Guidance Notes for the completion of the Hospital Traffic Light Assessment

Background Information:

The Hospital Traffic Light Assessment (TLA) was devised by Gloucestershire NHS Trust and has been adapted and used by many acute trusts in England.

“Audit outcomes in many Acute Trusts has indicated that the document is appealing to hospital staff, people who have learning disabilities and their carers because it is attractive, easy to fill out by the patient/carer, and easy and quick to read by the hospital staff.” – Knowsley NHS Trust (2010)

This document should be brought to hospital on ALL occasions, and remains the property of the patient, so should go home with them after.

HOW TO USE THE DOCUMENT:

• This document is not expected to hold ALL information about an individual; just the important information acute staff will need to support the person to have a positive hospital experience.

• The document should be completed by a person or team who know the person best (paid carer/ parent etc) to give concise and clear information to staff working with the person while in the acute setting.

• This document is only accurate at the time of completion, it is not expected that the document will last for a long period. The TLA will need to be updated and changed to reflect the individuals at certain points in time.

• The TLA should follow the person through their hospital experience, so if the person moves, so should the TLA. Always present the TLA to staff as soon as possible.

• Laminated traffic light symbols are included with the TLA to be displayed on the white boards at the back of the patient’s bed, to alert staff a document is in their notes.

• It is important if the TLA is photocopied, it is still in colour.

• The TLA should be filled in legible handwriting, and in ink.

Based upon guidance document produced by Knowsley NHS Trust (2010)
**RED ALERT:** Things you **MUST** know about the patient.

**Complete in full:** Forename, surname, telephone number (with area code), date of birth, NHS number (this can be found in the letter from the hospital or from your doctor, or if not don’t worry the hospital staff can find this)

**Likes to be known as:** Very important that the person is addressed with the name of their preference i.e. William may like be known as Billy.

**GP Details:** Please give details of the person’s current GP.

**Religion:** State what religion and any religious requests.

**Next of Kin:** Give details of the name of the person’s next of kin and identify the relationship to the person – REMEMBER some people do not always want families involved.

**Main carer/ Key worker:** Please give details of someone who knows the person really well and could be contacted to share more detailed information to the health staff; this could be the parents and or carer’s, the key worker, care-coordinator, the social worker/ community nurse and or therapist.

**Medicines:** Please identify accurately the current medications taken, the name of the medication, the dose, and times taken.

**Allergies:** Please state any known allergies.

**Medical conditions:** Include all known medical conditions the person may have.

**Medical Interventions:** Describe the best was to approach and carry out any medical interventions such as taking blood, taking blood pressure. How the person like to be approached, if they like to have support or items with them they find comforting.

**Advance Directive:** Has the person made and documented choices about future treatments or care?

**Lasting Power of Attorney?** Is there a person who can make choices legally on behalf of the individual under MCA guidelines?

**ALSO TICK IF THE PERSON HAS ANY HEART PROBLEMS, BREATHING PROBLEMS, EPILEPSY OR GASTRIC PROBLEMS.** This information will be very important to medical staff.

**AMBER ALERT:** Things that are **REALLY** important to the patient.
**Communication:** this should include how the person communicates, any gestures they may use, if key words are used, and what they mean.

**Information Sharing:** Does the person need symbols, pictures, easy read information? Use words that they use to re-enforce meaning i.e. “Ray Treatment” – Radiotherapy.

**Seeing and Hearing:** Identify any problems the person may have with their sight and or hearing. Does the person wear glasses or have a hearing aid?

**Eating and Drinking:** To include details of how the person normally eats and drinks, how food is prepared and or assistance given with food and drinks. Does the person need food to be chopped small and or liquidised, does the person’s fluid need to be thickened? Highlight any issues with dysphagia (swallowing difficulties). Are there any community Speech and Language assessments or plans the hospital need to be aware of?

**Moving Around/ Positioning:** Give details of how the person needs to be positioned to safely sit during the day and or night. Are any positions dangerous? Does the person need to bring any postural aids with them? Are there any community Physiotherapy plans the hospital should be aware of? Does the person use a hoist? What hoist do they use? What loop settings are their slings attached to the hoist?

**Taking of Medication:** Give details of how the person normally takes his/her medicines and the importance of medicines at the prescribed times. i.e. “Billy takes one tablet at a time off a tea spoon, taking a drink of water in between each tablet”. Will the person refuse medications if given by a stranger, or will they be co-operative?

**Pain:** Give details of how the person normally manages pain and or shows signs of distress. Are there facial expressions or certain behaviours the person will show? Can the person indicate where they are in pain? What phrases will they respond to when asked if in pain? i.e. “Do you have a poorly tummy?”

**Sleeping:** Include details of routine and any sleep problems. Times the person goes to bed and wakes when well. What do they usually wear in bed? Are they restless through the night? Do they have seizures at night?

**Keeping safe:** What does the person usually need to keep safe? Will they try and run away? Will they pull at tubes/ dressings or touch equipment on the ward? Do they self injure? Do they usually have bed rails at home? Are any Risk assessments needed related to behaviours?

**Personal Care:** To include any help the person may need with washing and or dressing, the levels of support needed and how to prompt or encourage people to be independent.

**Level of Support Required from Staff and Carers:** Identify relevant others who know the person well and support them i.e. family or paid carers. The level of support people need for daily living, i.e. Bathing 2-1 (moving & handling). Also please document if the person will be cooperative with hospital staff, or if they do not respond well to strangers.
GREEN ALERT: What you NEED to know about the patient

Things to consider in this section are related to person centred care and are not limited, things to consider in both categories are environments, physical touch, routines, hobbies, food & drink, lifestyle choices, and how people are talked to, things that mean a lot to a person.

Things that the person likes; i.e. Jane likes to be reassured when upset by holding the hand of someone she knows.

Things that the person does not like; Billy does not like foods that have green chillies in.

Advice & Support

If you require any advice or support please contact:

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