Emergency and Acute Medicine

UHW

Part B

LINC PROFORMA

Learning Disability, Cognitive Impairment and non compliant Behaviour

Addressograph:

Please check all details are correct on addressograph before applying

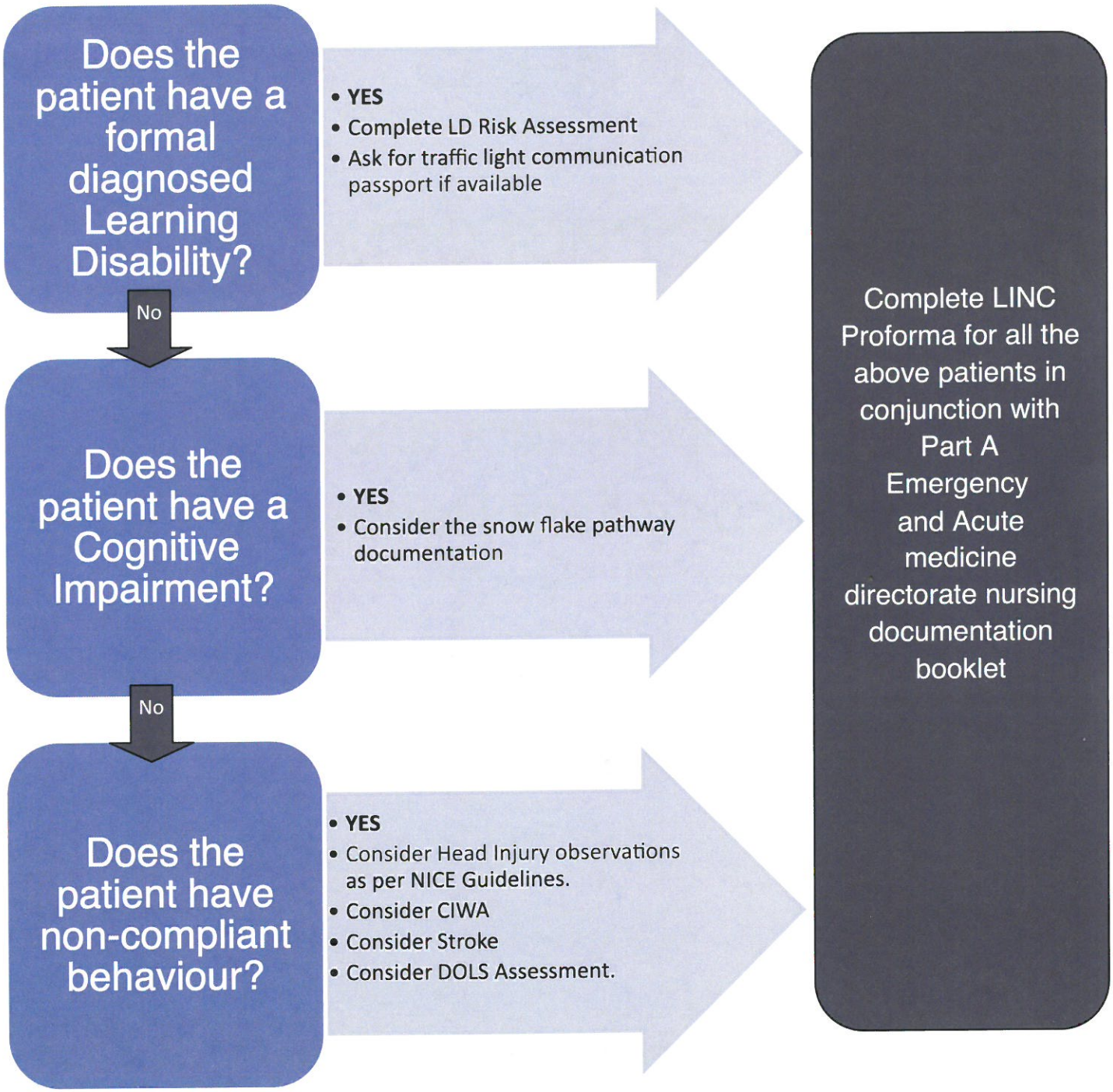
GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

PART B Pathway

Documentation booklet Part B should be completed for patients who attend the Emergency and Acute Medicine Directorate with Learning disabilities, cognitive impairment or with non-compliant behaviour. Early escalation should be considered in all cases.



PATIENT INFORMATION

CONCERNS / BACKGROUND

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PATIENT DESCRIPTION (IE hair, build, clothing etc)

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TRIGGERS OF BEHAVIOUR

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USEFUL INFORMATION TO RELIEVE ANXIETY

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Patient access team informed of priority need for bed ☐

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Risk Assessment for patients with Learning Disability and other vulnerabilities Cardiff and Vale UHB

Ward:

Date:

ADDRESSOGRAPH	GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Caerdydd a'r Fro / Cardiff and Vale University Health Board

Research has shown that people with Learning Difficulties and other vulnerable adults face significant challenges when accessing healthcare. This assessment has been formulated to help ensure that vulnerable patients are cared for appropriately and lawfully, in line with the Equality Act 2010 and, where appropriate, the Mental Capacity Act 2005.

Care Management

Staff must complete the risk assessment with the patient/carer to identify how the functional characteristics of a person's disability affects them, identifying areas of risk, what support is required to reduce risk, what reasonable adjustments are needed, who can effectively support this and whether the patient can make their own decisions about treatment and care..
There should always be the opportunity to discuss concerns, and seek advice from managers or a member of the Safeguarding Team.
Best practice is that all people with Learning Difficulties and other vulnerable adults have an identified GP prior to discharge.

Communication

1) Is the patient able to communicate effectively to staff to allow their needs to be met? (can they use call bell/call for help)

☐ Yes ☐ No Reasonable adjustments made **(consider level of observation needed)**

2) Can the patient indicate pain effectively?

☐ Yes ☐ No Reasonable adjustments made **(consider use of non-verbal pain tool)**

If NO to either of these questions please seek advice from the appropriate LD team or Safeguarding Team.

Mental Capacity

3) **Is there reason to doubt the person's ability to make treatment and care decisions for themselves?**

☐ Yes ☐ No if yes, the Mental Capacity Act 2005 must be followed.

4) If best interests' decisions need to be made about treatment and care for the patient, are there family/friends who can be consulted?

☐ Yes ☐ No if no, do you need to instruct IMCA? Remember to consult with LD Team as well.

If unsure, please seek advice from the Mental Capacity Act Manager – tel 2074 3652

Care Environment

5) **Can the patient be safely cared for in the ward without need for extra staff? (Does the patient's behaviour put them or others** at risk of harm?) Cubicle if possible and appropriate. Falls risk assessment and specialing risk assessment to be done

☐ Yes ☐ No Reasonable adjustments made **(Liaise with Safeguarding & LD team)**

6) Could there be a physical cause for the behaviour? **Is the patient's pain being effectively managed?**

☐ Yes ☐ No Reasonable adjustments made **(involve LD team & acute pain team)**

Medication

7) Can the patient take prescribed medication independently? (ensure patient's usual brand is given by the correct route and in preferred form e.g. liquid/tablet, etc)

☐ ☐

Yes No Reasonable adjustments made **(Liaise with pharmacy & LD team)**

8) Has the carer/patient brought their regular medication in with them?

☐ ☐

Yes No Reasonable adjustments made **(Liaise with carer, pharmacy & LD team)**

Nutrition& hydration

9) Can the patient independently meet their nutrition needs?

☐ ☐

Yes No Does the person need prompting or extra help? Consider use of red tray, plan mouth care provision) **(Liaise with SALT & Dietetics)**

10) Can the patient eat & drink without risk of chocking or aspiration?

☐ ☐

Yes No if no, obtain urgent swallowing assessment **(Liaise with SALT & Dietetics)**

Support Needs

11) Obtain "Patient Profile"or traffic light assessment & listen to patient/family/carers as they know person best .Ensure referral has been made to the LD team (& kept informed if patient is moved to another ward). Ward transfers to be minimised

☐ ☐

Yes No Reasonable adjustments made **(e.g. allow carers to be present outside normal visiting)**

12) Ensure medical staff & relevant MDT colleagues aware patient has a learning disability and that they are aware of specific individual needs (ensure info provided via "Patient Profile" is communicated)

☐ ☐

Yes No Reasonable adjustments made **(Liaise with admitting consultant, MDT & LD team) Ensure these needs are considered in any best interests' decision that needs to be made for the patient.**

Care and discharge planning

13) Can the patient return to their previous care setting without additional support/training/equipment?

☐ ☐

Yes No if no, alert LD Team, Discharge Liaison Team. If necessary refer to IMCA and arrange Best Interests meeting.

Please confirm that:

LD Liaison team have been notified ☐ **Next of Kin have been notified** ☐

Traffic light hospital passport gained ☐ **Patient Centred care plan shared with team** ☐

Named nurse for patient made known to patient and family ☐ **MDT discussion held within 7 days** ☐

Signature/Designation: ..... **Please send a copy to relevant DLM for Safeguarding**

Pain Assessment Tools

Pain Assessment & Management Toolkit for Adult Patients with Communication Difficulties

Patients who are able to self report pain

- For patients who are able to participate in the pain assessment process and can self report pain please use the numerical rating scale by asking the patient which word best describes pain on movement.

0	**No pain**
1	**Mild pain**
2	**Moderate pain**
3	**Severe pain**

Patients with communication difficulties

- For patients with communication difficulties please use The Bolton Pain Assessment Scale *(page 2)*.
- Observe the patient for five minutes before scoring his or her behaviours and ideally observe them under different conditions e.g. at rest, movement, during physiotherapy and after the administration of analgesia.
- The total score ranges from **0 - 14+**

0 - 2	**No pain**	
3 - 7	**Mild pain**	
8 - 13	**Moderate pain**	**SEE PAIN ASSESSMENT TOOL A CONSIDER USING 'SHOW ME WHERE' FAN**
14+	**Severe pain**	

Patients who can self report but are unable to verbalise pain

- Having explained to the patient what each face means ask them to choose the face and caption which expresses any pain they have at rest and movement or deep breathing *(page 3)*.
- The total score ranges from **0 - 10**

0	**No pain**	
1 - 3	**Mild pain**	
4 - 6	**Moderate pain**	**SEE PAIN ASSESSMENT TOOL B CONSIDER USING 'SHOW ME WHERE' FAN**
7 - 10	**Severe pain**	

Bolton Pain Assessment Scale (BPAS)

For patients with communication difficulties

SCORE	ABSENT SCORE 0	MILD SCORE 1	MODERATE SCORE 2	SEVERE SCORE 3	SCORE
VOCALISATION	None	Occasional moan or groan	Low level speech with a negative or disapproving quality	Repeatidly crying out, loud moaning or crying	
FACIAL EXPRESSION	Smiling or relaxed	Looking tense	Sad, frowning	Grimacing and looks frightened	
CHANGE IN BODY LANGUAGE	None	Tense, fidgeting	Guarding part of body	Withdrawn, rigid, fists clenched, knees drawn up	
BEHAVIOURAL CHANGE	None	Increased confusion	Refusing to eat alterations in usual pattern	Pulling or pushing away. Striking out	
PHYSIOLOGICAL CHANGE	Normal	Occasional laboured breath. Increased heart rate	Hyperventilation. Raised heart rate and BP	Change in pulse, BP, respiratory rate. Perspiring, flushed or pallor	
PHYSICAL CHANGE	None	Skin tears	Pressure sores, arthritis	Post-surgery trauma	
CONSIDER - does the patient usually take analgesics? **DISCUSS - with family and / or carers how the patient has reacted to pain in the past** **ASSESS - pain on movement, during physiotherapy and after an analgesic intervention**				**TOTAL SCORE**	
APPLY TOTAL SCORE TO ANALGESIC LADDER	**0-2 = No pain**	**3-7 = Mild pain**	**8-13 = Moderate pain**	**14+ = Severe pain**	

