

# GUIDANCE NOTES FOR COMPLETING THE HOSPITAL PASSPORT

To be completed by the person  
and/or someone who knows  
the person well



The hospital passport aims to provide important information about a person's needs and wishes. It should also include how they should be cared for when attending the hospital for an appointment or hospital stay. The passport is not designed to hold all the information about a person. It should have enough information to make sure hospital staff are able to communicate with the person well and help them to feel safe, comfortable, and understood.

The passport should be used alongside other important documents such as: communication passports, individual care and treatment plans, ReSPECT forms, REACH out to me and all about me documents. This passport should be used in the first instance when meeting the person and then should direct hospital staff to other documents the person may have in place.

People's needs change and therefore the hospital passport should be reviewed and updated regularly. This could be done yearly, before each hospital stay or as and when a person's needs change.

The hospital passport is designed to be a snapshot of important information that can help make a person's hospital stay better. The passport needs to be personalised to each person and include information that will help hospital staff get to know the person quickly and build a good relationship. Once completed the passport should be shown to doctors, nurses, and any other health professionals the person meets. This passport should always stay with the person, especially when moving wards and when being discharged home.

**The main aims are to:**

- Help hospital staff understand the person's needs better and get to know the person
- Plan appropriate care that works for a person
- Identify and put in place reasonable adjustments and support
- Identify the best way to communicate with a person
- Plan safe and timely discharge



## Complete as fully as possible

**These guidance notes are designed to prompt you to think about what is important to the person.**

Involve the person's family members and friends as appropriate. It is also important to make sure that people are

aware that the person has a hospital passport in place once this is completed. This may be when the person is admitted to hospital, moving wards, moving to a new care home or attending a hospital appointment.

## Name

**Complete with the person's full name (as it will appear on their health records).**

There is a separate box to enter the name that the person wishes to be known by.

## Things you must know immediately

**This RED section of the passport aims to inform hospital staff of the most important information they must know when caring for someone for the first time.**



## Communication

**How does the individual usually communicate?**

Verbally, body language, gestures, facial expressions, use of pictures, symbols or signing (British Sign Language or Makaton)?

Does the individual use a communication aid such as an iPad, lightwriter or Eyegaze?

Does the person use words or phrases that may have a different or dual meaning to what is generally understood?

What is the best way to engage with the person – do they have topics of interest or

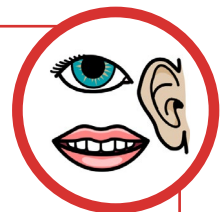
objects of reference we can use to initiate conversation?

Does the person require easy read information to help them understand what we are saying?

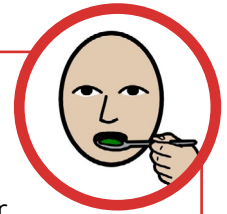
Does the person have a communication passport?

Would the person prefer to use simple clear words or benefit from written prompts.

Does the person need an interpreter?



## Eating and drinking



**This should include details of how the individual usually eats and drinks, how food is prepared, or any aids/adapted utensils or equipment required.**

If the individual has a gastrostomy fitted is this used to support oral intake or to replace it?

Include the time, support and assistance required to enable the person to have adequate fluids and nutrition. This should be considered in relation to hospital admission, how does feeling unwell usually affect the individual in this area?

Does the person need their food to be chopped up small or liquidised, do the person's fluids need to be thickened?

Does the person have involvement from the Speech and Language Therapist – is there a mealtime prescription or eating and swallowing guidelines in place?

Highlight any issues with eating and drinking. Does the person have dentures?

Consider positioning during meals/drinks. Comment on food/drink preferences.

## Positioning & Mobility



**Please give details of how the individual prefers / needs to be positioned safely during the day and night.**

Are any positions dangerous?

Does the person have a postural management plan?

Is the person able to maintain/change their own position?

Do they use a profiling bed at home?

Is the individual susceptible to pressure area damage?

Please give details of the individual's mobility needs.

Do they require a wheelchair or are they able to walk unaided?

Do they use any mobility aids?

Do they require assistance?

How many people are required?

Is the individual susceptible to falls?

## How will you know when I am in pain?



**Provide details of how the person normally manages pain and shows signs of distress.**

Is the person able to tell you when they are in pain and indicate location and severity?

Is there any visual cue/behaviour that would indicate the person is in pain?

Is the information provided by the person consistent – this may be dependent on how the questions are asked – include any words or signs/symbols that are used to

help the person indicate they are in pain/distress.

