Emergency Sheet 'GRAB SHEET'

I have a learning disability

Further details can be found in the 'About me - health overview' section

Name ..... Known as: .....

Date of Birth: ..... Address .....

.....

NHS Number ..... Ethnicity .....

GP name and address .....

.....

For more information contact:

Name:..... Who is? .....

Tel No: .....

Or

Name:..... Who is? .....

Tel No: .....

Support needs (Tick as Appropriate)		You can help by:
Speaking	☐	.....
Hearing	☐	.....
Seeing	☐	.....
Understanding	☐	.....
Eating/Drinking	☐	.....
Taking medication	☐	.....
Mobility	☐	.....

Tetanus injection dates: .....

I believe I am allergic to these drugs: .....

.....

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

Emergency Sheet 'GRAB SHEET' Continued

My first language is: .....

I need an interpreter/carer to help communicate ☐ YES ☐ NO
(tick as appropriate)

.....

.....

I am Left Handed ☐ I am Right Handed ☐
(tick as appropriate)

Is there any previous or current risk in any of the following areas?
(tick all boxes as appropriate)

Self harm / self injury? ☐ YES ☐ NO

.....

Aggression towards others? ☐ YES ☐ NO

.....

Swallowing difficulties? ☐ YES ☐ NO

.....

Epilepsy? ☐ YES ☐ NO

.....

Mental health? ☐ YES ☐ NO

.....

Any other relevant issue? ☐ YES ☐ NO

.....

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

Name ..... Known as ..... Date of birth: .....

Health Action Plan

(ONLY LATEST SHEET TO BE KEPT IN PURPLE FOLDER)

To be completed by the health professional on each visit to a GP / Nurse / Hospital / Dentist / Optician

If any information changes do not cross out or erase.
Complete a new sheet and store the old one securely.

Action										
Health Issue										
Profession										
Name of Health Professional										
Date										

Name ..... Known as ..... Date of birth: .....

Health Action Plan

(ONLY LATEST SHEET TO BE KEPT IN PURPLE FOLDER)

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Date										

Name ..... Known as ..... Date of birth: .....

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Name of Health Professional										
Date										

Name ..... Known as ..... Date of birth: .....

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Name of Health Professional										
Date										

Name ..... Known as ..... Date of birth: .....

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Complete a new sheet and store the old one securely.

Action										
Health Issue										
Profession										
Name of Health Professional										
Date										

Name ..... Known as ..... Date of birth: .....

Health Action Plan

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If any information changes do not cross out or erase.
Complete a new sheet and store the old one securely.

Action										
Health Issue										
Profession										
Name of Health Professional										
Date										

Information for people with learning disabilities and their carers

We know that people with a learning disability do not always receive good health services.

The *Purple Folder* helps health care professionals get the right health information about you. It will help to improve your health care and keep you informed about your health.

You should always ask people to explain if they say or show you something you do not understand.

Ask for your Health Action Plan (HAP) to be completed every time you meet with a health professional.

Contact your local Community Learning Disability Team to ask for replacement sheets (see contact details at the end of this folder). You will need to tell the person the heading or title of the page you need.

It is up to each person with a learning disability to decide if they want to use the *Purple Folder*. Where it has been assessed that a person lacks the necessary mental capacity to make this decision a best interest decision will need to be taken and recorded to show that it is in the individual's best interest to complete the *Purple Folder*. This decision should be recorded in the involvement checklist section at the end of this folder. The *Purple Folder* will be completed and shared with health professionals only as necessary. The 'Involvement Checklist' at the back of the folder needs to be completed in all Purple Folders and reviewed at least annually.

Everybody who chooses to use the *Purple Folder* should complete it with the help of a carer, professional or trusted friend. It is very important that the information in the *Purple Folder* is correct to help get the best health care for you.

Please take your *Purple Folder* to any health appointments so that information in it can be shared.

It is very important that the *Purple Folder* is kept in a safe place.

If you live on your own or with an unpaid carer it is a good idea to always keep your *Purple Folder* in the same place – for instance under your bed or in your wardrobe.

Paid carers:

It is part of your responsibility to advocate for the person you are supporting and as such you will need to encourage reference to the *Purple Folder* and completion by health professionals.

A separate record of any health consultation needs to be kept in accordance with your employers recording policies. Records should make reference to completion of the *Purple folder.*

Storage:

In Adult Care Services or Adult Care commissioned services, the Purple Folder needs to be securely stored. If the *Purple Folder* is lost, staff will activate the appropriate procedure relating to mislaid documentation. The local Community Learning Disability Team must also be informed (see contact details at the end of this folder).

Information for Health Professionals

The information within the *Purple Folder* is designed to help you to deliver person centred care. It contains information that will be needed for treatment plans and for risk assessments.

The information in the Purple Folder may not have been completed by a medically qualified professional. Care should be taken to identify who has helped the person with learning disabilities (the patient) to complete each of the sections and to make sure the information contained is cross referenced with the patient's current medical records.

- People with a learning disability will have difficulty in understanding complex information and may have difficulty with recall.

- You should always verify relevant information with the person with learning disability and any accompanying carer.

- Should in-patient care be required, it is important that the *Purple Folder* is used with the patient and carer and its content used to inform care plans and risk assessments. It is important that the *Purple Folder* is used to support good health care. The content and utilisation of the *Purple Folder* should be highlighted to all professionals involved in providing hospital care.

- When a person with a learning disability is admitted to a hospital, the hospital personnel who accepts the *Purple Folder* should complete a receipt slip (kept in the discharge summary section of the *Purple Folder*. A completed cut-out slip is to be given to the person with a learning disability/carer. The person with a learning disability/carer is to keep the slip as proof of receipt.

The Health Action Plan (HAP)

The health professional has the responsibility of explaining any treatment plans and outcomes to individuals/ carers. Within the *Purple Folder* is the Health Action Plan (HAP) – which is used to provide an overview of the current treatment and proposed follow-up care.

- Health professionals across the NHS (primary, secondary and tertiary care) have responsibility for completion of the HAP at each consultation

- At the time of discharge from in-patient care, the hospital staff will have the responsibility of ensuring that the HAP has been discussed with the patient/carer and legibly completed. A discharge summary needs to be provided, discussed and stored within the 'Discharge Summary' section of the *Purple Folder*. NHS care notes need to reflect these actions.

The *Purple Folder* belongs to the person with a learning disability/carer. It contains important personal information. It is the responsibility of the NHS provider to ensure the *Purple Folder* is used, safely stored in accordance with hospital policy and appropriately completed with a record contained with the NHS patient notes.

In the event of the *Purple Folder* becoming mislaid within an NHS setting activation of relevant 'mislaid document policy' needs to occur with a record kept in the patient's NHS notes. The local Community Learning Disability Team should also be notified (see contact details at the end of this folder).

Name ..... Known as ..... Date of birth: .....

If any information changes do not cross out or erase. Complete a new sheet and store the old one securely.

Health Overview

Please request the involvement of any accompanying person.

Ailment	Tick 'yes' or 'no'	Tick if you have emergency medication
General Health		
Communication		
Key Professionals		
Epilepsy	☐ Yes ☐ No	☐
Mental health / Fears	☐ Yes ☐ No	☐
Diabetes	☐ Yes ☐ No	☐
Allergies	☐ Yes ☐ No	☐
Alcohol / drugs	☐ Yes ☐ No	
Mobility	☐ Yes ☐ No	
Equipment / aids	☐ Yes ☐ No	
Eating / drinking	☐ Yes ☐ No	
Hearing problems	☐ Yes ☐ No	
Eyesight problems	☐ Yes ☐ No	
I need help with...	☐ Yes ☐ No	

For people in supported living, this section needs to be additionally signed by the manager.

Name of Manager:.....

Signed by Manager:..... Date:.....

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

Name ..... Known as ..... Date of birth: .....

If any information changes do not cross out or erase. Complete a new sheet and store the old one securely.

General Health

I think my health is: (tick as appropriate)

very good ☐

fairly good ☐

not good ☐

The medical problems I believe I have are:

.....

.....

.....

.....

.....

.....

People can tell when I am feeling unwell or in pain by:

.....

.....

.....

.....

.....

Continued Overleaf

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

General Health

Additional information.

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

Name ..... Known as ..... Date of birth: .....

If any information changes do not cross out or erase. Complete a new sheet and store the old one securely.

Communication

Tick all that apply:

I can express my needs and wants verbally ☐ YES ☐ NO

Details.....

I use signs or gestures to express myself and to understand other people ☐ YES ☐ NO

Details.....

I use photographs or symbols to express myself and to understand other people ☐ YES ☐ NO

Details.....

I use Objects of Reference to express myself and to understand other people ☐ YES ☐ NO

Details.....

I have other methods of communicating ☐ YES ☐ NO

Details.....

I use other communication aids: ☐ YES ☐ NO

Health Professionals can make things easier for me and help me understand by:

.....

.....Continued Overleaf

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

Communication

Additional information.

.....

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To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

Name ..... Known as ..... Date of birth: .....

If any information changes do not cross out or erase. Complete a new sheet and store the old one securely.

Key Professionals

GP .....

Address: .....

..... **Tel:**.....

Social Worker .....

Address: .....

..... **Tel:**.....

Other health professionals (for example; nurses, psychiatrist)

Name .....

Address: .....

..... **Tel:**.....

Name .....

Address: .....

..... **Tel:**.....

Name .....

Address: .....

..... **Tel:**.....

Name .....

Address: .....

..... **Tel:**.....

Continued Overleaf

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

Other health professionals (for example; nurses, psychiatrist)

Name .....

Address: .....

..... **Tel:**.....

Name .....

Address: .....

..... **Tel:**.....

Name .....

Address: .....

..... **Tel:**.....

Name .....

Address: .....

..... **Tel:**.....

Name .....

Address: .....

..... **Tel:**.....

Name .....

Address: .....

..... **Tel:**.....

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... **Date:**.....

Role: Carer/health professional/other professional .....

Name ..... Known as ..... Date of birth: .....

If any information changes do not cross out or erase. Complete a new sheet and store the old one securely.

Epilepsy

(tick as appropriate)

I have epilepsy ☐ YES ☐ NO

I have an epilepsy Management Plan ☐ YES ☐ NO

If yes, please include a copy in this section of the Purple Folder

This is what I believe happens when I have a seizure: .....

.....

I know I am going to have a seizure when: .....

.....

My seizure usually lasts: .....

.....

This is the help I believe I need:

BEFORE: .....

DURING: .....

AFTER: .....

I believe my usual recovery pattern is:

.....

My regular epilepsy specialist is: .....

Address: .....

..... Tel: .....

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by: ..... Date: .....

Role: Carer/health professional/other professional .....

Name ..... Known as ..... Date of birth: .....

If any information changes do not cross out or erase. Complete a new sheet and store the old one securely.

Behaviours and Mental Health

Please be aware that the following routines are important to me:

.....

.....

.....

.....

I believe I have the following mental health problems:

(For example: depression, anxiety, phobias, schizophrenia, dementia)

.....

.....

.....

.....

I believe I have behaviours (including self harm) that might be hard to understand

☐ YES ☐ NO

(tick as appropriate)

If yes, please indicate the behaviour and any guidelines to help people understand me.

.....

.....

.....

Continued Overleaf

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

Behaviors and Mental Health

Additional information.

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

Name ..... Known as ..... Date of birth: .....

If any information changes do not cross out or erase. Complete a new sheet and store the old one securely.

Fears

I have the following fears:

.....

.....

.....

.....

You can help me by:

.....

.....

.....

.....

The best way to help me have an injection is:

.....

.....

.....

.....

Continued Overleaf

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

Fears

Additional information.

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

Name ..... Known as ..... Date of birth: .....

If any information changes do not cross out or erase. Complete a new sheet and store the old one securely.

Diabetes

(tick as appropriate)

I believe I have Diabetes ☐ YES ☐ NO

I take medication by mouth for my diabetes ☐ YES ☐ NO

I have an injection for my diabetes ☐ YES ☐ NO

Allergies

I believe I am allergic to the following:

.....

.....

This is what happens to me if I have an allergic reaction:

.....

.....

I am prescribed medication for allergic reactions ☐ YES ☐ NO

Alcohol / Drugs

I would like to talk to you about my alcohol/drug use ☐ YES ☐ NO

.....

.....

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

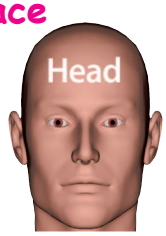
Name ..... Known as ..... Date of birth: .....

If any information changes do not cross out or erase. Complete a new sheet and store the old one securely.

Mobility and Getting Around

I have problems with my: (tick as appropriate)

Face

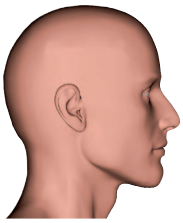


☐ YES ☐ NO

Details ....

You can help me by: ....

Neck

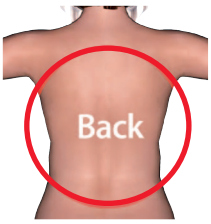


☐ YES ☐ NO

Details ....

You can help me by: ....

Spine

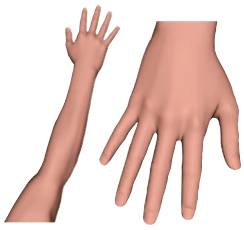


☐ YES ☐ NO

Details ....

You can help me by: ....

Arms/Hands

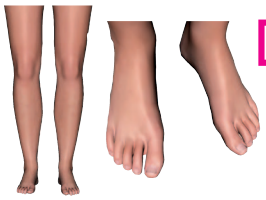


☐ YES ☐ NO

Details ....

You can help me by: ....

Legs / Feet



☐ YES ☐ NO

Details ....

You can help me by: ....

(Please give details)

.....

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

Name ..... Known as ..... Date of birth: .....

If any information changes do not cross out or erase. Complete a new sheet and store the old one securely.

Equipment / Aids I regularly require the use of:

Equipment / Aids	Tick as appropriate
Walking Stick/Aids	☐ YES ☐ NO
Hearing Aid	☐ YES ☐ NO
Glasses	☐ YES ☐ NO
Dentures	☐ YES ☐ NO
Wheelchair	☐ YES ☐ NO
Standing frame	☐ YES ☐ NO
Specialist seating	☐ YES ☐ NO
Pressure mattress	☐ YES ☐ NO
Hoist	☐ YES ☐ NO

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

Name ..... Known as ..... Date of birth: .....

If any information changes do not cross out or erase. Complete a new sheet and store the old one securely.

Equipment / Aids I regularly require the use of:

Equipment / Aids	Tick as appropriate
Foot straps	☐ YES ☐ NO
Wrist straps	☐ YES ☐ NO
Wedges/cushions	☐ YES ☐ NO
Helmet	☐ YES ☐ NO
Splints	☐ YES ☐ NO
Breathing equipment	☐ YES ☐ NO
Suction	☐ YES ☐ NO
Tube feeding/Pump	☐ YES ☐ NO
Other please give details	☐ YES ☐ NO

.....

.....

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

Name ..... Known as ..... Date of birth: .....

If any information changes do not cross out or erase. Complete a new sheet and store the old one securely.

Eating and Drinking

Tick all that apply

I have guidelines to help me when I eat (please include) ☐ YES ☐ NO

Details:.....

I have guidelines to help me when I drink ☐ YES ☐ NO

Details:.....

I am fed through a special tube ☐ YES ☐ NO

Details:.....

I have difficulties with food and drink falling out of my mouth ☐ YES ☐ NO

Details:.....

I have difficulties with chewing ☐ YES ☐ NO

Details:.....

I get food stuck in the roof of my mouth and cheeks ☐ YES ☐ NO

Details:.....

I have difficulties swallowing food ☐ YES ☐ NO

Details:.....

I have difficulties swallowing fluids ☐ YES ☐ NO

Details:.....

I sometimes inhale food and drink ☐ YES ☐ NO

Details:.....

I have other eating and drinking problems ☐ YES ☐ NO

Details:.....

WARNING SIGNS OF SWALLOWING PROBLEMS (DYSPHAGIA)

If I gag, cough, choke or sound very gurgly, do not put more food or drink in my mouth. Stop! Wait until my mouth is empty and I am breathing normally again. **PLEASE SEEK ADVICE FROM SENIOR STAFF!** These symptoms will require a swallowing assessment

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

Name ..... Known as ..... Date of birth: .....

If any information changes do not cross out or erase. Complete a new sheet and store the old one securely.

I need a modified diet

☐ YES ☐ NO

Tick as appropriate

DETAILS (Pureed, mashed, chopped or other):

.....

.....

.....

I need my fluids thickened

☐ YES ☐ NO

DETAILS:

.....

.....

.....

I need a special diet

☐ YES ☐ NO

DETAILS (Allergies, Religious/Cultural Preferences)

.....

.....

.....

Other things you need to know

(For example; equipment, technique, positioning):

.....

.....

.....

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

Name ..... Known as ..... Date of birth: .....

If any information changes do not cross out or erase. Complete a new sheet and store the old one securely.

Hearing problems

Tick as appropriate

I believe I have a hearing problem ☐ YES ☐ NO

If yes, please describe it:

.....

.....

.....

You can help me by:

.....

.....

.....

Eyesight problems

I believe I have an eyesight problem ☐ YES ☐ NO

If yes, please describe it:

.....

.....

.....

You can help me by:

.....

.....

.....

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

Name ..... Known as ..... Date of birth: .....

If any information changes do not cross out or erase. Complete a new sheet and store the old one securely.

I need help with...

	Tick as appropriate		You can help me by:
Dressing myself 	☐ YES	☐ NO	....
Washing myself 	☐ YES	☐ NO	....
Using the toilet 	☐ YES	☐ NO	....
Sleeping 	☐ YES	☐ NO	....
Cleaning my teeth 	☐ YES	☐ NO	....
Other (Please give details)	☐ YES	☐ NO	....

To the best of my knowledge this is an accurate account. Support to complete this section has been provided by:..... Date:.....

Role: Carer/health professional/other professional .....

Name ..... Known as ..... Date of birth: .....

If any information changes do not cross out or erase. Complete a new sheet and store the old one securely.

Health Care Reports / Discharges

BEFORE LEAVING THE WARD

- Please ask for the written discharge summary which gives an overview of the reason for admission/ treatment provided/ follow up treatment arrangements.

- Place the discharge summary in this section.

- You should always ask people to explain if they say or show you something you do not understand.

Name ..... Known as ..... Date of birth: .....

If any information changes do not cross out or erase. Complete a new sheet and store the old one securely.

Mental Capacity

The law presumes that each individual has the capacity to take a specific decision until it is demonstrated that they do not.

A best interest decision must be recorded in the involvement checklist section. When assessing capacity and taking best interest decisions the assessor and decision maker must have regard to the principles and statutory guidelines set out in the Mental Capacity Act and the statutory code. These are available to view on the Department of Health's website www.dh.gov.uk and by typing Mental Capacity Act 2005 into the search box.

You can also get advice from your local Community Learning Disability team, please see the useful contacts section at the end of the Purple Folder.

Mental Capacity Act implementation in Hertfordshire

Mental Capacity Act 2005

The Mental Capacity Act 2005 (MCA) is one part of the Government's strategy to improve the provision of health and social care services. It provides a statutory framework to empower and protect vulnerable people, aged 16 years and over, who are not able to make their own decisions. Anyone who works with people who lack capacity has a legal duty to comply with the MCA and have regard to the MCA Code of Practice.

Definition

Capacity is the ability of an individual to make decisions regarding specific elements of their life. (Ref. MCA, Code of Practice).

A person is able to make a decision for him/herself if he/she is able to meet all of the following criteria:

- understand the information relevant to the decision
- retain that information
- use or weigh that information as part of the process of making the decision, and
- communicate their decision, whether by talking, using sign language or any other means.

Vulnerable groups

These include people with:

- dementia
- learning disabilities
- mental health problems
- stroke and brain injuries
- substance misuse
- neurological disorders
- and temporary impairment due to medication or illness.

Who is affected by the Act?

All people (over the age of 16) with reduced capacity. All staff who work with people with reduced capacity.

All other carers and advocates who care for people with reduced capacity.

The legal framework of the Act is supported in these ways:

- Code of Practice
- The Office of the Public Guardian
- Lasting Powers of Attorney
- Court of Protection
- Independent Mental Capacity Advocates
- New Criminal Act – ill treatment or wilful neglect.

The five principles

1 - Always assume a person has capacity unless proved otherwise.
2 - Appropriate help must be provided to support individuals to make their own decisions.
3 - Individuals retain the right to make what might be seen as eccentric or unwise decisions.
4 - Apply 'best interest' principles (everything done for, or on behalf of, someone who lacks capacity must be in their best interest).
5 - Before doing something to someone, or making a decision on their behalf, consider whether the outcome could be achieved in a less restrictive way.

What triggers an assessment?

Start from a presumption of capacity.

Doubts as to an individual's capacity can occur because of, but cannot be based merely on:

- the person's behaviour
- their circumstances
- concerns raised by someone else.

Who is responsible for completing assessments?

All professionals working with adults in health and social care can carry out capacity assessments and best interest decisions.

Assessing capacity

- assess the person's capacity to make a decision
- use Hertfordshire documentation to record the assessment
- don't rush the person
- an eccentric or unwise decision does not necessarily mean lack of capacity
- capacity is decision specific and time specific
- encourage, assist and support the person to make their own decision if possible
- in case of fluctuating capacity if decision is not urgent - wait
- instruct an IMCA if eligibility criteria are met.

If a person lacks capacity, consult others.

Two stage (functional) test of capacity

There are two basic questions to consider:

1 - Does the person have an impairment of, or disturbance in the functioning of, their mind or brain at this moment?

If yes:

2 - Is the impairment or disturbance sufficient that the person lacks the capacity to make the decision needed at this time?

- always assess in relation to the specific decision to be made
- an unwise decision does not necessarily indicate lack of capacity
- the more complex the decision; the greater level of capacity is required.

Lack capacity

If the person does not have capacity:

- does the decision need to be made without delay?
- will the person regain capacity?
- is it possible to wait until the person does have capacity?

Should an Independent Mental Capacity Advocate (IMCA) be instructed?

You must refer to an IMCA if the decision concerns serious medical treatment or a change of accommodation, and there is no one close to the person who is appropriate and willing to support them in making the decision. You may refer to an IMCA for care reviews or adult protection cases if certain criteria are met (see Hertfordshire policy).

POhWER's IMCA service can be contacted on 0845 2230436 or www.pohwer.net

Best interests

Any action must be in the best interests (section 4 the Act) of the person. Consider anything relevant and in particular:

- past and present wishes and feelings of the person
- any beliefs and values of the person that may influence the decision
- any relevant views previously expressed, particularly in writing
- whether a valid and applicable advance decision has been made
- whether the act or decision is the least restrictive of basic rights and freedoms
- if appropriate, consult other people such as:
  - carers, close relatives, friends
  - attorney under LPA
  - any deputy appointed by Court of Protection.

Further information is available from:

- Code of Practice available at www.publicguardian.gov.uk
- Hertfordshire policy and documentation available on
  - Hertfordshire County Council Connect under A-Z of ACS Policies and procedures
  - NHS Trust staff intranets by searching for 'mental capacity act'
- The link for the Mental Capacity Act and other e-learning packages is: www.learningpool.com/hertfordshire if you work for Herts County Council or www.learningpool.com/hertssocialcare if you work for another organisation.

design ref: 053587

Name ..... Known as ..... Date of birth: .....

If any information changes do not cross out or erase. Complete a new sheet and store the old one securely.

Involvement checklist

As the owner of the Purple Folder – you should be involved in filling out and keeping your Purple Folder up-to-date.

Was the owner of the Purple Folder: Tick as appropriate

1. Involved in its completion? ☐ YES ☐ NO

   If no, why not? .....

   .....

2. Informed that the Purple Folder needs to be shown and the outcomes recorded at all NHS consultations? ☐ YES ☐ NO

   If no, why not? .....

   .....

3. Informed and reminded that the Purple Folder contains confidential information and needs to be kept safe and secure? ☐ YES ☐ NO

   If no, why not? .....

   .....

4. Informed that if the Purple Folder gets mislaid that the Community Learning Disability Team needs to be informed. (see contact details at the end of this folder) ☐ YES ☐ NO

   If no, why not? .....

   .....

Signed by owner of Purple Folder: .....

Print name: ..... Date:.....

Signed by person who helped with completion: .....

Print name: ..... Date:.....

For people in Supported Living - Name of manager: .....

Signature: ..... Date:.....

Useful telephone numbers

GENERAL NUMBERS

NHS Hertfordshire	01707390855
NHS Hertfordshire Patient Feedback (PALS)	01707 369699
NHS Direct	08454647
POhWER - advocacy - Independent Mental Capacity Advocacy (IMCA), Independent Complaints Advisory Service (ICAS)	03004562370

HERTFORDSHIRE GENERAL HOSPITALS

Watford General Hospital	01923 244366
St Albans City Hospital	01727 866122
Hemel Hempstead General Hospital	01442 213141
Hertford County Hospital	01438 314333
Mount Vernon Cancer Centre	01923 826111
Lister Hospital (Stevenage)	01438 314333
QE2 Hospital (Welwyn Garden City)	01438 314333

HERTFORDSHIRE MENTAL HEALTH

Hertfordshire Partnership NHS Foundation Trust	01727 804700

LEARNING DISABILITY SERVICES

Hertfordshire Partnership NHS Foundation Trust	01727 804700
Health Liaison Team	01438 845372
Hertfordshire Learning Disability Partnership Board	01438 844985

Adult Care Services Community Learning Disability Teams (CLDTs)

Dacorum	01442 454444
East Herts & Broxbourne	01438 843111
Hertsmere	01442 454242
North Herts & Stevenage	01438 843222
St Albans	01442 454300
Watford & Three Rivers	01442 454343
Welwyn Hatfield	01438 843111

Adult Care Services Transition Team

East	01438 844454
West	01442 453887

Adult Care Services - Customer Service Centre (out of office hours)	0300 123 40 42