Livewell Southwest

Syrena House Operational Policy

Version No 2.1

Review: May 2019

Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

Author: **Unit Manager**

Asset Number: **740**

Reader Information

Title	Syrena House Operational Policy Version 2.1
Asset number	740
Rights of access	Public
Type of paper	Policy
Category	Clinical
Document purpose/summary	Operational policy describing the function of Syrena House Recovery Unit
Author	Team Manager and Modern Matron
Ratification date and group	9th May 2016
Publication date	12th May 2016
Review date and frequency (one, two or three years based on risk assessment)	Three years after publication, or earlier if there is a change in evidence.
Disposal date	The Policy Ratification Group will retain an e-signed copy for the database in accordance with the Retention and Disposal Schedule; all previous copies will be destroyed.
Job title	Team Manager
Target audience	Staff employed to work in at Syrena House Recovery Unit, other stakeholders
Circulation	Electronic: Plymouth Intranet and LSW website Written: Upon request to the Policy Ratification Secretary on ☏ 01752 435104. Please note if this document is needed in other formats or languages please ask the document author to arrange this.
Consultation process	Working group including staff, service users and carers. Draft policy discussed with all staff and comments received.
Equality analysis checklist completed	Yes
References/sources of information	• The Care Programme Approach (DH 1990) • Modernising Mental Health Services: Safe, Sound and Supportive. (DH 1999). • Effective Care Co-ordination in Mental Health Services. (DH 1999) • National Service Framework for Mental Health. (DH 1999). • The NHS Plan. (DH 2000). • The Journey to Recovery. (DH 2001). • The Mental Health Act 1983, related subordinate legislation and associated Code of Practice. • Amended Mental Health Act 2007. • Mental capacity Act 2005.

Associated documentation	N/A
Supersedes document	New Policy – supersedes old operational policy for unit prior to change of use.
Author contact details	By post: Local Care Centre Mount Gould Hospital, 200 Mount Gould Road, Plymouth, Devon. PL4 7PY. Tel: 0845 155 8085, Fax: 01752 272522 (LCC Reception).

Document review history

Version no.	Type of change	Date	Originator of change	Description of change
0.1	Full review	March 09	Assistant Director (MH & LD Service)	New document
V1	Minor amendments/ formatting changes	May 2009	Policy ratification group secretary	Formatting/updating/ clarifying.
v1:1	Reviewed	Feb 2011	Author	Reviewed, no changes made.
V2.0	Full review	Nov 2013	Team Manager and Modern Matron	Full review following Recovery Service re-design and change to becoming an all male service
V2.1	Review	April 2016	Manager and Modern Matron	Review updated to Syrena specific Operational Policy rather than a pathway policy. Format changes to reflect this.

Syrena House Operational Policy

1. Overview of Service

1.1 Syrena House is located within the City Wide Service. It is part of a service that forms a recovery pathway comprising of two single sex in-patient Recovery Units, a Community Recovery Team (CRT) and Social Inclusion and Vocational Services. There are links with supported accommodation providing housing for local accommodation provision for people with severe and enduring mental health needs where three Mental Health Nurses are seconded to support transition and monitoring following discharge from services.

1.2 The aim is to provide a whole systems approach to recovery for people who have complex disorders and are often well known to mental health in-patient and community services. Recovery services provide intensive support and holistic individualised care. The intention is that this is delivered as medium to fast stream interventions but takes into consideration progression of illness, management of associated risk factors and individual needs.

1.3 There is a multi-disciplinary staffing resource across these services consisting of a Consultant Psychiatrist, Doctors, Psychologists, Nurses, Occupational Therapists, Assistant Practitioners, and Nursing Assistants.

1.4 The service comprises of 9 male beds at Syrena House in Plymstock . The in-patient unit support service users who step down from secure services including Lee Mill Low Secure Unit, need transition from acute services to the community or those who have become non-progressive in their recovery and may require intensive therapeutic intervention. The needs of service users are likely to be wide ranging with symptoms of relapsing and remitting illness, associated risk and vulnerability issues.

1.5 The services core values will be to engage and involve service users in decisions about their care using person centred planning and recovery tools. Treatment will enable people to enhance and develop skills and confidence. Treatment options will include medication and a range of psychosocial interventions that are complimented by social, recreational and vocational activities. Service users have structured individually tailored therapeutic activity plans in place during their admission. If transition work is required this will be referred to the Community Recovery Team. Some service users will be discharged with the support of care co-ordinators from Assertive Outreach Service (AOS) or Community Mental Health Teams (CMHT) determined by need and as agreed by the multi-disciplinary team.

2 Purpose

Syrena House provides 24 hour in-patient care in a residential location that is conducive to supporting a positive recovery. The team can support people with complex mental health needs, who may have received a period of treatment in a more secure environment or an acute facility. This may require varying levels of support to return to live independently, to move to new accommodation, to enhance or maintain levels of skills and independence. Therefore there is a requirement for

work to take place both on and off the unit and to be tailored to individual service users' needs.

The length of stay can vary. The expectation is that people will be in hospital for the minimum amount of time to meet their optimum level of functioning, especially if work can be expedited with support from the Community Recovery Team and there are no challenges with accommodation.

Therefore it is expected to vary from between six and eighteen months though it is recognised that some individuals may need longer term treatment.

The service provides benefits from a multi-disciplinary approach operating recognised processes and procedures. Treatment will ensure maximum benefit to each person, with an emphasis of moving on to more independent accommodation in the most timely was as possible

Additionally a 7 day service is provided from a designated Community Recovery Team which links directly with the unit whose aim is to support transition at the earliest opportunity.

The service works collaboratively to provide care and treatment that enables service users and carers to tackle mental health problems with hope and optimism and work towards a valued lifestyle within and beyond the limits of any mental health problem.

Service users will receive a holistic approach to care with emphasis on both their mental health and physical health needs.

They are likely to have multiple, complex needs and may be detained under the Mental Health Act (1983).

To provide creative and person-centred care for people who require varying periods of recovery according to their individual needs within an in-patient setting. This may be as a result of a referral from the low secure services, community teams or a recent acute in-patient admission. The overall aim is to support people to reach their optimum level of functioning which may involve a return to their own accommodation or working with service users to identify new accommodation options and support plans.

To consolidate the basic skills around ADL with emphasis on promoting independence.

Engagement with on-site group work as resources allow and ensuring effective use of resources e.g. STEP's and community resources.

The Syrena House team will work to provide a structured therapeutic weekly plan according to needs and personal interests. This provides a balance of meaningful activity and the opportunity to allow for continual monitoring and support from both mental health and third sector organisations.

Emphasis is placed on a recovery approach, but where service users are treated in a safe and supportive setting whilst requiring an inpatient admission. Packages of care are provided using the CPA process, involving service users at each stage of the process and carers depending on the service users and carer's wishes.

Assessment and treatment will take place in Syrena House and in people's homes as appropriate. All service users will move on from Syrena to live in the community, with the appropriate level of support from either the Community Recovery Team, or from the most appropriate other agency which may be AOS, Community Mental Health Teams or the Community Forensic Service. The Community Recovery Team will be able to undertake joint pieces of work in order to smooth the transition from an in-patient service to the community. They will be able to be responsive to work collaboratively with the Mental Health Nurses in the Housing Projects. Occasionally service users may need to be referred to other parts of the service for inpatient care.

The intention of the dedicated Community Recovery Team is that the service will operate with an emphasis on recovery and social inclusion providing a service over a 7 day period. It will provide care that ensures consistency and continuity in the care of people who are susceptible to acute relapse of their condition, vulnerable to social isolation and at risk of varying degrees of neglect.

2.1 Statement of Values.

The team believes that people with mental health problems have a right to:-

- A lifestyle that would be valued by other members of society.
- Be treated as valued equal individuals, with rights and responsibilities.
- Be offered a choice of treatments based on best practice supported by evidence.
- Be offered a service which is individually tailored to their needs and aspirations, and which accepts joint responsibility for outcome.
- Have their way of dealing with problems acknowledged and worked with, and not labelled as a "problem person."
- A service which is based on an optimistic and positive approach promoting recovery.
- Receive all information and support to enable them to make informed choices and decisions about their lives.
- Receive a service which respects cultural and ethnic diversity and tackles discriminatory practice.
- A service which respects the role and skills of carers, acknowledging them as partners in care and supporting them in this role.

3. Specific Service Functions

3.1 All service users in Syrena will have a care co-ordinator within the CPA process, if this is a Community Mental Health Nurse from a community team then each service users will have a named nurse from within the Syrena team, who will liaise closely with the care co-ordinator.

3.2 All service users will have a thorough medical, nursing and O.T. assessment including risk assessment. This will involve the use of the CPA framework, Recovery Star and additional specialist assessments that are discipline specific.

3.3 Service users will have access to a psychologist who is linked to the unit. This may include baseline assessments and/or specific psychological interventions as agreed by the multi-disciplinary team or by request from the service user

3.4 All service users will have a care plan which has been formulated and agreed with the service user and the multidisciplinary team (MDT). If there are areas of disagreement these will be highlighted and carefully documented within the care plan.

3.5 All service users will be involved in regular reviews of their care and as a minimum standard a CPA review will take place one month after admission and then at 6 monthly intervals. The care co-ordinator is responsible for arranging reviews and inviting relevant people.

3.6 To ensure all service users under a section of the Mental Health Act 1983 are fully aware of their rights under Section 132 and have access to a solicitor if they wish.

3.7 Prior to discharge there will be a discharge planning meeting organised by the care co-ordinator, to which all relevant people are invited. In the case of service users who have been detained under The Mental Health Act 1983 this will be a 117 meeting.

3.8 Ensure that upon discharge GPs are provided with information regarding the discharge plan including medication and follow up arrangements within 48 hours.

3.9 To ensure effective communication in all areas of work, using SystmOne and CPA systems for recording information.

3.10 To have effective links with other agencies including housing, voluntary sector and all other stakeholders.

4. The Staff Team

4.1 The in-patient team based at Syrena is managed by a Registered Mental health Nurse supported by a Deputy Manager. There are additionally approximately 10 WTE Registered Nursing Staff and 9 WTE unregistered Nursing Staff (including an Assistant Practitioner). Workforce planning and skill mix reviews are on-going and integral to the safety and cost effectiveness of the service.

4.2 The multi-disciplinary team meet weekly and consists of a Consultant Psychiatrist, A Specialty Doctor, Social Worker and Pharmacist. There is sessional input from Consultant and Clinical Psychologist. Additionally the service provides a learning environment for a range of medical and health care professionals and volunteers.

4.3 The unit is staffed 24 hours a day and staffing levels are publicised at the entrance of the unit in line with safer staffing requirements.

4.4 The Clinical team are supported by a senior Management structure. This includes a Modern Matron who is accountable to a Deputy Locality Manager/Locality Manager for City Wide Services.

4.5 Following admission to Syrena all Service Users will undertake a range of standardised functional assessments, these will be completed by the OT who is based within the Community Recovery Team. These might include the Canadian Occupational Performance Measure, The Model of Human Occupation Screening Tool, The Occupational Circumstances Assessment Interview and Rating Scale or the Occupational Self-Assessment Tool. Individualised treatment plans will then be agreed with service users to address the strengths and needs identified in these assessments.

4.6 Other opportunities for assessment include: assessment of service users cooking skills, use of public transport and provision of a graded programme to build up these skills. Additionally, referrals can be made to the OT or to STEPs to offer the opportunity for service users to explore the possibilities for engaging with community based support groups and educational or vocational services. Service user's named nurses and care teams will additionally support implementation of therapeutic programmes.

5. The Environment

5.1 The team is based at Syrena House, 284 Dean Cross Road, Plymstock., PL9 7AZ. This is a fairly large house on a busy road in a residential area, a few miles from Plymouth City Centre. There is a regular bus service into the city, and there are local shops, cafes, library, post office and banks.

5.2 The house consists of:

9 single bedrooms to which clients have their own keys.
1 main lounge.
1 dining room, which is also used for meetings and various activities such as art.
1 main kitchen, in which meals are regenerated, and light meals are prepared, cooked and served,
1 domestic type kitchen in which residents prepare meals with supervision as part of their individual programmes.
1 bathroom with a bath, shower and toilet
1 shower room with toilet
1 visitors toilet with hand washing facilities
1 laundry room, all laundry is done on the premises. All clients are responsible for doing own laundry.
1 Nursing Office
1 Manager's office
1 Staff Room
1 clinic room.

6 Admission Criteria

6.1 Adult males only, aged 18 upwards with the following:-

6.2 A severe and persistent mental disorder, such as schizophrenia, associated with a high level of disability.

6.3 May be detained under Mental Health Act (1983) or informal

6.4 Multiple, complex needs including a number of the following:-

Poor response to previous treatment.

Requiring full assessment of need, normally including review of accommodation needs.

Forensic history with identified need to move on to an open unit from low/ medium security.

Previous admissions to acute services.

Engagement and compliance issues

6.5 Exclusions when Service users may be signposted to other services, should their needs be better met by them may include:

- Those in the acute stage of illness.
- Those whose primary problems result from a learning disability.
- Those whose primary problem is organic in origin.

- Those whose primary problem is due to drug or alcohol abuse, although some service users may benefit if they have a dual diagnosis. Referral should be based on the need/benefit of psychiatric recovery.
- Clients with severe behavioural problems who may require higher staffing levels due to assessed risks.

7. Day to day operation

7.1 The Care Programme Approach (CPA) is the framework for providing care for all service users accepted by the specialist mental health services of Livewell Southwest.

7.2 There are four key elements that make up the CPA process:

1. The assessment of an individual's health and social care needs including risk.
2. Developing a care plan which meets those needs, linked with the Recovery Star
3. Identifying a professional within the mental health service who is responsible for co-ordinating the care.
4. Regularly reviewing progress and the effectiveness of care through CPA reviews.

8. Referral and Assessment Process

8.1 Referrals should be made using SystmOne if the service user is already in the Plymouth Services, but referrals are accepted from any source. Normally referrals are made by The Assertive Outreach Service, Community Mental Health Teams, Glenbourne, Medium/Low Secure Settings and Insight. Internal referrals should be followed up with a phone call.

8.2 The referral needs to provide specific information about the recovery needs and the reason an inpatient bed is required. Any relevant completed assessment e.g. OT assessments

8.3 The Unit Manager will identify two staff to assess the service user within two weeks receipt of referral and with consideration to bed occupancy. An assessment, risk assessment and a HONOS score will be undertaken as part of this process.

8.4 The assessment will be discussed at the following multi-disciplinary team meeting, and a decision made as to whether the person can be offered a bed, an estimated timescale for admission or is placed on the waiting list. If a bed is available there will be no delay in arranging admission with the referring team.

8.5 If the service is able to offer a placement, the referrer and the service user will be informed when a bed is available in the most timely way. The referrer will be made aware on SystmOne and by telephone.

8.6 An assessment is always undertaken before admission is accepted. In a

situation where a service user is out of area this may form communication with a care co-ordinator, are view of records, incident forms and communication with the referring team.

8.7 The service users must be aware of the referral and arrangements made to visit the unit prior or post referral whenever possible.

8.8 The outcome of the assessment is then sent back to the referrer and the service user. The service user is always given the opportunity to visit Syrena before admission, and is fully involved in the process.

8.9 An assessment is always undertaken before admission is accepted. In a situation where a service user is out of area this may form communication with a care co-ordinator, a review of records, incident forms and communication with the referring team.

8.10 Admissions will be planned. An outline of a therapeutic programme will be prepared collaboratively with the service user before they are admitted to Syrena House along with a person centred care plan. There will be a clear expectation that each service user will engage with an individual weekly programme that is tailored to their needs.

8.11 On admission the service user will be allocated a named nurse from Syrena; If they are expected to be admitted in excess of three months the named nurse will assume temporary responsibility as the care co-ordinator. Otherwise they will retain their own care co-ordinator if already on a community caseload. However, the expectation is that all service users referred will have a care co-ordinator. The service user will receive their own information pack about Syrena and services available.

8.12 All service users will have a comprehensive assessment carried out by members of the multidisciplinary team, and the outcome of this will be recorded on CPA on SystmOne. Special attention will be paid to comprehensive risk assessment and risk history information. Assessment should focus on identifying the service users' strengths, goals and aspirations. It is important at this stage to try and build a therapeutic relationship with the service user and the family to enable the recovery process to move forward; providing services which are age, gender and culturally sensitive.

8.13 The named nurse is responsible following assessment for drawing up the care plan with the service user and other members of the team as appropriate. The care plan should centre on what the service user has identified as important and should look at a recovery based approach, trying as far as possible to use ordinary community based services. Attention should be paid to risk management, mental, physical, emotional, spiritual and social care needs, and should identify possible future accommodation, work and education options.

8.14 Care plans should be reviewed as necessary, but all service users will be reviewed regularly by the MDT team and will have a CPA review at a minimum

of 6 monthly intervals. All care plans, risk assessments and reviews together with HONOS will be on SystmOne and service users will have their own copies of their care plans. As necessary carers will have their own assessment of needs and own care plan.

8.15 The unit encourages the use of recovery focused tools, person centred planning and the use of Health Action plans for people with a learning disability.

9. Discharge

9.1 Discharge planning should commence from when the service user is admitted.

9.2 It is important as part of discharge planning to have good communication and liaison with other agencies that may help in providing support to the service user on discharge.

9.3 A delayed transfer of care form will be completed to highlight and monitor any delays across the recovery service and the reasons that they occur.

9.4 Prior to discharge there will be a full discharge planning meeting, and if the service user has been on a section of The Mental Health Act this will be in the form of a 117 meeting.

9.5 At the point of discharge a care co-ordinator must be identified. Service users may be on leave for a period of time as part of their transition to new accommodation but this will be time limited.

9.6 Service users who are detained under the Mental Health Act may be placed on Community Treatment Orders dependent on their needs.

9.7 At the point of discharge the in-patient discharge form needs to be completed in full. A copy of this must be sent to the GP within 48 hours of discharge. The risk assessment and care plan must be updated on discharge and a clear contingency plan must be evident.

10. Other Key Services in the Recovery Pathway

10.1 **Community Recovery Team**
This team consists of Team Manager, Registered Mental Health Nurse, Mental Health Nurse, Occupational Therapist, an Assistant Practitioner and Support Workers. The service operates with an emphasis on recovery and social inclusion providing a service over a 7 day period working flexible hours.

10.2 It provides an in-reach and outreach function with service users who are in the in-patient units allowing for the development of relationships before discharge is planned in order to support smooth transitions. The level of input provides care that ensures consistency and continuity for the care of people who are susceptible to acute relapse of their condition, vulnerable to social isolation and at risk of varying degrees of neglect. The CRT will meet the personalisation agenda because it is flexible enough to meet the individualised needs of people and provides timely

and responsive care. This level of engagement will be conducive to early supportive discharge planning and provide confirmation of service user's readiness for discharge.

10.3 Core functions of Community Recovery Team

- Support transition from in-patient services to community setting.
- Monitor psychological, physical, emotional and social wellbeing.
- Work collaboratively with the service user to develop a goal oriented care plan.
- Devise a structured weekly programme in collaboration with the Occupational Therapist.
- Provide support and intensive input that is flexible according to need but without fostering dependency.
- Engagement with social support and signposting to services.
- Review of accommodation provision and suitability.
- Liaise directly with the supported accommodation providers who are commissioned to provide accommodation to plan support packages for service users and ensure efficient communication methods.
- Recognise signs of deterioration and any associated risk factors that need to be responded to in a timely way.
- Develop knowledge and contacts with third sector in order to access social and vocational and work opportunities.
- Assist with the flow through and out of in-patient services to ensure fluidity of care pathways processes.
- Provide support and education for carers and ensure that people have up to date information about important points of contact and contact information out of hours.
- Monitor medication and side effects and methods for safe administration and management.
- Monitor for any concerns that relate to safeguarding and processes of raising alerts.
- Make referral to housing/accommodation providers
- Undertake assessments for suitability to engage with Community Recovery Team.
- Attend MDT meeting to ensure collaboration around discharge planning and 117 aftercare arrangements.
- Identify a range of groups and activities within the Plymouth area that service users can access and develop an up to date portfolio of resources.

10.4 Social Inclusion and Vocational Services

The Recovery units can access the range of groups that STEP's offer to individuals aged 18-65 experiencing any form of mental health difficulties. Horticultural qualifications and therapy, personal development courses and computer training, return to work/purposeful occupation programmes and help in finding voluntary work are on offer. Additionally, the service also helps support those looking to gain training or education and will work with individuals on a one to one basis or by running groups. Other

psychosocial groups that are provided include Anxiety Management, Assertiveness, Anger Management and It's a Goal.

There has also been strong involvement with offering pre-employment courses, work opportunities, support in seeking paid employment and work retention, but may now move towards activity and skills based working, in line with the changing needs of clients referred and the complex needs they present. Work related issues can be signposted to other agencies/workers.

10.5 Community Mental Health Nurses (Housing Support)

These posts, managed by the Community Recovery Team Manager are situated within Housing Projects across three geographical sites offering a 7 day service. The secondment of three Livewell Southwest staff provides a nursing presence to ensure that there is strong liaison with the in-patient services, Community Recovery Team and community teams. The role is seen as crucial in progressing, supporting and monitoring care pathways for people who may be discharged from Syrena with severe and enduring mental health problems and the success and stabilisation of the transition period. The move on to accommodation in a community setting requires intensive input and individualised care.

11. Communication and Meetings

11.1 **MDT Clinical Meetings**. These are held weekly. All clients are reviewed and CPA reviews are at least 6 monthly, both for inpatients and outreach service users. Referrals are discussed and decisions made regarding the outcome. Any other clinical business is discussed relevant to Syrena.

11.2 **Business Meetings.** These are held monthly to discuss non-clinical issues. The meeting should be used to pass on information about developments/business items relating to the organisation. The meeting should also be used to cover matters directly relating to Syrena House.

11.3 **Daily Meetings.** These are held to hand over service user information, and to plan activities for the day. Other important urgent information relating to the organisation can also be handed over at these times.

11.4 **Resident Meetings.** These are held monthly with service users as a group to discuss anything they or staff wish to raise, apart from confidential clinical information relating to individuals.

11.5 **1:1 named nurse meetings.** Each service user should meet regularly with their named nurse to discuss their treatment, care plans, progress and to update individual client information packs.

11.6 **Service Meetings.** The Manager/deputy or other staff may attend meetings within the organisation. It is those staff's responsibility to report back to other team members about these meetings and to action any points arising from these meetings.

12. Staff Support and training

12.1 On appointment all staff receive a corporate induction, this is then consolidated with a local induction.

12.2 Each staff member is allocated a line manager who takes responsibility for regular line management supervision and annual appraisal.

12.3 All staff employed at Syrena are expected to engage with peer Reflective Practice that is facilitated by a Consultant Psychologist, this is seen as an essential part of supporting staff and is not viewed as optional. Additionally the Organisation supports staff to engage in 1-1 clinical supervision in line with the Organisations policy.

12.4 The Organisation provides a programme of mandatory training for every employee.

13. Management responsibility

13.1 The Unit Manager has responsibility for the unit on a 24 hour basis, supported by the deputy and all other members of the team, and is responsible to the Modern Matron for Recovery Services who in turn is accountable to the City Wide Locality Manager..

13.2 There is an out of hours on call arrangement for the Unit.

13.3 Out of hours medical cover for physical illness is covered by Devon Doctors, and out of hours psychiatric cover by the Psychiatric Registrar/Duty Consultant who are contacted through switchboard.

14. Service user involvement

14.1 Service Users are involved in all aspects of their care, along with carers as appropriate. Availability of advocacy services are publicised and service users are assisted to access resources as required. Service user questionnaires are completed on discharge and on an annual basis.

14.2 A service user representation is encouraged as part of open staff meetings, service development initiatives and as part of interview panels.

15. Clinical Governance

15.1 Services are monitored for compliance against Care Quality Commission standards. These are reviewed on an ongoing basis and evidence is kept on a shared drive. The Current Key Lines of Enquiry focus on areas during inspection would rate performance in the following areas:-

Are our services:

- Safe
- Effective
- Caring
- Responsive
- Well Led

15.2 There is a process of clinical audit in place across the year which includes action planning where standards fall short.

15.3 There is an identified link person to attend Infection Prevention and Control meetings, and to contribute to Infection Control audits.

15.3 The service has defined systems and processes in place to continually monitor and improve the quality of care delivered.

16. Safety and risk

16.1 The organisation takes seriously its responsibility for staff and service user safety. All staff however have a responsibility for safe working practices and to follow Health and Safety Guidelines, Lone Working policies and the LSW's Violence & Aggression Management Policy.

16.2 There is an electronic risk register on the unit that must be kept up to date.

16.3 All staff must use the white board to record visits/activities outside the unit and must report back at the end of any visit/activity.

16.4 If there is a known risk in visiting any service user then safeguards should be put in place. e.g. visiting in pairs or at certain times of the day.

16.5 All staff must be aware of any warnings recorded on SystmOne and update these if necessary in line with SystmOne policy.

16.6 Syrena has a SAS alarm system that must be used by all staff.

16.7 All staff should be trained in conflict resolution and physical intervention techniques.

17 Drugs and Alcohol and New Psycho Active Substances Management

17.1 Greenfields recognises the potential problems of alcohol/drug misuse. A proactive approach is taken in identifying potential risks. Good links and liaisons with the local alcohol/drug service are in place, and health promotion in relation to alcohol/drug misuse is paramount in the care of the individual.

17.2 In order to have a successful outcome, staff need to establish and maintain effective communication, ensuring matters of a confidential

nature are treated in a manner to assist any investigation and protect any individuals involved.

17.3 The unit has a policy of zero tolerance to drugs, New Psycho Active substances and or alcohol. However all service users with dependency will be supported to look at and deal with underlying problems to alleviate the need to misuse alcohol/drug misuse. Individuals will be supported to gain appropriate advice and treatment. All staff will demonstrate a professional, non-judgmental and sensitive approach to those with a dependency.

17.4 An honesty box is placed in the clinic room for individuals to give up should they have any illicit substances.

17.5 The organisation supports the use of drug screening to monitor and maintain the safety of the service users who are receiving care. It recognises that wherever possible this can be supported by the care planning process where people are working with substance misuse issues.

17.6 However, in order to recognise the potential impact to increase and escalate risk issues the decision to screen service users may be for a range of reasons to include:-

- Clinical judgement based on knowledge and history of the service user
- Need to review treatment plan or interventions
- Consider safety of service users, environment and the staff
- When the service user is under the influence of illicit substances and staff need to determine the cause in the event of a new or change in presentation
- To determine the level of monitoring required to maintain their safety
- To consider whether search procedures need to be implemented to establish whether substances are present on the premises

17.7 The process of routine drug screening will be carried out using screening kits in a way that promotes service users privacy and dignity. The units will provide information on notice boards and as part of admission procedures to ensure that service users are well informed that routine drug screening by request and the use of drug detection dogs is integral to ensuring safe healthcare environments and forms part of care that is delivered by the service.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Operations

Date: 10th May 2016