1. Introduction and Who Guideline applies to

1.1 This guideline covers roles, responsibilities, daily routine tasks and applies to all staff when providing care or services to patients and visitors that have a Learning Disability or Autism.

2. Guideline Standards and Procedures

2.1 Reasonable Adjustments. By law, we are required to make reasonable adjustments which are outlined in the Equality Act 2010. Therefore we should consider the patients and their family's needs and how we can reasonably meet them.

2.1.1 Prioritise time to be seen using the DPS score.

- This could be due to the late presentation as some might find it challenging to seek medical help.
- Patients might struggle more than others to cope with waiting long periods of time.
- Patients might be unknowingly critically unwell, however due to communication barriers, clinicians would be unaware.

2.1.2 Ensure a quiet space is provided while waiting in ED/CED. If staff are unable to move the patient into a quiet area such as a cubical, the patients' DPS should be increased until in a suitable area and this must be escalated to area co-ordinators. If after 15 minutes patient is still in an inappropriate area, this should be escalated to the NIC and EPIC.

- Many patients can find loud and busy environments challenging.
- Loud environments could impact on communication preventing efficient assessment.

2.1.3 Giving extra time can improve the care we provide.

- More time to overcome communication barriers, consider using picture charts and/ or Makaton.
- Use Patient Passports, "Helping me in Hospital", "Know Me Better" profiles or Grab Sheets, and ask family/carers for their input if available.
- More time to complete investigations.
- Patient might breach due to patient factors but will be transferred or discharged safely.

2.1.4 Bed Requests.

- Not suitable for rapid flow/boarding of patient on wards corridors.
- Excluded from cohorting in ED/CED, Rapid Flow etc. Use of the POA Escalation Pod should be considered on an individual basis as extended waits on ambulances could be distressing to the patient. This decision will be made by the POA clinician. Please consider the use of the Transer Hub and EDU as these areas can be quieter than Majors and be a calming environment to the patient. Avoid moving patients to Ambulatory as this can be very distressing for the patient.
- Request side rooms or bays depending on patient's needs.
- Careful consideration is to be made if admission is in best interests of the patient.

2.1.5 Investigations should not necessarily be front loaded in assessment areas unless a senior decision maker has requested the investigations.

- If blood tests or a cannula is needed, consider if it is safe for the patient to have Ametop and wait for the procedure to be carried out in due time. If investigation is time critical, cold spray can be used along with gentle restraint and a best interest decision clearly documented.
- Desensitisation of investigations can also aid the procedure. For example allowing the patient to hold an empty blood bottle or a cannula once the needle is removed.
- Distraction techniques should be considered at all times. Seeking guidance from the meaningful activity team, play specialists or from experienced staff.

2.2 Guidance aimed at staff roles and responsibilities.

2.2.1 Reception staff should fix a Learning Disability reasonable adjustments sticker to the front of notes when booking in if the Nervecentre alert is prompted.

2.2.2 VAC Nurse must prioritise using DPS and after speaking with patient or care giver document what the patients Learning Disability is in the progress notes. If possible, move patient straight into an assessment cubical. If patients are waiting longer than 30 minutes to be assessed, discuss with other area co-ordinators to assess if patient can be moved to Ambulance Assessment. If unable to do this, escalate to NIC and EPiC.

2.2.3 Assessment Clinician is not to focus on front loading investigations, but to hand over invasive investigations to the reviewing clinician where appropriate, such as Doctor blood tests and working flexibly according to patient needs. Hand over all patients in person to receiving area. Appropriate DPS- maintain a level of priority while in ED/CED – DPS 1 or 2.

2.2.4 Named Nurse is to ensure the "Know Me Better" or Helping me in Hospital Handbooks are completed and present. Start the Learning Disability assessment on NerveCentre. When escalating critically unwell patients, ensure the clinician is aware of late presentation and communication barriers. Consider appropriate analgesia especially if staff expect injury or illness to cause pain, use non-verbal pain assessment tools and make use of sensory equipment.

2.2.5 Reviewing clinician must consider higher risk of sepsis, late presentation and high risk of constipation. Trauma patients have higher risk of c-spine/significant head injuries. Take careful

consideration of bed requests- think about whether the patient can be treated at home safely, and what's in the patients' best interests. To be mindful that having a Learning Disability is not to be used as justification on Respect paperwork for DNAR.

2.2.6 Healthcare Assistant provide patient centred care, support in 1:1 supervision when needed, raise concerns to names Nurse or Doctor. If asked to perform blood test or cannulation, ask if Ametop is needed. Make use of sensory equipment. Take a step by step approach when completing physiolocgical observations.

2.2.7 Patients with a Learning Disability have a right to be fully involved in their care and treatment so all clinicians should make every effort in ensuring this is being done unless they having to work in best interest.

2.2.8 Named Nurse must ensure that regular medication is prescribed and administered in a timely manner. Often, patients with a learning disability have other medical conditions that they are prescribed time critical medications. These are required to be identified and prescribed at an early stage.

2.2.9 Supporting Roles:

- Learning Disability Acute Liaison Team
- Emergency Floor Learning Disability Team
- Meaningful Activity Team if the patient also has Dementia
- Play Specialists
- Pharmacy
- Safeguarding Team
- Autism Champions
- Medicines Management Team

2.3 Safeguarding must be considered with all patients. As a patient group there is a high prevalence of abuse such as hate crime, abuse from care staff, financial abuse and sexual abuse (for example). Any concerns should be escalated to a senior Nurse and Clinician for assessment.

2.3.1 ICE referrals to safeguarding must be completed if any concerns are suspected or if the patient is looked after in a form of residential/ nursing care.

3. Education and Training

3.1 Training will be included on the ESM mandatory training for Nurses and Healthcare Assistants.

3.2 Training will also be included on the Safeguarding level 3 training which is for all patient facing roles.

3.3 Complete e-learning called "Oliver McGowen training". This is for all staff members.

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Patient Experience	Questionnaire	Naadira Adam	Annual	Qualitative - fed back to Learning Disability

				Strategic Team
Staff Experience	Questionnaire	Alastair Fawkes	Annual	Qualitative - fed back to Learning Disability Strategic Team

5. Supporting References (maximum of 3)

Equality Act 2010

6. Key Words

Learning Disabilities, Learning Disability, Autism, Autistic, Disability, Reasonable Adjustments, LD.

CONTACT AND REVIEW DETAILS	
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Details of Changes made during review: Updated on 14.10.23	

Appendix

Hints and Tips

- **Communication is key**
    - **Involve family and carers early on, refer to community care plan.**
    - **Avoid jargon and check understanding.**
    - **Use communication tools such as; Makaton, Picture boards, British Sign Language, Language Line to arrange face to face translation.**
    - **Find out likes, dislikes, comforts and be aware of topics that could trigger behaviour that challenges.**

- **Analgesia**
    - **Ametop for venepuncture/cannulation will improve patient experience, reduce risk of needle stick injury and promote future access to healthcare.**
    - **Give analgesia for known painful illness, injuries and procedures. There are patients that will struggle to communicate the pain they are feeling.**
    - **Medication can be given covertly however a full assessment must be completed first to establish capacity and the best interests of the patient.**

- **Behaviour**
    - **Behaviour that challenges can be caused by many reasons however often it is a way of communicating an unmet need.**
    - **Consider what behaviour is normal for the patient often family and carers can provide information which can give indications to the cause off illness or injury.**

- **Common preventable causes of death**
    - **Aspiration pneumonia, complete SALT referrals on all patients with a presenting complaint of aspiration pneumonia.**
    - **Constipation, Emergency staff should start the process of completing bowel charts and acting on them. Do not leave it for the ward staff.**
    - **Inappropriate DNACPR/ Respect form. Learning Disability/Autism is not reasons for a DNACPR/ Respect form. If this has been the case ensure there is a review of the DNACPR/ Respect form.**