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Managing the Care Needs of People with a Learning Disability in the Kidderminster Hospital Day Surgery Unit

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Date of Approval	**26th April 2021**
Date of next review This is the most current document and is to be used until a revised version is available	**26th April 2024**

Aim and scope of Standard Operating Procedure

This Standard Operating procedure (SOP) provides guidelines for clinical staff, managers and the Learning Disabilities Liaison team for the expected standards to manage the care of adult patients who have learning disabilities, as they attend or are admitted to hospital.

The joint working practices and procedures apply to all adult patients in hospital who have Learning Disabilities, irrespective of their place of residence. The philosophy of care is for equality of access to services, treatments and clinical care, taking into account the specific needs of individuals.

Target Staff Categories/ Scope the process applies to:

The care of adult patients with learning disabilities must be well planned and co-ordinated and involve the patient, their family, carers, community services and care providers.

The LD Liaison Team are aware of all patients with learning disabilities and will be involved in the facilitation of Treatment Escalation Plan discussions and the care planning of patients with complex needs.

Information regarding the patient’s needs should be gathered before hospital admission/attendance wherever possible.

Information from the Hospital Passport and reasonable risk assessment tool should be used to inform the patient’s care plan in hospital.

Transfers between should only be considered where clinically necessary for the patient eg failure to discharge. Any such ward transfers must be in line with the current transfer policy (appendix 1)

Planning discharge should commence at pre-assessment for elective day case admissions.

This SOP is dedicated to the care of individuals with Learning Disabilities on The surgical pathway going through ward 1 and theatres at KTC.

Definition and Introduction

Learning disabilities are defined as lifelong conditions, with an onset before adulthood, which are neither illness nor disease. Learning disability is defined as;

Significant reduced ability to understand new or complex information, to learn new skills (impairment of intelligence, usually within IQ of less than 70)
WITH
Reduced ability to cope independently (impaired social functioning)

(Valuing people, A new Strategy for learning Disability in the 21st Century, Department of Health 2001)

This Standard Operating procedure (SOP) provides guidance for all clinical staff, managers and the Learning Disabilities Liaison team of the expected standards to manage the care of adult patients who have learning disabilities, as they attend or are admitted to hospital on the surgical pathway. The joint working practices and procedures apply to all patients in hospital who have Learning Disabilities, irrespective of their place of residence. The philosophy of care is for equal and timely access to health services, treatments and clinical care, taking into account the specific needs of individuals.

Patients with learning disabilities are likely to have additional needs, sometimes complex, which may impact on their clinical condition and access to investigations or treatment. These may include communication needs, consent to treatment issues, need for specialist equipment, need for specialist assessments (eg. Speech & language,), complex discharge needs and/or challenging behaviours.

Use of this SOP should always take account of the requirements of the Equality Duty Act (2010). The basic principle of health services is equal access for all according to need. Healthcare is provided to a range of ‘groups’ who have different needs, and will use services differently, but need to be able to access the same level of care as the general population.

Individuals attending as a Day patient may need to be supported with the following:
Pre-hospital planning, acclimatisation, reasonable adjustments to meet the needs of the individual and management of anxiety or phobias

Clear communication with individual and carers

Medication to reduce anxiety and/or agitation in hospital

Management of behaviours which may challenge or disrupt - may require increased observation, carers known to the individual, sedation

Hoists or other manual handling equipment – to move or be moved

Support with activities of daily living – using toilet, eating/drinking. Maintaining dignity and respect of the individual

Support/help from community services/carers/family/community liaison staff – to provide continuity of care and help from carers known to the individual

Patient Criteria

Levels 1,2,3 descriptors describes the level of competence required by the clinician in conjunction with the environment in which the care is being delivered.

Although the current clinician has the required competence to undertake level 3 case mix of patients the current environment doesn't provide the level of care for patients with high medical complexity or risk (Appendix 2 Guides for commissioning dental specialties- special care dentistry)

Patients along with the Level 1,2,3, complexity needs would also be required to fit within the KTC surgical admission criteria (Appendix 3 KTC adult surgical admission criteria)

Responsibility of special care dentistry team

Mental capacity assessment, Best interest decision and/ or consent, where appropriate, should be completed at time of referral by special care dentistry team.

