of what is required:	
	Can the person understand what is said to them? <input type="checkbox"/>	Does the person have a Communication Passport? <input type="checkbox"/>
Does the person need pictorial prompts to enhance communication? <input type="checkbox"/>		
Can the person read? <input type="checkbox"/>	Does the person need some assistance /explanation re: the written word? <input type="checkbox"/>	

	Can the person write? <input type="checkbox"/>	Can the person write their signature? <input type="checkbox"/>
	Are there any specific issues regarding this person's communication /comprehension which need to be acknowledged whilst in hospital e.g. sign language, how things need to be phrased, particular tone of voice, facial expressions general approach etc.	

Daily Living Skills

circle all appropriate statements

	Can the person Wash themselves	Independently <input type="checkbox"/>	With assistance <input type="checkbox"/>	Is dependent on others <input type="checkbox"/>
	Teeth cleaning:	Independently <input type="checkbox"/>	With assistance <input type="checkbox"/>	Is dependent on others <input type="checkbox"/>
	Does person have dentures or a dental plate?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	Dress themselves	Independently <input type="checkbox"/>	With assistance <input type="checkbox"/>	Is dependent on others <input type="checkbox"/>
	Brush their hair	Independently <input type="checkbox"/>	With assistance <input type="checkbox"/>	Is dependent on others <input type="checkbox"/>
	Shaving	Wet Shave <input type="checkbox"/>	Electric <input type="checkbox"/>	Frequency
	Help shaving	Independently <input type="checkbox"/>	With assistance <input type="checkbox"/>	Is dependent on others <input type="checkbox"/>
	Bathing	Independently <input type="checkbox"/>	With assistance <input type="checkbox"/>	Is dependent on others <input type="checkbox"/>
	<i>Uses aids to bath - describe</i>			

	Menstruation	Independently <input type="checkbox"/>	With assistance <input type="checkbox"/>	Is dependent on others <input type="checkbox"/>
	<i>Any other routines around Self Care/daily living skills</i>			



Eating

Uses knife and fork appropriately no assistance required

Requires food cutting up into bite-size pieces and can then continue independently

Once food is cut up can use a spoon without further assistance

Requires supervision to ensure eats at all

Requires spoon feeding

Requires constant supervision throughout mealtimes to ensure person does not choke

Prefers food to be loaded onto spoon and can then place spoon in mouth without assistance

Provide information regarding any specific aids used e.g. plate guard, angled cutlery, liquidized food etc.



Drinking:

Person can drink both hot and cold liquids without assistance

Person needs support to hold the drinking vessel

Person must have a cup with a handle

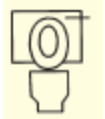
Person must have drinks cooled to reduce risk of scalding

Person requires specialized drinking vessel

Specify any other information regarding any specific aids used including PEG Feeding



Any other information on specific dietary requirements



Continence /Elimination

Is the person continent

Yes

No

Do they go to the toilet?

Independently

With assistance

Is dependent on others

Does the person use continence aids?

Yes

No

What aids do they use?

What support do they need regarding the use?


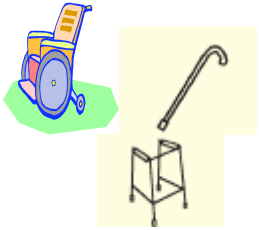
Independently

With assistance

Is dependent on others

Are there issues regarding elimination? Please specify

Mobility and Positioning

	Can the person walk ?	Independently <input type="checkbox"/>	With assistance <input type="checkbox"/>	Is dependent on others <input type="checkbox"/>
	Can they walk up and downstairs ?	Independently <input type="checkbox"/>	With assistance <input type="checkbox"/>	Is dependent on others <input type="checkbox"/>
Does the person require any equipment to assist their mobility /comfort /safety whilst in hospital? <i>Give details</i>				
Does the person need any special help with positioning <i>Give details</i>				

Important Routines



Sleep: *Give details of usual bedtime routine and sleep pattern. Any objects that help the person sleep*



Morning *Give details of waking routine*

Other Routines

Are there activities the person enjoys that could be undertaken in hospital

Epilepsy

provide information on any type of seizure regarding type, frequency severity, pattern, treatment, Triggers.

Other

Give details of any other pertinent information e.g phobias, anxieties, or specific requirements

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Likes and Dislikes




Things which make
the person feel good



Things that don't help

CURRENT MEDICATION INFORMATION

Medication: 	Strength (mgms)	Dosage (how often)	Method of administration: Oral, Injection, applied to skin, rectal	Who usually administers : self, carer etc.	Any special routines needed to take medication – does a check need to be made that the person has swallowed

Consent to treatment



Can the person consent to treatment if the procedure is explained ?

Yes

No



Can the person usually make decisions regarding their lifestyles?

Yes

No

If **No** : Issues regarding consent will need to be discussed via the Trust's Consent Policies and Procedures using Consent Form No. 4.

Parents/carers cannot consent for adults over the age of 18 years regardless of degree of son/daughter's learning disability.

Information provided by: Title

Relationship to person:..... Signature:

Name of person entering information on the sheet if not the above named:

Date: