

GUIDELINES FOR COMPLETION OF THE HOSPITAL PATIENT

ASSESSMENT/INFORMATION DOCUMENT

**(For people who have a learning disability who may need to go into
hospital)**

PILOT DOCUMENTATION

Date of guidelines: October 2007

Review of guidelines: April 2008

GUIDELINES

This document has been produced to aid people who have a Learning Disability, their families and or paid carers in completing the hospital patient information document, which is available on the Wigan Learning Disability Service Partnership Board web site: - www.wiganldpb.org.uk

The patient information document was produced by the Hospital Liaison Team, ALW PCT, to help assist people with a Learning Disability during their hospital admission, treatment and discharge.

Research highlights that many people with a Learning Disability who need to access hospitals receive an inequitable service in comparison to the general public as a whole (DH 2001, Mencap 2007)

By completing this document the person needing to go into hospital should have the necessary information to assist them to be cared for more effectively, and the document should help to inform doctors and nurses about the holistic health care needs of the person requiring treatment and or investigations.

It is expected that someone with good verbal communication skills, and the ability to read and write may not wish to have the document completed, as they may be able to convey all the necessary information to hospital staff, however the document is available for all.

There are two documents, which can be used with either words and symbols or just words. In addition to these documents there is a single side A4 sheet, which covers basic care and communication for hospital staff to read.

If the hospital information document is completed we would appreciate it if you contacted the Hospital Liaison Team, in addition your thoughts on its usefulness and experiences using it would be most welcomed. The information will help our pilot study and audit the numbers of users completing the document.

If any parties wish to have further information around the documents use, we are more than happy to discuss this with individuals and or groups.

Alternatively we are happy to provide training around the completion of the document for provider services and carers groups

Please contact: -

Julie Matthews (Nurse Team Manager) or

Magz Smith (Community Support Worker) on Telephone **01942 832592**

EXAMPLES OF HOW TO COMPLETE A SECTION

Epilepsy

In this section you would include: -

1. How long you have experienced epilepsy.
2. What types of seizure you experience
3. How long they last
4. How frequent they are
5. How well you recover
6. What medication you take
7. Any rescue medication prescribed
8. What usually triggers the seizure (for e.g. an infection, noise, or lights)
9. Which consultant you are under
10. Include any risk management plans

Bowel Management

In this section you would include: -

1. Can you independently use the toilet
2. Do you need help to use the toilet
3. Would you be able to sit on a commode
4. Would you be able to sit on a bed pan
5. Do you usually wear pads
6. Do you ever experience constipation/ loose stools
7. How often do you open your bowels
8. Do you take laxatives and or stool softeners
9. How would hospital staff know you needed to open your bowels
10. Include any bowel management plans

We value your support in helping us to develop this patient document during our six month piloting process.