GUIDELINES
FOR THE CARE OF VULNERABLE PATIENTS

Includes
Patients with Mental Health Needs
Patients with Learning Disabilities
Patients with Acute Confusional States
MCA / DoLS

Caring for vulnerable patients can be challenging and it is important that all staff are confident in how that care is delivered. If staff have concerns or need further clarification about decisions made about their patient please contact the following (even if patient has already been assessed) and discuss further;
Liaison Psychiatry – ext 76203 or pager 07699703470
There is someone available 24 hours a day for advice and support.
Learning Disability – Daniel Marsden – 07786171008
Safeguarding Lead – Tricia Bennett – 62556 or 07770701840
Contact Site Matrons
Out of hours – contact Clinical Site Manager
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<th>Avril McConnachie</th>
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<tr>
<td>Date</td>
<td>June 2011</td>
</tr>
<tr>
<td>Policy Version</td>
<td>3</td>
</tr>
<tr>
<td>Policy Application</td>
<td>East Kent Hospitals University NHS Foundation Trust East Kent &amp; Social Care Partnership Trust</td>
</tr>
<tr>
<td>Policy Status</td>
<td>Mandatory</td>
</tr>
<tr>
<td>Approving Body</td>
<td>Risk Management and Governance Group</td>
</tr>
<tr>
<td>Date approved</td>
<td></td>
</tr>
<tr>
<td>Review</td>
<td>June 2013</td>
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<tr>
<td>Distribution0</td>
<td>All Clinical Staff : Divisional Directors/Leads Senior Matrons for distribution Hospital Managers/Site Clinical Managers Available on the Intranet</td>
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PART 1

INTRODUCTION

Safeguarding is a crucial element of providing care for all patients. It is essential that all staff understand their role and responsibility in the identification of a vulnerable patient and how to respond and action in accordance with Trust Policies.

A vulnerable adult (defined in ‘No Secrets’ Governments Guidance of Adult Abuse) is someone who is aged 18 and over, who is or may be in need of community care services by reason of mental or other disability, age, or illness and who is or may be unable to take care of him/herself and protect him/herself against significant harm or exploitation and those who are ill or dependent upon another for any of the aids to daily living.

We all have the right to live our lives free from abuse. It is recognised that certain groups of people may be more likely to experience abuse and may include the following:

- A learning/physical/sensory disability
- Mental ill health or dementia
- Frailty due to age
- Acquired brain injury
- A drug/alcohol problem
- Certain types of physical illness
- Many frail or confused older people are especially vulnerable

How can you tell if an adult is being abused?

- Physical abuse – including hitting, slapping, rough handling, pushing, kicking, misuse of medication, restraint.
- Sexual abuse – including rape and sexual assault.
- Psychological abuse – including emotional abuse, threats of harm, intimidation, harassment, verbal abuse and isolation.
- Financial abuse – including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions and the misuse or misappropriation of property, possessions or benefits.
- Neglect – including ignoring medical or physical care needs, failure to provide access to appropriate health and social care services and withholding medication, nutrition and heating.

All staff must adhere to Trust Policies (EKHUT Safeguarding Vulnerable Adults 2009), undertake appropriate training to enable abuse to be recognised, report and take action to safeguard the individual/s.
Part 2

CARING FOR PEOPLE WITH MENTAL HEALTH NEEDS

One in four people will have or will develop a mental health problem. As EKHFU has 1028 beds, this accounts for over 250 patients at any one time.

People with mental illness have reduced life expectancy and are more likely to have poor physical health. Problems associated with mental illness include serious conditions such as respiratory and cardiovascular diseases, diabetes, cancer and epilepsy.

Mental health problems can range from self harm, anxiety, depression, confusion or disturbed behaviour. Disturbed behaviour is defined as behaviour that interferes with a person’s care or safety of others. There are occasions when such behaviour is due to a variety of reasons such as physical illness or infection, side effects of medications or medical interventions, confusion, cognitive impairment, distress, mental illness or intoxication. In these situations the Liaison Psychiatry Service can assist the staff to develop a management plan to alleviate the patient’s stay in hospital.

People with mental health problems should receive the same priority as those with physical problems. There should not be any discrimination against an individual because of mental health problems, including self harm. Good management of mental health problems can make a significant contribution to the effectiveness and efficiency of acute hospitals and improve the outcome for patient.

