South West London and St George's NHS
Mental Health NHS Trust

Reprovision of Mental Health Step Down Facility in Merton

DRAFT

Document Control Summary

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1. PURPOSE, PRINCIPLES AND FUNCTIONS

The recovery focussed unit will provide a step-down care pathway from acute inpatient facilities for adults with enduring mental health problems who have complex problems. It will be a single sex/ male only facility with 7/8 beds along with a drop in centre attached and an inreach service provided.

It will provide short term support for up to 12 weeks for adult Merton residents, who are ready to be discharged from Merton acute adult inpatient facilities, but who are unable to manage independently and have complex problems which are difficult to place in community resources. The facility will be DDA compliant and will aim to assess and improve service users' independence skills and explore appropriate longer term community placement.

The service will provide service users with a sense of progress using the Recovery Approach (control, hope and opportunity) and they will be involved at all levels of care. Staff seek to work with service users to evolve creative new ways of meaningfully promoting independence which build on the work which they are likely to have already completed whilst in an acute inpatient facilities including educational and vocational work, and daily living skills. The service promotes client-led recovery and requires service user involvement.

Outcomes:
Each service user will work with his key worker and care co-ordinator to tailor an individual care/recovery plan designed to address all the issues required to facilitate a graduated return into the community either to their own home or long term placement such as interpersonal difficulties, social skills, activities of daily living etc., including self-medication.

Each service user is expected to be responsible for the cleanliness and maintenance of their individual living areas and to share communal areas. They will be guided, as necessary, to gain independent living skills (e.g. budgeting/financial management, cooking, social integration, work and leisure skills). Days will be fully structured and carefully planned in collaboration with the Service User, to underline the fact that rehabilitation is an active process that requires active participation.

PHILOSOPHY OF CARE AND AIMS

Social enterprise:
The staff will encourage and facilitate 'self-management' building on the individuals' strengths to instil hope and enhance active control over their lives as well as working towards healthy living and wellness. The staff also will ensure that care is always of a high standard and that is delivered to the service users' satisfaction. The staff will endeavour to help address any concerns and problems raised by the service user and will help to communicate their needs to the appropriate people concerned with providing care and support.

The service aims to take account of the particular needs and values of service users from different ethnic communities. The service we provide will ensure that service users are not discriminated against on the grounds of race, gender, age or sexuality. The unit is committed to the philosophy of openness and fairness with emphasis on the management of diversity within a multicultural environment.

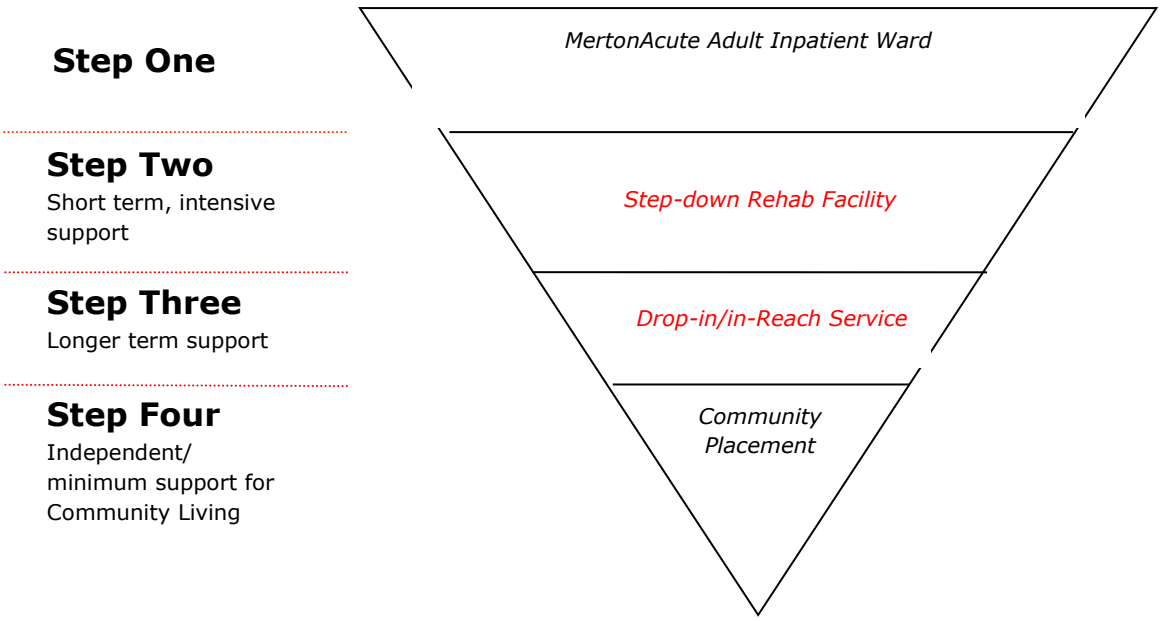
The step down rehabilitation and drop-in/in-reach facility will promote a learning environment for both service users and staff where personal development and growth will be encouraged.

The service shall provide: (outcome measures)

- A safe and secure environment where individual service users will be assisted to develop the skills and level of functioning that will allow them to live as independently as possible.
- A holistic and recovery focussed approach to the assessment and treatment of individual service users with emphasis on health, strengths and wellness and not pathology, illness and symptoms.
- A recovery orientated approach (fostering hope, control and opportunity) which requires the full cooperation, collaboration and engagement of the service user.
- A recovery-based service emphasising the personal qualities of individuals – service users and staff alike, to cultivate capacity for hope, creativity, care, compassion, realism and resilience.
- Facilitation of individual growth and the journey to recovery through inspiring and maintaining optimism, social interaction, and encouraging skills training towards user employment.
- Enhancement of the strengths, hopes and recovery of service users and their families by working in partnership with them to improve their quality of life by facilitating access to the roles and relationships which other citizens enjoy.
- A step down service which will enable more recovery orientated and localised services.
- Support and guidance to service users to enable a return to independent community living
- Effective team working enabled by regular team meetings, effective communications and clarity of purpose and method.
- Work in partnerships with our service users, carers, referral agencies, and Trustwide services.
- Care in a non-judgmental and non-discriminatory way which maintains the dignity and integrity of every service user.
- Celebration of the cultural diversity reflected in the client mix, staff mix and the society at large.
- Clear and transparent pathway for service user to progress to discharge.
- Single sex, male only accommodation

Functions of the Step-down Rehab and Drop-in/in-reach service:

The resource is configured to enable the Trust to provide service users with the care, support and accommodation they require at each point in their care pathway and recovery route. The core function of the service is to provide the opportunities for integration into the community using a Recovery Approach. The service provides a pathway towards independent community living.



2. HOURS OF OPERATION

The Step-down Rehab facility shall operates 24 hours a day on shift rotation, 365 days a year. The Drop-in/In-reach service shall operate between the hours of 9am – 5pm, Monday to Friday **or 7 days a week excluding bank Holidays???**

Visiting Hours
Service users are encouraged to maintain/develop links with family, carers, friends and social/community networks.

- All visits/visitors are expected to take place in reasonable hours and not cause disruption to other service users, neighbours or the treatment programme. Late hours visits shall be negotiated with the manager/nurse in charge.
- All service users are entitled to maintain contact with and be visited by whoever they wish, subject only to some carefully limited exceptions.
- It is important that service users have the opportunity to partake in planned treatment sessions and friends, relatives and carers to respect this.
- Where it is a planned part of treatment or continuing care that relatives and carers visit and take service users out of the facility this will be documented in the service users' progress notes.
- A visitor may be restricted where the service user's relationship with that visitor is anti-therapeutic, where the nature of the relationship causes significant concern over the potential safety to the visitor or service user and where the visitor's past or current behaviour is disruptive to a degree that exclusion is necessary as a last result.

3. STAFFING

The Staffing establishment consists of the following:
[PLEASE INSERT] **Finance to assist with costings**

The Team Manager provides overall leadership and responsibility for consistent care delivery and resource management. Each of the staff has supervisory responsibility for Recovery Workers/non-traditionally qualified workers. A key worker system shall be in place to ensure direct accountability for coordinating service users' care on an individual basis.

The team manager is also accountable for the operational management of the service and for ensuring that the service operates in a manner consistent with care plans and the recovery approach. The team manager is is professionally and managerially responsible for the nursing team.

The Acute Care Pathway Operational Manager will be responsible for monitoring the contract KPIs, and the provider is expected to report monthly against these indicators.

4. CASELOAD

The care coordination responsibilities will remain with the Community Teams.

5. TARGET CLIENT GROUP

Adults (age 18 to 75) with enduring mental health problems who have complex problems, who are Merton residents and are ready to be discharged from the Merton acute adult inpatient facilities.

6. SOURCE OF REFERRALS

Referrals will be made primarily via inpatient facilities in Merton, but also from Merton community mental health teams for those who require either "stepped up" care or require use of the drop in facility.

Criteria for Admission:

- Resident of Merton
- Currently a Merton Acute Care Inpatient or an open Merton RST referral
- Service users have enduring mental health problems and complex problems which limit their ability to live independently in the Community.
- Service users can be managed in a community setting away from the facilities and emergency support available on the hospital site
- Age range 18-75
- Currently only male Service Users will be able to access the service
- Service users are normally expected to be able to manage their own finances
- Occasionally service users may be admitted to prevent admission to an acute bed, for example, where a placement has broken down, and where if a bed was not available at the service, an acute bed would have been required.
- Service user need to demonstrate willingness to engage and participate in a step down programme towards self-medication, self-catering and independent living skills.

- All service users must agree to part-take in random drug and urine screening, as deemed necessary for the safety of individuals and the service as a whole.

Exclusion Criteria:

- Violent or aggressive behaviour requiring more than one or two staff to be immediately available
- Unpredictable episodes of self-harm
- Severely socially unacceptable behaviour that may draw negative public attention in a community setting
- Unpredictable behaviour requiring a higher level of observation than is possible in Step-Down Rehab facility/setting.
- Service users held under a section of the Mental Health Act, with the exception of S17 leave.
- Service users with physical or sensory impairments (particularly mobility impairment) will require an Occupational Therapy assessment to check environmental suitability of the Step-Down Rehab facility..

7. REFERRAL PROCESS

All referrals to the service will be made via the Operational Manager – Sutton & Merton Adult Acute Care Pathway, or designated deputy in his/her absence.

I. The referral may be made by any discipline, but should have the support and knowledge of the full multidisciplinary team, in particular the RC (Responsible Clinician).

II. Information in RiO should be available to support the referral. This should be to a level of detail similar to that of a discharge summary; should make clear the reason for referral, identify the psychiatrist, named nurse/key worker/care coordinator and other professionals who know the service user and can be involved in the assessment and treatment process.

III. The following documents are also required: current care plan and current risk assessment/ Crisis and management plan.

IV. The referral will be processed within 3 days or less depending on the circumstances and current presentation, and the Operational Manger reports back giving a decision whether the service user is suitable for admission to the service.

V. If the service user is deemed suitable, an estimated time will be offered for acceptance and transfer.

VI. The Operational Manager Acute Care Pathway will ensure that contractual requirements are met, and work closely with finance in the event of financial implications of over/under-performance.

VII. Monthly reports will be provided to CCG.

8. ASSESSMENT

Outcome measure:

- Current Service Users should have initial referral/care plan as documented on RiO. Other assessments such as Carers assessment, HoNOS (Health of the Nation Outcome Scales) and Model of Human Occupation (MOHO) tools and outcome measures are used to assess their social and support needs by the Occupational Therapist.
- These assessments should be completed prior to transfer of the service user or completed within 2 weeks after transfer to the service.
- If the service user has physical or sensory impairment, an Occupational Therapist will need to assess the environmental suitability of the placement and/or to advise whether appropriate adjustments can be made.

- The assessment will commence with a review of the available electronic records and discussion with the Inpatient Operational Manager. Appropriate entries will be made in RiO outlining mental health or physical needs. These include:

    a. Core Assessment
    b. Mental Health Examination
    c. Physical Examination
    d. Physical Monitoring (to establish baseline)
    e. Risk Assessment
    f. HONOS (working age adults)
    g. Ethnicity
    h. Individual Occupational Therapy
    i. Vocational services
    j. Access to education/work schemes
    k. Health education and promotion
    l. Unit group programme – including spirituality, relapse prevention, recovery.

9. INTERVENTIONS AND CARE PLAN

Interventions are tailored to the individual circumstances/needs of the service user. The emphasis is on service users led recovery of individual hopes and aspirations, and independent living skills, including personal care, social skills and self-medication.

The service users' key worker (with the assistance of a Recovery Worker, where appropriate) will provide and explain all the information required for their stay. Service users will have a minimum of once weekly 1:1 individual sessions during which the key worker listens to the service user and supports them in leading their own recovery. Each service user will work with his key worker and community care coordinator to tailor an individual care/recovery plan designed to address all the issues required to facilitate a graduated return to the community, interpersonal difficulties social skills, activities of daily living, etc.

Service users are assisted and supported to develop and monitor their own care plans, and have a personal copy of these. They may use a range of recovery oriented tools as appropriate, including the Trust recovery packs ('Taking Back Control: A Guide to Planning Your Own Recovery' Service User pack), Recovery Star/Social Inclusion web and other recovery tools. Service users are also encouraged to produce an Advance Agreement in case of future relapse and to play an active role in discussion of their risk, assessment plan and zoning (crisis plan).

Each service user is expected to assist with the cleanliness and maintenance of their individual living areas and for shared communal areas.
They will be guided/taught/supported to gain as much independent living skill as possible (e.g. budgeting/ financial management, cooking social integration, work and leisure skills).
Days will be structured and carefully planned in collaboration with the Service User, to underline the fact that rehabilitation is an active process that requires active participation.

Service users assessed to be suitable for the service will receive assistance for:

- Self-care, personal hygiene and budgeting/shopping for clothing and personal items
- Planning, budgeting, shopping and preparing healthy, nutritious and cost effective meals
- Cleaning and care for their own residential areas and sharing in the cleaning and care of the shared residential areas particularly the kitchen.
- Understanding tenancy agreements, utility bills and other living expenses
- How to use local resources appropriately
- Assistance to improve interpersonal skills, make appropriate social contacts and networks, vocational, educational and leisure skills
- Developing goals for own recovery and care plan in preparation for independent living in the future.

Regular business and/community meetings will be held with all Service Users to discuss/share/allocate communal tasks, plan communal events, share problems, grievances, good news etc., to encourage shared responsibility/enhance the therapeutic milieu, improve social skills and social responsibility, make shared decisions/plans for change. All Service Users must attend these meetings. The meetings are led by a nominated Service User in rotation, and staff attend to facilitate, guide, support and answer questions.

10. DISCHARGE

Discharge planning for service users starts at the point of admission and is reviewed regularly with the service user, the community team and the care coordinator. The aim will be to assist the service user until they are able to develop their skills and manage their symptoms to move to independent/community living, in their own local community. The named nurse will assist in the process, but the administrative responsibility is with the care coordinator.

10. MEDICAL AND CLINICAL RESPONSILITY
MEDICINES CODE

Medication and Pharmacy
Medication will be prescribed from GP surgeries or community teams, except in the case of service users on Community Treatment Orders, where medication will be collected from the Hospital Pharmacy.

Service users receiving clozapine medication go to the Clozapine Clinic for blood testing preferably, or arrangements can be made for blood to be collected at the hostel. Clozapine medication is dispensed as per service users' blood testing regime.

Administration of Medication
The administration of medication policy at the hostel encourages self-administration of medication. Service users' medication should be dispensed by Trust pharmacy or local pharmacy in individual, appropriately labelled containers, dosset boxes or blister packs. The container/doset box/blister pack label must clearly indicate the service user's name, name of medication, dose, date of prescribing/dispensing, and frequency to facilitate self-medication where possible.

11. THE CARE PROGRAMME APPROACH (CPA)

CPA provides a framework for care of people with mental health problems outside hospital. South West London & St George's Mental Health Trust has agreed the approach and recording of CPA jointly with the five London boroughs. Every service user should have a CPA review meeting arranged by their care coordinator in the community team in collaboration with the service team between 3 to 4 weeks after admission/transfer followed by a minimum of one CPA annually or as determined by Responsible Clinician (RC) and community team. Carers, relatives and other partnership agencies are welcome and should be invited to attend CPA meetings.

Trustwide Policy TWC12 Care Planning Programme Approach Policy states:

- Care planning will involve collaboration with the service user, including at admission
- All "needs" and all interventions will be care planned. Interventions will fit the needs and goals identified. For example, psychology assessment may link to the need of "I want my team to understand me better" or "I want to get out of secure care".
- All team members involved with a service user will develop care plans outlining identified needs and interventions.
- All care plans will be recorded in the Care Planning section of RiO.
- Care plans will regularly be reviewed by all staff working with a service user and will be amended when goals or interventions are achieved or changed.
- Care plans will be in the first person ("I will, I want, I need) wherever possible.
- Service Users will be encouraged to generate self-defined recovery goals in collaboration with staff and these will be reviewed within CPAs.
- The Service User will be expected to attend and participate in the CPA process.

12. TEAM ROLES AND ACCOUNTABILITY

Key workers and Recovery Workers

The key workers are responsible for the day to day care of the service users under their care and they are assisted in carrying out this function by the Recovery Workers. Key workers and Recovery Workers are responsible to the Community Hostel Team Manager and their respective organisation. The provider organisation will account for service performance against an agreed set of performance and governance metrics.

Role of the Provider Organisation (designated manager)

- To provide overall leadership and responsibility for consistent care delivery and resource management
- To facilitate the operational management of the service and ensure that the service operates in a manner consistent with care plans and the recovery approach
- To manage shift arrangements to ensure appropriate staff cover.
- To take the lead on safeguarding children issues, including liaison with local Children & Family Departments whenever service users might have access to children (including child visitors as per the child visiting policy)

Roles and Responsibilities

The Key worker

- Has a professional qualification
- Has primary responsibility for the service user's care from admission to discharge.
- Will spend time with allocated service users whenever they are on duty in order to fully understand their care needs.
- Will be responsible for drawing up care plans together with allocated service user(s) and other members of the care team. To plan, coordinate, assess, implement and evaluate the care of allocated Service Users in conjunction with the care coordinator in the community team
- Will ensure that the service user has been given a copy of their care plan.
- Will have a weekly 1:1 session with allocated service users to develop/review the care plan.
- Will talk with service user about matters they may wish to discuss at the care planning review meetings.
- Will ensure that records pertaining to the care of the service users are up to date including any reports relating to service users' feedback at Care Planning Review Meetings.
- Provide frequent feedback and updates to the MDT and other relevant agencies and significant others.
- Will ensure that other staff members responsible for the service users' care carries out tasks assigned to them.
- Will have a close working relationship with the care co-ordinator to ensure continuity of care. Will ensure fortnightly contact with care co-ordinator for update on allocated service users and document on RIO.
- Will be the person to talk/update the service users carer/next of kin with the service users agreement
- As far as is possible will always be allocated to their allocated service user when they are on shift.
- Ensure family/carer have an opportunity to take an active part in the planning and delivery of care

- To provide guidance to enable the service user to develop independence skills and participate in activities of daily living, self-care, life skills, social integration, medication management, etc. in accordance with the care plan and ethos of the service
- Support the service user to develop own recovery plan and goals utilising recovery approach, social inclusion web or other recovery tools
- To provide specific advice to the MDT concerning medication administration, compliance and potential side effects
- To provide specific advice to the MDT concerning infection control

The Associate key worker (or Recovery Support Worker)

- Supports the key worker in ensuring that the service users' needs are met during their stay.
- They will spend time with their allocated service users whenever they are on duty in order to fully understand their needs.
- They should have a strong working relationship with the named nurse to ensure continuity of care for allocated service users.
- They work under the supervision of the named nurse if non-registered nurse.
- As far as is possible will always be allocated to their named service users when they are on duty

Role of the Recovery Worker (for In-Reach support)

To provide individual activity with service users, under the clinical guidance of the named keyworker/care coordinator. This will include assistance, guiding, teaching and support for:

- Self-care, personal hygiene, budgeting, shopping for clothing or personal items; planning, budgeting, shopping for and preparing healthy, nutritious and cost effective meals
- Cleaning and care for their own residential areas and sharing in the cleaning and care of the shared residential areas (via rota system) including purchase of domestic cleaning products, shopping and meals preparation.
- How to use local resources appropriately
- Assistance to improve interpersonal skills, make appropriate social contacts and networks
- Vocational, educational and leisure skills
- Developing goals for service users recovery/care plan in preparation for more independent living in the future
- Making links with the local community and developing knowledge of appropriate local resources for the benefit of service users.

Drop-in Services (what should it look like?)

Medical Staff

The Responsible Clinician (RC) for each of the service users will be located in the appropriate Recovery and Support Team (RST), except in the case of service users on S17 leave, where the RC will be the Ward Consultant from the referring Ward.

The service users will be registered with a local GP surgery for their general medical needs.

Care Coordinators

- Care coordination is the responsibility of the relevant Merton Community Team. Service Users (and carers where appropriate) should be clearly informed of the name and contact details of the care coordinator.

- Will have a close working relationship with the named nurse or associate to ensure continuity of care. Will ensure fortnightly contact with named nurse or associate for update on allocated service users and document on RIO.

- CPA meetings will take place in accordance with service user need (a minimum of annual) and will be facilitated by the care coordinator, but both the service user and the named nurse are expected to take an active role to ensure these meetings take place in a timely manner, addressing all the relevant aspects of the service user's life.

13. USERS AND CARERS INVOLVEMENT

User involvement is a high priority and service users are actively encouraged to make informed choices and be involved in the CPA. Carers may require support and involvement from the Team, for example, explanations of symptoms and effects of particular medications, family work. The team follows the trust policy on copying letters written to other professionals about the service user with their consent.

All carers and relatives are essential partners in the service user care and all attempts will be made to engage them in care planning, implementation and evaluation of treatment. The Trust promotes positive carer involvement in the care of their relatives.

Carers are involved with the service user's permission as part of the care plan assessment process prior to all major reviews and their views recorded in the standard care plan on RiO. Information about the unit and the treatment received by their relatives can be provided for users:

- Discussion with individual team members
- Discussion with Key Worker
- Information leaflets
- Attendance at reviews and CPA meetings.