Saint John of God Kerry Services

Hospitality- Compassion - Respect

47

# Procedure to Support Care of Resident in Hospital

Saint John of God Kerry Services

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# *Saint John of God Kerry Services Local Protocol*

## *Initial Contact with Hospital Services*

The health care needs of people with Intellectual disabilities are usually met by their GP and the Primary Care Team at their Health Centre and by the Intellectual Disability specialist services. Occasionally however it may be necessary for a referral to secondary services. It is at the point of referral that a person with an Intellectual disability needs to be identified in order to ensure that advance planning is undertaken to address any specific needs and where necessary to modify investigations, treatments and supports to meet those needs.

## *Referrals*

Saint John of God Kerry Services will identify a person with an Intellectual disability when they are referred to hospital services and provide appropriate information about other professionals involved in their care. The Hospital Passport/ Critical Information Document or other relevant documentation will be used to support the person with an intellectual disability. It is envisaged this information will support the basis of the persons care plan on admission.

## *Routine Planned Admissions*

Pre-admission Saint John of God services will provide the hospital with the relevant Hospital Passport/ Critical Information Document or other relevant documents, the staff member/manager/CNM within the person's residential service will contact the ward supervisor/CNM to outline the person's needs during the hospital stay. Where possible/appropriate some documented information generated during their stay in hospital may be incorporated into the Hospital Passport/ Critical Information Document or other relevant documentation for future reference if the person has to come into hospital again at any time. This approach will assist hospital staff to provide more individualised care during the persons stay and enable the person with an Intellectual disability to gain the maximum benefit, with least distress, from their stay in hospital.

## *Presentation to Accident and Emergency Department*

When an individual with Intellectual disabilities attends accident and emergency they will be accompanied by support staff from their residential setting or family. The support staff will inform the emergency department and highlight any additional

supports the person may require to cope with their time in the Emergency department, support staff will remain with the person throughout their stay in accident and emergency in the absence of a family member.

## *Transfer from Accident and Emergency to an Admitting Ward*

Where a person with an Intellectual disability is to be transferred to an admitting ward the support staff will advise the nurse in charge of the receiving ward with the relevant information and share the Hospital Passport/ Critical Information Document or other relevant documentation to provide an initial assessment of the patient's communication and care needs. The residential provider will Transfer the person from their residential setting into the care of the hospital.

If there are any specific changes or developments in the patient's condition during the duration of hospitalisation the main carer and residential service should be contacted as soon as possible where applicable and in the best interests of the person. If there are any concerns relating to the persons capacity to cope with their hospital stay the main carer and the relevant manager/CNM in the residential service should be contacted to support the hospital to identify a strategy on how hospital staff can appropriately support the particular needs of the patient.

Behaviours of concern in this instance would be defined as behaviour of such an intensity or duration that it severely affects the individual's opportunity to receive treatment and/or presents a risk of harm to the individual, other patients or staff.

## *Transfer/Discharge*

Transfer / discharge planning should be discussed with the patient and their family. All patients with an Intellectual disability should be considered to have complex Transfer / discharge planning needs. The hospital staff should make contact with their professional colleagues in the community residential setting to ensure a coordinated approach to Transfer / discharge planning. The Staff member/CNM/Senior Nurse will liaise with the appropriate hospital CNM/staff to support this process.

On the day of Transfer/discharge the main carer and specialist services should be issued with a copy of the patient's Transfer/discharge plan detailing the patients' care needs on Transfer/discharge and arrangements for support in the community. The residential

provider will complete the transfer of the person into the care of their residential service.

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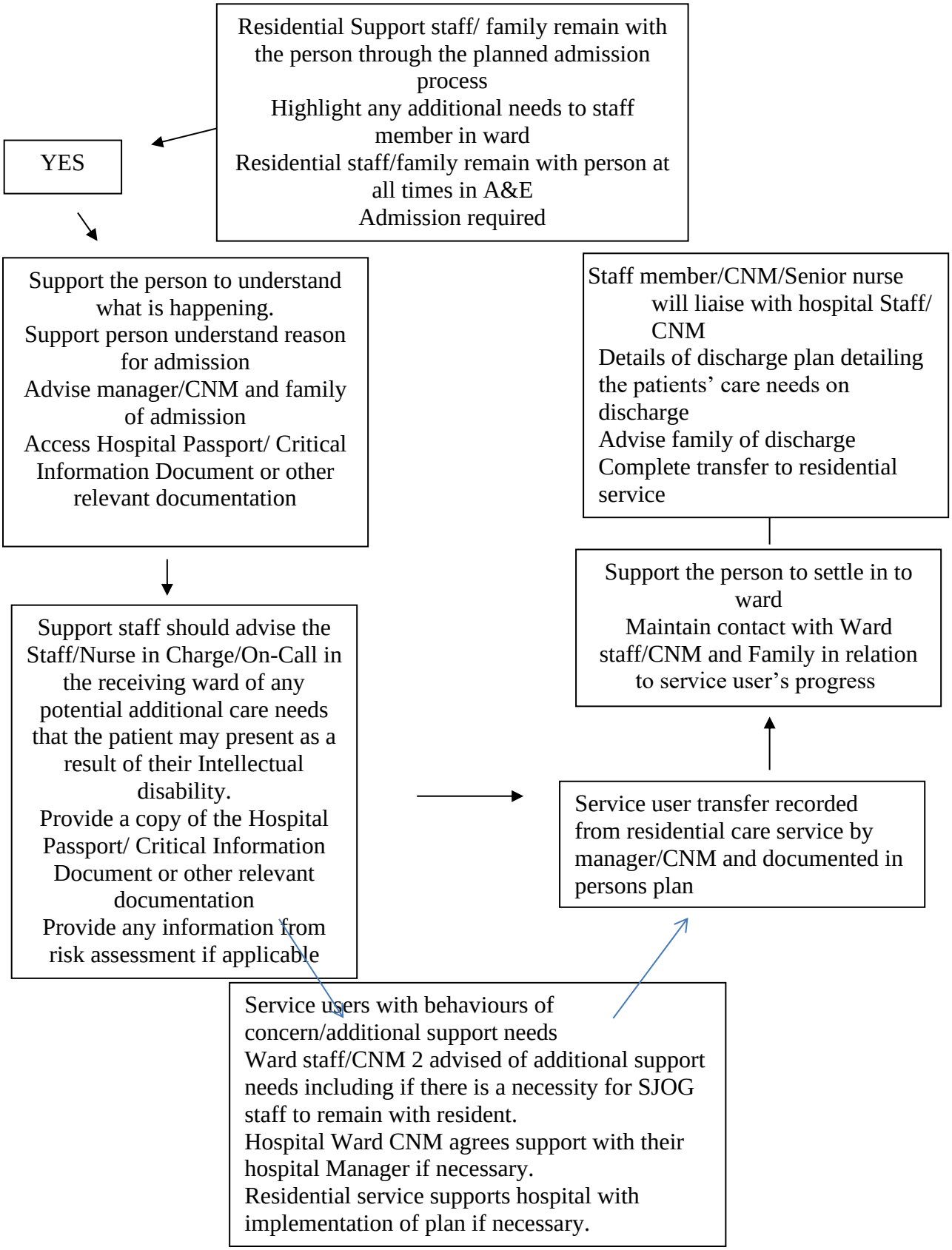

## SIGNATURE PAGE

I have read, understand and agree to adhere to the attached Procedure:

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