The purpose of the Liaison Psychiatry Service is to support the general hospital with the management of patients whose mental health problem or behaviour interferes with their care or safety (agitation, self harm, mood disturbance, confusion, medical unexplained symptoms, complex capacity assessments).

It is envisaged that the Liaison Psychiatry service will help increase awareness among clinicians about the relationship between mental and physical health in order to facilitate recovery and a positive experience for the patient. This should be supported with good communication between all staff groups.

1 People Under the Care of the Mental Health Unit

There are 2 ways a person may be involved with the general hospital whilst an inpatient of the mental health service:

1a Urgent Attendance at the Accident & Emergency Dept for Investigation or Treatment

On occasions mental health inpatients may require urgent investigation or treatment for a physical illness or injury. The nurse in charge of the mental health ward can contact the A&E Department shift coordinator to discuss if it is appropriate for an A&E practitioner or middle grade Dr to attend the mental health unit or if the patient should be accompanied to the A&E/Minor Injuries Dept.
Any patient requiring attendance to the A&E dept will be accompanied by a member of the mental health ward nursing staff.

In either case a time needs to be mutually agreed for the patient to be seen so to make the necessary arrangements to receive the patient and utilize staff time efficiently.

The mental health ward will advise liaison psychiatry service only if they require support or it is anticipated that the person will require transfer to a general ward.

1b Transfer to a General Hospital Ward for Urgent Investigation or Treatment

If the patient requires transfer to the general hospital, the nurse in charge of the mental health ward will advise the liaison psychiatry service.

Psychiatric medical responsibility remains with the inpatient consultant psychiatrist as in most cases it is likely that the patient will be returned to the mental health unit, with the liaison psychiatrist providing the general hospital with advice and support.

A patient who is transferred to the general hospital ward whilst detained under the Mental Health Act will be accompanied by mental health nursing staff under enhanced observations (either arms length or eye sight) in accordance with KMPT Observational Policy. There may be exceptions to this which must be agreed locally by both the mental health and general hospital ward managers/nurse in charge. The decision will be based on identified risks and being on a general hospital ward, the person’s mental state and physical condition. This risk assessment will be jointly agreed. It will be the responsibility of KMPT to arrange for a nurse to remain with the patient.

Those carrying out the observation will ensure the general hospital ward nurse in charge of the person’s care is updated on any change to the person’s mental state or risk. The observation template (within the Observational Policy) will be kept on the general hospital ward and will be completed hourly by the nurse undertaking the observation. Expectations of each staff group must be agreed with no-one working outside of their scope of practice.

If a person’s physical state be such (i.e. unconscious) a mental health nurse may not be required to escort.

Although some of the mental health wards are on the same site as the general hospital there are two different Trusts involved and thus two sets of ‘Hospital Manager’s’ and therefore an “EK form H4” or “Section 17” leave forms need to be completed.

If a patient is transferred to the general hospital for a brief period of time, then a Section 17 leave form appropriately completed by the Responsible Clinician (RC) is sufficient. This gives the authority for the detained patient to 'leave' the mental health ward and reside elsewhere subject to the parameters set by the RC. The Liaison Psychiatry Service will review if a formal transfer of the patient’s section is needed, (2 weeks is the maximum time a patient can be on a EKHUT ward without formal transfer of the section) and if so will facilitate.
However, if the patient is being transferred on a permanent basis or for a prolonged period of time, i.e. more likely to be from the general hospital to a Mental Health Unit, then a form H4 needs to be completed.

Accordingly, the form H4 provides the legal basis to transfer the authority to detain under the MHA from one set of Managers (Trust) to the other.

2. General Hospital Patients and the Mental Health Act

There are occasions when a patient under the care of EKHUT requires to be detained under the MHA whilst undergoing treatment or investigations and needs to remain in the general hospital.

KMPT are obliged to coordinate, pay and provide mental health nursing staff under enhanced observations when an EKHUT patient has been assessed and detained under the MHA.

Once the arrangements are made they should be fully communicated to the relevant general hospital ward manager.

However it is the responsibility of EKHUT to make the necessary arrangements and cover any additional costs for patients subject to a Section 5(2) MHA whilst a general hospital patient.

Once the liaison psychiatry team has been advised that a patient has been transferred to a general hospital ward they will agree the level of contact and intervention with the patient, the mental health ward and the general hospital team. In addition they will liaise with the community mental health team (CMHT), the mental health ward staff and bed manager regarding the patient’s progress and anticipated date of transfer. Mental health ward staff and CMHT staff may be required to contribute to ward rounds or Multidisciplinary meetings.

3. Patient Clinical Pathways

Clinical Pathways have been developed, based on NICE guidance and all staff should read and have available for reference, so patients who have or develop mental health problems can have the same standard of urgent assessment, diagnosis and intervention as is expected for physical health care. The following pathways were developed in June 2010 and give a brief description of the standards agreed for each pathway:

3a Self Harm

Everybody who attends A&E following self harm should be offered and have comprehensive assessment of needs and risks.

Staff should be trained in the treatment of people who harm themselves. Following the assessment of needs and risk, verbal and written information of the summary of the assessment should be agreed with and given to the patient.
3b Depression

Screening should be undertaken in general hospital settings for depression in high risk groups, for example those with a past history of depression, significant physical illnesses causing disability or other mental health problems such as dementia. Health care professionals should bear in mind the potential physical causes of depression and the possibility that depression may be caused by medication and screened using a recognised tool.

3c Alcohol

This pathway is aimed at ensuring that there are clear guidelines of appropriate procedures to follow when an EKHUFT patient is suspected of having problems with alcohol use so to diminish unacceptable variations in the provision and quality of care.

3d Mother and Infant

Pregnant women will have easy access to information on emotional and psychological changes during pregnancy, including information on mental health problems and how to access help. All pregnant women should be asked about previous history of psychiatric disorder and or family history of serious mental illness by midwives / obstetricians competent to elicit relevant information in a sensitive manner. This pathway describes the joint working arrangements for maternity and mental health services.

3e Learning Disability

People with learning disabilities who are suspected of having a mental health problem should be referred to the Liaison Psychiatry service in the same way and on the same basis as other people. Liaison psychiatry staff should ensure they establish good links with specialist Mental Health of Learning Disability services for advice support and guidance during office hours.

3f Mental Health Act

Each Hospital Manager has a folder with the pathway, section papers and guidance and must be advised of any patient who requires to be placed on a section 5(2) of the Mental Health Act or is being cared for whilst under a section. The Dr in charge of the patient’s care must inform and discuss with the Hospital Manager in hours and Site Clinical Managers out of hours to ensure patients are treated in accordance with the law. Liaison Psychiatry will provide a route for general hospital staff to follow to assist them in requesting a mental health act assessment and support in ensuring a timely assessment both in and out of hours.

3g Dementia Pathway in Development

People with dementia who develop non cognitive symptoms that cause them significant distress or who develop behaviour that challenges should be offered an
assessment at an early opportunity to establish likely factors that may generate aggravate or improve such behaviour.

3h Delirium Pathway in Development

People at high risk of delirium will be identified at referral and prevention strategies incorporated into their care plan. People who develop a delirium will be identified quickly and the underlying cause treated.

4 Determining Risk

4a Patients should have a risk assessment on admission and as an ongoing process to ensure patient safety. As well as needing general acute nursing care, it is recognised that patients with actual or potential mental health needs, or in a confusional state may require an additional level of nursing supervision, either due to their behaviour, identified risk or because they are subject to a section of the Mental Health Act. It is important to recognise collaborative working to ensure the patient is jointly assessed and a care management plan is agreed and commenced.

If extended patient observation is required, a decision must first be made as to whether or not this can be provided within existing staffing levels. If so, the necessary arrangement should be made and your Matron and Site Clinical Manager out of hours informed. If additional nursing cover is required, staff must contact the Matron and out of hours the Site Clinical Manager to ensure this is co-ordinated and implemented, it may mean moving staff to ensure patient safety.

4b The starting point for a decision on additional nursing should be the Safeguarding and Managing Risk Tool. This should be employed when a patient is believed to be a risk to him/her, staff or other patients and is meant as a guide to help staff make a decision. It should complement the professional judgement of nursing and medical staff and not replace it. If there is any doubt, the Ward Manager or Matron should be contacted or Site Clinical Manager out of hours.

4c The risk assessment must be completed for patients identified at risk and where possible decisions should be made jointly by medical and nursing staff. Always remember that patients’ conditions can change and the risk assessment must be reviewed more than once a day if required. Changes should be reported to medical staff, matron, hospital managers and out of clinical site manager. It is essential that any nurse undertaking observation of a patient must have a full handover and the risk assessment discussed and agreed.

4d Observation is an important skill for all nurses, however in the acute phases of illness some patients become a risk to themselves or others. The aim is then to maintain safety. NICE (2005) defined four levels of observations that were deliberately given a title rather than a number to avoid confusion and ensure that consistency is maintained across settings. The following observation levels are taken from Kent and Medway NHS and Social Care Trust’s Observation Policy 2010 (NICE 2005) and relate to EKHUFT’s Safeguarding and Managing Risk Tool (SMaRT)
4e General Observation is the minimum acceptable level of observation and care for all inpatients. The location of all patients should be known by staff and checked one to two hourly, however not all patients need to be kept within sight.

4f Intermittent Observation means that the patient’s location must be checked every 10 to 30 minutes (exact times to be specified in the management plan). This level is appropriate when patients are potentially, not immediately at risk.

4g Within Eyesight is required when the patient could, at any time, make an attempt to harm him/her or others. The patient should be kept within sight at all times, by day and by night, and any tools or instruments that could be used to harm self or others should be removed. It may be necessary to search the patient and his/her belongings whilst having due regard for patient’s legal rights.

4h Within Arms Length Patients at the highest level of risk of harming themselves or others may need to be nursed in close proximity. However, on rare occasions more than one nurse may be necessary. Issues of privacy, dignity and consideration of gender when allocating staff, and the environmental dangers need to be discussed and incorporated into the care plan.

4i Staff must document clearly what level of observation has been undertaken and update as this changes.

5. Training

Training is available as part of the safeguarding programme but also staff who identify specific training needs can contact, Liaison Psychiatry Service to discuss and can include ward specific training.

6. Escalation

Any issues that cannot be resolved should be raised with the Liaison Psychiatry Service manager on extension 76203 or out of hours to the on call psychiatric manager via the hospital switchboard.
Part 3
OUT OF HOURS PROVISION FOR ADOLESCENTS

CAMHS

When a young person presents at A&E with a suspected/actual mental health related difficulty the following occurs:

A&E contacts the Paediatric SHO, who would then discuss the situation with their SPR. If necessary the SPR would then take advice from their Consultant. If admitted to the ward then the CAMHS team responsible for that young person’s catchment area would be contacted the next working day or if at the weekend or bank holiday the CAMHS duty team (via switchboard), and an assessment arranged pre-discharge. Best practice would be to admit young people to the paediatric ward (if appropriate), so that a mental health assessment can take place. However if the young person is discharged from A&E then the CAMHS team need to be notified the next working day or the CAMHS duty team at weekends and bank holidays.

For future information Commissioners and Providers will be working together to provide a 24 hours service, as per the recommendations of the NSF for Children and Young People.

The Manager for CAMHS is Paul Haith, contact number 01227 766877 ext 73366
Part 4

MAKING ADJUSTMENTS FOR PEOPLE WITH LEARNING DISABILITIES

1) Introduction
Evidence shows that people with learning disabilities often require adjustments to be made to the clinical care and therefore the pathways through hospital care to ensure an equality of outcome.
The below guidelines offer tools, tips and places to go for extra support to ensure each individual patient receives the best possible care and support while in Hospital.

The Department of Health (2001) defines a learning disability which includes the presence of:

- A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
- A reduced ability to cope independently (impaired social functioning);
- Which started before adulthood, with a lasting effect on development.

This can be identifiable through a known syndrome, like Down’s, or an Autistic Spectrum Condition, but can also be non-specified. If you are unsure, reviewing the patient’s notes, checking the Patient Administration System (PAS) or discussing your concerns with the Practice Development Nurse would be advisable.

Carers and Care workers are a vital source of support and a mine of information about the individual, how to support them and how to engage them in their healthcare choices; the Improving Communication section recommends ways of working together to provide the best possible care.

The Guide to Managing Risk of the Ward provides a number of tools for delivering safe person centred care. Some people will not have capacity to understand their healthcare choices and will actively refuse even when the procedure is in their best interests; as such these situations require management and minimisation. This flow diagram provides ways of identifying and managing these risks on admission.

Lastly, the Community Learning Disability Teams provide a multi-disciplinary source of expertise throughout Kent. They will often have knowledge of the individual and may be currently working with them. As such their details have been included.

For further information please check the Trust Website at [www.ekhuft.nhs.uk/valuingpeople](http://www.ekhuft.nhs.uk/valuingpeople)

or contact Daniel Marsden – Practice Development Nurse on 07786171008 or Daniel.marsden@ekht.nhs.uk
2) **Improving Communication**

**Between Clinician & Patient**

- Direct communication to patient, using simple clear language.
- Use the Hospital Communication Book.
- The Big Word provide an interpreting service for those using British Sign Language and Makaton they can be contacted by telephone on 0800 3213042 email [ekh-tr.interpreterservice@nhs.net](mailto:ekh-tr.interpreterservice@nhs.net)
- Ensuring patient information is made accessible using symbols, pictures and photographs, further advice can be found on the Trust website at [www.ekhuft.nhs.uk/valuingpeople](http://www.ekhuft.nhs.uk/valuingpeople)
- Ask whether the individual uses a ‘patient passport’ or any paper work that may help staff with engaging the individual in healthcare choices.
- Patients and carers will require clear guidance about what will happen next, and who will help. This may need to be written down.
- If a diagnostics are required in other parts of the hospital, arrange visits to the place and show the individual what may happen.

**Between Clinicians & Carers**

- Negotiation of roles between carers and ward staff is essential. See the Carers’ Checklist.
- Identify whether the patient requires extra support to perform activities of daily living.
- Identify whether there are additional risks to the patient, the ward, and the other patients of having the individual on the Ward. A ‘patient passport’ and the Carers’ Checklist will help with this.
- Identify whether and for how long carers and care workers can support Ward staff with managing these risks
  - Identify particular times that present the most risk.
  - Identify if carers or care workers can cover this time.
  - Staff that are assessed and trained to work with people with learning disabilities are available via NHSP – see attached guidance.

**Between Services**

- See the Attached Patient Pathways
- Contact the individuals local Community Learning Disability Team of the individual admission
- Ensure all Clinical staff have completed mandatory training on Mental Capacity Act and Informed Consent, Safeguarding Vulnerable Adults.
- Education in caring for people with learning disabilities is available through the Practice Development Nurse for patients with learning Disabilities.
- Consult the individual, carers, and the ‘patient passport’.
Pre-assessment planning an admission to an acute hospital environment for a patient with Learning Disabilities

Primary Care referral identifying disability

PATIENT - Brings completed Patient Passport to Clinic

LETTER: Includes Pre-assessment clinic appointment, transport arrangements and Patient Passport

INFORMS

PRE-ASSESSMENT NURSE
Nurse reviews information, begins Capacity assessment.

For further advice:-
- Check Trust Website
- Contact Local CTPLD
- Contact Practice Development Nurse

Anticipates the care needs of the patient and makes necessary arrangements with admitting ward.

On the patient’s arrival, establish an appropriate means of communication. E.g. Communication Book

Review information

Identify specific requirements and plan accordingly, retain copy in patient’s notes

Complete Hospital Passport

Establishes as to whether Patient Passport has been completed

YES

NO

CONSIDERATIONS – WHEREVER POSSIBLE

COMPLETE ADDITIONAL TESTS IN THE CLINIC ENVIRONMENT

IF THE PATIENT DOES NOT ATTEND FOLLOW THEM UP

ENSURE THAT DISEASE SPECIFIC PROTOCOLS ARE ADHERED TO
The planned admission of a patient with a Learning Disability to an acute hospital environment

Primary Care service

Sends referral identifying patient’s disabilities

Consultant

Clerical staff

Pre-assessment Nurses

Ensure Ward Staff are aware of patient requirements

Establishes the most appropriate means of communication. Use of the Hospital Communication Book.

Orientates the patient to the ward environment. Is a pre visit to the Ward useful?

Patient passport – Does the patient have one? If not supply one for Carers to complete.

Compile an individualised care plan including Carers’ Checklist.

Provide the patient and Carer with the procedure information in a way that they are able to understand. Consider if easy to read patient information is required.

Completion of the Safeguarding Risk Assessment is required to identify need for extra staffing.

CARER and or SIGNIFICANT OTHER
Emergency Admission of a patient with a Learning Disability

The Nurse

- Introduces him/herself
- Identifies most appropriate method of communication and collates the patient’s details
- Responds to the immediate health needs
- Ascertains patient ability to understand what is happening through questioning and reaffirmation

The Patient

If the patient arrives unescorted and is unable to provide any information → contact the police
If the patient arrives unescorted and is able to provide only limited information (i.e. name and address) contact their GP

- Informs the carer or significant other of admission

Carer/significant other

- Provides additional information
- Brings current medication
- Brings Health records including Patient Passport

Reviews or Completes the Patient Passport

A plan of care is established

The patient and Carer/significant other are aware of the proposed plan of care
Considerations when transferring a patient with learning disabilities from Hospital setting

The patient’s destination

- Other acute hospital setting
- Residential Care
- Own Home
- Respite Care
- Other

There is a need to notify

- District Nurse/Health advisor
- Key worker/social worker
- Residential Home Manager
- Carer
- GP
- Other hospital staff

Community Psychiatric Nurse

Community Learning Disabilities Nurse

Information which may be useful

- Changes in medication
- Diagnosis
- Ongoing treatment
- Treatment received

- Any particular anxieties
- Changes in behaviour
- Changes in physical ability
- Changes in level of independence
- Use of additional equipment/devices

Other considerations may be

- Transportation of equipment
- Is the patient’s medication in the appropriate form
- Does the patient require an escort
- Does the patient require ongoing medical intervention
Attendance to the outpatient department

General Practitioner → Referral Letter

Consultants → Review the referral → Identifies the patient has learning disabilities → Makes the appropriate transport arrangements

Ward Staff → Informs → On arrival → Makes any necessary arrangements and adjustments

The patient → Approaches the patient and establishes the most appropriate means of communication → Meets the patient’s immediate needs

The Doctor → The Nurse → Significant other i.e. carer

Ensure that the patient

- Is referred to other appropriate agencies
- Understands what is going on
- Is treated with dignity and respect
- Has the opportunity to ask questions
- Understands why they are attending hospital
- Is able to access PET or Site Practitioner

Refer to Effective Transfer of Care Guidance

Informed consent gained

The appropriate accessible information is used
Guide to managing and minimising risk on the ward

Person with learning disabilities admitted to the ward

Liaise with patient and carer or care worker

Complete a Carers’ Checklist with the patient, carer and care worker

Are there additional risks to the patient, the ward or to other patients?

Complete a patient passport with the patient and carer / care worker

Keep passport by the bed, and ensure carers and ward staff review at beginning of each shift.

Yes - Can these be managed by changing position of the bed?

No – Are there particular times that pose greatest risk? Can carers attend at these times?

Yes – Identify if the carers / care workers could be reimbursed for the extra time they spend with the patient – see attached guidance for setting up this arrangement.

No – Does the risk require management by someone that knows the patient?

No – Make request for CSW77 from NHSP – see attached guidance.
Role Negotiation Carers Checklist

1. ASSIST WITH HYGIENE CARE   YES/NO
2. ASSIST WITH FEEDING         YES/NO
3. DRESSING PATIENT           YES/NO
4. ACCOMPANY PATIENT WITH/FOR PROCEDURES YES/NO
5. SHIFT TIMES .......................
6. BREAK COVER REQUIRED        YES/NO
7. AGREED WITH (NAME AND POSITION)

..............................................

8. VERIFIED BY:
   HOME MANAGER..............................
   WARD NURSE IN CHARGE....................

9. DATE AND TIME AGREED ............

DEVISED AND DEVELOPED BY J BADE, P YOUNG, S BOTTLE
Version 3 May 2010
Accessing NHS Professional Staff Assessed and Trained to Work with People with Learning Disabilities

Further to recent conversations at William Harvey Hospital, 35 Band 2 and 3 staff who have an interest and been assessed to work with people with learning disabilities are available via NHSP workforce for EKHUFT.

This group of staff would be best utilised in situations where:-

- There are risks on the wards.
- Staff need to engage the patient in difficult healthcare choices.
- Support to engage in activities may minimise anxieties.
- Minimise reliance on parent and paid carers.

The process for booking these individuals is the same as general nursing NHSP staff i.e. make your request via the web using your usual login and password. Please note the code required is CSW77 (band 2) or CSWH77 (band 3)

These shifts will be automatically available to any of the staff (CSW77 or CSWH77) who requested that EKHUT is added onto their profile. They are able to contact the National Service Centre or book themselves in via the web.

Once the request has been made, you are also welcome to contact a member of your local NHS Professionals team (David Eliot or Jessica Fowler) who will alert the National Service Centre of this request so proactive calling targeting this specific requirement is completed.

There is also the opportunity to use the Secondary Assignment code (00 for general or 03 for mental health) option while making your request. This will open up the request to other staff members (i.e. general or mental health band 2’s) should there be no available learning disability specialists to cover the shift. This is a worthwhile option when cover is essential.
There are six Community Learning Disability Teams in East Kent. They are integrated Teams and are made up of:-

- Care Managers
- Community Learning Disability Nurses
- Speech Therapists
- Physiotherapists
- Occupational Therapists

The Community Teams may know the patient you are working with and wish to support them and you with care planning. Always contact the Community Team local to where the patient lives.

**Dover**  
Cairn Ryan, 101/103 London Road, River, Dover CT16 3AA.  
Tel: 01304 828555

**Ashford**  
Civic Centre, Tannery Lane, Ashford, TN23 1PL  
Tel: 01233 205752

**Canterbury**  
Brook House Reeves Way, Whitstable, CT5 3SS  
Tel: 01227 598500

**Thanet**  
St Peter's House, Dane Valley Road, Broadstairs, CT10 3JJ  
Tel: 01843 860000

**Swale**  
Avenue of Remembrance, Sittingbourne, ME10 4DD  
Tel: 01795 418817

**Shepway**  
Eversley House, 19 Horn Street, Hythe. CT21 5SB  
Tel: 01303 717000
PART 5

CARING FOR PATIENTS WITH DELIRIUM/ CONFUSION/ DEMENTIA

Staff should only record dementia if the patient has a confirmed diagnosis.

1. Delirium (sometimes called ‘acute confusional state’) is a clinical syndrome characterised by disturbed consciousness, cognitive function or perception, which has an acute onset and fluctuating course.

2. Dementia is a disease of the brain; it results in progressive decline in multiple areas of function, including memory, reasoning and communication skills. Individuals may develop additional behavioural and psychological symptoms. Dementia includes Alzheimer’s disease, dementia with Lewy bodies, frontotemporal dementia, vascular dementia and mixed dementias. Dementia in Parkinson’s disease shares a number of similarities. Younger people with dementia have special requirements. (NICE Guideline 42 Dementia 2006). 70% of acute hospital beds are currently occupied by older people. The prevalence of dementia in older people in general hospitals is 30%. People with dementia in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation. There are currently 15,000 younger people with dementia in the UK. Dementia costs the UK economy £17 billion a year. The number of people with dementia will double over the next 30 years with the costs trebling to £50 billion a year. The impact of dementia on those with the illness and on their families is profound. Family carers of people with dementia are often old and frail themselves. (DH 2009 – National Dementia Strategy and Alzheimer’s Society 2010)

3. Caring for patients with delirium/dementia can be challenging, however all staff are accountable and have a duty of care to ensure patients and carers needs are met safely including the following;
   Enhanced communication with patients and their carers. Use the ‘This is Me’ booklet available on all sites from your matron.
   Co-ordinated management of care needs with clear management plans which are reviewed at least daily. Undertake risk assessments including involvement of Psychiatric Liaison Service where needed.
   More attention to hydration, nutrition, falls, pressure ulcer prevention and very important to ensure patients receive their prescribed medication.
   Co-ordinated discharge planning
   Escalating concerns promptly to appropriate nursing/medical teams and agreeing management plan. Always think about involving carers.

Safeguarding these vulnerable patients by ensuring timely and appropriate care is everyone’s responsibility/accountability. Take time to see and listen to your patient.
PART 6
CAPACITY/DEPRIVATION OF LIBERTIES GUIDANCE

1. The Mental Capacity Act 2005 is a comprehensive legal framework for the
decision making for people over the age of 16 who lack capacity to make particular
decisions for themselves. It puts the needs and wishes of a person who lacks
capacity at the centre of any decision making process.

The Mental Capacity Act Deprivation of Liberty Safeguards was introduced into the
Mental Capacity Act 2005 through the Mental Health Act 2007 (which received Royal
Assent in July 2007)

The safeguards are designed to protect the interests of an extremely vulnerable
group of service users and to:

- Ensure people can be given the care they need in the least restrictive regimes
- Prevent arbitrary decisions that deprive vulnerable people of their liberty
- Provide safeguards for vulnerable people
- Provide them with rights of challenge against unlawful detention
- Avoid unnecessary bureaucracy

2. Definitions

- **Consent** – a person’s decision to accept or refuse care of treatment
- **Mental Capacity** – a person’s ability to make the decision or accept or refuse
  a proposed treatment
- **Lack of Capacity** – following a capacity assessment, the person is
determined to be unable to make a particular decision (i.e. not give consent) at the
time the decision needs to be taken

- If the person does not have the ability to give consent, a best interest decision
  has to be made. Consideration needs to be made about the urgency of the
decision to be made. Urgent decisions will be made in the patient’s best
interest. Some decisions can and should be made over the telephone with an
appropriate person and legislation states that this can be next of kin, carers
and relevant others.

3. **An Independent Mental Capacity Advocate** (IMCA) should be arranged for any
person who meets all of the following criteria:-

1. Person is over 16 years old.

2. Lacks capacity to make a particular decision (about serious medical treatment
or changes in accommodation.)
3. The decision made is about non urgent, serious medical treatment, a change of accommodation; or a care review or adult protection procedures?

4. There is nobody (other than paid staff providing care or professionals) whom the decision-maker considers willing and able to be consulted about the decision? (This does not apply to adult protection cases.)

4. **Serious medical treatment is that which involves:-**
   
   - Giving new treatment
   - Stopping treatment that has already started; or
   - Withholding treatment that could be offered

**And where there is either:**

- A fine balance between the benefits and the burdens and risks of a single treatment
- A choice of treatments which are finely balanced; or
- Significant risks which can be associated with the proposed treatment. This includes, but is not limited to, treatments that
  
  1. cause serious and prolonged pain, distress or side-effects
  
  2. have potentially major consequences for the patient (e.g., anaesthetics, major surgery, perforation or stopping life-sustaining treatment); and
  
  3. have a serious impact on the patient’s future life choices (e.g. interventions for ovarian cancer)

An IMCA will act as an advocate for the incapacitated patient and will look at whether the best interest principles have been followed, ensure the person’s wishes and feelings have been considered and seek a second medical opinion if necessary.

**Changes to Accommodation**

Accessibility to / involvement of an IMCA applies to decisions about long-term accommodation moves to or from a hospital or care home or a move between such accommodation if:

- If provided or arranged by the NHS
- It is provided under section 21 or 29 of the National Assistance Act; or
- It is part of the after-care services provided under section 117 of the Mental Health Act 1983 – following a decision made under section 47 of the National Health Service and Community Care Act 1990.
‘Long term accommodation’ moves applies if an NHS organisation or Local Authority decides to place a person who lacks capacity:

- In a hospital (or to move them to another hospital) for a stay likely to last longer than 28 days; or
- In residential accommodation for a stay likely to last longer than eight weeks.

5. Important to Note

It is not illegal or a breach of human rights, to use restraint if the restraint is:

- **Necessary** to prevent harm to the person lacking capacity
- **Proportionate** to likelihood and seriousness of harm
- In the **Best Interest** of the person.

The essential thing is to use the above terminology and record in the patient’s records why decisions have been made. If we do not record then we are breaching the legislation, not able to evidence and hence not legal.

MCA evidence must be documented as follows:

- Valid consent or capacity assessment
- Named decision maker
- Reasons for best interest decision
- Restriction, restraint used and duration
- Other actions (e.g. DoLS checklist)
- Review of actions

6. Short term or emergency use of restraint or restriction of freedom can be used without a DoLS authorisation if all MCA requirements are followed.

Consideration for a DoLS request should be made if following the MCA assessment the person does **NOT** have the ability to consent to the arrangements proposed for their care or treatment.

DoLS Urgent Authorisation should not be used:

1. To legitimise the short-term deprivation of liberty
2. When a person is for example, in an accident and emergency department and it is anticipated that the person will no longer be in the environment in a matter of a few hours or a few days.
3. The treatment of a physical illness is expected to lead to rapid resolution of the mental disorder that such a standard deprivation of liberty authorisation
would not be required (e.g. patient with UTI, confusion, behavioural problems, however following treatment patient improves.)

All staff groups have a duty to ensure patients’ rights are protected by adhering to Trust Policy and Guidelines

If in doubt or have any concerns contact and discuss with Trust Lead for Safeguarding on ext 62556 or mobile 07770701840.
### Part 7

**KEY POINT CONTACTS**

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| **East Kent Alcohol Services**                       | 01227 473820              |

| **24 hour Kent Dementia Helpline**                   |                           |
| For people with dementia and their carers            | 0845 604 4391             |

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