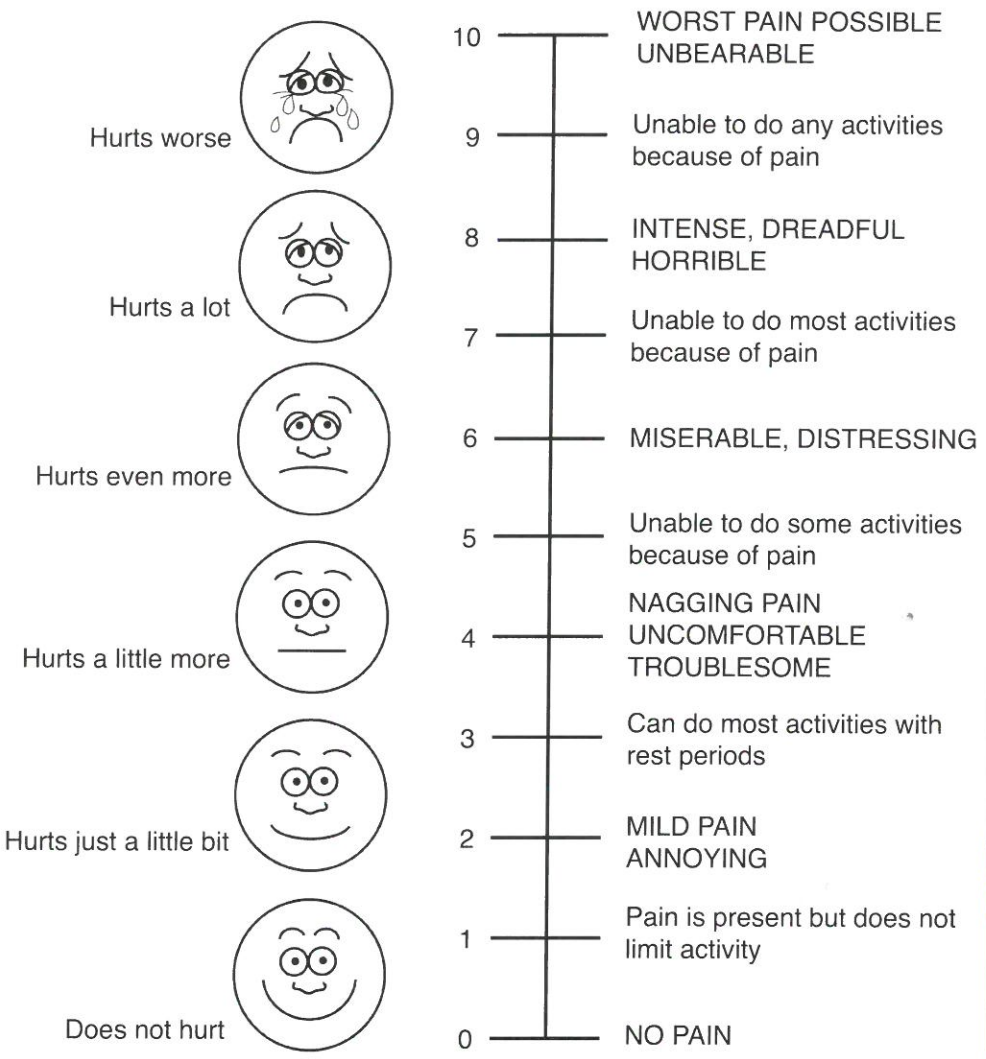
Pain Assessment Tool

For those who can self report but who are unable to verbalise pain

Instructions:

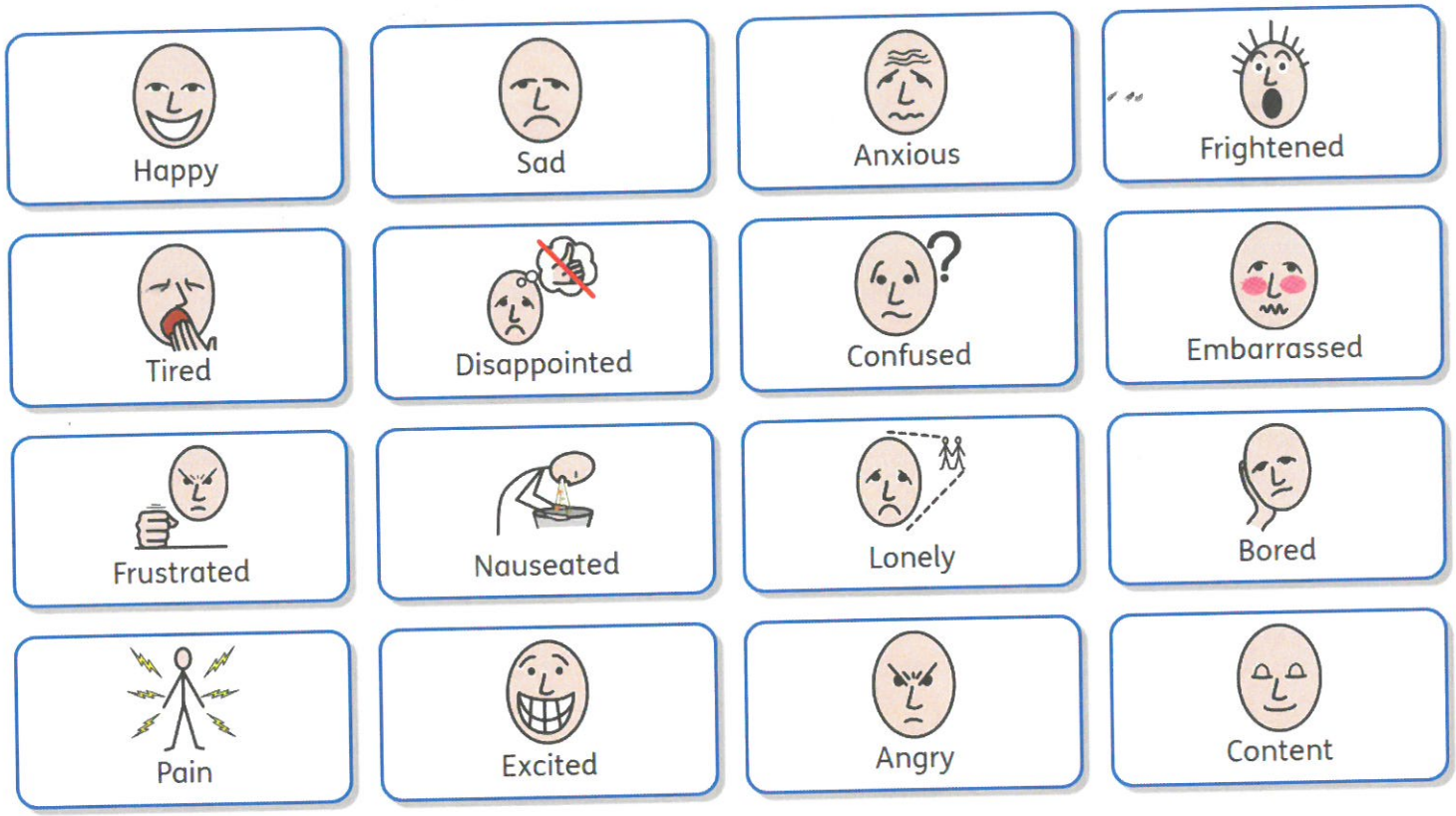
- **Having explained to the patient what each face means ask them to choose the face and caption which expresses any pain they have at rest and movement or deep breathing.**
- **The total score ranges from 0 - 10.**

- **1 - 3 mild pain**
- **4 - 6 moderate pain**
- **7 - 10 severe pain**



Date/time	Pain Score	Action

How Do I Feel?



Date/time	How Do I Feel	Action

REVISED NEWS CHART FOR LEARNING DISABILITY PATIENTS

	Physiological Parameters	3	2	1	0	1	2	3
A	Respiratory Rate (bpm)	≤ 8		9-11	12-20		21-24	≥ 25
B	O2 Saturations (%)	≤ 91	92-93	94-95	≥ 96			
	Any supplemental Oxygen		YES		NONE			
C	Systolic BP (mmHg)	≤ 90	91-100	101-110	111-219			≥ 220
	Pulse (BPM)	≤ 40		41-50	51-90	91-110	111-130	≥ 131
D	AVPU score				ALERT			VPU
E	Temperature (°C)	≤ 35.0		35.1-36.0	36.1-38.0	38.1-39.0	≥ 39.1	

Concern about a patient should lead to escalation, regardless of the score

NEWS	MINIMUM MONITORING	ALERT	REVIEW
Score 0-2	4 Hourly	If concerned inform Nurse in Charge (NIC)	
Score 3-5 **3 = THREAT!**	2 Hourly Increase frequency dependant on patient response	Inform Nurse in Charge, then immediately inform designated nurse/doctor	Review in 1 hour. SBAR
Score 6-8 **6 = SICK!**	1 Hourly	Inform Nurse in Charge, then immediately inform most senior designated nurse doctor	Review within 30 minutes SBAR
Score 9 **9 = NOW!**	15 - 30 mins	Inform Nurse in Charge, then Call Resuscitation Team via 2222	Immediate SBAR

The Nurse in Charge of each shift must ensure that the designated nurse/doctor names and bleep numbers are updated and clearly displayed on a Patient Status at a Glance Board (PSAG).
Frequency of Observations are increased in relation to the patient's condition.
If there is any concern, please escalate regardless of the NEWS score.

SEPSIS SCREENING / AWARENESS

Suspect sepsis if 2 of the following criteria are present - go to sepsis tool

- ☐ Temperature <36°C or >38.3°C
- ☐ Pulse >90bpm
- ☐ WCC>12 or <4x10°/1
- ☐ Respiratory rate >20/min
- ☐ Acutely altered mental status
- ☐ Hyperglycaemia in the absence of diabetes

START SEPSIS CARE / MONITORING PATHWAY	CONTINUE MONITORING OBSERVATIONS & NEWS REGULARLY AS PLANNED

Patient details: (Affix Addressograph)

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LEVEL OF SPECIALLING – RISK ASSESSMENT AND DECISION AID
(ADULT GENERAL WARDS) *Complete and file in patient's notes*

SECTION 1: IMMEDIATE ACTIONS TO ACCESS AND REDUCE RISKS
Please tick - **Yes** or **No** in response to actions below

Immediate Actions:	Yes	No	Subsequent Actions:
Recent medical / medication review?			If No – Request review
Behavioural chart completed?			If No – Chart behaviour and record triggers. (If not applicable record N/A)
Life history / carers questionnaire i.e. 'this is me', / 'getting to know you / REACH' commenced?			If No – Provide questionnaire and involve patient and family in completion. (If not applicable record N/A)
• Have the appropriate referrals been made to the multi-disciplinary team? • Is there a clear multi disciplinary management plan?			If No – Make referrals and use behavioural chart / triggers to develop a management plan
Is there a current substance misuse problem?			If Yes – Refer to Substance Misuse Liaison Nurse
Have environmental concerns been considered?			If No – Reduce environmental stimuli / Move to a more observable position etc
Has the Falls Risk Indicator (parts 1&2) been completed?			If No – Complete assessment (consider ultra low bed / mats etc)
Is a mental health assessment required?			If Yes – Refer to Liaison Psychiatry (adult / older people or on-call if urgent)
Has intentional rounding / intermittent observation been introduced?			If No – introduce. Document interventions and outcomes
Can the patient's care be safely maintained within usual staffing levels?			**If No – Proceed to Section 2**

SECTION 2: RISK REASON & SPECIALLING RECOMMENDATION Please tick appropriate risk

Patient must consenr to specialling. If patient lacks mental capacity to consent the Mental Capacity Act and Restraint Policy **must** be followed

No.	Risk / Reason	Tick ✔	Recommend Level of Specialling: professional judgement must be used
1	Acutely ill / Complex care requiring constant observation and intervention by RGN		**1:1 RGN**
2	Preventable falls requiring 1:1 observation (as per Falls Risk Indicator)		**1:1 HCSW**
3	Confused and wandering presenting risks to self and others (patients and staff)		**1:1 HCSW** (ideally "SIMA" or "Care Control" trained)
4	Pulling lines / tubes that may result in significant harm		**1:1 HCSW** (ideally "SIMA" or "Care Control" trained)
5	Expressing intent or recently attempted to self harm / suicidal ideation		**1:1 RMN** (to assess, plan, deliver and evaluate mental health care) dependant on patient need, HCSW may be suitable
6	**Extreme** challenging behaviour (violence & aggression)		**1:1 RMN** (to assess, plan, deliver and evaluate mental health care) dependant on patient need, HCSW may be suitable

To be used in conjunction with supporting resources (tick which resources are to be used)

o **HCSW Pack and patient / carer information leaflet**	
o **RMN Pack and patient / carer information leaflet**	
o **Specialling User Guide**	

Print Name: **Designation:**

Sign: **Date:**

p.t.o. for continued assessments

RE-ASSESS RISK REASONS EACH SHIFT HANDOVER AND IF PATIENT CONDITION OR PRESENTATION CHANGES

Date	Time	Can the patient's care be safely maintained within usual staffing levels? (circle appropriately)	If NO – Indicate Risk Reason number (1-6)	Sign
Day 1	07.00	YES / NO		
	10.00	YES / NO		
Day 2	07.00	YES / NO		
	13.00	YES / NO		
REVIEW risks with ward sister and senior nurse *before* 48 hours				

WARD NURSE TO REVIEW INDIVIDUAL PATIENT NEEDS		Circle appropriately	
Date	a) behaviour chart for triggers and effective interventions reviewed	YES / NO	
	b) plan of care (can be delegated to 1:1 RMN / RGN if this is the level of specialling) reviewed	YES / NO	
time	c) Intentional rounding / intermittent observations has been considered to reduced risk?	YES / NO	
	d) Using the above interventions (a, b and c) can the patient's care now be safely maintained within usual staffing levels	YES / NO	
	If NO - are other patients within the clinical area receiving specialling?	YES / NO	Print Name:
	If YES - consider cohorting patients to enable closer supervision and interaction with 1 RGN, RMN or HCSW for 2 or more patients		Designation:
	If NO - are options for care and determination that specialling is the least restrictive intervention (develop use of restraint care plan)	YES / NO	Sign:
	Assessment outcome: are specialling levels of observation required?	YES / NO	

RISK REASON & SPECIALLING RECOMMENDATION Please tick appropriate risk

No.	Risk / Reason	Tick ✔	Recommend Level of Specialling: professional judgement must be used
1	Acutely ill / Complex care requiring constant observation and intervention by RGN		**1:1 RGN**
2	Preventable falls requiring 1:1 observation (as per Falls Risk Indicator)		**1:1 HCSW**
3	Confused and wandering presenting risks to self and others (patients and staff)		**1:1 HCSW** (ideally "SIMS"A or "Care Control" trained)
4	Pulling lines / tubes that may result in significant harm		**1:1 HCSW** (ideally "SIMA" or "Care Control" trained)
5	Expressing intent or recently attempted to self harm / suicidal ideation		**1:1 RMN** (to assess, plan, deliver and evaluate mental health care) or HCSW
6	**Extreme** challenging behaviour (violence & aggression)		**1:1 RMN** (to assess, plan, deliver and evaluate mental health care) or HCSW
7	**Reason as above**		**1 RGN, RMN or HCSW or 2 or more Patients**

LEVEL OF SPECIALLING – RISK ASSESSMENT DECISION AID AND CONTINUED ASSESSMENT RECORD

RE-ASSESS RISK REASONS EACH SHIFT HANDOVER AND IF PATIENT CONDITION OR PRESENTATION CHANGES. CONSIDER:				
Date	**Time**	**Can the patient's care now be safely maintained within usual staffing levels?** (circle appropriately)	**If NO – Indicate Risk Reason number (1-7)**	**Sign**
		YES / NO		
		YES / NO		
		YES / NO		
		YES / NO		
		YES / NO		
		YES / NO		
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		YES / NO		
		YES / NO		

Adapted Behaviour monitoring documentation form

Expectations: - This form **MUST** be completed on a 1 hourly basis as minimum. Please ensure early escalation to a senior member of staff with any clinical concerns.

Date Time	Interventions	Revised News	Actions taken / escalation
Example 3/3/13 02:25	Observations unable to be recorded due to level of agitation, patient sweaty, clammy and distressed. Refusing medication and oral fluids. Respiratory rate 35bpm.	Review in 30 mins	Medical registrar bleeped at 02:05 hours as unable to assess NEWS score accurately and patient extremely agitated. Registrar replied at 02:20 hours will attend the unit asap. Nurse in charge aware and escalated.

Date Time	Interventions	Revised News	Actions taken / escalation

Date Time	Interventions	Revised News	Actions taken / escalation