Please provide information about the individual's usual presentation and then how that would differ when they are experiencing pain.

Think about the following areas: vocals / verbalisation, facial expression, body language, positioning, repetitive behaviours, pointing to, clapping or hitting areas.

## Things that will help you support me



This **ORANGE** section of the passport aims to provide hospital staff with information that is useful to know when supporting the person, particularly if they are staying for a longer period of time.

### Health Conditions

**Please provide details of any pre-existing health conditions.**

Does the individual have epilepsy?

Is there an epilepsy management plan in place?

Is the person a diabetic?

Type I or Type II, how well is this managed?

Does the individual have asthma, high blood pressure, heart conditions, do they have any allergies?

Try to provide as much detail as you can.

Are they under any other services that the hospital need to know about.

Do they ave any allergies or sensitivities to medication.



### Personal Care

**Please provide details of any help the person may need with washing and/or dressing.**

Does the person prefer a bath or a shower?

Provide details of how the person currently uses the toilet and manages their continence/incontinence, including any support they require.

Include details of the management of

constipation if applicable, does the individual require regular laxatives or bowel massage?

Does the person require any aids or equipment to use the toilet?

Does the person have a Bowel management plan in place?

Does the person have any prescribed creams or ointments?



### Support I may need during a medical procedure / intervention

**Please provide details of any specific support that the individual may require.**

Does the individual become very anxious around medical interventions?

Are they afraid of needles?

Are they likely to become very distressed?

Will they try to pull any tubes or cannulas out?

Will they benefit from being accompanied by specific individuals?

May they require some supportive hand holding or more restrictive interventions?

Would the person benefit from being talked through what will happen or shown physical equipment.

Is there anything hospital staff can do to help relax the person.



## Sensory needs



**Identify any problems the person may have with their sight, hearing, noises, smells, touch and taste.**

Does the person wear glasses or have a hearing aid?

Is there any behaviour that might suggest sight/hearing problems?

What are the individual's sensory needs?

Are they likely to become overstimulated?

Do they need the area to be quiet or have the lights dimmed?

Does the person require a single room or waiting area away from the busy, noisy ward or department?

How does the individual respond to touch, should touch be avoided or would deep pressure be calming?

Does the person have any sensory aids or equipment? E.g., fidget toys or weighted blanket.

Are there any hyper/hypo sensitivities?

## Things that will help make my stay better



**This GREEN section of the passport aims to provide hospital staff with extra information that can help make a person's stay as comfortable as possible.**

## Additional things that will help me feel more comfortable



**These could be food and drink choices, things that make the person happy and feel good, lifestyle choices or leisure activities.**

Are there any personal items/activities the person can bring into hospital to keep them happy and settled?

These things are important to help hospital staff to meet the holistic needs of the

person and not just treat the illness or health problem.

Would the patient benefit from a familiar person attending an appointment or during their stay?

Does the person require a quiet environment or private room?

## Things I may find upsetting whilst in hospital



**These are the things that the person does not like, and again could be food or drink or lifestyle choices; things that may upset the person and make them unhappy or distressed.**

Does the individual have a positive

behavioural support plan (PBSP) which will help hospital staff to understand and avoid triggers for distress?

Would the person require extra support with a change to their routine?

## Support I have in the community



### What support does the person usually need?

Do they live in their own home?  
Do they have paid carers?  
How many hours care do they have?

It is important to note that if the individual is funded for 1:1 care whilst in the community then this care can come into hospital with them if it is required.

Does the person have a social worker?

## What I need for a safe discharge

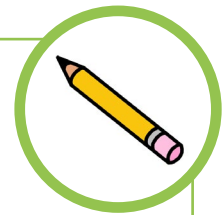


### What support will need to be in place to allow the individual to return home?

Will they need any additional support / assessments or funding?  
Are there carers who may need additional support?

Is there anyone who needs to be informed when the person is ready for discharge?

## Additional information / notes



### This may include any additional information that may be helpful to hospital staff when supporting this person at an appointment during a hospital stay:

**Medication** – any specific needs for example administer with juice, or covertly.  
**Behaviour** – any triggers, management plans, PRN protocols.  
**Reasonable adjustments** – anything specific which has not been covered in another section.

Details of any additional supporting documentation – sensory profile, communication passport or PBS Plan.

Does the person have a ReSPECT form, advanced decision or Lasting Power of Attorney?

Has any end of life decision making or planning been considered?

Developed in partnership with:

