

**Hospital Passport**

**This should be completed prior to hospital admission where possible – please bring to all health appointments**

**Please ensure I am ‘flagged’ on the hospital system – this is to make sure everyone caring for me knows I have a learning disability and will need reasonable adjustments**

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| My name is:Please call me:  |
| [x]  **This passport was completed with the person’s consent** [ ]  **This passport was completed in the person’s Best Interest**   |
| **Date of Birth**:  | **Pronouns: he/him** |
| **Address**:  | **Religion**:  |
| **Main Language**:  |
| **My GP Practice is**:  |
| **Tel. No**:  |
| **People who are really important to me:** |
| **Relationship** | **Name** | **Tel. No** |
| Next of kin:  |  |  |
| Person that knows me best:  |  |  |
| Emergency Contact:  |  |  |
| Where I live: [ ]  With Family [ ]  Supported Living [ ]  Independent [ ]  Care Home [ ]  Other |
| **! ALLERGIES or INTOLERANCES !**(include what the reaction looks like) | **ADDITIONAL CARE PLANS** Positive Behaviour Support [ ] Eating and Drinking [ ] Skin Integrity [ ] Communication [ ] Pain [ ] Other (specify) [ ]  |

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| **Reasonable Adjustments** The Equality Act 2010 states that hospitals are required to make reasonable adjustments to enable people to access appropriate healthcare.  |
| **Reasonable adjustments I need to access healthcare:** **Reasonable adjustments I need to receive medical examinations/treatment:** |
| **Mental Capacity and Advocacy** |
| **Consider a mental capacity assessment for consent to admission and each decision.****If I am assessed as lacking capacity regarding a decision, a best interest meeting will be required.**Do I have a Health and Welfare Lasting Power of Attorney or have an Advance Statement?[ ] Yes [ ]  No If yes, please specify: Do I have a family member or friend (not paid carer) who can attend a best interest meeting: [ ] Yes [ ]  No If no, refer for an IMCA (independent mental capacity advocate)**Go to ‘Safeguarding Adults Information and Referral Forms’ on the staff intranet for IMCA referral process.** |
| **Further information about my capacity and how to help me make decisions**: |
|  **Brief medical history and long-term health conditions:** |
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| **Important people that support my health needs:** |
| **Role/Service** | **Contact details:** |
| Community Learning Disability Team: |  |
| Social care:  |  |
| Other:  |  |
| Other: |  |
| Other: |  |
| Other: |  |
| **Support needs** | **How to support me** |
| **I communicate by:** | *As much detail as possible – understanding of verbal communication, ways they communicate (words, pictures, AAC, objects of reference etc.)* |
| **I need this accessible information:** | *Can they read and write? Do they need easy read? Short sentences? Quiet environment? Interpreter?* |
| **I show pain by:** | *Use of pain tools, ability to describe pain, behaviour that indicates pain* |
| **Support me when I’m distressed by:**  | *What distressed behaviours might the person present with? How to help if a person is distressed, do they have a behaviour support plan?* |
| **Support me with my sensory needs by:** | *Do they struggle with busy areas, bright lights, sounds, physical touch? Do they have tools that help them with this? Additionally, do they have any sensory disabilities – require glasses/hearing aids?* |
| **Support my eating and drinking by:** | *Do they have eating and drinking guidelines? Ensure they are up to date. Do they need special equipment to help their eating and drinking. Do they require observation or practical support?* |
| **Support my toileting needs by:** | *What level of support do they require at baseline? Do they need specialised equipment or continence products? Are they prone to constipation and if so what is their bowel management plan?* |
| **Support me to move around safely by:** | *What level of support they require at baseline, any equipment required? Consider risk of falls and skin integrity.* |
| **Support me to sleep by:** | *Do they have a usual sleep routine? Do they have any postural management needs?* |
| **Support me with personal care by:** | *Do they require support with washing and dressing, what level of support? Always try to encourage independence.* |
| **My family and care staff will support me by:** | *Will family/carers require open visiting? Ensure it is made clear who is supporting with what. If no family/carer support, will they require enhanced care?* |
| **Support me with medication by:** | *Do they need medications in a certain form? What level of support do they need? Do they require covert medications?* |

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| **Making my stay in hospital better** |
| **Things that will make my hospital stay better** |  |
|  **Things that will upset me in hospital, so please avoid**  |  |
| **Other things that are important to me** |  |
| **Form Completed by**: | **Date Completed or Updated:** (ensure this is reviewed regularly): |

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| **MFT Staff Guidance** |
| **A group of people with different faces  AI-generated content may be incorrect.****What do MFT staff need to do?** | **On attendance to hospital:** * Ensure orange equalities monitoring flag in place
* Talk to the patient and carers about reasonable adjustments
* Consider capacity to consent and ensure Mental Capacity Assessments are completed via the safeguarding tab

**Within 24 hours of admission:** * Upload Hospital Passport and keep at bedside – all staff to read (patient and carers should complete this with support)
* Reasonable adjustments flowsheet and care plans to be completed
* Senior nurse review to be completed

**Ongoing considerations:** * Ensure Mental Capacity Act is followed throughout admission
* Review ReSPECT and ensure rationale is appropriate
* Think about plans for discharge early to prevent delays
* Ensure ongoing review of reasonable adjustments and regular senior nurse reviews
* Utilise the expertise of patient’s family, regular carers and wider MDT
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| A circular logo with different colored text  Description automatically generated**What do the Learning Disability & Autism Team need to do?** | * Complete an initial visit with the patient, then visit the ward ‘as and when required’ throughout admission to offer advice
* Complete a Quality Care Checklist 24 hours after admission to ensure all hospital staff are making adjustments required and escalate any concerns
* Advise staff on topics such as reasonable adjustments, communication, the mental capacity act and discharge planning
* Liaise with community learning disability teams and the wider MDT
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| **Contact details for MFT Learning Disability & Autism Team** | **North Manchester General Hospital**Kate Cunningham and Alesha Lewis**Oxford Road Campus** (MRI, St Mary’s, RMEH & Dental)Katie Damer and Cara Oldham**WTWA** (Wythenshawe, Trafford, Withington & Altrincham)Paige Doyle and Faye Snelgrove**Email contact for all sites:** LDASD.support@mft.nhs.uk |

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| **Hospital Discharge Plan****To be completed by Hospital Staff when preparing for discharge**  |
| **Hospital and ward** | *Where I stayed and who looked after me?* |
| **Date of admission and planned discharge** | *Proposed discharge date should be agreed by all* |
| **Who was involved my discharge meeting?** | *Attendees and apologies* |
| **Why did I come to hospital?** | *Information about initial attendance and lead up to this* |
| **What was my diagnosis and what treatment have I had?** | *Investigations that took place, treatment had including ongoing or date this finished, all diagnoses throughout admission, any new medications* |
| **Do I need new equipment?**  | *Who will provide this, when will it arrive, what do I do with it afterwards, will I or my carers need training to use this?* |
| **Do I or my family/****care staff need training?**  | *Who will provide this, does it need completing before discharge?If training not required, is there anything we need to look out for?* |
| **Do I need any follow up appointments or referrals?**  | *Have these referrals been made? When should I expect to be seen? Who can I contact to follow up on these if needed?* |
| **Were any changes made to my care plan?** | *E.g. Was a ReSPECT form completed? Were there any best interest decisions made that will change my care plan at home?*  |
| **Do I or my carers have any other questions or concerns about my discharge home?** | *Document any concerns raised and resolutions, consider if change in care needs requires a formal mental capacity assessment and best interest meeting* |
| **Is everyone in agreement that we have a safe discharge plan?** |  |
| **Ensure that a copy of this document is shared with the patient/family/carers and a copy is uploaded to HIVE or alternative hospital system** |