

# STOP LOOK CARE

**An information guide for anyone providing  
direct support to people with learning  
disability and/or autism**



**Southampton, Hampshire, Isle of Wight  
and Portsmouth (SHIP)**

Version April 2020

Supported by



# Introduction

This booklet is designed to support carers and care workers (hereafter referred to as carers) who live and work in the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) area. Carers should recognise changes in a person's condition by monitoring them and/or recognising any deterioration in their wellbeing. The aims of the SHIP STOP LOOK CARE booklet are to:

- provide a guide for people with a learning disability and/or autism who are supported in the SHIP area
- improve quality of care, maintaining and improving health and wellbeing
- be a [Care Certificate](#) companion.

This booklet promotes basic awareness and knowledge of certain needs and conditions and advises where to refer to, if needed. It highlights:

- why different aspects of observation and care are important
- what to look for
- what action to take.

The actions on some of the pages are colour coded like a traffic-light system, providing a **STOP LOOK CARE** approach:

- **GREEN – No ACTION**
- **ORANGE – ACTION – Monitor and document**
- **RED – ACTION – REFER – Seek further support and advice**

If people have complex health needs and/or long-term conditions, carers should seek appropriate training and support.

There are links to the internet throughout this booklet to help you access additional information. This booklet will be available electronically on websites in the SHIP area.



● GREEN – ACTION – None    ● ORANGE – ACTION – Monitor and Document    ● RED – ACTION – REFER – Seek further support and advice

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# Use the Right Service



 <b>Self Care</b> Care for yourself at home  Minor cuts & grazes Minor bruises Minor sprains Coughs and colds	 <b>Pharmacy</b> Local expert advice  Minor illnesses Headaches Stomach upsets Bites & stings	 <b>NHS 111</b> Non-emergency help  Feeling unwell? Unsure? Anxious? Need help?	 <b>GP Advice</b> Out of hours: Call 111  Persistent symptoms Chronic pain Long term conditions New prescriptions	 <b>UTCs</b> Urgent Treatment Centres  Breaks & sprains X-rays Cuts & grazes Fever & rashes	 <b>A&amp;E or 999</b> For emergencies only  Choking Chest pain Blacking out Serious blood loss
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 **GREEN – ACTION – None**    **ORANGE – ACTION – Monitor and Document**    **RED – ACTION – REFER – Seek further support and advice**

# SBAR communication tool

## Situation Background Assessment Recommendation

If you need to refer someone, use this SBAR tool to help you remember all the important information to handover.

This tool can be used to help you when you are referring someone to another service – <b>when action is needed</b>	
<b>S</b> Situation	I am a carer (Name), working for (Organisation) I am calling about Mr./Mrs. Name I am calling because I am concerned that / I am unsure about / I need advice ...
<b>B</b> Background	Their normal condition is (e.g. alert/drowsy/confused/ self-caring) How has this changed? Their relevant history includes (e.g. asthma, dementia, ischaemic heart disease) Current medications include
<b>A</b> Assessment	I have found that he/she is (e.g. struggling to breathe/walk/has pain/has injured/confused) Vital signs if equipment available (e.g. blood sugar, temperature, blood pressure, pulse) I think the problem is/may be OR I don't know what's wrong but I'm really worried
<b>R</b> Recommendation	I now need your assistance I would like you to visit the resident (when is it urgent or routine?) I would like your advice as to what to do next/in the meantime

● GREEN – ACTION – None    ● ORANGE – ACTION – Monitor and Document    ● RED – ACTION – REFER – Seek further support and advice

# Top tips for recognising deterioration in an individual

Continuous assessment, both visual and audible, of people being cared for is an important skill. If they have any changes in the areas listed below, ask more probing questions/report changes. SBAR can be used as a tool when passing on important information to others.

**N.B. Check what is normal and then consider the items listed below.**

Score: **1 for Green** and **2 for Red**

Is the individual drinking?	Yes	No
Is the individual eating?	Yes	No
Any changes in mobility (i.e. less mobile)?	Yes	No
Do they appear in pain (i.e. a change from normal)?	Yes	No
Do they appear distressed (i.e. a change from normal)?	Yes	No
Are they vomiting?	Yes	No
Are they confused or muddled (i.e. changed mental state)?	Yes	No
Is there any change in urine output (i.e. passing more or less)?	Yes	No
Is there any change in bowel habits?	Yes	No
Are there any signs of skin infection or deterioration? (i.e. redness, broken skin)?	Yes	No
Any new skin damage?	Yes	No
Any cough (i.e. change in the normal)?	Yes	No
Any change in breathing (i.e. change from the normal)?	Yes	No
Are they hot to touch (i.e. have they got a temperature)?	Yes	No

## When to report changes

- A score of 15 or more?
- Any new or increase in symptoms?
- Any change in symptoms?
- Abnormal observations?

## Consider using the SBAR tool when reporting changes

**S - Situation** – identify service user, concern, location of problem

**B - Background** – patient's medical history and any background information

**A - Assessment** – concerns

**R - Recommendation** – explain what you need i.e. seek advice/guidance from a health care professional

● GREEN – ACTION – None    ● ORANGE – ACTION – Monitor and Document    ● RED – ACTION – REFER – Seek further support and advice

# What is a learning disability?

A learning disability is different for everyone who has one. There are, however, common elements that a person may experience.

A person with a learning disability may experience the presence of a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), and may have a reduced ability to cope independently (impaired social functioning), which started before adulthood and has a lasting effect on development.

Several factors may contribute to having learning disability and these can occur as follows:

- **before birth** – genetics, metabolic disorders, a specific illness contracted by the mother, accident/trauma during pregnancy, substance misuse, diet deficiency
- **during birth** – oxygen starvation, head trauma, born prematurely
- **post birth (before the age of 18)** – neurological illness, accidents (head injury), reduced social and environmental circumstances
- or an **UNKNOWN** cause/s.

A learning disability can be mild, moderate or severe. A person can also have a profound and multiple learning disability (PMLD). Additional information can be found on the Mencap [website](#).

# What is a learning difficulty?

**A learning difficulty is often confused with a learning disability.**

A learning disability is different from a learning difficulty as a learning difficulty **does not** affect general intellect.

There are many different examples of learning difficulties, such as:

- dyslexia
- dyspraxia
- dyscalculia
- attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)
- auditory processing disorder (information/stimulation overload).

People can have one learning difficulty or a combination.

Further information can be obtained from the Mencap [website](#).



# Autism spectrum condition (ASC)

## ASC is not a learning disability.

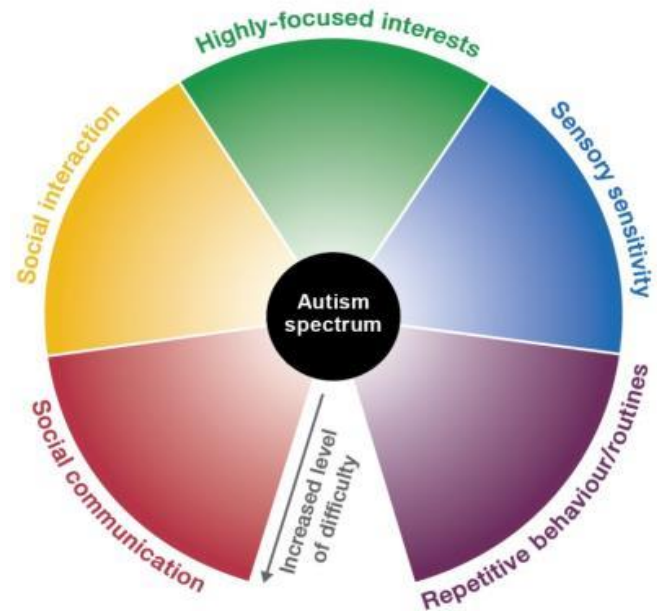
ASC is a lifelong developmental disability that affects how a person communicates with, and relates to, other people.

It also affects how people make sense of the world around them. People with a learning disability are more likely to have autism (20-30%, compared to 1% of general population).

People with ASC may have difficulties in areas specified within the graph (see right); the level of difficulty in each section may vary.

More information about autism and ASC can be found here:

- Connect to Support Hampshire [website](#)
- National Autistic Society [website](#)
- Autism Hampshire [website](#)



● GREEN – ACTION – None    ● ORANGE – ACTION – Monitor and Document    ● RED – ACTION – REFER – Seek further support and advice

# Communication



**In person:** many people with a learning disability will prefer face-to-face and one-to-one communication.



**In writing:** use bigger text and bullet points and keep writing to a minimum. Too much colour can make reading harder for someone too. It is helpful to support text with pictures also.



**On the phone:** speak slowly and clearly, using easy to understand words.



**Communication isn't only about talking.** It is also about listening. When you are communicating with someone with a learning disability, think about your tone of voice and your body language, as well as the words you are using.



**People with learning disabilities** may require longer to process information, so please do not rush the communication process.

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice



People may also use **alternative communication methods**.

**Makaton:** Makaton is a language programme that uses symbols, signs and speech to enable people to communicate.

**PECS** (Picture Exchange Communication System) is an augmentative and alternative communication system developed and produced by Pyramid Educational Consultants UK.

**Object of reference:** An **object of reference** is any **object**, which is used systematically to represent an item, activity, place, or person. Understanding real **objects** is the first stage of symbolic development. Therefore, using **objects** are considered the most concrete way of representing a word.

Always find out how the person communicates and familiarise yourself with such communication.

### **Resources to support and promote good communication:**

- Mencap's Accessible Information Standard [leaflet](#)
- Mencap's [information](#) on communicating with people with a learning disability

● GREEN – ACTION – None    ● ORANGE – ACTION – Monitor and Document    ● RED – ACTION – REFER – Seek further support and advice

# Top 10 tips for communication

1. Find a good place to communicate in - somewhere without distraction. If you are talking to a large group, be aware that some people may find this difficult	6. Learn from experience - you will need to be more observant and don't feel awkward about asking parents or carers for their help
2. Ask open questions; questions that don't have a simple yes or no answer	7. Try drawing - even if your drawing isn't great, it might still be helpful
3. Check with the person that you understand what they are saying e.g. "the TV isn't working? Is that right?"	8. Take your time, don't rush communication
4. If the person wants to take you to show you something, go with them	9. Use gestures and facial expressions. If you're asking if someone is happy or unhappy, make your facial expression unhappy to reinforce what you're saying
5. Watch the person; they may tell you things by their body language and facial expressions	10. Be aware that some people find it easier to use real objects to communicate, but photos and pictures can really help too

**Remember, all communication is meaningful, but you may need to work harder to understand.**

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

# Behaviours that challenge us

It is estimated that around 1 in 3 people with learning disabilities will display behaviours of concern at some time. The term “challenging behaviour” is often used to describe these behaviours. It is important to note that this term is used to describe how the behaviours affect us, we are challenged by these behaviours. It is not a label for people, i.e. people do not have a diagnosis or label of “challenging behaviour”.

All behaviours happen for a reason. People with a disability in learning often learn fewer behaviours than us. Consider how many behaviours you have learned to ask for help. Now consider how many behaviours the person you support has learned. If the person hasn't learned an effective behaviour to achieve something, or they are not understood, this might be distressing for them.

It is therefore very important to understand a person's communication. **(Please refer to communication section)**. It may be that the behaviour is understood, but we find that behaviour challenging so we either ignore it or try to stop it. Instead, we should be trying to understand and respond to the behaviours and teaching more effective behaviours to get their needs met.

The things all our behaviours achieve are commonly grouped into four areas:

- **sensory**: to remove unpleasant internal feelings (like pain, frustration), or to gain pleasant feelings (happiness, fun, nice sensations)
- **escape**: to avoid tasks we don't want to do, or people we do not want to be with
- **attention**: to gain attention or interaction from others
- **tangibles**: to obtain things that we want, like food, or belongings.

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If we focus on helping people achieve the purpose of behaviour, we can avoid restrictive approaches/practices. **This approach is called positive behaviour support (see the next page for more information).**

**A list of restrictive approaches/practices is enclosed:**

- physical restraint: using ourselves to hold people in a way that prevents them doing things
- chemical restraint: using medication to sedate people in order to prevent them doing things
- mechanical restraint: using clothing, or equipment (such as belts or splints) to prevent people doing things
- environmental restraint: using the environment (locking doors, placing obstacles) to prevent people doing things.

There may be times when restrictions are needed, but this should always be detailed in a support plan, the least restrictive approach possible, and used for the least time possible. There should also be a restraint reduction plan in place.

You can use the antecedent, behaviour and consequence (ABC) chart to record behavioural concerns, as shown in the example below.

Day, date and time	Antecedent	Behaviour	Consequence	Notes

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

# Positive behaviour support

The “house” model pictured here details how positive behaviour support should work. The “roof” of this house depicts our approach to the behaviour. It is a triangle as the strategies used at the bottom should be used more than those at the top.

**Proactive strategies** are strategies that are used when there are no behaviours that challenge us. They are strategies that help us avoid challenging behaviours happening.

**Active strategies** are the plans we have for when there are warning signs challenging behaviour may occur. This might be that the person looks agitated, or you may be planning for a situation they will find difficult.

**Reactive strategies** are what to do when challenging behaviours happen. The aim is to bring the situation to an end as quickly and safely as possible.

**Post incident support** is how we help the person recover, and the support recover from an incident and return to a happy state.



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The bottom of the house are our plans for meeting the function.

**Positive programming** is about how we support the person to learn or use more productive, less challenging behaviours to meet the function.

**Ecological strategies** are about getting the environment supportive of more effective behaviours, and **focussed strategies** are plans for ensuring that these replacement behaviours achieve what they should achieve consistently. Whilst these terms may sound complicated, they are presented here in the same way as **Antecedent, Behaviour and Consequence (ABC)**. The ABC acronym is commonly used to understand behaviours that challenge us. It can also be used for behaviours we want to increase in the same way.



Behaviour interventions can have serious negative effects if they are not applied correctly. When using positive behaviour support, this should be overseen by an appropriately qualified person. This should be someone with a recognised professional registration (Nursing & Midwifery Council, Health Care Professionals Council, or Behaviour Analyst Certification Board), with training in positive behaviour support, whose practice is accountable to a professional code of conduct.

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

# Respiratory problems - breathing

There are several different respiratory problems which can affect people, these include:

- asthma
- chronic obstructive airways disease (COPD)
- fibrosis

People with respiratory problems can require extra time support and patience with their activities of daily living, particularly activities which may cause them to become breathless.

Breathlessness can increase anxiety in people, so being calm and understanding can help.

People may use inhalers, nebulisers and or oxygen to support their breathing.

- correct inhaler and nebuliser use can prevent complications, for example chest infections, which can potentially cause admissions to hospital
- people should be using their oxygen as per their prescription, this should be written in their yellow folder in the oxygen section. If in doubt, phone and check with the community respiratory team

**Good inhaler technique is important to ensure the correct amount of medication reaches the lungs**

**Breathing is a normal rate and depth for the person  
No further action required**

**Know how to support persons with inhaler / nebuliser if they require this  
Monitor and document**

**Breathing is abnormal for the person above 20 or below 10 breaths per minute, the person could have blue lips/nails  
Seek additional support from GP or community respiratory team if known  
consider dialling 999 and document**

People will generally know what is normal for them. People can present as anxious, and more confused if breathless.

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

# SEPSIS IN ADULTS IS A SERIOUS CONDITION

that can initially look like flu, gastroenteritis or a chest infection. Sepsis affects more than 250,000 people every year in the UK.

The UK Sepsis Trust registered charity number (England & Wales) 1158843


Seek medical help urgently if you develop any or one of the following:

- S**lurred speech or confusion
- E**xtrême shivering or muscle pain
- P**assing no urine (in a day)
- S**evere breathlessness
- I**t feels like you're going to die
- S**kin mottled or discoloured

**JUST ASK**  
**"COULD IT BE SEPSIS?"**

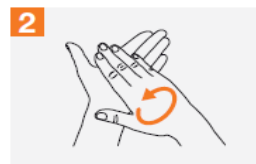
IT'S A SIMPLE QUESTION, BUT IT COULD SAVE A LIFE.

## RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

 Duration of the entire procedure: 20-30 seconds



Apply a palmful of the product in a cupped hand, covering all surfaces;



Rub hands palm to palm;



Right palm over left dorsum with interlaced fingers and vice versa;



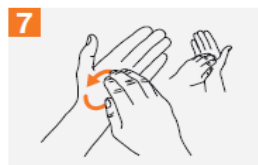
Palm to palm with fingers interlaced;



Backs of fingers to opposing palms with fingers interlocked;



Rotational rubbing of left thumb clasped in right palm and vice versa;



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



Once dry, your hands are safe.

## HOW TO HANDRUB?

Clean hands to help reduce spreading germs

When should I wash my hands?

Before meals and meal preparation  
After using the toilet  
Contact with source of germs e.g. people, animals, surfaces




World Health Organization

Patient Safety  
A World Alliance for Safer Health Care

SAVE LIVES  
Clean Your Hands

 GREEN – ACTION – None  ORANGE – ACTION – Monitor and Document  RED – ACTION – REFER – Seek further support and advice

## WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

 **Duration of the entire procedure: 40-60 seconds**



Wet hands with water;



Apply enough soap to cover all hand surfaces;



Rub hands palm to palm;



Right palm over left dorsum with interlaced fingers and vice versa;



Palm to palm with fingers interlaced;



Backs of fingers to opposing palms with fingers interlocked;



Rotational rubbing of left thumb clasped in right palm and vice versa;



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



Rinse hands with water;



Dry hands thoroughly with a single use towel;



Use towel to turn off faucet;



Your hands are now safe.

### HOW TO HANDWASH?

Clean hands to help reduce spreading germs

When should I wash my hands?

Before meals and meal preparation  
After using the toilet  
Contact with source of germs e.g. people, animals, surfaces

[World Health Organization – Hand Hygiene](https://www.who.int/hand-hygiene)

 GREEN – ACTION – None  ORANGE – ACTION – Monitor and Document  RED – ACTION – REFER – Seek further support and advice

# Severe infection (sepsis)

## Sepsis – community screening and action tool

- Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs.
- Sepsis leads to shock, multiple-organ failure and death, especially if not recognised early and treated promptly.
- Screening, early intervention and immediate treatment saves lives.

### 1. Could this be a severe infection?

For example:

- Chest/lung infection
- Water/bladder/kidney infection
- Does the person have new tummy/belly pain?
- A new severe headache or neck pain
- A new red rash or swollen joint

### 2. Are any of the two symptoms present?

- Feverish / hot with uncontrolled shaking
- Fast or irregular breathing
- A fast heartbeat or palpitations
- New confusion or difficult to wake up

### 3. Is any red flag present?

- Unable to feel a pulse at the wrist
- Very fast breathing (more than one breath every two seconds)
- Blue lips
- Responds only to voice or pain/unresponsive
- Non-blanching rash or mottled skin

### RED FLAG SEPSIS

- This is a time critical condition; immediate action is required.
- Communication: phone 999
- Inform ambulance call taker that the person has 'Red Flag Sepsis'
- Tell the paramedic team about any allergies the person may have (especially antibiotic allergies)

#### If time allows:

- Find all the person's medication they currently take and give them to the paramedic

# Preventing and managing urinary tract infections (UTIs)

Complications of a UTI are not normally common but can be serious and can lead to kidney failure or septicaemia. Complications can affect people with pre-existing health problems, such as diabetes or a weakened immune system. A sudden change in behaviour is one of the best indicators of a UTI.

## Preventing UTIs

Encourage **regular bladder emptying** and **mobilise** as much as able

**No further action required**

**Prevent dehydration**  
Encourage people to **drink 1.5-2 litres of fluids every day** (unless advised not to by GP)  
**Monitor and document**

Act quickly to resolve **constipation** and **continence** problems  
**Seek additional advice and support from GP**

### ALSO REMEMBER

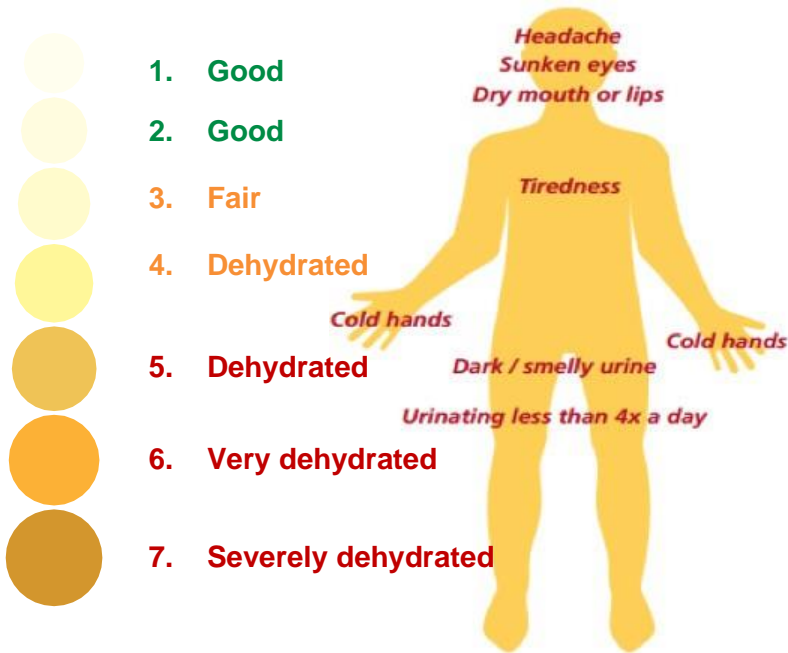
- regular good catheter care – make sure you have been shown how to do this properly
- when supporting females with continence care, wipe from front to back
- diabetes and diet management

### Symptoms of infection can include:

- pain on passing urine
- new or worsening incontinence
- lower tummy pain
- passing urine more frequently
- blood in urine
- inappropriate shiver or chills
- temperature  $<36^{\circ}\text{c}$  or  $> 38^{\circ}\text{c}$
- new or worsening agitation or confusion
- consider using a Newcastle pack to gain a urine sample if individual wears continence pads.

**If a UTI is suspected, seek additional advice and support from GP, on the day identified, and document**

# Preventing UTIs due to dehydration



1. Good

2. Good

3. Fair

4. Dehydrated

5. Dehydrated

6. Very dehydrated

7. Severely dehydrated

If the urine is the colour of the first two colours on urine colour chart, and the person shows no symptoms of dehydration

**No further action required**

If the urine colour matches either of the middle colours (3 and 4) on the urine colour chart, and the person is starting to show symptoms of dehydration, offer more water or fluid to drink. Keep a fluid chart so you can observe fluid intake.

**Monitor and document**

If the urine colour matches the last three colours in red on the urine colour chart, and the person is showing symptoms of dehydration. The person needs to be encouraged to drink more fluids. Keep a strict fluid chart, document fluid intake and urine output. Also observe whether the urine is clear or cloudy as this can indicate infection and or require further testing.

**Seek additional support. If the person is in pain, seek professional help. Be aware that some medications can change urine colour**

● GREEN – ACTION – None    ● ORANGE – ACTION – Monitor and Document    ● RED – ACTION – REFER – Seek further support and advice

# Healthy eating is good for you

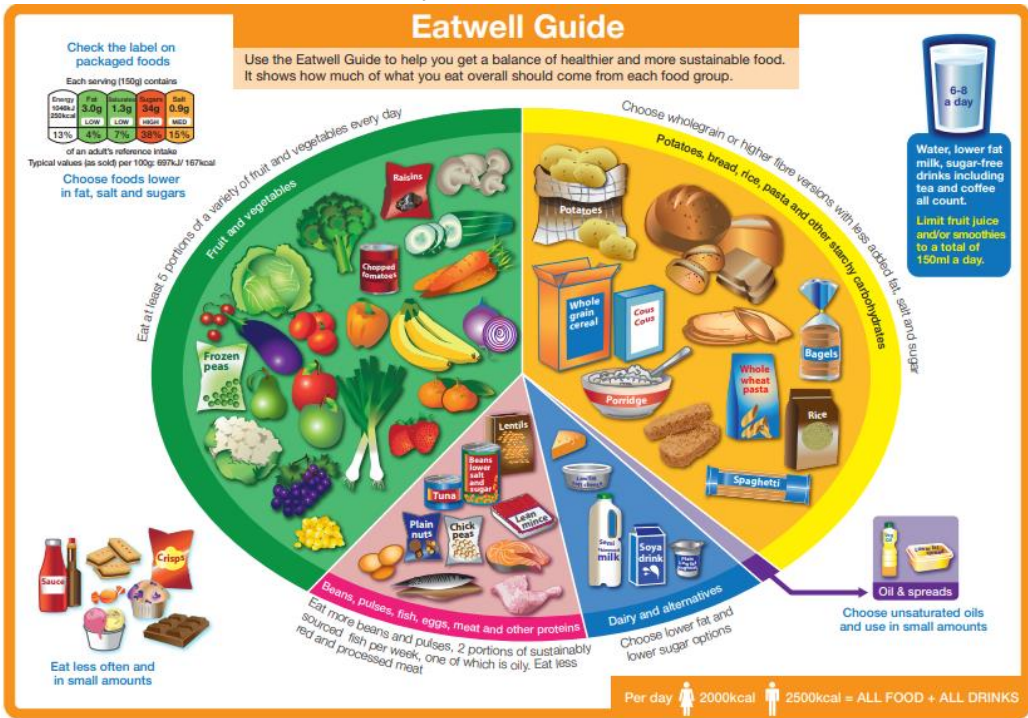


It can help to:

- promote healthy skin, bones and teeth
- provide energy and wellbeing
- reduce loneliness and can help with social skills

# The Eatwell Guide

This Public Health Education [guide](#) highlights the different types of food that make up our diet and shows the proportions we should eat to have a healthy, balanced diet.



It is important that individuals receive all the energy and nutrients that their body needs through a healthy and balanced diet.

- GREEN – ACTION – None
- ORANGE – ACTION – Monitor and Document
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# Promoting appetite in later life

## If a person's appetite reduces, you can try the following:

- Switch to smaller meals and frequent snacks, to avoid the struggle to eat three large meals a day
- Increase calorie intake by eating foods, like milky puddings and cheesy main courses
- Avoid filling up on foods that are high in saturated fat or sugars, such as sugary cakes, fizzy drinks and biscuits

## To ensure an appropriate calorie intake for the person whose appetite is poor, consider including these foods within their diet:

- porridge made with whole (full fat) milk, with fruit or dried fruit on top
- sardines on toast
- peanut butter on toast
- soups with pulses, pasta or meats
- cottage/shepherd's pie
- beans on toast with cheese sprinkled on top
- milky drinks as a bedtime snack
- unsalted nuts

## Information on healthy weight

If the individual cannot chew some of the food, then pureed food or juices may be preferred.

It is important to monitor people's weight as per suggestion from a GP.

The Body Mass Index (BMI) calculator is a nationally recognised tool identifying a person's weight against their height.

	kgs	41	45	50	54	59	64	68	73	77	82	86	91	95	100	104	109	113	118	122	127	132
HEIGHT		Underweight				Healthy				Overweight				Obese		Extremely Obese						
ft/in	cm																					
4'8"	142.2	20	22	25	27	29	31	34	36	38	40	43	45	47	49	52	54	56	58	61	63	65
4'9"	144.7	19	22	24	26	28	30	32	35	37	39	41	43	45	48	50	52	54	56	58	61	63
4'10"	147.3	19	21	23	25	27	29	31	33	36	38	40	42	44	46	48	50	52	54	56	59	61
4'11"	149.8	18	20	22	24	26	28	30	32	34	36	38	40	42	44	46	48	51	53	55	57	59
4'12"	152.4	18	20	21	23	25	27	29	31	33	35	37	39	41	43	45	47	49	51	53	55	57
5'1"	154.9	17	19	21	23	25	26	28	30	32	34	36	38	40	42	43	45	47	49	51	53	55
5'2"	157.4	16	18	20	22	24	26	27	29	31	33	35	37	38	40	42	44	46	48	49	51	53
5'3"	160.0	16	18	19	21	23	25	27	28	30	32	34	35	37	39	41	43	44	46	48	50	51
5'4"	162.5	15	17	19	21	22	24	26	27	29	31	33	34	36	38	39	41	43	45	46	48	50
5'5"	165.1	15	17	18	20	22	23	25	27	28	30	32	33	35	37	38	40	42	43	45	47	48
5'6"	167.6	15	16	18	19	21	23	24	26	27	29	31	32	34	36	37	39	40	42	44	45	47
5'7"	170.1	14	16	17	19	20	22	24	25	27	28	30	31	33	34	36	38	39	41	42	44	45
5'8"	172.7	14	15	17	18	20	21	23	24	26	27	29	30	32	33	35	37	38	40	41	43	44
5'9"	175.2	13	15	16	18	19	21	22	24	25	27	28	30	31	33	34	35	37	38	40	41	43
5'10"	177.8	13	14	16	17	19	20	22	23	24	26	27	29	30	32	33	34	36	37	39	40	42
5'11"	180.3	13	14	15	17	18	20	21	22	24	25	27	28	29	31	32	33	35	36	38	39	40
5'12"	182.8	12	14	15	16	18	19	20	22	23	24	26	27	28	30	31	33	34	35	37	38	39
6'1"	185.4	12	13	15	16	17	18	20	21	22	24	25	26	28	29	30	32	33	34	36	37	38
6'2"	187.9	12	13	14	15	17	18	19	21	22	23	24	26	27	28	30	31	32	33	35	36	37
6'3"	190.5	11	13	14	15	16	18	19	20	21	23	24	25	26	28	29	30	31	33	34	35	36
6'4"	193.0	11	12	13	15	16	17	18	19	21	22	23	24	26	27	28	29	30	32	33	34	35
6'5"	195.5	11	12	13	14	15	17	18	19	20	21	23	24	25	26	27	28	30	31	32	33	34
6'6"	198.1	10	12	13	14	15	16	17	18	20	21	22	23	24	25	27	28	29	30	31	32	34
6'7"	200.6	10	11	12	14	15	16	17	18	19	20	21	23	24	25	26	27	28	29	30	32	33
6'8"	203.2	10	11	12	13	14	15	16	18	19	20	21	22	23	24	25	26	27	29	30	31	32
6'9"	205.7	10	11	12	13	14	15	16	17	18	19	20	21	23	24	25	26	27	28	29	30	31
6'10"	208.2	9	10	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
6'11"	210.8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	25	26	27	28	29	30

● GREEN – ACTION – None    ● ORANGE – ACTION – Monitor and Document    ● RED – ACTION – REFER – Seek further support and advice

# Nutrition

Being **underweight** can be serious for some people. It can increase their risk of health problems, including:

- pressure damage
- weakens their immune system, leaving them more susceptible to infections
- increases their risk of being deficient in important nutrients, such as vitamins and minerals
- bone fractures if they fall (particularly in older person's)

Being very **overweight** can cause problems, some of the day-to-day problems that can be caused by obesity can include:

- breathlessness/difficulty with physical activity
- swollen legs
- feeling very tired a lot of the time
- joint and back pain

And can increase the risk of:

- type 2 diabetes
- high-blood pressure
- asthma

You may be asked to record a person's daily intake if there are concerns about dietary intake.

- [Information on keeping your weight up in later life](#)
- [An overview of obesity](#)

People should be encouraged to follow a healthy diet  
**No further action required**

People eating less than normal.  
People being overweight or underweight  
**Consult GP, monitor and document**

People eating a poor diet. People experiencing sudden weight loss or gain  
**Monitor and document. Seek additional advice and support from their GP and document**

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

# Swallowing

Complications associated with swallowing dysfunction (dysphagia) are common in people we support. **Increased risk of death is associated with swallowing problems as it can cause pneumonia, dehydration, malnutrition and choking.**

**Some signs and symptoms of difficulty in swallowing include:**

- putting too much food or drink in the mouth
- difficulty managing saliva (production of either too much or too little)
- food or liquid leaking from the mouth
- food sticking in the throat, which is difficult to swallow
- weight loss or dehydration from not being able to eat or drink enough
- discomfort during eating/drinking
- holding food in the mouth
- coughing when eating and drinking
- choking (blocked airway)
- watery eyes when eating and drinking

**If someone has difficulties swallowing food, fluid or saliva can enter the airway and/or lungs, this is called 'aspiration', which can result in:**

- coughing or choking during, or immediately after, eating or drinking; aspiration can also happen without coughing or choking
- repeated unexplained chest infections, a chesty cough or high temperatures. A wet or 'gurgly' sounding voice during or after eating or drinking.

## What do you know about swallowing problems?

Did You Know...

a large number of adults with a learning disability have a problem swallowing? This is called dysphagia and it is a major cause of early death.



● GREEN – ACTION – None ● ORANGE – ACTION – Monitor and Document ● RED – ACTION – REFER – Seek further support and advice

# Swallowing awareness

Being able to eat and drink safely is fundamental to maintaining health and wellbeing. It is important to follow swallow safety recommendations to reduce the risk of serious complications. Complications may include **chest infections, dehydration and malnutrition and choking**, as well as susceptibility to pressure damage and urinary tract infections.

**Support workers are in an ideal position to support, monitor and identify any concerns with individuals eating and drinking.**

Some persons may require a modified diet, food and fluid; it is important to follow directions in people's care plans.

**It is important to contact the GP or speech and language team for advice if you have any concerns.**

Able to swallow with no problems identified (see previous pages)  
**No further action required**

Swallowing has been assessed, by a speech and language therapist (see person's swallowing / dysphagia care plan)  
**FOLLOW GUIDELINES AND MONITOR**

Signs of new swallowing problems (see previous pages)  
**SEEK ADDITIONAL SUPPORT IMMEDIATELY contacting the GP/ speech and language team and DOCUMENT**

● GREEN – ACTION – None    ● ORANGE – ACTION – Monitor and Document    ● RED – ACTION – REFER – Seek further support and advice

# Guidance on supporting mouth care

<ul style="list-style-type: none"> <li>• Explain how you are going to support the person, as some people can feel anxious</li> <li>• Encourage the person to look in the mirror whilst being supported will enable them to see what is happening</li> <li>• It can be easier for the carer to stand slightly behind, or to the side, when supporting the person with oral health care</li> </ul>	<ul style="list-style-type: none"> <li>• Encourage the person to spit out after brushing and not to rinse</li> <li>• It is better to leave a little toothpaste residue in the mouth to maintain fluoride concentration levels</li> <li>• The frequency and amount of sugary food and drink should be reduced and where possible, kept to mealtimes</li> <li>• Offer healthier alternatives</li> </ul>	<ul style="list-style-type: none"> <li>• Support the person twice a day to clean their teeth</li> <li>• Replace the toothbrush every three months or sooner if required</li> <li>• <a href="#"><u>Guidance on oral care and people with learning disabilities</u></a></li> </ul>
<ul style="list-style-type: none"> <li>• Ensure the person is comfortable and ensure that you are not rushed</li> <li>• Remember you may not be able to support brushing the person's whole mouth in one go</li> </ul>	<ul style="list-style-type: none"> <li>• Loss of dentures may cause great distress and can be expensive and time consuming</li> <li>• Dentures which do not fit well can affect eating, drinking and speaking and can be uncomfortable</li> </ul>	<ul style="list-style-type: none"> <li>• Support the person's with false teeth to clean them daily</li> <li>• Ensure when the person's dentures are removed, they do not have any residual food left in their mouth</li> </ul>
<ul style="list-style-type: none"> <li>• Specialist toothbrushes, sprays and toothpaste may be required. If you have any concerns seek advice from the dentist, dental hygienist or GP as appropriate</li> </ul>	<ul style="list-style-type: none"> <li>• Frequent oral health care is important for those who are unable to take any food or drink orally. It is important to minimise oral bacteria that might be aspirated, as well as optimising oral comfort</li> </ul>	<ul style="list-style-type: none"> <li>• A person may refuse to brush their teeth because it hurts. Consult the dentist for alternative ways to keep teeth healthy and clean. Try to establish why the person is refusing</li> </ul>

● GREEN – ACTION – None    ● ORANGE – ACTION – Monitor and Document    ● RED – ACTION – REFER – Seek further support and advice

# Mouth care awareness

Good oral health care enables people to take a normal diet without difficulty and every support should be offered to promote independence and understanding of this. Carers play an important role in supporting people to maintain good oral health. Carers are ideally placed to monitor changes in individual's mouths and refer on as appropriate.

Gum disease and poor oral health may increase the risk of all kinds of other health complications, including:

- lack of appetite
- malnutrition
- heart disease
- pneumonia



Mouth is healthy, clean and moist  
**No further action required**

Mouth is dry, food and bits remain around teeth

**Monitor, document and support the person's with mouth care if needed and explain the importance of mouth care to them, as well as seeking advice from dentist and dental hygienist if problems persist**

Mouth is inflamed, dry and sore or ulcerated

**Seek additional support on day identified from GP, or their own dentist and document**

● GREEN – ACTION – None    ● ORANGE – ACTION – Monitor and Document    ● RED – ACTION – REFER – Seek further support and advice

# Fluid intake – why it is important

## Dehydration occurs when our bodies don't have enough water.

Water helps to lubricate the joints and eyes, aids digestion, flushes out wastes and toxins, and keeps the skin healthy.

### Dehydration can directly contribute to:

- constipation
- increased risk of UTIs
- feeling lightheaded, which might cause the person to fall
- confusion and irritability

### Some signs of dehydration include:

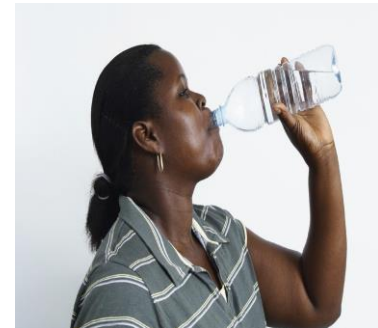
- feeling thirsty and/or dry mouth, lips, skin
- Lightheaded, tiredness, changes in mental health
- headaches

**Darker urine, strong-smelling urine and only passing small amounts of urine may indicate reduced hydration intake but can also be signs of disease or infection. If in doubt, check with your GP.**

### [Information on dehydration](#)

## Who is at risk of dehydration?

- Any person who may need reminding or support to drink.
- People with certain diseases have increased water requirements, e.g. fever, diarrhoea, vomiting, kidney stones
- People not able to control factors which may make them hot due to weather conditions, environment, exercise, excessive sweating, inappropriate clothing
- People with oral discomfort and or swallowing difficulties
- People who have limited or restricted access to fluids
- Anyone after regular alcohol consumption
- Some medications can cause thirst. Check prescription guidance for more information.



● GREEN – ACTION – None    ● ORANGE – ACTION – Monitor and Document    ● RED – ACTION – REFER – Seek further support and advice

# Fluid awareness

In climates, such as the UK, it is recommended we should drink about two litres (**six to eight glasses**) of fluid every day, to stop us from getting **dehydrated (see previous page)**.

Sometimes a person may be on a restricted fluid intake due to a health condition, but all others should be encouraged to drink the recommended amount.

Consider recording daily intake of fluids if the person is at risk of dehydration or is dependent on full support.

There are a range of foodstuffs which are also rich in fluid and can be offered to help with fluid intake, these include:

- smoothies
- jelly/fruit juice
- ice-cream/ice-lollies
- yoghurt
- soup



Drinks the recommended eight glasses daily independently  
**No further action required**

Drinks only five cups daily  
**Monitor amount may require some additional support and encouragement to drink. Refer if concerned**

Drinking two cups or less daily, with signs of dehydration  
**Seek advice from GP on day identified and document**

● GREEN – ACTION – None ● ORANGE – ACTION – Monitor and Document ● RED – ACTION – REFER – Seek further support and advice

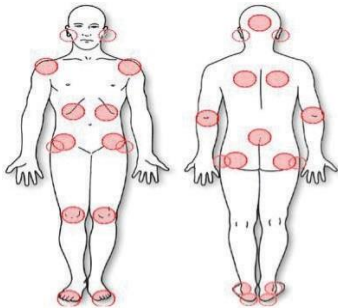
# Skin

## Preventing pressure damage ([bed sores/pressure sores](#))

Maintaining good skin condition is really important; pressure damage can have a huge impact on the person's wellbeing, causing pain, distress, etc.

Carers should monitor the person's skin condition; the parts of the body that are at higher risk of developing pressure damage are:

- shoulders or shoulder blades
- elbows
- back of the head
- rims of the ears
- knees, ankles, heels or toes
- spine
- tail bone (the small bone at the bottom of the spine)



Wheelchair users, are at risk of developing pressure damage on:

- buttocks
- the back of arms and legs
- the back of the hip bone

**Surface:**  
Make sure people have the right support

**Skin Inspection:**  
Early inspection means early detection. Show people and carers what to look for

**Keep people moving.**  
Ensure people regularly change position

**Incontinence/ moisture:**  
People need to be clean and dry

**Nutrition/ Hydration:**  
Help people have the right diet and plenty of fluids



# Skin

The start of grade one pressure damage looks like this:

- skin that appears discoloured
- it is red in people with light skin tone
- it is purple or blue in people with dark skin tone
- the skin is intact, but it may hurt or itch
- it may feel either warm and spongy, or hard
- the **skin does not turn pale** when **PRESSURE IS PLACED ON IT**

If you see discoloured skin that does not turn white when pressure is placed on it, the person could be starting to develop pressure damage.  
**Seek further advice for additional assessment and support**

Skin intact and good colour  
**No further action required, follow skin care guidance on previous page (see hand picture on previous page)**

Skin is painful swollen discoloured or sweaty  
**Follow skin care guidance on the previous page (see hand picture on previous page)**  
**Refer on for further support, monitor and document**

Skin is red, purple, blue, blistered or broken  
**Seek additional support on day identified from GP, or community nurse if known to them and document**

[An overview of pressure ulcers \(also known as pressure sores or bedsores\)](#)

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

# Falls prevention

<b>Environmental</b>	<ul style="list-style-type: none"> <li>• keep rooms and stairways lit, using the brightest bulb available</li> <li>• remove clutter, trailing wires and frayed carpets, slippery floor surfaces</li> <li>• mop up spillages</li> <li>• use non-slip mats and rugs, or ensure they are tacked down or removed</li> <li>• make sure there are suitable grab rails around the house if needed</li> <li>• ensure easy access to commode or toilet</li> <li>• advise not to rush</li> <li>• make sure cats or dogs have bright collars or bells to help prevent tripping over them</li> </ul>
<b>Impaired sight and hearing</b>	<ul style="list-style-type: none"> <li>• support those who wear glasses to keep them on or have them close by, ensure they are clean and in good condition and they can see out of them and are the right prescription</li> <li>• if vision seems to be deteriorating, check for a recent eye test. If not refer to optician</li> <li>• is hearing reduced? Check hearing aids are clean and working</li> </ul>
<b>Unsteady on feet</b>	<ul style="list-style-type: none"> <li>• support people with recommended exercises and equipment</li> <li>• ensure aids are well maintained</li> <li>• promote physical activity and mobility</li> <li>• if unsteadiness is new – seek support from community nurse or GP</li> </ul>
<b>Feet, footwear and clothing</b>	<ul style="list-style-type: none"> <li>• check condition of feet and check for pain. Seek podiatry guidance as appropriate</li> <li>• check footwear is suitable, fits well, is in good condition and supports the ankle</li> <li>• ensure shoes have non-slip soles</li> <li>• ensure clothing allows the person to move their legs and feet freely. Encourage people not to wear clothes that are too tight or too loose-fitting, trailing clothes that might trip them up</li> </ul>
<b>Illnesses and medication</b>	<ul style="list-style-type: none"> <li>• if known to have low blood pressure when standing (postural hypotension), advise to stand slowly</li> <li>• if complaining of dizziness, ensure eating and drinking adequately, may need to seek support from community nurse, GP or pharmacist</li> <li>• medications may cause imbalance, be aware if on four or more medications of started new medication – seek support from pharmacist.</li> </ul>

● GREEN – ACTION – None    
 ● ORANGE – ACTION – Monitor and Document    
 ● RED – ACTION – REFER – Seek further support and advice

# Mobility and falls

Mobility and prevention of falls is fundamental in supporting people to retain their independence.

- falls can have a significant effect on people's health

Keeping people mobile can reduce the incidence of:

- infections
- pressure damage

It is important that people seek early intervention from specialists to maintain mobility. Confidence can be affected following a fall; it may also increase anxiety and reducing mobility levels.

The [NHS](#) has advice on exercises, which can be undertaken in the home – including exercising when seated and exercises to improve balance, flexibility and strength.

**Mobility** - independently mobile with or without aids  
**No further action required**

**Falls risk** - good mobility, good mental status and good continence

**No further action required**

**Mobility** - needs assistance beyond their usual level  
**Monitor and document, consider further advice and support**

**Falls risk** - near misses, unsteadiness, reduced confidence

**Monitor and document, consider further advice and support from GP, or community nurse/physiotherapist or community falls prevention team**

**Mobility** - can no longer move independently when could before  
**Seek additional support and advice on the day identified and document**

**Falls risk** - recent falls, falls causing injury, dementia or medication affecting balance and coordination

**Seek additional support and advice on the day identified from GP and document. Consider 999... if fallen and injured**

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

# Frailty

**Frailty** varies in severity, people should not be labelled as 'frail' rather described as living with frailty.

Signs of frailty can include:

- **falls** – collapse, legs giving way
- **immobility** – sudden change in mobility
- **delirium** – sudden change in levels of confusion
- **incontinence** – change or worsening in continence
- **medication** – change or increase in side effects

People living with frailty can have a fine balance between vulnerability and resilience.

**Encouraging people to:**

- maintain physical activity can improve strength and balance
- eat a healthy diet and drinking enough fluids can help minimise the impact of frailty. Checking how much fluid people have had, particularly those dependent for support

Although these symptoms can indicate frailty, there can sometimes be a straightforward explanation with no further problems; however, it is best to get the person reviewed by a GP if concerned.

**Person fit and active**, independent with most activities of daily living, washing, dressing, provision of food  
**No further action required**

**Person less fit and active**, requires some support with activities of daily living, monitor and support in a person-centred way  
**Monitor and document as this enables better detection of increased frailty**

**Change in person's level** of independence; appears frailer  
**Seek additional support and advice from GP or community nurse on the day identified and document**

● **GREEN – ACTION – None**   ● **ORANGE – ACTION – Monitor and Document**   ● **RED – ACTION – REFER – Seek further support and advice**

# Continence - urine

Problems with continence, both bladder (urine) and bowels (faeces) are relatively common; however, embarrassment can often cause people to not ask for help.

Carers should support and refer people on for help and advice.

People generally go to the toilet to pass urine four to seven times in a day.

However, some people may develop incontinence; some of the common signs that indicate people may need to have a proper continence assessment include:

Common signs that indicate people may require some additional support	
Stress incontinence	Urge incontinence
Leaking when exercising	Described as having a sudden urge to pass urine and often described as unable to get to the toilet in time
Leaking small amounts of urine when sneezing	Going to the toilet frequently, either during the day or overnight
Leaking small amounts of urine when laughing	Urine may have more odour than usual and look different than usual
Leaking urine when lifting heavy objects	The person may describe pain on passing urine and/or notice that urine looks cloudy or less clear

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

# Catheter care - urine

It is recommended that all carers who support with catheters undertake some form of formal training.

The colour of urine can indicate dehydration; however, some foods and medicines can also cause urine to become discoloured. If the person is drinking the recommended eight glasses per day and urine appears an unusual colour or darker please monitor and seek advice if necessary.

- [An overview of urinary incontinence](#)
- [An overview of urinary catheters](#)

**Urine continence care** - urine light in colour, continent

**No further action required**

**Catheter care** - flowing clear urine light in colour

**No further action required**

**Urine continence care** - urine dark or cloudy – encourage fluids. Long-term urinary incontinence, support with appropriate pads

**Monitor, document and support person**

**Catheter care** - cloudy with sediment; encourage fluids monitor

**Document and refer on to community nurses if concerned**

**Urine continence care** - new urinary and faecally incontinent

**Seek further ADVICE AND SUPPORT**

**Catheter care** - catheter blocked, pus, blood, dark urine  
**Seek additional support from GP or community nurses immediately and document**

● GREEN – ACTION – None    ● ORANGE – ACTION – Monitor and Document    ● RED – ACTION – REFER – Seek further support and advice

# Continence – bowels

**Different people have different bowel habits, so it is important to note what is normal for a person.**








- Most people have a bowel movement more than three times a week and pass good textured faeces (not too hard or soft) without straining.
- Since it can be hard to state what is normal and what is abnormal, some health professionals use a scale to classify the type of stool passed. For continuity in recordings, the Bristol Stool Chart should be used.

Type 1 is described as a constipated stool; this has spent the longest time in the bowel, and Type 7 has spent the least amount of time in the bowel, which could be described as diarrhoea.

Faecal overflow can sometimes be confused with diarrhoea and therefore accurate recordings are important. An ideal stool should be a type 3 or 4 and depending on the normal bowel habits of the person, should be passed within three days without straining.

To date, the LeDeR Mortality Review programme has reported 12 people with a learning disability dying of constipation. Therefore, monitoring and escalation procedures are vital to identify issues.

## Bristol Stool Chart

Type 1 	Separate hard lumps, like nuts (hard to pass)
Type 2 	Sausage-shaped but lumpy
Type 3 	Like a sausage but with cracks on the surface
Type 4 	Like a sausage or snake, smooth and soft
Type 5 	Soft blobs with clear-cut edges
Type 6 	Fluffy pieces with ragged edges, a mush stool
Type 7 	Watery, no solid pieces. Entirely Liquid

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

# Continence - bowels

## Bowel support and recognition

People may require additional support and personal care due to incontinence issues with their bowels, for example, people may be incontinent of faeces, or have a stoma bag.

The colour of stools can vary; however, if someone has very dark stools (black), it may be related to medication (iron) or something more serious. Ensure care plans document any medication that may affect the colour of stools.

## Correct position for opening bowels

- feet supported, so knees higher than hips
- lean forward
- legs apart
- elbows on knees
- bulge out abdomen and widen waist
- do not hold breath

Everyone's bowel habits can be different, so it is important to note what is normal for a person.

The LeDeR Mortality Review programme emphasises that monitoring bowel health and constipation is vital.

**Bowels normal for person  
No further action required**

**Change in bowel habit, constipation without pain; make a routine referral to GP  
Monitor, document and support person with continence care, if needed**

**If stools are very dark (black) or very pale, constipated with pain or diarrhoea  
Seek additional support and advice on the day identified from GP and document**

# Foot care

Foot care is particularly important if the person being supported has diabetes or abnormal feelings in the feet (peripheral neuropathy). People with diabetes can also have a reduced blood supply to the feet due to narrowing of the arteries in the legs (peripheral arterial disease).

## Legs

Carers, who support diabetic individuals, should check the person's feet on a regular basis when supporting with personal care. Refer on if any concerns, for example if you see red areas, inflammation, or blisters, corns/callus or open areas.

### Here are some top tips for the promotion of good foot care:

- check feet daily for redness, swelling, pain or hard skin – monitor for changes
- good control of blood sugar level can prevent foot problems or help heal open wounds
- keep feet clean, wash and dry thoroughly daily and dry well particularly in between the toes
- always ensure shoes/slippers fit well
- explain importance to person of never walking barefoot, especially outdoors
- cut or file toenails regularly. If the person is unable to see or reach their feet or have no carer/family to help with nail care, then a referral to a Podiatrist could be arranged. Ensure corns or hard skin are treated by a podiatrist if gentle filing and emollient cream do not control the hard skin
- paid carers are advised not to cut individuals toenails. They can use a file for regular nail care
- if there are any changes in sensation or feeling to the feet, ensure you report this to your health professional
- make sure the person attends their annual diabetic review with your GP or practice nurse as a foot check should be performed every year

### How to look after your feet if you have diabetes

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

# Diabetes

It is important that people with diabetes receive regular check-ups to help manage their condition.

Supporting people to keep their blood glucose, blood pressure and blood-fat levels under control will greatly help to reduce the risk of developing complications in diabetes.

**The short-term complications of diabetes can be very serious and require action. They include:**

- low blood sugar (hypoglycaemia)
- high blood sugar (hyperglycaemia)

## Signs of hypoglycaemia

- feeling shaky
- short tempered
- pale
- sweating
- tiredness
- lack of concentration

## Signs of hyperglycaemia

- feeling thirsty
- tiredness
- headaches
- passing more urine

**The long-term complications for people with diabetes can include problems with:**

- vision
- heart (cardiovascular disease)
- kidneys (nephropathy)
- nerves and feet (neuropathy)
- [Further information on diabetes](#)

Not diagnosed with diabetes, eats a varied diet

**No further action**

Diabetes is well managed with no problems – be alert

**Monitor, document and support individual and refer on if concerned to GP or nurse**

Diabetes is fluctuating or person is presenting as unwell with a hypoglycaemic (low blood sugars)/hyperglycaemic (high blood sugar) episode

**Seek additional support and advice on the day identified from GP, or community nurse and document. Consider 999... if confused or a change in normal**

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

# Epilepsy

**Epilepsy is a common condition that affects the brain and causes seizures.**

Seizures are bursts of electrical activity in the brain that temporarily affect how it works, so the brain's messages become mixed up. They can cause a wide range of symptoms.

Epilepsy is more common in people with a learning disability, with 20-25% of people with a learning disability also suffering from epilepsy.

There are many different types of seizure, and what happens to someone during a seizure depends on which part of their brain is affected. During some types of seizure, the person may remain alert and aware of what's going on around them, and with other types they may lose awareness. They may have unusual sensations, feelings or movements. Or they may go stiff, fall to the floor and jerk. Different people also have different things that trigger their seizures.

More information can be found on the NHS [website](#).

If you support someone with epilepsy, then you should ensure that you are familiar with the persons epilepsy guidance/care plan, and have the appropriate knowledge and training required.

The person's seizures are what is normal for them. They are well controlled and health is good  
**No further action**

**Monitor closely during a seizure.** Ensure the person is appropriately supported during and after the seizure. Ensure all seizure details are recorded. Check that there are no underlying health issues, such as infection

**Seek medical support if a person's seizures are not what is normal for them.**

**Call 999 for an ambulance if someone:**

- **is having a seizure for the first time**
- **has a seizure that lasts more than five minutes**
- **has lots of seizures in a row**
- **has breathing problems or has seriously injured themselves**

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

# Medication safety

Medicines need to be stored appropriately and safely, so that the products are not:

- damaged by heat or dampness
- mixed up with other people's medicines
- stolen
- posing a risk to anyone else

## Remember the 'Six Rights'

1. right person
2. right medicine
3. right route
4. right dose
5. right time
6. person's right to decline



**STOMP = stop the overmedication of people with a learning disability or autism or both**

## [STOMP easy read leaflet](#)

Ask the pharmacist for advice if you have a medication related query; they are qualified to respond to any questions you have.

**Tip:** Write the telephone number of the person's pharmacist on the medication chart or care plan, along with the GP surgery in case of any queries.

## **Key tasks to be carried out during medicines' administration by the carer:**

- confirm that the medication and dose is correct; on the Medicines Administration Record (MAR) chart *and* the medicine label
- check that the medication is in date and that if the medicine is prescribed, that their name is on the container
- confirm it is the right person
- check notes for any allergies and/or side effects
- ask whether the person wants the medicine
- makes sure that no one else has already given this dose to the person
- prepare the correct dose for the time of day, ensure medication is appropriately spaced out following directions e.g. follow guidance regarding timings in 24 hours
- give the medicine to the person. Offer a drink of water or food as directed on the label
- sign, time and date the MAR, or make a note if you are a family carer.

# Medication support

Managing medicines for someone you look after can be a challenge, particularly if they are taking several different types.

Medicines can legally be administered by anyone, if it has been prescribed by an appropriate practitioner. Seek training and refresher training.

## Advice for carers who support people with medication:

- Always read the instructions on the packaging or DOSETTE box before giving medicines to anyone. They should always be given either according to the instructions or as advised by whoever prescribed them.
- Instructions for when and how to give medication should be clear. If you are experiencing any problems, ask a doctor, nurse or pharmacist to explain.
- It is important to give medicines at the recommended time of day. Not doing this can make them less effective. You also need to know if the medicines should be taken before food, with food or in between meals.
- **Paid carers should adhere to their company's medicines policy, which may have information regarding what they can and cannot administer after appropriate training. Seek immediate advice if not sure. Seek regular medicines reviews for the person they are supporting and report any concerns back to the GP and pharmacist.**

**Person competent** and able to take their own medication with no problems  
**No further action required**

**Requires support taking medicine** assist in a person-centred way  
**Monitor and document**

**Problems with taking medication or giving medication**  
**Seek additional support and advice from pharmacist, GP or nurse on the day identified and document**

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

# Mental health and wellbeing

Mental illness affects one in four of us in any one year. 40% of people with learning disabilities are thought to have mental health needs. Carers are in an ideal position to identify and signpost any concerns they have, in relation to the people they support.

People with learning disabilities are at a higher risk of mental health needs as a result of generally having more risk factors present. Risk factors include being unemployed, limited social circles, limited communication skills, lifelong conditions, sensory difficulties, low income and limited coping skills.

## **Mental health conditions include:**

- **psychosis i.e. schizophrenia or bipolar disorder**
- **disorder** - can cause confusion and acute distress, due to hallucinations, delusions and lack of self-awareness or profound lethargy
- **depression** - can cause a change in mood/personality and problems with sleeping, dietary intake and relationships
- **anxiety** - can induce problems sleeping, heart palpitations, dry mouth. Feelings of panic or fear and cold or sweaty hands or feet.



Carers can help by supporting people with personalised approaches, assisting person's to be empowered and in control. Your own attitude can impact both positively and negatively when supporting a person with mental health needs.

Many people with learning disabilities will be unable to describe their mental wellbeing. They are therefore dependent upon their support to actively monitor for signs of mental distress and promote mental wellbeing. It is important to give people time and space to talk about how they may be thinking and feeling, if they are able to do so. Promoting an active and enabled lifestyle is also important, as well as proactively removing unnecessary distressing things from people's lives.

**Legislation that you need to know about:** [Human Rights Act 1998](#) [Mental Health Act 1983 \(revised 2007\)](#) [Mental Capacity Act 2005](#)

● GREEN – ACTION – None    ● ORANGE – ACTION – Monitor and Document    ● RED – ACTION – REFER – Seek further support and advice



## Activity and exercise are important to mental health and well being

To help mental health wellbeing, some people may like to connect with activities, e.g. being with friends and families, music, singing, being creative, gardening, exercise, learning something new or going outside.

- [Connect to Support Hampshire Mobile App](#)



## In times of social distancing this can be difficult for everyone.

The following guides may be helpful:

- The Government's COVID-19 [guidance](#) for supported living provision
- MIND's [website](#) on coronavirus and your wellbeing
- Chatterpack's list of online [resources](#) for anyone isolated at home

# Dementia

- Dementia is an umbrella term for a number of conditions that affects thinking skills, such as memory, language, object perception, attention and the ability to plan and organise.
- People with learning disabilities have an increased risk of dementia, particularly people with learning disabilities who are likely to experience early onset dementia, such as people with Down's Syndrome.
- A person-centred and individualised approach is needed for all people with dementia. Dementia is a progressive illness, so our approach needs to change as this develops for each person.
- People can live well with dementia. If individuals are showing signs of distress, then they may have physical or mental health issues that can be managed.

No concerns identified, support in a personalised way as normal

**No further action required.** Sometimes baseline measures of skills and abilities are taken at this stage by community learning disability teams so these can be checked against if there are concerns in the future

Person has a diagnosis of dementia: support in a personalised way and follow care plan.

**Monitor and document**

Person is showing some changes in their behaviour

**Liase/inform the GP or mental health team, if known**

Sudden or serious change in presentation:

**Urgently contact the GP surgery or mental health team if known to document concerns.**

**Refer and seek advice**

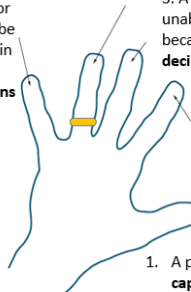
● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

# Mental capacity

## What is mental capacity?

- mental capacity is the ability to make a decision
- it can vary over time
- it can vary depending on the decision to be made
- physical conditions and location can affect a person's
- ability to make decisions

## Five principles of the Mental Capacity Act (2005)

- 
1. A person **must be assumed to have capacity** unless it is established that they lack capacity.
  2. A person is not to be treated as unable to make a decision unless **all practicable steps to help him to do so have been taken without success.**
  3. A person is not to be treated as unable to make a decision merely because he makes an **unwise decision.**
  4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his **best interests.**
  5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is **less restrictive of the persons rights and freedom of action.**

Person has capacity to make their own decisions

**No further action required**

Person has fluctuating capacity or is unable to make some decisions. **Support** them to make decisions when they do have capacity. Use pictures and familiar objects to help support them to make the decision

**Monitor and document**

Person lacks capacity to make serious decisions, such as managing their finances, moving to a new house

**Contact the adult social care team to request a capacity assessment. For medical decisions, contact the GP**

● GREEN – ACTION – None    ● ORANGE – ACTION – Monitor and Document    ● RED – ACTION – REFER – Seek further support and advice

# Pain

Assessing pain and understanding when a person is in pain will be one of the most important things you can do. As carers, you get to understand a person really well and can read both the verbal and non-verbal signs.

## **There are different types of pain:**

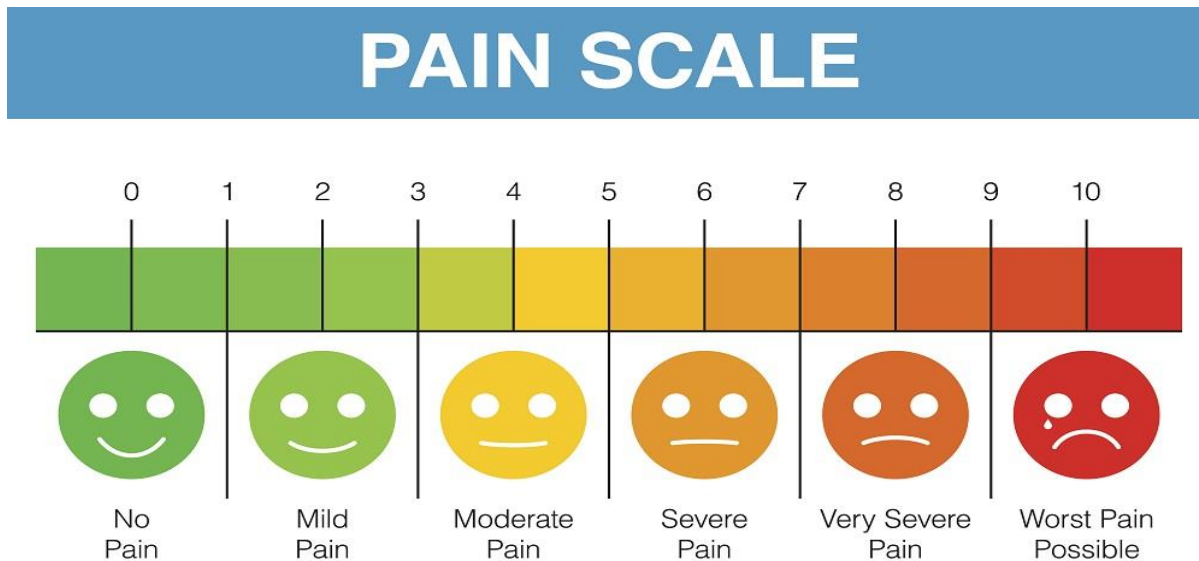
- acute pain starts suddenly and is short-term
- chronic pain lasts for a longer period
- breakthrough pain often happens in between regular, scheduled painkillers
- bone pain happens when cancer is affecting a bone
- soft tissue pain happens when organs, muscles or tissues are damaged or inflamed
- nerve pain happens when a nerve is damaged
- referred pain is when pain from one part of your body is felt in another
- phantom pain is when there is pain in a part of the body that has been removed
- total pain includes the emotional, social and spiritual factors that affect a person's pain experience.

It can be difficult to assess a person's pain if they are unable to verbalise it and/or unable to point to the FACES scale (see next page). There are some signs and symptoms that a person may exhibit if they are in pain:

- facial grimacing or a frown
- writhing or constant shifting in bed
- moaning, groaning, or whimpering
- restlessness and agitation
- appearing uneasy and tense, perhaps drawing their legs up or kicking
- guarding the area of pain or withdrawing from touch to that area.

The more symptoms a person has, and the more intense they appear to be, the more you will get a grasp of the degree of pain they are experiencing. You can then record their pain as "mild", "moderate", or "severe".

The numerical pain scale below is often used and is a very effective in describing pain. Asking the person their score and assisting them to keep a pain diary while doing various activities means that they can get the best treatment.



● GREEN – ACTION – None    ● ORANGE – ACTION – Monitor and Document    ● RED – ACTION – REFER – Seek further support and advice

# Health facilitation

People with [a learning disability](#) are more likely to have greater health needs than the general population; however, people with a learning disability are less likely to have their health needs met.

**Carers have a health facilitation role, helping individuals to access health services.**

## Going into hospital

Carers can help a person produce a hospital passport to give to hospital staff and other information to make the hospital stay a better experience.

Learning disability hospital liaison nurses should be contacted to help support people, carers and staff for outpatient, day surgery and inpatient stays, making reasonable adjustments.

**Don't forget that any information provided to people about matters that could affect them, should meet the Accessible Information Standards.**

**More information about accessibility is available [here](#).**



Contact the Learning Disability Acute Liaison Nurses for support. [See also page 10 about...](#)

## MY HOSPITAL PASSPORT

Place photo here (optional)

My name is:

I like to be known as:

Type of home I live in:   
E.g. supported living, family home

My address:

Hours of staff support I get each day:

Who to contact for more information about me:

If I go to hospital this book needs to go with me.  
It gives hospital staff important information about me. This book should be kept at the end of my bed, with my notes, and used when you talk to me.

This is essential reading for all hospital staff working with me

Things you must know about me

Things that are important to me

My likes and dislikes

Please return my passport to me when I am discharged

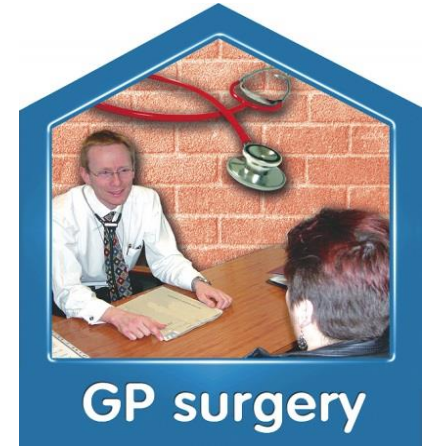
# Primary care



Carers should support the person to access health services like the GP and practice nurses.

Persons with a learning disability should be included on the learning disability register held by the GP.

[Learning disability annual health checks](#) should be offered by the person's GP practice.



## Concerns

If carers have concerns that the person is unable to successfully attend appointments, such as preventative screening, contact should be made with the local learning disability service for help and advice.

[A guide about better health for people with learning disabilities](#)

● GREEN – ACTION – None    ● ORANGE – ACTION – Monitor and Document    ● RED – ACTION – REFER – Seek further support and advice

# Health action planning

All people with a learning disability should be offered a health action plan (this can be part of a care plan). These state what is needed to keep a person fit and well, other things the person wants to do to maintain their health and any support needed to do this.

The plan should be completed with the person by supporters who know the person well. An easy-read version of the plan should be offered, if appropriate.


More information can be found in this [document](#).

<i>Health Action Plan</i>		
<i>Area of Need</i>	<i>Action</i>	<i>By Whom</i>
● [Symbol]	● [Symbol]	● [Symbol]
● [Symbol]	● [Symbol]	● [Symbol]
● [Symbol]	● [Symbol]	● [Symbol]
● [Symbol]	● [Symbol]	● [Symbol]
● [Symbol]	● [Symbol]	● [Symbol]

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

Better health for people with learning disabilities

What social care staff need to know about GP learning disability registers, annual health checks and the Summary Care Record



March 2017

V O D G

# Reasonable adjustments



Under the Equality Act, all health services should make [reasonable adjustments](#) to help people use their service. A reasonable adjustment is a change that must be made to a service so a person with additional needs can use them the same as everyone else.

## **Possible adjustments could be:**

- providing accessible information to aid a person's understanding
- having a flagging system highlighting that the person has a learning disability to help identify additional support may be required
- mental capacity assessments and best interest decisions being undertaken when required
- ensuring that reasonable adjustments are put in place regarding appointment times and lengths, e.g. offer first or last appointments of the day.

[Guides on how reasonable adjustments should be made to health services and adjustments to help people with learning disabilities to access services](#)

● GREEN – ACTION – None    ● ORANGE – ACTION – Monitor and Document    ● RED – ACTION – REFER – Seek further support and advice

# Care and wellbeing support Hampshire



Hampshire County Council have produced an App which supports people in the community. It can be downloaded to your smart phone or iPad for free. [Connect to Support Hampshire](#) is accessed via Google Play or the Apple Store.

It covers:

- health and wellbeing
- managing at homecare homes and other housing options
- equipment and adaptations
- getting out and about
- conditions, disabilities and end of life care
- money matters
- carers
- advocacy and powers of attorney

A British Sign Language version of getting help and support can be found [here](#).

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

# Southampton – useful contacts

## Southampton City Council Adult Social Care Team

Email: [adultsocialcareconnect@southampton.gov.uk](mailto:adultsocialcareconnect@southampton.gov.uk)

Tel: 023 8083 3003

## Community Learning Disability Social Work Team

This [fact sheet](#) provides information on health and adult (social) services for adults with learning disabilities living in Southampton

## Integrated learning disability teams

An integrated service is in place, bringing together the [Southern Health NHS Foundation Trust Specialist LD Health Team](#), the Southampton City Council adult social care learning disability team and [the CCG Continuing Healthcare Team](#)

## Learning Disability Acute Hospital Liaison

[Service](#) is delivered by learning disability nurses at Southampton General Hospital

**Autism assessment & diagnosis service [for adults provided by Southern Health NHS Foundation Trust](#), and [for children by Solent NHS Trust](#)**

## Specialist Community Learning Disability Health services - Southern Health NHS Foundation Trust

[Southampton City Community Learning Disability Team](#) and [West Hampshire Community Learning](#)

## [Disability Service](#)

## Intensive Support Team

[Southern Health NHS Foundation Trust](#)

## Community Forensic Team

### Southern Health NHS Foundation Trust

This [team](#) provides forensic assessment, treatment and rehabilitation service in the community.

## Southampton Health services

A list of local services can be found [here](#).

## Autism support

Service provided by [Autism Hampshire](#)

## Carers Service - supporting unpaid carers in Southampton

[Carers in Southampton](#) are the commissioned service provided by Mencap, [Young Carers work is provided by No Limits](#).

## Advocacy

[A Commissioned advocacy service is provided by Choices Advocacy working in partnership with Solent Mind](#) to deliver services under the Care Act, SEND (Special Education Needs and Disability), and Community Advocacy.

## **Sexual Health Community Health Service**

[Solent NHS Trust](#)

## **Employment Support and Life Skills Development**

Southampton City Council has combined various work streams into one integrated employment [service](#) to provide supported employment to people with a learning disability who are known to the adult social care team

## **Learning Disability Commissioning**

[LDCommissioning@southampton.gov.uk](mailto:LDCommissioning@southampton.gov.uk)

Contact for enquiries related to the commissioning of services for adults with learning disabilities and/or autism, including development of new services.

 **GREEN – ACTION – None**    **ORANGE – ACTION – Monitor and Document**    **RED – ACTION – REFER – Seek further support and advice**

# Hampshire – useful contacts

## **Hampshire County Council Adult Contact Team / Adult Social Care teams**

Tel: 0300 555 1386

Monday to Thursday 8:30am to 5:00pm

Friday 8:30am to 4:30pm

## **Textphone users**

Tel: 0300 555 1390

Email: [adult.services@hants.gov.uk](mailto:adult.services@hants.gov.uk)

## **Out-of-hours**

Tel: 0300 555 1373

Monday to Thursday 5:00pm to 8:30am

Friday 4:30pm to 8:30am

All day on bank holidays

## **Community Learning Disability Social Work Team**

If you would like to speak to someone about  
having an assessment, please call:

Tel: 0300 555 1386

## **North Hampshire Integrated Community Learning Disability Teams:**

### **Basingstoke Team**

The Vertex Centre

Chineham Court

Basingstoke

RG24 8AG

Tel: 01256 776 151

### **Winchester Team**

Poles Copse

Poles Lane

Otterbourne

Winchester

SO21 2DZ

Tel: 01962 764 560

**East Hampshire Integrated Community  
Learning Disability Teams:**

**Havant & East Hants Team**

Havant Public Service  
The Plaza  
Civic Centre Road  
Havant  
PO9 2AX  
Tel: 02392 441 416

**Fareham & Gosport Team**

7 The Potteries  
Wickham Road  
Fareham  
PO16 7ET  
Tel: 01329 316 350

**West Community Integrated Community  
Learning Disability Teams:**

**Test Valley Team (Eastleigh and Andover)**

Beech Hurst  
Weyhill Road  
Andover  
SP10 3AJ  
Tel: 01264 368 636

**New Forest Team (Totton/New Milton/Waterside)**

Rufus Lodge  
Tatchbury Mount  
Calmore  
Southampton  
SO40 2RZ  
Tel: 02380874 222

**Carers Service - Supporting unpaid carers**

9 Love Lane  
Romsey  
SO51 8DE  
Tel: 01794 519495

[Website](#)

Email: [admin@carerstogether.org.uk](mailto:admin@carerstogether.org.uk)

**Autism Hampshire**

Outreach Department  
22 Midanbury Lane,  
Bitterne Park  
Southampton  
SO18 4HP  
Tel: 02380 766 162

[Website](#)

## **Autism assessment & diagnosis advocacy**

[Advocacy](#) for people with a learning disability or autism.

## **Sexual Health - Ready to Shine**

Training Manager / Learning Facilitator and Assessor

Tel: 07917 237 251 / 07739 385 031

[Website](#)

E-mail: [hello@ready2shine.co.uk](mailto:hello@ready2shine.co.uk)

## **Southampton City Community Learning Disability Team**

Thomas Lewis House

236 Empress Road

Southampton

SO14 0JY

Tel: 02382 310 300

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

# Isle of Wight – useful contacts

## **Community Learning Disability Social Work Team**

County Hall  
High Street  
Newport  
Isle of Wight  
PO30 5  
Tel: 01983 82100 Ext 6100

## **Specialist Community Learning Disability Health services**

Arthur Webster Clinic  
Languard Manor Road  
Shanklin  
Isle of Wight  
PO37 7HZ  
Tel: 01983 866 179

## **Isle of Wight Health Services**

St Mary's Hospital  
Parkhurst Road  
Newport  
Isle of Wight  
PO30 5TG  
Tel: 01983 822 099

## **Learning Disability Acute Hospital Liaison**

St Mary's Hospital  
North Hospital  
Parkhurst Road  
Newport  
Isle of Wight  
PO30 5TG  
Tel: 01983 822 099 Ext 5478

## **Adult Autism assessment & diagnosis**

Arthur Webster Clinic  
Languard Manor Road  
Shanklin  
Isle of Wight  
PO37 7HZ  
Tel: 01983 866 179

## **Autism support**

People Matter I.w  
1-2 Bernard Way  
Newport  
Isle of Wight  
PO30 5YL  
Tel: 01983 241 494

[Website](#)

**Carers Service - Supporting unpaid carers in the Isle of Wight**

IWCarers  
Riverside Centre,  
The Quay  
Newport  
Isle of Wight  
PO30 2QR  
Tel: 01983 533 173

[Website](#)

**Advocacy**

Southern Advocacy Service  
Riverside Centre  
The Quay  
Newport  
Isle of Wight  
PO30 2QR  
Tel: 01983 559 299

[Website](#)

**Sexual Health Community Health Service**

St Mary's Hospital  
Parkhurst Road  
Newport  
Isle of Wight  
PO30 5TG  
Tel: 01983 534 202

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

# Portsmouth – useful contacts

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## **Integrated Learning Disability Service**

The Kestrel Centre  
2<sup>nd</sup> Floor,  
Mountbatten Gallery  
Civic Offices  
Guildhall Square  
Portsmouth  
PO1 2GJ  
Tel: 0300 123 4019  
Email: [alduty@portsmouthcc.gov.uk](mailto:alduty@portsmouthcc.gov.uk)

**An integrated service made up of health and social care professionals, divided into 4 teams, community, complex health, intensive outreach and LD hospital Liaison**

## **Learning Disability Acute Hospital Liaison**

Queen Alexandra Hospital, Portsmouth Learning Disability Hospital Liaison Nurses  
Room A1162  
Queen Alexandra Hospital  
Cosham  
Portsmouth  
PO6 3LY  
Tel: 02392 286 000 Ext 5825  
Nicky Gough - [nickygough@nhs.net](mailto:nickygough@nhs.net)  
Karen Price - [karenprice7@nhs.net](mailto:karenprice7@nhs.net)

## **Portsmouth Hospital**

Queen Alexandra Hospital  
Cosham  
Portsmouth  
PO6 3LY  
Tel: 02392 286 000  
[Website](#)

## **Portsmouth Patient Advice and Liaison Service (PALS)**

Queen Alexandra Hospital  
Cosham  
Portsmouth  
PO6 3LY  
Tel: 02392 286 309 or 0800 917 6039  
Email: [PHT.PALS@porthosp.nhs.uk](mailto:PHT.PALS@porthosp.nhs.uk)

## **Autism assessment & diagnosis**

Surrey and Borders  
Tel: 0300 555 5222

**Autism assessments are undertaken by Surrey and Borders. If a person is open to the Integrated Learning Disability Service, autism assessments may be undertaken under the Portsmouth team.**

### **Autism advice and information**

Autism Hampshire

[Website](#)

### **Community healthcare**

[Website](#)

### **Single Point of Access (SPA)**

Tel: 0300 300 2011

### **Carers Service - Supporting unpaid carers in Portsmouth**

Portsmouth Carers Centre

117 Orchard Road

Portsmouth

Southsea

PO4 0AD

Tel: 0239 285 1864

Email: [Carerscentre@portsmouthcc.gov.uk](mailto:Carerscentre@portsmouthcc.gov.uk)

### **Advocacy**

Solent Mind

15-16 The Avenue

Southampton

SO17 1XF

Email: [info@solentmind.org.uk](mailto:info@solentmind.org.uk)

### **Stepping Stones to Positivity - Self Advocacy**

Email: [Jon.woods@portsmouthcc.gov.uk](mailto:Jon.woods@portsmouthcc.gov.uk)

### **Employment Support & Life Skills Development**

You Trust

116 Kingston Crescent

Portsmouth

PO2 8AL

Tel: 02392 793000

### **Learning Disability Commissioning**

Email: [Dominic.Dew@portsmouthcc.gov.uk](mailto:Dominic.Dew@portsmouthcc.gov.uk)

### **Portsmouth Learning Disability Partnership Board (including the Health Equalities forum)**

Email: [Christopher.Noden@portsmouthcc.gov.uk](mailto:Christopher.Noden@portsmouthcc.gov.uk)

 **GREEN – ACTION – None**    **ORANGE – ACTION – Monitor and Document**    **RED – ACTION – REFER – Seek further support and advice**

# Useful national organisations

- [Skills for Care](#)
  - [Learning Disability](#) (STOP LOOK CARE)
- [Connect to Support Hampshire](#)
- [SHIP TCP Workforce Training Resources DIRECTORY](#)
- [Hampshire Advocacy My Life, My Way](#)
- [National Autistic Society](#) – T: 020 7833 2299
- [Mencap](#) – T: 0808 808 1111
- [Epilepsy Society](#) – T: 01494 601 400
- [Alzheimer's Society](#) – T: 0330 333 0804, T: 0333 150 3456 (Dementia Connect Support Line)
- [British Heart Foundation](#) – T: 0300 330 3311
- [Diabetes UK](#) – T: 0345 123 2399

● GREEN – ACTION – None   ● ORANGE – ACTION – Monitor and Document   ● RED – ACTION – REFER – Seek further support and advice

# Acknowledgments and Thanks

- Carol Hards – Brighton and Hove CCG
- Helen Rignall – Brighton and Hove CCG
- Karen Hampton – Frimley Health and Care Integrated Care System
- The SHIP STOP LOOK CARE Workforce Group:
  - Debbie Boys – Skills for Care Locality Manager (SHIP)
  - Patricia Reynolds – Solent NHS Trust
  - Julie Chapman Solent NHS Trust
  - Marta Coates, Amy George, Becky Sparks – Southern Health NHS Foundation Trust
  - Jonathan Beebee – PBS4 Ltd.
  - Ian McDonald – Southampton CCG Integrated Commissioning Unit/Health Education England
- Photographs taken by Creative Snaps Photography Group supported by Nicole Jones
- Funding support by Skills for Care
- Formatting assistance commissioned by Skills for Care
- Natalie Scarimbolo – Additional Editing, Skills for Care
- Margaret Sharpe – Skills for Care Locality Manager
- K Baker – parent carer who provided valuable feedback

# The original STOP LOOK CARE booklet

Created by Carol Hards and Helen Rignall

**Carol Hards** is a Registered General Nurse with over 20 years clinical experience specialising in Community Nursing and has a BSc in Health Studies. She worked as Nurse Assessor for NHS Continuing Healthcare before taking up her current post as a Clinical Quality and Patient Safety Manager for Brighton and Hove CCG. This role involves monitoring the quality and safety of commissioned services and working with providers to improve the quality of patient care throughout Brighton and Hove. She is particularly committed to the improvement of care in the community including Care Homes.

**Helen Rignall** is a Primary Care Workforce Tutor working for Brighton and Hove Clinical Commissioning Group (CCG). She has had a vast and varied career, qualifying as a Registered Nurse in 1986, a midwife in 1989, acquired a BSc in Health visiting in 1998 and Adult Intensive Care Nursing in 2009. She lived and worked in the Middle East for 7 years, learning about different cultures, health beliefs and healthcare. Currently she is delivering on strategic projects in primary care to support education and workforce priorities and is also supporting projects across health and social care. Helen is committed to helping others acquire the correct knowledge, to be able to deliver safe, effective and good quality care.

# Creative Snaps Photography Group

The Photography Members of Creative Advances, Portsmouth took the photos that are in contained in this booklet.



**Original print:  
Other versions:**

**SHIP LD/autism version:  
National LD/autism version:  
To be reviewed:**

**Brighton & Hove CCG (v1.0)  
Frimley Health and Care Integrated Care System (December  
2018 v2)  
April 2020  
April 2020  
April 2022**