Livewell Southwest

Greenfields Unit 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: **114**

Reader Information

Title	Greenfields Unit Operational Policy. V.2.1
Asset number	114
Rights of access	Public
Type of paper	Policy
Category	Clinical
Document purpose/summary	Change of service to women only service. Operational policy describing the function of the Greenfields Unit
Author	Unit Manager/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 PRG will retain an e-signed copy for the archive in accordance with the Retention and Disposal Schedule, all copies must be destroyed when replaced by a new version or withdrawn from circulation.
Job title	Team Manager, Greenfields and Modern Matron
Target audience	Staff employed to work in the Greenfields, other stakeholders
Circulation List	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	DOH Mental Health, Health and Social Care Standards and Quality Group - Mainstreaming Gender and Women's Mental Health Implementation Guidance - 22 09 2003 Beijing Platform of Action (1995)
Associated documentation	N/A
Supersedes document	Reviewed Policy – supersedes old operational policy for unit prior to change of use, relocation and service re-design following Recovery QIPP and Greenfields Unit and Recovery Pathway Operational Policy.
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 Version Control

Version no.	Type of change	Date	Originator of change	Description of change
0:1	Updated	July 2007	L. Stanton	
0.2	Updated	February 2008	D. McAuley	Update prior to submission to Governance Committee
0.3	Updated	March 2008	D. McAuley	Feedback from Governance Group.
1.0	Final version	March 2008	D. McAuley	Ratified by Governance Group
1.1	Update	March 2009	J Vella	Appendix two and links to PCT guidance rather than local arrangements
1.2	Update	May 2011	J Vella S. Horsham	Updated to bring in line with corporate standards. Updated visiting conditions according to MHA. Appendix six inclusion of House Rules.
2.0	Review	November 2013	Unit Manager/ Modern Matron	Reviewed following the closure of Gables and service re-design following Recovery QIPP 2012 – 2013 and relocation to Greenfields at the Mount Gould Hospital site
2.1	Review	April 2016	Unit Manager/ Modern Matron	Reviewed and condensed. Removal of service user welcome pack.

Greenfields Unit Operational Policy.

1. Overview of Service

1.1 The Greenfields Unit 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 access to Social Inclusion and Vocational Services. There are links with a supported accommodation provider for housing for local accommodation provision for those people with complex and enduring mental health needs where three Livewell Southwest Mental Health Nurses are seconded to support transition and monitoring and healthcare needs 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.

2. Purpose of Greenfields Unit

2.1 The service comprises of 9 beds for women based on the Mount Gould Hospital site. The in-patient unit supports service users who step down from secure services 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.

2.2 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.

2.3 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.

2.4 The unit has been developed to meet national and local strategies to address inequalities in the delivery of women's mental health services and to tackle discrimination and disadvantages.

2.5 Greenfields is a specialised unit for women; which aims to provide individualised

care, treatment and recovery for women. This will be achieved in a manner that treats women with dignity and respect and which enhances individual choice and quality of life.

2.6 The unit provides in-patient recovery for service users who may have received a period of treatment in a more secure environment, an acute facility or for those who have been unable to function in their home environment. The typical length of stay is expected to vary from between six and eighteen months though it is recognised that some individuals may need longer term treatment.

2.7 The service provides benefits from a multi-disciplinary approach. Treatment will ensure maximum benefit to each person, with an emphasis of moving on to the most appropriate accommodation option.

2.8 Greenfields will provide a service for nine individuals requiring a women's only service in a 24 hour nurse staffed setting. Assessment and treatment will take place at Greenfields and in people's homes as appropriate. Treatment will support all service users to move on from Greenfields to live in the community, with the appropriate level of support from either the Community Recovery Team, or from the most appropriate team which may be the Assertive Outreach Service, 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. Occasionally service users may need to be referred to other parts of the service for inpatient care.

2.9 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.

2.10 All service users care falls within the framework of the Care Programme Approach and will have an allocated professional and a care co-ordinator from community services where appropriate.

2.11 Greenfields provides a service to both informal service users and those detained under the Mental Health Act.

3. Philosophy

3.1 We aim to provide a seamless service providing continuity, quality of care and interface between different services and settings.

3.2 The service promotes "whole life" and socially inclusive approaches to individual's care, treatment and recovery. We value strengths and abilities and recognise individual's potential for recovery in the context of a holistic assessment and care plan.

3.3 We believe that every individual is unique and must be afforded care, which promotes a sense of personal value and self worth, and promotes empowerment, choice and self-determination.

3.4 We aim to fulfil individual objectives of care, and reduce the likelihood of relapse, through providing an individual care package, using evaluated evidence based models of care, taking gender issues into account. Through the nurturing and supportive milieu provided and through working collaboratively with service users, it is anticipated that tangible improvement in social and skills functioning will be realised.

3.5 We work from a Recovery perspective with the principle of promoting independence, social inclusion and personal choice and from the point of admission will work with the individual on a Recovery pathway.

4. Locality and Environment

4.1 Greenfields is a 9 bedded unit situated on the Mount Gould Hospital site, within the City Wide Service in Plymouth.

4.2 It is a single level building and provides single bedrooms with washing facilities located in the bedrooms. There are fully fitted shower rooms and bathroom. Service users are encouraged to personalise their bedroom to promote the sense of belonging. However, whilst we encourage personal belongings they must be in accordance with health, safety and fire regulations, be checked by an engineer on admission and with the agreement of the Team Manager.

4.3 There is a multi-purpose lounge and dining area which is used or therapeutic activities. A court yard is accessible from the lounge and provides enclosed outside space. There are laundry facilities, and a small Activities of Daily Living (ADL) kitchen. The unit can access space for group work where provision cannot be made on the unit.

5 The Staff Team

5.1 The in-patient team based at Greenfields is managed by a Registered Mental Health Nurse supported by a Deputy Manager. There are additionally approximately 9 WTE Registered Nursing Staff,1 Assistant Practitioner and 8 WTE unregistered Nursing Staff.

5.2 Responsible Clinician responsibilities for the inpatient and Community Recovery

Team will be assumed by a Consultant Psychiatrist who will hold weekly multi-disciplinary team meetings. In addition a specialty Doctor, and when possible, a core trainee will provide additional cross cover for the in-patient units.

5.3 Consultant Psychologists provide sessional input into the two Recovery Units. The Greenfields Unit has an additional ward based Psychologist.

5.4 Occupational Therapy provision is accessed through the Community Recovery Team or through Vocational Services. This can provide a range of standardised functional assessments both in and in-patient setting and if appropriate within the home environment. 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.

5.5 Regular 1:1 support sessions to plan goals that service users wish to achieve and to monitor progress are in place. The nursing team takes a lead role in planning and support the provision of a daily group programme including ward based low key engagement sessions and psycho- educational

5.6 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, the nursing and OT team offers the opportunity for service users to explore the possibilities for engaging with community based support groups and educational or vocational services.

5.7 Other key team member who contribute to MDT include Social Work and Pharmacist.

5.8 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.

5.9 The unit is staffed 24 hours a day in line with safer staffing ratios and this is publicised in the reception area.

5.10 The functions of the clinical team are:

- To act as care co-ordinators, Named Nurse and Co-Workers for service users.
- To provide 24 hour assessment, support and treatment for service users at Greenfields.
- To undertake assessment of potential service users and to offer advice to service users, carers and referrers based on the teams assessment.
- To strive towards increasing independence and community integration.
- To ensure good communication and liaison within the team and other stakeholders involved in service users care.
- To form good therapeutic rapport with clients and to be mindful of advocacy issues.

6. Aims and Objectives

6.1 The aim of the service is to maintain a therapeutic environment where women can recover and receive treatment based upon recovery approaches, which are person centred.

6.2 The objectives of Greenfields are:

- Prioritise the needs of the individual as paramount and allow for informed understanding of gender and other aspects of inequality.

- Provide specialist assessment, recovery and treatment to women with serious and enduring mental health problems.
- Maximise individuals' potential and reduce stigma and inequalities to facilitate independence where possible.
- Plan individualised care packages with service users in a collaborative way, using service user-focused outcome measures where possible and appropriate, such as the Recovery Star.
- Be part of the wider community using local resources where possible.
- Provide professional, evidence-based practice/care.
- Provide access to the greatest possible variety of physical, psychosocial, psychological and complimentary interventions.
- Regularly review practice by using quality assurance, clinical audit and principles of clinical governance, as per organisations policy.
- Provide a holistic approach to care where physical, social, psychological, spiritual, cultural, religious and educational needs are given equal importance, and appropriate care plans and interventions are put into place.
- Provide advice and support to carers and other agencies.

6.3 Service Users staying at Greenfields can expect:

- To be valued as individuals and treated with respect and dignity.
- Named Nurse to assess, be aware of and give advice on any issues that may be of particular concern to women. Including social inequalities, domestic violence or other forms of abuse, childcare, risk of self-harm, change of life issues, and side effects of medication, weight loss/gain, hormonal impact, physical health matters and others. This matter will be integrated into the Care Programme Approach assessment and Care Plan.
- Service users will have their own lockable room with a lockable cupboard.
- During periods where it is necessary to increase a service users level of observation we will endeavour to respect their privacy and dignity balanced with risk, and where it is temporarily withheld it will be restored at the earliest opportunity.
- All communal bathrooms and toilets are fitted with locks.
- Staff are required to knock prior to entering bedrooms and communal bathrooms, and then await a response. If no response a female member of staff will enter first.
- Requests for female care co-ordinators should be facilitated, as deemed appropriate.
- To be educated about their mental health needs in a way they understand.
- To be fully involved in negotiating care, and therefore to be in a position to give informed consent wherever possible.
- To receive a range of interventions delivered by The Greenfields MDT geared towards gender sensitivity.
- To be assisted to reach their maximum potential.
- Invasive intervention for example depot medication, or physical examinations will be conducted in a discreet and private manner with a staff gender preference, a female staff member will be present during these times. Access to female staff such as Doctors, Approved Social

Workers etc. will be responded to sensitively although it may not always be possible to meet this request.

- To be given verbal and written information about the service we offer and to be listened to when they offer ideas about improving our service.

7. Admission Criteria

7.1 Greenfields provides a service to women with a range of mental disorders requiring enhanced support and greater opportunity for recovery.

7.2 Women with serious enduring mental health problems who have a treatment resistant illness, who despite treatment still have persistent and pervasive difficulties associated with their mental health, this would not include anyone in an acute phase of illness.

7.3 Women who need high levels of resources for a period of time.

7.4 Women who may have a significant forensic history requiring reduced levels of security in a local service.

7.5 Women who receive a diagnosis of borderline personality disorder associated with psychological trauma i.e. Post Traumatic Distress or Complex Post Traumatic Stress Disorder.

7.6 Age between 18-65 years.

7.7 Women with a primary drug or alcohol problem, primary organic problems, and severe learning disability, would not normally access this service although in keeping with Green Light developments, individuals with a learning disability and co-morbid mental health problems would not be excluded. Service provision for these individuals can be accessed enhanced through joint working via Learning Disability services, Drug and Alcohol services, Harbour and specialist assessment for Organic problems on an individual basis.

8. Referral System and Assessment Process

8.1 All referrals are sent to the Team Manager, by means of letter, or current internal SystmOne referral followed up by a phone call.

8.2 The referral will be discussed with the Unit clinical team.

8.3 The Unit Manager will identify appropriate staff to complete an assessment within two weeks of receipt of the referral.

8.4 Written advice and feedback will be available within one week after the assessment has been completed.

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 The referral will then be discussed at the Multidisciplinary team Meeting that is held weekly to update the team.

8.7 If a bed is available there will be no delay in arranging admission with the referring team.

8.8 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.

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

8.10 Following assessment, on occasions it is necessary and seen in the best interest of some service users to have a care co-ordinator identified from the Community Mental Health Team. This would enable robust planning in event service users disengage from therapeutic activity and stop working towards their recovery. This minimises risk when discharge plans needs to be implemented at a time when delays would otherwise occur. This is considered on an individual basis dependent on service users' needs, length of stay and their care pathway.

Referrals and Discharge Flow Chart

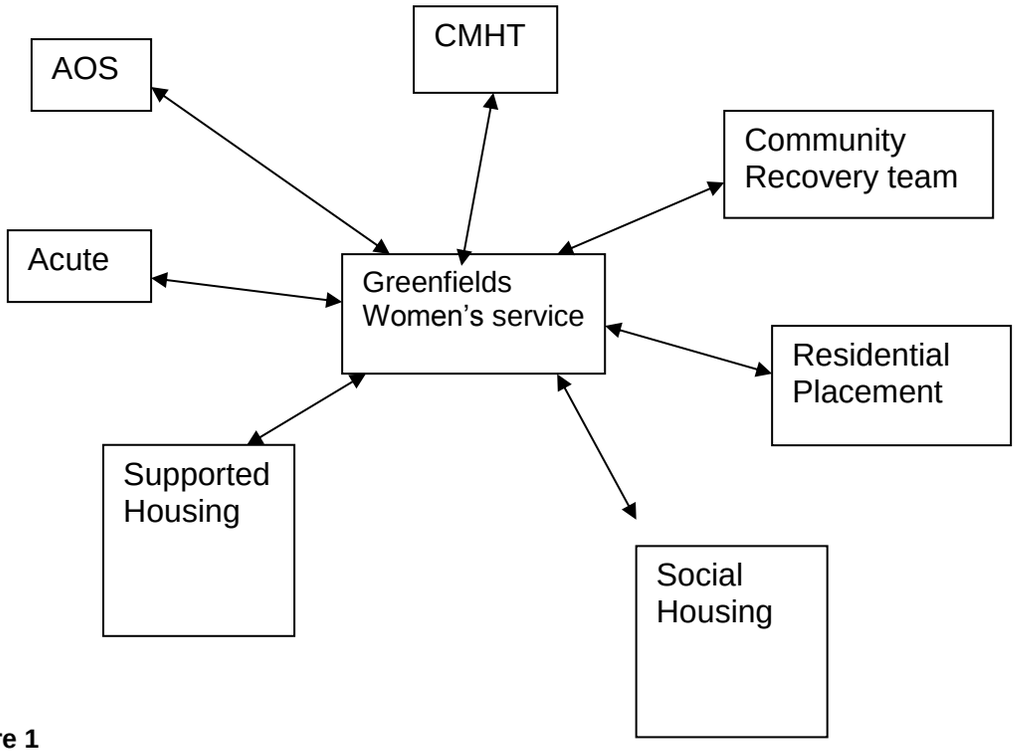

Figure 1

9 Discharge Procedure

9.1 Planning towards discharge will begin at admission. Agreed objectives and goals will be regularly reviewed with the service user as required within a minimum six month period.

9.2 The service user will be supported in choosing the most appropriate venue to move onto from a range of suitable/potential placements, and the care co-ordinator will be responsible for informing the service user about the positives and negatives of each environment. Thus the service user will be equipped to enter negotiations/discussions with the team prior to any decision being made by a potential future provider. CPA requirements and MHA aftercare requirements will be met through a pre-discharge planning meeting.

9.3 A referral will be made to the most suitable team or service to take over care co-ordinator responsibility immediately on planning discharge, to enable and support involvement and to allow for a planned hand-over period. It is expected that Greenfields will continue to support service users for a period of time deemed appropriate by the clinical team and the service user. This will be undertaken by the Community Recovery Team.

9.4 Greenfields Named Nurses will work in conjunction with named nurse/care co-ordinator to establish new goals.

10 Treatment and Continuing Care

10.1 Mental Health Services aim to provide a range of services to respond to individual's diverse needs – Social, therapeutic, environmental, creative activities, self-help practical support, medication, and complimentary and psychological therapies.

10.2 At Greenfields medication will be prescribed as one option alongside a range of other treatment options and service users will be reassured that the use of medication is only one element of a holistic approach to their care.

10.3 Self-medication is encouraged at the earliest opportunity.

10.4 The service has adopted an eclectic model to guide and direct individuals care. The therapeutic programme is aimed at addressing:

- Risk identification/management including forensic issues and criminal behaviour if this is deemed necessary.
- Coping Mechanisms.
- Assessment of Psychological and Physical Health needs.
- Social issues in respect of the client working towards developing socially inclusive opportunities and integration.
- Legal issues in relation to legal framework such as the MHA, discharge planning, housing, monies and voting.

10.5 Each discipline at Greenfields will contribute to the therapeutic programme to provide a multi-disciplinary approach to care.

10.6 The service will offer:

- Full multi-disciplinary assessment of all aspects of life.
- An identified Named Nurse and co-worker for each service user.
- A named link worker from Community Recovery Team within 2 weeks of admission
- Clear individual care plans, outlining goals and treatment.
- A safe environment for clients and staff using approved risk assessment tools.
- A structured environment, offering clear boundaries and expectations.
- The undertaking to facilitate a move to a more suitable environment at the earliest opportunity, if Greenfields is not appropriate/helpful for service users continued progress.
- All staff trained in the safe and effective use of de-escalation and physical intervention

11 Other Key Services In the Recovery Pathway

Community Recovery Team

11.1 This team consists of Team Manager, A Registered Mental Health Nurse a Mental Health Nurse, an Occupational Therapist, an Assistant Practitioner who can care co-ordinate 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.

11.2 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.

11.3 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.

Social Inclusion and Vocational Services

11.4 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.

11.5 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.

Community Mental Health Nurses (Housing Support)

11.6 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 Greenfields 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.

12 Physical Health and Wellbeing

12. 1 Physical health concerns will be assessed and monitored by the medical staff, who are attached to the unit. Out of Hours medical cover is provided by a Duty Doctor on-call service.

12.2 A holistic well women approach is part of the unit's philosophy. Service Users are able to be referred to and access a wide range of health care services as appropriate; these include well women sessions, dentistry, physiotherapist, chiropodist, dietician, optician and audiologist. All clients will have a monthly health check, which could include a general base line observation (weight, blood pressure, pulse, urine sample, blood glucose testing). Referrals will be made to specialists in physical health care when required. Annual health checks are completed as standard practice.

12.3 Health education is promoted within the therapeutic programme. Opportunities

are provided within the service to participate in regular exercise. Healthy eating is promoted and special dietary requirements will be catered for.

13 Advocacy Service

13.1 The service is committed to providing a full independent advocacy service, which is available to all service users.

14. User Involvement

14.1 An individualised approach tailored to service user's preferences, circumstances and resources underpins the service offered at Greenfields. The philosophy advocates that increased opportunities should be created so that the service users feel actively involved in planning their own care and empowered during the process.

14.2 Opportunities will be provided wherever possible for the individual to be autonomous in decision-making.

14.3 A unit information booklet will be provided on admission to each individual service. This will include an outline of the role of the unit, rights under the Mental Health Act, how to make a complaint or plaudit and details of the individuals care plan and medication.

14.4 Decisions will be made with service users and not 'for the service user' – although it is acknowledged there may be occasions when an individual's mental health is such that decision-making may be impaired by mental ill health and staff may need to make decisions in the short term. Care plans will reflect the person wishes for care when they are mentally unwell.

14.5 Service users are central to any review meeting and take account of their needs and wishes and not just those of the MDT. Informed consent will always be sought before prescribing and administering medication. Detained service users would be subject to the consent to treatment regulations and second opinions requested as necessary. Care plans will be written with, agreed and signed by the service user wherever possible. The service user will be involved with any care plan reviews.

14.6 Provide service users and carers opportunities to influence and advise the clinical team as to future development issues.

14.7 Service users asked to complete service user survey, at CPA review, annually and on discharge.

15 Arrangements for Contact between service users and Relatives

15.1 Greenfields values the opinions of relatives and carers. Feedback will be collected and responded to in the appropriate way.

15.2 We offer relatives and carers the opportunity to play a key role in supporting service users. This involves forming strong familial networks and the relatives being educated about the mental health difficulty, which the service user is suffering. Great emphasis is placed upon the links with' service users' family and friends. Visitors are welcomed at appropriate times. One of the core themes is family centred intervention, with service users' permission. If a service user is unable to give consent, the Registered Clinician will record this in the service users' notes.

15.3 Greenfields philosophy aims, wherever possible to maintain links between Mother and children in a safe and appropriate environment. All individual needs will be assessed and met in line with Children Visiting Inpatient and Residential Units Policy.

15.4 Greenfields also recognises that some relatives and carers may not want this level of engagement however we will encourage relatives to conduct informal visits to clients. From time to time, the patient's responsible clinician may decide, after the assessment and discussion with the multidisciplinary team, that some visits could be detrimental to the safety or wellbeing of the patient, the visitor, other patients, or staff on the ward. In these circumstances, the responsible clinician may make special arrangements for the visit and relevant policy with adhered to in relation to practice. These may include Adult or Children Safeguarding Policies and Procedures. At all times consideration will be given to least restrictive principles.

16. Service Users from Ethnic Minority Backgrounds

16.1 All individuals are treated equally regardless of race or culture. It should not be assumed that units that are gender sensitive and single sex services automatically meet the needs of women from ethnic minorities, however the unit will adopt a zero tolerance policy to discrimination of any kind. The service will meet specific individual, ethnic and cultural needs when at all possible. This will be facilitated in a sensitive and respectful manner. Service users will be involved in development of staff awareness of the particular details/aspects of their culture/religion/background.

16.2 Greenfields will seek the services of interpreters as required.

17. Spiritual and Religious Beliefs

17.1 Through comprehensive care planning the spiritual needs of service users are identified. Those who are able to use community facilities are encouraged to attend religious services at local places of worship of their choice.

17.2 Patients can have access to a visiting Chaplain.

18. Managing Finances

18.1 Strict protocols and policies are in place at Greenfields to prevent abuse of

neglect of service users' finances. This is subject to regular and comprehensive monitoring both internally and externally.

18.2 Due to the nature of the environment and some of the risks (absconding, vulnerability and exploitation) associated with keeping large amounts of money on the unit, advice may be given about the amount of money that a service user may keep on their person at any given time. Greenfields therefore anticipate the need to assist with managing some finances whilst at the same time ensuring that the unit does not conflict with human rights.

18.3 If necessary appointeeship can be applied for to enable a more structured approach for individuals to manage their finances.

19. Adult Safeguarding

19.1 Livewell Southwest is signed up to and committed to a multi-agency approach to Safeguarding Adults. Safeguarding adults has the same commitment and priority to that of child safeguarding procedures. All concerns will be taken seriously and thoroughly investigated with appropriate protection plans put into place to protect and support women. All staff are trained in the safeguarding of adults.

19.2 Plymouth has developed multi-agency guidelines and the Deputy Locality Managers are identified as Safeguarding Adults Lead for the Locality to provide advice and support.

20. Monitoring and Controlling Alcohol/Drug Misuse

20.1 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.

20.2 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.

20.3 The unit has a policy of zero tolerance to drugs, New Psychoactive Substances and 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.

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

20.5 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.

20.6 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.

20.7. 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 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.

21. Staff Support & Supervision

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

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

21.3 Line management will be provided as a minimum every three months for all staff. This will cover both performance and development needs. Line management will feed into the annual appraisal.

21.4 All staff employed at Greenfields are expected to engage with peer Reflective Practice that is facilitated by a Clinical Psychologist, this is seen as an essential part of supporting staff and is not viewed as optional.

21.5 Additionally the Organisation supports staff to engage in 1-1 clinical supervision in line with the Organisations policy. Clinical Supervision can be a self-actualisation process that assists the clinician in performing to their potential by fostering development. Clinical supervision is not an option but part of continual professional development. Supervision compliments the process of appraisals, professional standard setting and clinical audit. The use of regular and appropriate supervision and reflective practice can contribute to an organisation culture, which encourages innovative practice providing high levels of motivation and satisfaction and encourages strong colleague relationships. Regular individual line management and externally facilitated group professional supervision is available to all staff.

22. Service User and Staff Personal Possessions

22.1 All service users have a key to a lockable cupboard. Whilst service users are encouraged to be responsible for their own possessions there is also an office safe.

22.2 A staff room and cloakrooms are available with a selection of lockers to place their possessions. There is also a separate male and female toilets for staff.

23. Greenfields Routine

23.1 The Unit has domestic staff team who maintain the standards of cleanliness and prepare meals.

- Breakfast is served between 7am – 9am
- A lunch is served between 12 – 2pm
- Dinner is served between 5.15pm – 6pm
- Hot and Cold beverages are supplied daily

23.2 Service users are involved in therapeutic activities away from the unit, which often involve eating out, as part of their recovery programme.

