**Identifying the need for 1:1 special, for people with learning disabilities: (Please refer to flow chart Appendix X)**

When a patient with a learning disability and/or autism is admitted to the hospital, the admitting nurse should complete the Learning Disability Rapid Risk Assessment (Please see POLICY NAME) with the individual and their family/ carers to identify any areas of risk.

For planned admissions, assessment for supervision should form part of the pre-assessment process. The matron for the speciality should be notified in advance of the admission. The Hospital Passport should also be reviewed, and the relevant section updated to reflect this.

If a medium or high-risk score is indicated and the patient has significant risks in relation to personal safety i.e. fall from bed, removal of drips/ drains leading to potential poor health outcome, or significant behaviours or anxiety that will challenge services, the nurse should also assess the patient using the Trust policy for enhanced supervision and engagement. (Please see POLICY).

If the patient’s risks are mainly due to the removal of medical devices, wandering due to poor orientation, or falls, and there is no indication for the need for the patient’s own care team to provide support, the nurse should highlight /discuss the need for a 1:1 special from the hospitals internal nurse bank with the senior nurse on duty.

If they agree that a special is required, they should follow the agreed protocol to ensure that a special is available to support the patient. All discussions and decisions should be documented clearly in the patient’s health record, and the Hospital Passport should also be reviewed, and the relevant section updated to reflect this.

If the nurse bank is unable to find a special to support the patient this should be recorded in the patient’s health record, discussed with the senior nurse on duty, and steps taken to reduce risk as far as possible i.e., increased observation, relocation of bed closer to nurse’s station, use of nursing staff already on ward to increase level of monitoring and supervision etc. This should also be recorded via the incident reporting system.

The need for the 1:1 special for all patients with a learning disability should be reviewed on a 24-hour basis, due to the potential for decreased or increased risk as their health improves.

**N.B: If the patient is assessed as lacking capacity to consent to this process please also follow the Trust policy and guidelines POLICY NUMBER (Mental Capacity Act policy) and POLICY NUMBER (Deprivation of Liberty Safeguards policy**

**Agreeing the need and funding for the support to be provided from the patient’s own care team.**

If the risk assessment indicates a significant risk to the patient’s own safety, the safety of other patients and the hospital staff due to anxiety, behaviour, severe hospital phobia etc. (possible in cases where patients have diagnosed autism or significant self-injurious behaviour/ behaviour that may become challenging), the only option may be that the patient’s own care team provide the 1:1 support required to assist the patient to reduce their anxiety and manage their behavioural needs.

This should be discussed with the admitting nurse, ward sister/charge nurse and matron in charge of the ward.

It should never be presumed that the carers will automatically do this, as they may not be funded to provide this level of support or have the additional staffing required to release carers to stay at the hospital. It is important to remember that the patient is admitted to hospital their care and treatment becomes the hospitals responsibility.

If agreement is reached for the patient’s own care team to provide the required 1:1 support, the following process will need to be followed and authorised by the matron (or out of hours, by the clinical site manager). The Hospital Passport should also be reviewed, and the relevant section updated to reflect this.

**NB: This process is only agreed for patients whose support is funded by Essex County Council.**

1. **Check that patient patients’ support is funded by Essex County Council.**

Care/support providers will be able to confirm whether they are funded by Essex County Council or another authority.

1. **Completion of Proforma 1: In Hospital Support**

Authorising staff to complete all details on proforma and then securely email the form to the Specialist Placement Team (SPT) who will liaise with the support provider to determine whether the requested support can be provided. When the SPT is not available, the authorising staff should liaise directly with the provider. Ensure that once the completed copy of the proforma is placed into the health record.

1. **Completion of Proforma 2: Paid carers partnership agreement**

The nursing team will then complete a paid carer’s partnership agreement with the home manager to agree and document the support that will be provided by the care team. Please remember that the home care team will be here in a supportive role to work alongside the hospital team. Please ensure that paid carers are included in roster for breaks and that they receive an induction, following the Trusts Induction policy

All assessments, agreements and decisions should be documented clearly in the patient’s health record.

If the patient is transferred to another ward area before discharge home, it will be the responsibility of the transferring ward to ensure that the ward co-ordinator and senior nurse for the admitting ward are aware of the risks the patient has and the agreements reached in relation to 1:1 special etc.

1. **Completion of Proforma 3**: **Checklist for outsides agencies working within the Trust**

The nurse in charge of each shift should ensure that the checklist is completed for **every** member of staff to provide assurances that they are fit for practice.

1. **Completion of Proforma 4: Carers work record**

With the contract also provide via e-mail, a copy of the carers work record. A copy of the work record should be provided for **every** carer that will be providing support during the patient’s admission. These should be filled in by the carer and signed by the nurse in charge of the ward at the end of each shift they complete.

A copy of the work record should be kept by both parties and will be returned by the carer’s management team with the invoice for the additional support that has been provided after the patient’s discharge.

**Appendix X Paid Carers Flow Chart**

****

**Admission of patient with LD & complex needs**

**Complete LD Risk Assessment and/or Enhanced Observations Tool**

**Patient identified as medium or high risk**

**Confirm that patient’s care/support is funded by Essex County Council**

**Complete Proforma 1 –**

**In Hospital Support and send to Specialist Placement Team**

**Complete Proforma 2 –**

**Paid carers partnership agreement**

**Complete Proforma 3 -**

**Checklist for outside agencies working within the Trust**

**(for each staff member)**

**Complete Proforma 4 –**

**Complete carers work record**

**(for each staff member – to be retained by MSE)**

**YES**

**Assess patient for 1:1 using trust policy for enhanced supervision/engagement**

**NO**

**Implement appropriate care bundles and any adjustments required**

**Risk assessment indicates need for**

**1:1 support**

**NO**

**Request 1:1 Special via HCA Nurse Bank using agreed protocol**

**YES**

**Discuss with Matron**

**(or Clinical Site Manager out of hours)**

**NO**

**Implement appropriate care bundles and any adjustments required**

**YES**

**Is this required from patient’s own care team**

**Appendix X Proforma 1: In Hospital Support**

|  |  |
| --- | --- |
| \*Full Name:  Preferred Name:  \*Date of Birth: | \*NHS No:  Hospital No:  \*Hospital Name:  Mosaic Number if known: |
| \*Permanent address: | **NHS/IDT budget holder agreement**  *(for ECC reclaiming of costs)*  Name of Budget Holder:  ICB Name:  Unique ICB Patient ID Code/Personal Ref.  *(to quote on invoice)*:  Hours required per week:  Required start date:  Signed:  Date: |
| \*Postcode: | Position: |
| \*Telephone No:  Email contact: | \*Telephone No:  Email contact: |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Provider:** *(Provider to notify SPT when normal support at home resumes)*   |  |  | | --- | --- | | **\*Start date:**  **End date:** *(To be added by SPT once provider notify)*  **ECC BUDGET CODE** | **Support hours provided per week:**  **Hourly rate:** | | \*Admission date to hospital: | | | \*Ward Name: \*Ward Telephone No: | | | \*Ward fax number and/or email: \*Ward Staff Name & Telephone No: | |   \*indicates mandatory fields, if these are not filled in the form **WILL NOT** be processed  Please email to[**SPT.PackageChanges@essex.gov.uk**](mailto:SPT.PackageChanges@essex.gov.uk)  To ‘chase’ phone 03330139975 Monday to Friday or Saturday 07774337494  Please allow 3 hours for admin processing and communication with care provider |
| Authorising staff name: |
| Authorising staff signature: |
| Authoring staff designation: |
| Date: |

**Appendix X Proforma 2: Paid carers partnership agreement**

|  |  |  |
| --- | --- | --- |
|  | | |
| **It is the responsibility of the Registered Nurse**  **to complete the details below with the**  **manager of the patients residential/ nursing / supported living home** | | |
|  | |  |
| **The Carer Must Not Administer Any Medications** | | |
| **Subject area** | **What has been agreed** | |
| Agreed Care activities to be provided;- |  | |
| Personal care and Oral hygiene |  | |
| Bowels / urine output |  | |
| Eating and Drinking |  | |
| Moving and handling |  | |
| Anxiety management |  | |
| Risk management |  | |
| Skin condition |  | |
| Emotional and communication support |  | |
| Any other issues of significance |  | |
| Signature of Nurse............................................ Print Name:....................................................  Designation:.................................................... Date:.............................................................. | | |
| Signature of Home Manager............................... Print Name:..................................................  Designation:....................................................... Date:............................................................  Copy of completed form to be provided to home manager | | |

**Appendix X Proforma 3**: **Checklist for outsides agencies working within the Trust**

**Checklist for Outside Agency working Within the Trust**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of carer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| To be completed once for each carer during episode of admission | Nurse in charge Signature | Carer Signature |
| Orientate to ward environment Including health and safety, fire exits, Procedures & Fire Safety. |  |  |
| Check Agency Id badge |  |  |
| Ensure awareness of manual handling procedures (It is the agency responsibility to ensure training is up to date. |  |  |
| Ensure Carer is aware to inform nurse in charge of any concerns or changes in condition |  |  |
| Ensure that the Carer is aware of their role and responsibility whilst on the ward |  |  |
| Discuss awareness of medical equipment in use and ensure carer is aware that hospital Equipment hoist etc only to be managed by nurse in charge. |  |  |
| Any Clinical issues that need to be discussed please document. |  |  |

This checklist covers the minimum requirements to be covered for all outside agency staff working within the Trust.

**Appendix X Proforma 4: Carers work record**

**Carer’s Work Record**

|  |  |  |
| --- | --- | --- |
| **Carer’s Name:** | **Patient’s Name:** | **Clinical Area:** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date dd/mm/yyyy** | **Start**  **Time** | **Finish**  **Time** | **Break**  **minutes** | **Total Hours** | **Nurse in Charge**  **(PRINT NAME)** | | **Nurse in Charge**  **(SIGNATURE)** |
|  | **:** | **:** |  |  |  | |  |
|  | **:** | **:** |  |  |  | |  |
|  | **:** | **:** |  |  |  | |  |
|  | **:** | **:** |  |  |  | |  |
|  | **:** | **:** |  |  |  | |  |
|  | **:** | **:** |  |  |  | |  |
|  | **:** | **:** |  |  |  | |  |
|  | **:** | **:** |  |  |  | |  |
|  | **:** | **:** |  |  |  | |  |
|  | **:** | **:** |  |  |  | |  |
|  | **:** | **:** |  |  |  | |  |
|  | **:** | **:** |  |  |  | |  |
|  | **:** | **:** |  |  |  | |  |
| **Please deduct your breaks Total Hours** | | | |  |  |  | |

Please return your work record to: