Health Care Support Pathway for Individual Referrals For Adults with a Learning Disability

GP /Carer/ Service User / Anyone who has identified a health issue for the Person

Any obvious health concerns should firstly addressed by GP with carer support to enable the person to understand and accept investigations and treatment required. If there is uncertainty of whether reason for changes are health related then CLDN can be first point of contact.

If additional help is needed with enabling the person to accept investigation /treatment

CLDNs - Community Learning Disability Nursing Service

Can support on an individual referral basis with:

* Desensitisation to receiving health investigations / treatment
* Communicating what is needed and why to the person
* Suggesting alternative reasonable adjustments
* Ensuring patient understands and follows GPs advice / support carers in establishing systems as necessary and provide monitoring health changes role

This can relate to any health issue:- obesity, diabetes, cancer, mental health, behavioural changes, [proving initial PBS support] dementia, respiratory, swallowing/eating, dental, gastro intestinal , epilepsy, CHC assessments, medication changes etc

Additional CLDN Roles

- Delivering proactive Health related training sessions to groups of service users and to care providers and unpaid carers [eg breast and testicle checks, bowel health awareness, infection control through hand hygiene and sepsis info, health lifestyles, leaving life workshops etc]
- Support GP's through Link nurse role
- Provide quality checking and enabling service to health providers to reduce health inequalities, via the Purple Star strategy
- Support services in their production of easy read material via our Expert by Experience
- Deliver Health messages via creative mediums of dance song and theatrical production via our Creative practitioner

Will refer onto and work jointly with

Social Care

If health issues/nurse assessment identifies issues which also impact their social care and wellbeing or raises safeguarding / serious concerns [nurses supporting the health aspect of theses

Will refer onto and work jointly with

Community Assessment & Treatment Service [CATS] SPA HPFT

If additional help is needed requiring :

Intensive Support Nurses – step up / down PBS support, OT, SALT – re communication and Dysphagia, Dietetics- dysphagia only, Psychology, Arts Therapy, Psychiatry, Loss and Bereavement counselling, Sexual health counselling , Offending Behaviour & Intervention Service -OBIS , Positive Partnerships Team -PPT

Will refer onto and work jointly with

Health Liaison Team

If additional help needed with

- Accessing secondary health
- Epilepsy – new diagnosis or significant concerns
- Using creative mediums to deliver health messages

Others

Herts Community trust Staff and other Social Care Staff

- District nurses
- Diabetic services
- Palliative Care
- Child and Family
- Practice nurses , School nurses
- Drug and Alcohol
- Care providers and families

Some ways the Community Learning Disability Nurse can help with meeting Annual Health Check Actions and bridging the health inequality gaps faced by people with a learning disability

- Support with needle phobia issues to help the person understand the reason for blood tests / injections and then support the mental capacity and possible best interest decision making process.
- Provide **easyread info on flu vaccines** and liaise with people who aren't attending re the benefits and options of nasal spray where injections will not be tolerated
- Share any known accessible means of communication for the person, to enable health professions to build a better rapport and to improve their ability to deliver health care to them.
- Act as link between GP, HCT and carers to embed health messages through easyread info and creative thinking re diet and exercise and help overcome barriers to success.
- Educate people on constipation and the risks through enabling people to understand what is a healthy poo and what they should do if this changes – we have easyread info and a **clay Bristol stool chart model** we can use.
- Support people to understand importance of completing bowel screening when AHC identifies they have failed to take part.
- Educate people in importance of checking breasts. This can be down, to some level, for absolutely everyone. We have developed a **breast pack and have breast models.** This should be in all ladies care plans.
- Educate ladies re the risks of not having cervical screening and prepare them for what the process entails through use of **cervical screening model.**
- Support with breast screening preparation and planning.
- Educate people in importance of checking testicles. This can be done to some level, for all men. We have developed a **testicle pack and have testicle models**. This should be in all mens care plans.
- Support with enabling successful AAA screening – this screening service has the Purple Star Award
- Support with enabling eye tests – we can loan opticians **eye test tools** that enable testing on people unwilling to engage and people who are non verbal.
- Support with dental through close links with specialist dental service. This service has the Purple Star Award. We have **easyread info and a teeth model** to help educate on the additional health risks beyond the teeth, with poor dental hygiene
- Liaising with HPFT regarding any concerns re swallowing to ensure a full assessment is done.
- Completing urine testing with people who wear pads through in pad test kits and supporting to understand and monitor fluid intake
- Supporting with epilepsy through our specialist epilepsy nurses.
- Enabling better understanding of diabetes through joint work with HCT in developing an **adapted DESMOND** for people with learning disabilities.
- Enabling access to Diabetic eye screening. This is a **Purple Star Awarded service**.
- Providing information in easyread regarding Bone Health
- Support with completing a risk assessment and history gathering to enable careful planning in reducing unnecessary medication which may be proving more harmful than beneficial. [STOMP –LD]
- Carrying out baseline dementia assessments [From age 30 for all people with Downs Syndrome] and support at point of diagnosis with monitoring where medication is newly prescribed and enabling carers to understand and adapt their care delivery. **[Additional Purple Folder Pages for dementia are available]**
- End of Life Planning – the nurse can support with this – a number of Herts hospices are awarded their **purple Star and additional purple Folder pages are available**

Contact or Refer – NON URGENT – email ldnursereferrals@hertfordshire.gov.uk URGENT call the duty line 03001234042