23.3 Service users may also be learning how to budget and cater for themselves as part of their individual programmes, so they routinely prepare their own meals under supervision.

23.4 CPA reviews and/or MDT every week for the review of patient care and CPA care plans and goals and discharge planning.

23.5 There is staff reflective practice sessions for staff facilitated weekly by the Clinical Psychologist.

23.6 There is a staff meeting on the first Monday of the month to discuss specific Greenfield business and policy reviews.

23.7 The Domestic staff maintains a very high standard within the building. Service users are prompted and assisted, if necessary, to also contribute to keeping their own rooms clean.

23.8 The general repair and external upkeep is the responsibility of the central estates department, although it is the general responsibility of all staff to ensure all repair requirements are reported as identified.

23.9 Grass cutting is contracted out by the estates department, as is window Cleaning Livewell Southwest takes the issue of infection control very seriously and Greenfields adheres to standards of best practice. An annual infection control audit programme and Matrons Charter is in place across the unit.

23.10 There is also an office telephone, fax machine and clients payphone. Patients also have access to a computer and the internet under supervision

23.11 Internal mail is collected and delivered daily Monday to Friday, and circulated as necessary. Other post is sent and received via the usual Royal Mail service.

24. Organisation Policies

24.1 The Greenfields Unit and the staff team adhere are required to adhere to all relevant organisations policies.

24.2 Staff need to ensure that they maintain an up to date working knowledge of policies and refer to on line policies for guidance as required.

24.3 Associated Policies in relation to the Operational Policy

Compliments, Concerns and Complaints
Serious Investigation Requiring Investigation
Care Programme Approach Policy

25. Dealing with Complaints

25.1 Greenfields follows the Organisation Compliments, Concerns and Complaints procedure. All concerns will be responded to promptly and is always taken seriously.

26. Dealing with and Learning from Untoward Incidents

26.1 Livewell Southwest Livewell Southwest has an Incident reporting policy. This involves incorporating the information and guidance from ‘a learning organisation’. The Serious Incident requiring Investigation (SIRI) policy will be followed when reviewing serious untoward incidents. The Manager and staff from Greenfields will be fully involved in any review and staff will be supported to implement any necessary changes to practice. Lessons and recommendations will be fed back through the organisation following the development of action plans.

27 Clinical Governance

27.1 The purpose of clinical governance is to ensure that clients receive the highest quality of care possible. The unit is inspected by the Care Quality Commission and adherence to the standards set. It inspects the organisation’s systems and processes from monitoring and improving services and to gain feedback from our patient’s experience.

The service will be reviewed and rated across the following areas:-

- Safe
- Effective
- Caring
- Responsive
- Well Led

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

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

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

28. Smoking

28.1 Smoking is permitted in designated smoking areas in only. At Greenfields service users can only smoke in the outside courtyard area where a smoking shelter is located.

.

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

Appendix 1

Glossary of Abbreviations

ADL	Activities of Daily Living
AOS	Assertive Outreach Service
CPA	Care Programme Approach
DDA	Disability Discrimination Act
GP	General Practitioner
MDT	Multi Disciplinary Team
MHA	Mental Health Act
NHS	National Health Service
SIRI	Serious Incident Requiring Investigation

Appendix 2

Date

PRIVATE AND CONFIDENTIAL

Name of service user
Address

Dear (Client Name)

I am writing to inform you that a date has been set inviting you to attend a full **Care Programme Approach Review (CPA),** including S117 Review. Attached to this letter is a helpful information sheet about CPA and the Review Process.

Date:

Time:

Venue:

As part of the CPA Review, you are welcome to bring a friend, relative or partner, whoever you feel may help to support your care needs at the review meeting.

If this date/time is not convenient, please contact your Care Co-ordinator on the above number.

Your Care Co-ordinator contact details are:

Yours Sincerely,

(Name of person sending letter)

If you decide you would like to bring a **friend, relative, partner and carer** please let your Care Co-ordinator know before the set review. You may also want to consider the support of an independent advocate instead. The contact for Advocacy Services:

The Guild of Voluntary Services, Ernest English House, Buckwell Street, Plymouth, PL1 2DA.

Tel: 01752 201766