Northamptonshire Healthcare
NHS Foundation Trust

Operational Policy

Meadowbank Rehabilitation Unit (OP.MRU)

1. Document Control Summary

Policy Title	Operational policy – Meadowbank Rehabilitation unit
Policy Purpose	To give operational guidance for admission and management of the inpatient rehabilitation service
Status: - Review or New	Review
Presented at DMT/MH Clinical Executive	27/11/2017
Areas affected by the policy	Meadowbank Unit
Policy originators/authors	Carlotta Oakenfull - Unit Ward Manager Meadowbank Multidisciplinary Team
Consultation and Communication with Stakeholders including public and service user group involvement (if necessary)	Adult Inpatient Service Manager, Ward Matron, Head of Mental Health South Consultant Psychiatrist, Psychologist, Occupational Therapist, Service user and staff focus group. Mental health Clinical Executive
Archiving Arrangements	A central register is held by the CGST which will hold archived copies of this policy.
Register of Procedural Documents	A current copy of this policy will be held on a central register, on the Trust's intranet page.
Equality Impact Assessment (including Mental Capacity act 2005)	Completed
Training Needs Analysis	N/A
Monitoring Compliance/Effectiveness	Ward Manager, Service Manager
Approved by (Committee Name and Date)	Clinical Executive

2. Definitions

NHFT – Northamptonshire Healthcare NHS Trust
CPA – Care Programme Approach
DBS – Disclosure and Barring Services
GP – General Practitioner
HCAI – Healthcare Acquired Infections
HoNOS - Health of the Nation Outcome Scale
IPDR – Individual Performance and Development Review
MDT - Multi-disciplinary Team
MHA- Mental Health Act (1983)
NIC – Nurse in Charge
OT – Occupational Therapist
PALS – Patient Advice and Liaison Service
PMVA – Prevention and Management of Violence and Aggression
WWR - Working with Risk documents

3. Policy Purpose

The purpose of this Policy is to provide operational guidelines for Meadowbank Unit which is the in-patient rehabilitation Service based within Berrywood Hospital. The document outlines core components and rationale of the service and highlights operational procedures that guide staff and service users in the day to day workings of the unit. This operational policy is informed and supported by Northamptonshire Healthcare NHS Foundation Trust policies, procedures, practice guidance and other general information.

4. Overview of the Service

Meadowbank is a 12 bedded 24 hour 7 day a week rehabilitation unit for adult males and is located on the Berrywood Hospital site. Its primary role is to re-integrate individuals back into the community to regain a meaningful life by supporting and enabling them in their daily living skills through development of awareness/understanding of their diagnosis via relapse prevention work and increasing responsibility for self-management.

4.1 Our service and our Focus

Meadowbank provides an environment that replicates domestic living. The ward routine encourages opportunity to develop skills for independent living that involves having positive expectations, support in making choices and taking risks, having realistic hopes for the future and a focus on the persons own successes. It aims to enable service users to move forward in their recovery by taking increased responsibility for their own needs in areas of personal management work and leisure.

Staff assist in promoting social inclusion by encouraging service users to access local community facilities for daily living, education and leisure including direct access to volunteering and employment with the support of an employment specialist as part of the core team.

The multidisciplinary team will closely monitor a service users' ability to meet their own needs with a focus on enabling service users to succeed and achieve their goals and will carry out initial and on-going assessments of functional skills to monitor progress.

4.2 Mission Statement (developed by Meadowbank Service users)

Meadowbank is a rehabilitation unit aimed to reintegrate people back into the community, get them well, and develop their independence so that they stay well.

Meadowbank's philosophy of care is centred on a shared recovery ethos in which service users can meet their own needs supported by staff, as required, and that the care planning process will reflect levels of support and monitoring needed; strengths and needs of individuals; and the progression towards independent living.

Service users need an environment where they can develop skills for independent living that involves having positive expectations, support in making choices and taking risks, having realistic hopes for the future and a focus on their own successes to enable service users to move forward in their recovery by taking increased responsibility for their own needs. We believe in open honest communication and treating people with respect.

Meadowbank is unique in that it supports development of skills for community survival in an environment that provides opportunity to meet the demands of every-day living, including volunteering and competitive employment.

Its purpose is to deliver effective rehabilitation and recovery to people whose needs cannot be met by mainstream adult mental health services. The focus is on the treatment and care of people with severe and complex mental health issues who are or would otherwise be high users of in-patient and community services. The aim of rehabilitation is to enable someone to achieve a role in society valued by and selected by that individual.

The main function of the service is to provide specialist treatment in a suitable setting that helps service users gain or regain the skills and confidence to achieve their own goals. We aim to provide an intensive service that:-

- *Is durable and sustainable*
- *Has a focus on individual's unique experiences not on diagnostic labels.*
- *Underpins principles of a Rehab and recovery model of care*
- *Is designed to support people as their needs change*
- *Is adaptable to sustain change*
- *Is able to improve physical health and life expectancy*

The team aims to provide a meaningful, collaborative approach to the appropriate management and treatment of this service user group, (including full working and joint working, as appropriate), specialist risk assessment and links with other agencies.

4.3 National/local context and evidence base

The rationale for a rehabilitation unit is that service users need support when facing transition from a highly supported setting to a less supported placement including potentially lengthy stays in conditions of security.

Support in accomplishing the demands of everyday living such as budgeting, catering, job seeking, alongside managing a severe and enduring mental health condition will enhance chances of making a successful move out of inpatient mental health services.

In order to reflect current 'best practice' there is a need for an integrated approach to treatment and care that includes Medical/biological, Psychological, Social and Values Based approaches. A Recovery focused approach embraces all of these.

4.4 Local defined outcomes

The team will aim to achieve, through a process of working with individuals, their optimum level of functioning, with a flexible approach giving support to maximise therapeutic engagement to assist and encourage in the following:

- Working to the individual's strengths and needs, being flexible and responsive.
- To promote the concept of recovery and enable choice and autonomy.
- To encourage individual's to take responsibility for their actions, and make informed choices about their care and treatment.
- To encourage individual responsibility, respect and consideration of self and others.
- Allow individuals to maintain and learn skills that promote independence, positive risk taking, dignity, culture and choice
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- To address social needs and improve social network

- Ensure effective person centred recovery planning using the Care Programme Approach
- To act as an integral part of the whole mental health service within Northamptonshire

4.5 Core values

A recovery-oriented service with a bio-psychosocial model is the underlying principle within our rehabilitation unit, embedding recovery values and social inclusion into everyday practice. Combining a strengths model of care planning and a positive approach to risk-taking for service users means involving them in every decision about their care and creating co-produced recovery plans.

Mental health services are most effective when delivery is within the context of the service users locality and cultural context. Involvement of a person's family, partner and friends may enhance the recovery process. The user of service should define whom they wish to involve at every stage. Service user direction is essential as part of the principles of the recovery approach. The principles behind this will ensure that:

- Hope is encouraged, enhanced and/or maintained;
- Life roles with respect to work and meaningful activities are defined;
- Spirituality is considered;
- Culture is understood;
- Educational needs as well as those of families/significant others are identified;
- Socialisation needs are identified;
- Individuals are supported to achieve *their* goals.
- Individual differences are considered and valued across the life span.

4.6 Principles of Care

The following principles will underpin the daily activities undertaken by all staff who provide care within Meadowbank Unit

- Professionals are facilitators who find solutions by working with their service users.
- To work with service users and actively encourage them to take an active part in all decisions regarding the care they receive supporting self-management.
- Help people to discover and use their own resources and resourcefulness
- Enable people to access the expertise of lived experience not only the expertise of mental health workers
- Recognise the important role of carers and provide support that they need, thus promoting the optimum mental health of both service user and carer.
- (CPA).
- Staff will actively promote the ethos of recovery through co-production. Where possible service users will direct when and how to begin the recovery process.
- Staff will work collaboratively with Service Users to plan towards discharge and support in the community at the point of admission. Any teams that are, or will be involved, should commence joint working at the earliest opportunity.
- Recovery plans should be portable, accessible and follow the service user between services.
- All staff will ensure that there is an emphasis on early assessment and initial care plans that identify therapeutic activities and interventions required and ensure access to address immediate risks, anxieties and concerns.

- To communicate through regular team meetings, CPA reviews and handover meetings and for every stage of this process to be discussed openly with the service user, carers and advocacy services, if service user wishes. To offer education as needed in aspects of self-care, medication management, etc.
- To promote the use of adaptive coping strategies, including education about Medication Management, Symptom Management, Relapse prevention and meeting each individual's skills requirements.
- To liaise with the Accommodation and Commissioning team for referrals when considering discharge to less dependent settings.
- Ensure risk to the public is managed and minimised so that the service user can live independently in an appropriate placement in the community or transfer to an open rehabilitation ward. The service user will receive treatment to support psychological and social functioning aimed at promoting person centred recovery.
- Provide care and treatment within a safe, secure environment for service users, staff and visitors.
- Identify, assess and manage risk to the service user and public through the use of robust operational and clinical protocols and procedures.
- Provide an effective range of care and treatment interventions that support service users to move through an integrated pathway of care as quickly as possible.
- Work closely with referrals to negotiate assessment, admission and discharge processes.
- Provide timely advice and support to other services on the management of referred service users who do not meet the criteria for admission.
- Provide recovery focused and individualised care and treatment that is focused on collaborative working to the achievement of outcomes via delivery of interventions.

5. Service Care Pathway

The service provides opportunity for a patient pathway for those who have been identified with a need for further rehabilitation. Referrals are received county wide from acute inpatient mental health services, community mental health teams, low secure services and the Individual Packages of Care (IPC) team for patients deemed suitable for stepping down from locked rehabilitation or similar . The service user demographic is adult males 18 – 65 and might include people who may be subject to judicial processes i.e. courts/prisons/low secure units or who require a further period of rehabilitation following treatment on an acute mental health unit. On discharge service users are likely to be transferred to a range of accommodation providers under the care of community mental health or community forensic teams.
There are close links with police liaison services and probation where relevant to the service user; locally available supported accommodation; agencies to help service users to access work and education, this includes schemes such as supported employment projects; links with local colleges and 'bridge-builder' initiatives which facilitate social inclusion, such as access to mainstream leisure facilities access to advocacy services and peer support.

Referral to rehabilitation services as part of the care pathway may be considered for people with ***major and complex mental health needs***:-

- if discharged from an acute ward as unlikely to benefit further from an acute setting
- for assessment of a person who has become non-progressive in their recovery
- when facing transition from a highly supported setting to a less supported placement, e.g. Forensic or secure services; out-of-area placements.
- when a person would benefit from a structured environment and intensive therapeutic programs available on a rehabilitation unit
- for specific advice on assessment, diagnosis, risk, engagement, treatment, placement, care packages, and other aspects of individual care.

- more general advice about the needs of people with long-term conditions such as recovery-oriented practice and service evaluation for this service user group

5.1 Referrals

5.1.1. Referral criteria

The unit accepts referrals for service users with enduring mental health problems and complex needs, who require a period of rehabilitation after spending time in a mental health setting. The emphasis will be on functional skills for independence developed and practiced in a highly supportive environment with an emphasis on increasing self-management in basic living skills, cooking, shopping and self-care

Referral protocols will be discussed with relevant inpatient services and made as flexible and accessible as possible. Open, transparent dialogue and clarity of care pathways are essential, with key referral criteria being that the person has:-

- A primary diagnosis of mental illness, rather than personality disorder
- Identifiable rehab needs
- No recent episode of violence or aggression, AWOL, substance misuse.
- Successful utilisation of unescorted leave
- Optimised medication regime
- Actively engaged in treatment process & agreeable for period of rehabilitation

5.1.2. Referral Process

The Community Forensic Team and Low Secure service will make referrals directly to Meadowbank . Referrals from PICU and Acute Inpatient Mental Health Services must be made to the IPC Team initially who will consider Meadowbank within the full range of rehabilitation placements available to them. The IPC Team will also consider Meadowbank as part of the stepping down process from the wider range of locked rehab and external low secure providers.

This unit takes planned referrals only, there are no emergency admissions.

Referees should send a comprehensive record of current information guided by the 'Rehabilitation Referral Checklist' to support the rationale for referral to the service. The following information must be included on rehabilitation checklist

- Full summary of psychiatric history, including detailed progress during current admission
- Detailed summary of current admission and progress (fully completed part 1 admission summary)
- Episodes of violence or aggression warranting de-escalation or seclusion during current stay
- Detail leave conditions and incidents of AWOL
- Positive drug screen results/refusals for testing/instances of alcohol abuse

All CPA1 referrals must be accompanied by some form of risk assessment completed within 1 week of referral date (WWR1, HONOS, HCR-20, SVR) plus an up-to-date OT report.

Referrals should be acknowledged within 48 hours and discussed at the earliest bed management or Meadowbank referral meeting to determine suitability of the referral.

An appointment is made for a visit to the service user within the next seven days. This visit should include two members of the team who should assess the service user and inform them about the working practices of the unit and also meet with at least one member of staff.

Wherever possible, the outcome of the assessment will be presented at the next bed management meeting and discussed with all members of the team. This will be placed onto System 1 once completed and sent to the referrer.

A decision should be made at the next bed management meeting and disclosed to the referrer and service user that day.

If accepted the service user should be given the option of visiting the unit as soon as possible and given some indication as to when a bed may become available.

In the case of an internal transfer electronic patient records should be up to date before transfer with an up to date risk assessment must be provided prior to transfer.

Carers and the staff involved in the care process and all parties involved to be informed regarding the referral process

5.2 Admission Process

Upon admission, the service user will be met and greeted by a member of nursing staff. They will be shown around the ward and the ward procedures such as the storage of property, visiting times, and smoking policy will be explained to them. It is important that all service users are greeted professionally and warmly.

Nursing staff will discuss with the service user details of their family or carers and seek the service users permission for them to be advised of the admission.

A member of medical staff will be contacted and advised of the admission. They will attend and will complete a mental health assessment form and a physical examination. This is a standard admission form and is situated within System1 electronic recording system. A member of nursing staff will be present throughout this process. It is known within the service as “clerking in”.

As part of the clerking in process the admitting doctor must complete a Medication Reconciliation Form also found within SystmOne. The GP summary will be required for this form to be completed if the GP is not on SystmOne This is to ensure that existing physical conditions and treatments can be clarified and also so that the medication prior to admission has been validated. The GP summary will be required for this form to be completed.

Prior to, or following the clerking in process, a member of staff will initiate the admission care plan and staff will complete all of the tasks within the care plan.

The service user will be asked to assist with the formulation of their care plans. The service user will be advised of their key worker, Consultant Psychiatrist and it will be explained to them the time of their ward round.

Following admission, all service users will have an ECG completed on the next working day and routine blood investigations. The philosophy within the Adult service is that existing physical healthcare needs are assessed on an on-going basis. Support in the management of these conditions is available locally through liaison with provider services that are part of NHFT.

Welcome information will be supplied on each ward giving information about the team, contact numbers and other useful information on admission to the service. These packs are kept in the ward bedrooms and are updated as necessary.

The service aims to provide a safe environment for service users, visitors and staff. Staff aim to support positive risk taking to promote recovery.

5.3 The allocation of a Keyworker

The decision to allocate a key- worker will be made by the nurse in charge of the ward at the time the service user is admitted/transferred. The allocation will be made based upon the availability of staff over the 72 hour period following admission/transfer. The decision to allocate a key-worker will be strongly influenced by a team member's current workload.

5.4 Responsibilities of a Keyworker

The keyworker will introduce themselves to their allocated service user as soon as possible following admission/transfer. It is essential that a therapeutic relationship is developed quickly through demonstrating skills of compassion, understanding and a caring attitude. The key-worker will ensure that the Admission Care Plan and the tasks within it are completed within the first 72hours of admission / transfer.

The key- worker must also make sure that contact is made with the service user's family or any individual who cares for the service user in the community. The purpose of this contact is to ensure that carers are asked if they require an assessment of their needs as a carer. If this is the case then the key worker will refer the carer to the appropriate Northampton Carer's Service.

If a service user has not given consent for information to be given to the carer/family, this will not prevent the keyworker from seeking relevant information about the service user from their carer/ family. This contact is an extremely important part of the information gathering process and aims to support the development of recovery plans following admission.

The key- worker will meet with their allocated service users at least once a week . The purpose of this 1:1 time is to build and maintain the therapeutic relationships through therapeutic engagements e.g. morning walk or Supper Group. These 1:1 sessions will be the forum for the key worker to re assess and prioritise needs in partnership with the service user and evaluate care plans. They will also be used to update and evaluate risk assessments.

5.5 Responsibilities of a co-worker

On each ward, a co- worker will also be allocated to each service user. The role of the co-worker is to support the key worker in the care delivery and undertaking the role of key-worker. This is largely to undertake the duties of the key- worker in the event of the key-worker not being on duty, to ensure that the service user receives the continuity of care
HCAs will be allocated to each Service User. Their role is to support the Key Worker/ Co-Worker to maintain therapeutic relationships through therapeutic engagements e.g. Morning walk or Supper Group.
Each day patients are allocated to a member of the nursing team and this is displayed on a board on the ward. This will provide a first point of contact for the patient. The identified member of staff will be responsible for actioning the patient's care plan.

6. Assessment of need care planning and treatment interventions

The Care Programme Approach provides the corner stone of current Mental Health policy. It denotes a structure of assessment, care planning, service delivery, evaluation and review, which provides for individualised, integrated care for each service user.

The aim of rehabilitation is to maximise potential for self-management, effective work competencies and community survival. It will address the social, vocational and educational aspirations of individuals at the earliest opportunity to progress rehab goals, and enable successful step down back into the community.

The team will provide a meaningful, collaborative approach to the appropriate management and treatment of this service user group,(including full working and joint working as appropriate), specialist risk assessment and links with other agencies.

It starts with a comprehensive assessment of health and social care needs, including physical, social, mental health, risk & carer's assessment, work, education and vocational skills. It then provides an effective range of care and treatment interventions that support service users to move through an integrated pathway of care as quickly as possible.

The unit is integrated with and serves to link, primary, secondary and tertiary levels of mental health services and the wider community to ensure multi-agency co-ordination that supports goals in employment, housing and other aspects of community functioning.

The success of this service is it allows individuals to gradually develop and take responsibility to achieve their own maximum level of ability, independence, and quality of life using interventions at stepped levels of intensity.

In order to achieve meaningful, sustainable and positive change amongst the service users we support, community involvement as defined by the user of service is central to the recovery process as they are gradually enabled to live with greater independence. Interventions are designed to empower the person to make effective choices, have hope and focus on individual's strengths and interests .

6.1 Assessment

Within 6 weeks of admission a comprehensive assessment of health and social care needs is conducted to support formulation of a baseline of needs to guide treatment objectives as part of the initial Care Programme Approach. It includes physical, social, mental health, risk and carers assessment (may include assessment of drug & alcohol use, involvement in criminal justice system).
Service users have a formal assessment of their daily living skills including meal planning and preparation, laundry, bed making, money handling, household skills, budgeting, social skills and road safety. This is re-assessed at intervals as appropriate for each patient.
Baseline of functional ability will include personal management, social ability, constructive use of time, education, work aspirations and work ability. Where relevant, home environment, support networks and daily structure will be evaluated in line with impact of symptoms on emotional resilience, life skills and functional ability.
Assessment supports identification of appropriate coping strategies for managing symptoms, stress and dealing with difficulties, including assessment and management of risk factors, de-stabilisers and effective risk management plans.
The assessment will be carried out by nursing, medical occupational therapy and psychology staff, and all disciplines play a part in establishing recovery oriented goals with the service user.
Employment and work related outcomes are established as part of the rehabilitation provision. Recognising a person's aspirations toward paid work and vocational assessments are routinely evidenced at the earliest opportunity on admission, including involvement with supported

employment programs (Individual Placement & Support) as recommended by NICE guidelines for Schizophrenia.
The assessment and baseline will identify current readiness for discharge & aims to establish treatment aims, interventions and likely length of admission.

6.2 Care Planning and Reviews

Every service user will have a written care plan, reflecting their individual needs, clearly outlining

- Agreed intervention strategies for physical and mental health;
- Measurable goals and outcomes;
- Strategies for self-management;
- Any advance directives or stated wishes that the patient has made
- Crisis and contingency plans;
- Review dates and discharge framework.
- Care plans and risk assessments will be developed collaboratively with the service user and their carers (with service user's consent). Care plans will be reviewed and updated, according to clinical need and at least every four weeks.
- Risk assessments and management plans will be updated according to clinical need and at least monthly

Service user clinical reviews are conducted in ward rounds - there are weekly meetings and all parties of the MDT attend this meeting, where possible. Each service user's care is discussed on a fortnightly basis. Community staff (i.e. Care coordinators, Social workers etc.) will attend, as and when requested; family, carer's and friends are encouraged to attend these meetings with the permission of the service user.