Pre-operative assessment

Pre-assessment –

A reasonable adjustment summary (where available) and Hospital Passport (where available) will be used in the assessment of patient needs to identify any special requirements either whilst in hospital or following treatment. Anticipated needs on discharge should be assessed and planned for at pre-operative assessment.

A full Synopsis assessment must take place with a face to face/ telephone/ virtual nurse led pre assessment followed by an anaesthetic review

Care Pathways -

Will normally define the patient care needs according to the condition or treatment provided. However, consideration will need to be taken as to the specific needs of a patient with learning disabilities – so that Reasonable adjustments can be made to take the specific/complex needs of the patient into consideration. These should be discussed with the patient and their carer, or the Community Learning Disabilities/Primary Care Liaison Nurse at pre-assessment

Examples of Reasonable adjustments may include – General Anaesthetic 'Day case' procedures Patients may need carer support up until sedation for procedure has taken effect.

Pre-operative must take place within locally agreed time frame prior to admission.

A full dental, medical including anaesthetic, social and when available family history should be recorded as well as if possible an oral and physical examination where indicated.

There should be a discussion of possible need for pre-medication and physical intervention (clinical holding) during induction of anaesthesia as well as advice about the pre and post administration of any regular medication taken by the patient. A patient specific plan for pre-operative sedation should also be discussed and recorded in the anaesthetic review.

The assessment should also include any likely requirement for specialist equipment such as anaesthetic equipment, moving and handling aids etc.

Specialist tests required prior to surgery where possible. Where this is not possible these test should be carried out in theatre

At time of nursing pre assessment the nurse will generate hospital passport and forward to patient, family or carers to facilitate return of completed document to ward 1 3 days prior to admission to ensure any reasonable adjustments can be made.

Verbal and printed instructions should be given to include the following:

- Pre-operative fasting
- Any medication that should/ should not be administered prior to admission
- Details about escort and transport
- Time and venue for admission for treatment
- Items that should be brought along with the patient (dressing gown slippers, medication)
- Advice about analgesia
- Post-operative care
- Contact numbers for advice about surgery and anaesthesia as well as post-operative complications

COVID Swabbing and guidance

See ward 1 COVID SOP (appendix 4)

Ward Admission

Day Surgery Admissions

For patients with learning disabilities, careful planning will be required at pre-admission clinic and on the day of surgery, to ensure reasonable adjustments are assessed, agreed and communicated. If at all possible this should include visiting the post-op ward prior to surgery or observing the Video via the link ------------.

Patients attending for day surgery at the KTC site will report straight to Ward 1 on the 2nd Floor.

On arrival at Ward 1, patients are to ring the bell and wait for the nurse to come and collect them.
On admission to the ward, patient and cares/ relatives temperature will be taken and also lateral flow test for anyone except the patient.

- All patients will be admitted to an Anti-Ligature, high visibility room

- Named nurse to ascertain patients usual baseline level with family and or Carers and determine if there are any challenges with behaviour which may impact on pre and post op care and document in patients notes.

- All patients must have a completed hospital passport

- All females of child baring age will require a pregnancy test prior to surgery. In the event this cannot be achieved the anaesthetist will be informed.

- Patient should be reviewed pre operatively by the Special care dentist and anaesthetist in the patients room prior to going for surgery

- In the event the patient will not wear an identification wrist band or tolerate it taped to their gown, patient identification will be confirmed by surgeon, anaesthetist family/ carer and named nurse in the anaesthetic room and any allergies must be identified.
- All essential documentation to be completed

VTE and required prophylaxis applied
MCA completed (if required)
Best interest discussion documented (if required)
Consent where appropriate
Theatre safety checklist
(If any routine or essential theatre safety checks cannot be completed this must be clearly documented in notes. Clinical advice must be sought from anaesthetist and plan for continuation to be recorded)

- Named nurse will escort the patient to theatre and return with family member or carer.

MDT Safety Huddle to be held with Special Care Dentistry Team, Anaesthetist, Ward Nurse, Theatres and Learning Disability nurse prior to commencement of theatre list on Ward One.

Theatres

Transfer of patient from ward to theatre

Patients that have not been sedated and are fully cooperative will be walked or taken by wheelchair to theatres with HCA theatre escort and patient carer or relative.

Patients that have had pre-medication and/ or other sedation will need to be transferred to theatres by trolley. This will require a minimum of 2 staff members to transfer the patient along with the patient carer and/ or relative.

Where possible, patient monitoring will be attached prior to induction. If this is not possible the monitoring will be applied as soon as is reasonably possible. Where clinical holding is undertaken monitoring will need to applied as soon as the patient is asleep and it is safe to release the holding.
On completion of the surgical procedure a member of the theatre team will contact the ward in order to ensure that the patient’s carer or relative can be in first stage recovery for when the patient wakes up.

The dental surgeon should provide recovery staff with information regarding the dental procedures undertaken and any precautions required including:

1. Site and type of local anaesthetics used, including anticipated duration of action
2. Site and types of dental extractions (surgery, sutures etc) and of any dental/ surgical packs
3. Instructions for further pain relief

This must be handed over to named ward nurse on return to ward

Patient will be transferred back to the ward, once discharge criteria has been met. A recovery practitioner and one other staff member will escort the patient back to the ward on a theatre trolley. Full hand over from recovery nurse to named ward nurse must take place as soon as it is safe to do so.

Post Op ward care and discharge

Named nurse will escort family member or carer to theatre recovery upon request.
Patients will return from theatre with clear documentation of treatment received and a post op care plan.

Patients will be recovered by the named nurse to their usual/ baseline level with support from family/ carers.

In order for safe discharge the following criteria should be met

1. 1.Patient should be at a pre-operative level of consciousness and mobility
2. 2.All physiological monitoring should indicate a stable state
3. 3.Pain Nausea and vomiting should be minimal and controlled
4. There should be NO haemorrhage from the operative site
5. Diet and fluids to be taken as tolerated

Every patient should be seen following surgery prior to discharge by the dental surgeon and Anaesthetist involved in his/her care. Responsibility for the discharge process is shared between the dental surgeon, the Anaesthetist, and the Named Nurse.

When the patients are ready for discharge they must be accompanied by a responsible competent adult who has been given clear written instructions regarding the implications of the surgery and Anaesthetic undergone. (If the patient resides in a nursing/care home, The named nurse should telephone the home to give full instructions to nurse in charge prior to discharge).

Verbal and written post-operative instructions, including a 24 hour emergency contact number, should be given along with any prescriptions and information on future appointments to the most appropriate person e.g family member or carer An easy read version of post-operative care will also be provided to the patient where appropriate.

Details must be taken for most appropriate person to contact for Ward team to undertake a next day phone call. This must be documented on the discharge criteria.

In the event the patient does not meet discharge criteria. Transfer policy to be commenced (Appendix 1).

Ongoing review of standards of care and patient experiences for people with Learning Disabilities, will be undertaken

Regular audit of care practice through the safeguarding through ward link nurse

Friends and Family survey to be made easy read so to include patients with Learning Disabilities

Regular discussion on directorate clinical governance meetings

Review by the Learning Disabilities Liaison team of clinical incidents reported and flagged as involving individuals with Learning Disabilities

Involvement of Learning Disabilities Liaison team in any complaint investigation required, regarding concerns with care of patient with Learning Disabilities; annual review of such complaints and PALS concerns

Feedback from community services/providers/carers re patient experiences of hospital – to Learning Disabilities Liaison team

Annual review of service specification via business meeting

Staff will endeavour to resolve any concerns or issues of dissatisfaction as they arise. If the issue cannot be resolved at a local level or with the assistance of the Patient Advice Liaison Service (PALS) and a written complaint is made, the trust will provide an open, fair and accessible complaints process in line with the National Health Service Complaints Procedure that encourages communication on all sides.

Appendix 1 Transfer Policy

Appendix 2 Guides for commissioning dental specialties- special care dentistry
https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/09/guid-comms-specl-care-dentstry.pdf

Appendix 3 KTC adult surgical admission criteria

Appendix 4 Ward 1 COVID SOP