CPA's are held throughout the course of the individual's admission: initial CPA is held 6 weeks after admission, and then follows a 6 monthly frequency whilst treatment progresses and prior to section renewal, as well as discharge planning. Case formulation meeting are held at least once yearly for each individual. Comprehensive discharge summaries should be completed when service users leave Meadowbank. These are the responsibility of the specialty doctors, and should integrate work for all disciplines, service user's history and progress.
Service users are offered support by members of staff to prepare for formal reviews of their care and are encouraged to lead their own care reviews.

6.3 Intervention

The service provides high quality tailored interventions developed to recognise each individual's strengths, needs and risk with specific emphasis on collaborative working and a recovery focussed approach. The multidisciplinary team aim to address the complex and diverse treatment needs of service users referred for rehabilitation.
All disciplines deliver their specialist interventions within the collaborative framework of the recovery approach. A key value of using activity as a treatment medium is that repeated activity, unique with individuals own preferences, culture and interests, develops skills and independence, enables re-emergence of identity and roles and promotes pleasure and enjoyment.

- ***Personal management plan*** – establishing effective personal management skills is fundamental to the development of higher functioning self-management. From the commencement of admission everyone is supported to recognise their stage of recovery and progress through taking shared responsibility for planning and working toward recovery goals.

- ***Occupational Analysis & Grading*** - underpins all intervention techniques and incorporates the core principles used by occupational therapists of using activity as treatment to improve occupational performance and psycho-education techniques designed to enable the development of self-knowledge and self- management in line with personal recovery principles.

- ***Psychosocial interventions*** - interventions are employed, including psychological therapies such as cognitive–behavioural therapy adapted for psychosis, work with families to promote mutual understanding and reduce stress, specific interventions for comorbid substance misuse, social skills training and skill building.

- ***Available treatments***
  - National Vocational Qualification in Employability
  - Mindfulness
  - Anxiety Management
  - Social Skills Training
  - Substance misuse program
  - Reasoning and Rehabilitation
  - Psychological therapy
  - Family Therapy
  - Relaxation
  - Health education and Lifestyle
  - Understanding Mental Health
  - Medication Management is used therapeutically to treat both physical and psychiatric conditions. Consideration is given to the recommendations from the National Institute of Clinical excellence

- ***Healthy living*** - guidance and support to promote healthier lifestyles and monitoring of physical health, such as exercise, smoking cessation and dietary advice.

- ***Self-care*** - nurses and support workers have a key role in helping service users gain or regain the confidence and routine involved in managing their own self-care, keeping their living space clean and doing their laundry.

- ***Complex living skills*** - Occupational therapists are able to offer responsive interventions at all stages of rehabilitation to identify specific problems that the service user may have with more complex living skills such as budgeting, shopping, cooking, accessing education and work.

6.4 Review & Discharge planning

CPA reviews are carried out 6 monthly. This will include Liaison between community teams & resources to determine readiness for discharge; level of support required on discharge; need for continued on-going treatment goals; recommendations for treatment to be delivered within home environment/community where possible, for continued development, maintenance of skills for self-management.

Service users will be discharged from the Service when they no longer require adult inpatient specialist intervention and appropriate support is in place. The team is reliant on other services within NHFT being part of the care pathway when service users no longer require the use and functioning of the unit.

The decision to discharge is based on multidisciplinary discussion but is ultimately the responsibility of the Consultant Psychiatrist in charge of the individual service user.
Planning for discharge and aftercare will be part of the on-going process of care commencing at the initial assessment of the patient.
As soon as appropriate, the multi-disciplinary team will prepare a discharge and after-care plan in collaboration with Accommodation and Commissioning team for referrals and when considering discharge to less dependent settings, in accordance with agreed policies and procedures.
The person responsible for the co-ordination and dissemination of information regarding the discharge and after-care plan will be clearly identified and recorded in the electronic patient record.
On discharge, clear information regarding any special instructions and follow-up arrangements will be passed on to the patient and their carers/relative.

Prior to discharge a clear identified plan involving the service user and other relevant persons will be put in place. On discharge, service users will be given the date and time of their follow up appointment and will receive a copy of their discharge summary. This will also be faxed to the service users GP and also the service that is undertaking the follow up arrangements post discharge from hospital.

6.5 Discharge Against Medical Advice

Service users may decide to discharge themselves from the hospital against clinical advice. If a person wishes to self-discharge see CLP 056 Discharge Transfer Policy

6.6 Consent

Staff can refer to the identification of patients policy and information governance policy, there is also the mental health act consent guidelines to follow should patients be under section and consent to treatment provisions to be followed. Within the patient profile on system one there is an information consent form to complete as part of the discussion with the patient. Staff to be made aware that consent can change at any time and to always check with the patient before giving out any information to family, carers, new professionals and providers involved in their care and to give clear explanations of the reasons behind this to patients and service users.

7. Clinical Team

Meadowbank MDT work collaboratively with the service user to create a co-produced care plan with the key objective of promoting social inclusion, encouraging and supporting access to local community facilities for education and leisure, volunteering and employment. The ward also has input from an Employment specialist working along evidence based Individual Placement and Support Principles.

The service user will have a key worker who is responsible for planning care from admission through to leaving the ward. They will also have an associate nurse who will manage the care when the key worker is not available (sections 5.4 and 5.5)

We aim for a short admission as possible using a model of practice that provides stepped intensity of interventions for individuals at every stage of recovery. Co-produced care planning and the development of a wellness recovery action plan will focus on wellbeing, the treatments and supports that will facilitate recovery and the resources that will effectively support and guide the service user to monitor their own progress through services and on discharge.

The team consist of a full complement of professionals to support the physical, psychological and occupational recovery of individuals:-

- Consultant psychiatrist
- Staff grade Doctor
- Occupational Therapist
- 2 x Charge Nurses
- 5 x Staff Nurses
- 6 x Health Care Assistants
- Health Exercise Practitioner
- Physical Health Nurse
- Assistant Psychologist supported by forensic & clinical psychologist
- Ward Manager

Shifts are comprised of 3 staff per day duty with additional therapy and activity staff and 2 per night duty.

8. Controlled access to ward

The adult in-patient service operates a controlled access system to all entrance and exit doors within the open ward areas. This is one of the measures the service takes to minimise risk to service users, staff and visitors in providing a safe environment.

Controlled access allows ward staff to ascertain who is attempting to gain entry or exit the ward and also make an assessment as to whether or not they should be permitted into the ward area. All visitors to the ward are met and greeted by a member of the ward team. Controlled access is not to try and keep service users detained against their will.

8.1 Entering the ward area

To enter the ward area, a bell is situated on a key pad at the entrance to the Main Meadowbank building. This activates a bell in the ward office and ward staff will then attend as soon as possible to meet whoever has rang the bell in a friendly and welcoming manner.

8.2 Exiting the ward

Meadowbank unit has a "Closed Door" facility meaning the unit doors are accessed by a fob system, preventing open access to the unit. Individual service users can, where appropriate, be given their own fobs to allow them to utilise their leave independently. Once it is felt an individual has attained and demonstrated a safe level of risk then the MDT will authorize issuing a door fob – this allows a higher degree of access on and off the ward.
The adult in-patient service will ensure at all times that the rights of informal patients are not compromised and will undertake regular audits to ensure that these rights are maintained. All ward exits have a sign clearly explaining the rights of informal patients should they wish to leave the ward.

8.3 Leave from the Unit

The team will develop a leave plan jointly with the service user, adhering to any restrictions from the MoJ, which includes:

- A risk assessment and risk management plan that includes an explanation of what to do if problems arise on leave;

- Conditions of the leave;
- Contact details of the ward/unit.

Staff members follow a lone working policy (HSC006 Lone Working Policy) when escorting patients on leave.

Service users are sent on leave into the care of carers only with carer agreement and timely contact with them beforehand.

The team follows the Mental Health Act Section 18 Absent Without Leave Policy (CLP028) for managing situations where patients are absent without leave.

8.4 Use of illicit substances

There is a zero tolerance to the use of alcohol and illicit substances on the ward. Service users will be subject to random urine drug/alcohol screening. In addition, searches of service users and their personal property will be conducted if required to maintain the safety of the ward environment.

9. Management of property within the service

The management of property on the wards is undertaken through individual risk assessment. Plastic bags are not allowed in any of the ward areas apart the individual ward kitchens and clinic rooms. Sharps items such as razors are not allowed to be stored in communal areas.

Service users can use technology devices such as TV, games consoles, smartphones, laptops and computers on the unit. There is guest WiFi provision on the Trust site and service users can make their own arrangements to access the internet, such as 4G or purchasing WiFi hotspots. The purpose of allowing these items is to replicate everyday living and promote the use of effective free time, however does not preclude the expectation that service users prioritise engagement in the ward routine and the therapy programme to aid their recovery. We encourage service users to, if at all possible to maintain their personal possessions to a minimum due to the limited storage space in bedrooms and on the unit.

The NHFT property disclaimer is clearly displayed on each ward entrance and within the day areas of the ward. The service will not take responsibility for any item of property that is not handed in to the ward for safekeeping. A list of property handed in for safe keeping will be taken upon admission.

10. Daily Ward Routine

10.1. Handover

The daily routine of the wards starts with a handover between night staff and those working the early shift 0730 hrs and 0800 hrs. Further handovers take place between 13.45hrs – 14.30hrs and 20.15hrs – 20.45hrs.
The purpose of handover is to pass information about the ward from the out-going shift to those staff coming on duty. The format used within the service is that each service user is discussed in turn, with the essential components of the report being their name, legal status, leave status, feedback of the nursing observations of the service user's presentation from the previous shift and any tasks that are needed to be completed by the incoming shift. This will be done in turn for each service user.

The handover enables out-going staff to share important, relevant information regarding the care of Service Users with staff coming on duty. The format used within the service is that each Service User is discussed in turn, with the essential components of the report being their name, legal status, leaves status, feedback of the nursing observations of the Service User's presentation from the previous shift and any tasks that need to be completed by the incoming shift.

Although the handover is primarily to handover the care delivery of service users, it also provides support for team members that are present. The handover allows nursing staff to express their feelings concerning service users and situations, including emotional events and sometimes may function as a de-briefing session. It may provide an opportunity for safe individual and team reflection.

10.2 Shift planner and Allocated Nurse

As part of the daily routine, at the start of each shift the nurse in charge will use the shift planner to allocate duties to all of the staff on shift.
As part of this process, the nurse in charge will consider who is on duty and what tasks need to be undertaken by the team during the shift. All service users on the ward will be allocated to an individual member of staff. The purpose of this allocation is to ensure that every service user has a named member of staff for that shift who will facilitate 1:1 time as well as deal with any routine issues that arise for the patient on the day.

The allocated nurse system intends to give each staff member a clear and defined group of service users to care for during each shift. Each allocated nurse is responsible for maintaining the clinical records of those on their list and feeding this information back to the nurse in charge. Where possible, keyworkers and co-workers will be allocated to their own caseload but this may not always be possible.

10.3 Ward Round / Multi-disciplinary Team Meetings

Ward rounds and multi-disciplinary meetings will take place on a day allocated in the working week. There is a timetable for each meeting and service users will be offered the opportunity to utilise independent advocacy services. Where time-tabled appointments cannot be met, staff will endeavour to inform relevant parties at the earliest opportunity. Staff will give the service user the option of deciding who will attend the ward round. It is desirable that multi-disciplinary meetings are organised in a way that only one takes place on a ward at any one time. .
Ward round will provide an opportunity for open, honest and informal communication between the service user, family, carer and the MDT. Each service user will be invited to attend a ward round a minimum of once a fortnight.

10.4 Access to Occupational Therapy

Occupational therapy is automatically accessible to all individuals as part of the rehabilitation pathway. It provides a specialist service with a unique occupational focus using activity to both assess and treat needs within a person's everyday life (personal care, work ability, social ability and leisure). Service user participation in occupational therapy treatment is an essential part of the overall therapeutic care provided within the units, alongside medical and nursing care. Occupational therapists assess and continually evaluate individuals' levels of functioning, contributing to the overall MDT care planning process and discharge planning.

Occupational therapy treatment is based around graded activity which meets the needs of the individual and facilitates a sequential development in occupational performance. The activity

prescribed will take a variety of forms – this may be on a 1:1 basis, in a small group, on the ward or within a community environment.

On-going assessment of functioning and participation within treatments ensures timely identification of changes (positive or negative) and adjustment of treatment accordingly.

10.5 Access to Employment Specialist

Rehabilitation services was the first to establish an Individual Placement and Support approach, with an employment specialist as part of their workforce working with the MDT to include goals for work and vocation as part of the recovery journey. An employment team is now established county wide across the Trust. The ward also provides a vocational focus to the development of everyday skills that can be recognised as part of a National Vocational Qualification awarded in conjunction with the learning and development department.

10.6 Patient Experience Group

Service Users are encouraged to explore their experience of rehabilitation and collaborate with staff to address practical problems and mutual expectations affecting their stay on the ward to identify areas for improvement within the service. The group is chaired by service users as part of the community meeting using 'I want great care' domains as a guide and for comments to be shared and responded to in this forum.

10.7 Daily Activities

Ward activities are a mixture of both social and therapeutic individual and/or group based programmes. These interventions are evidence based and promote self-management of symptoms/problems, relapse prevention, psycho-education and health promotion and development of work competencies.

These are tailored to the individual's requirements following the appropriate assessment of identified needs/strengths i.e. social/physical/psychological/Activity of Daily Living (ADL).

These are facilitated by ward staff/OT and Psychologist, each service user has a weekly programme that reflects both their own interests and their clinical need. In addition, each service user receives a pre-arranged 1 hour session with their key worker, weekly, to discuss progress, care plans and concerns.

A weekly (minuted) community meeting attended by staff and service users offering the service users the opportunity to share experiences, highlight issues on the unit, and review and plan the provision of activities on the unit with staff.

Service users can make and receive phone calls in private using the unit's phone.

Service users have access to both a secure garden/courtyard areas to access outdoor space every day, when required.

Service users and carers (with the permission of the service user) are offered written and verbal information about their mental illness.

Service users are encouraged and supported to maintain and develop friendships and social networks as well as pursuing personal recovery goals outside of the hospital environment.

Staff will support service users to attend physical healthcare and dental appointments when required.

Staff will nurture people's cultural identities by supporting them to access information about customs and practices, culturally relevant food stuffs and beauty products, etc.

On weekdays each service user is allocated daily domestic tasks that they are responsible for (identified in the daily morning planning meeting) also each has an identified personal/bed linen laundry slot (x 2 per week). These tasks are monitored by the staff team.
The Trust has a Chaplaincy team which supports service users' religion, faith and culture. Anyone can ask for the Chaplain to visit them, service users should ask nursing staff to arrange this. In addition, service users can arrange for a representative from their own faith community to visit them in hospital. Wherever possible, space will be made available for service users to pray or find a quiet place for reflection. Berrywood hospital has an interface Chapel in the main building which can be accessed at any time.

The ward operates a protocol that ensures standards of care and safety/infection control are maintained, to these ends a range of routine unit duties have been developed into practice i.e. the checking and recording of sharp knives/fridge temperatures at the commencement of each duty, random weekly bedroom searches for prohibited items, daily clinic cleaning schedule, monitoring of the hygiene standards in both ADL kitchen areas, etc.

The ward adheres to the Trust's Fire Policy protocols – these can be found on the Trust's intranet website. All staff will meet requirement to attend annual fire training provided by the Trust and to be familiar with the equipment/procedures established in practice.

All staff members who deliver therapies and activities are appropriately trained and supervised.

All staff will adhere to the established dress code as per Trust's policy (Uniform and work wear Policy ICP019).

10.8 Ward Night Routine

Service users are encouraged to develop and maintain a healthy sleep pattern as part of their treatment plan. Service users should be aware that observations remain throughout the night on an hourly basis and staff are available for therapeutic interventions during the night where needed.

10.9 Ward Facilities

Meadowbank has two ADL kitchens, laundry facilities, TV lounge, games room and a quiet room. There are also a secure garden area and courtyard. Service users have access to a TV and DVD player, board games, books, and magazines. Each bedroom has its own en-suite facilities with shower. In addition, the unit also has 2 independent bathrooms.

10.10 Kitchen access

Service users are supervised/supported in the kitchen areas as directed by their level of competency – the use of sharp knives (located in locked drawers in both kitchens and accessible ONLY by staff) MUST be supervised, unless agreed otherwise by the MDT.

Meal times are coordinated via weekly planners, where appropriate; these are developed by service users with support from staff for the forthcoming week, and they identify all planned meals from which a subsequent "shopping list" is established. The service user is given an allocated budget of shopping money each week to obtain the necessary food items either supported by staff or independently.

10.11 Medication

When medication is prescribed, the risk and benefits are discussed with the service user and reviewed in ward round meetings once fortnightly. Information about prescribed medication and its effects including side effects and contraindications is offered to service users and their carer's (with the service user's permission).When new medication is prescribed the service users tolerability and side effects are monitored daily.

During the service user's stay one of the main criteria is the promotion of "wellbeing" and "medication collaboration".

The ward operates the Trust's policy of "Self-medication" (Self-Administration Of Medication Policy, MMP004) and to this end the service users will be encouraged and supported to reach the goal of self-administration and storage of all their prescribed medication.

The process is facilitated through a 3 stage education/competency process, the first being

- Stage 1 - all medication administered by staff in the clinic area to the service user as determined by the frequency of their prescription chart.
- Stage 2 - the service user prompts staff as to when their medication is due and self-administers in the clinic area supervised by staff.
- Stage 3 – the service user's medication is stored in their bedrooms and self-administered; this is monitored via an indirect supervision process (i.e. stock checks by staff on a set frequency).

10.12 Smoking Policy

Meadowbank unit is "Smoke Free" and therefore patients who smoke must leave the hospital grounds to do so. The Trust promotes a smoking cessation approach with all service users and support for service users is available through the smoking cessation service.

10.13 Visiting times

Visiting times are flexible between 10am & 20.00pm and fit in with the individual's personal routine. We discourage any visiting during any identified treatment/therapy times. No children under the age of 18yrs are allowed on the unit and we encourage family visits to take place in either the Trust's Family room (located in the main building of the hospital) or in the hospital cafeteria.

11. Dissemination and Implementation

The Policy will be circulated to all staff for them to read and assistance will be provided for any questions or queries. Training to be given as requested via team meetings.
The Policy will be implemented immediately.

12. Monitoring and Review

The Policy can be monitored by verbal and written feedback from unit staff and service users. This can take place via team meetings, discussion at Community meetings and at the Inpatient Management meeting.
This Policy will be reviewed yearly via the Inpatient Management meeting and any changes to the policy will be fed back to staff and service users in order that all are aware of any changes made.

13. Equality considerations

The Trust has a duty under the Equality Act and the Public Sector Equality Duty to assess the impact of Policy changes for different groups within the community. In particular, the Trust is required to assess the impact (both positive and negative) for a number of 'protected characteristics' including:

- Age;
- Disability;
- Gender reassignment;
- Marriage and civil partnership;
- Race;
- Religion or belief;
- Sexual orientation;
- Pregnancy and maternity; and
- Other excluded groups and/or those with multiple and social deprivation (for example carers, transient communities, ex-offenders, asylum seekers, sex-workers and homeless people).

The author has considered the impact on these groups of the adoption of this Policy and in accordance with the Equality Act 2010 (section 149) the service will not discriminate against service users, carers or staff on grounds of their protected characteristics: age (where it cannot be objectively justified), disability, gender reassignment, marriage or civil partnership, race, religion or belief, sex or sexual orientation. Where appropriate the service will make reasonable adjustments for services users and carers, who may need information in alternative formats or languages or require interpreters or provide appropriate assistance. The service will ensure that all environments are physically accessible.

Where appropriate and relevant services will consult and engage with diverse communities. If a service redesign or change is to be implemented and Equality Analysis will be undertaken.

In accordance with the Public Sector Equality Duty, the service will monitor the equality of access across the protected characteristics and report performance in the statutory annual Equality Information Report. The service will report equality outcomes and good practice in service provision.

14. Document control details

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1	27/11/2017	28/11/2017	27/11/2020	New.