Livewell Southwest

Therapy Unit Operational Policy

Version 1

Review: April 2020

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: **TU Manager**

Asset Number: **952**

Reader Information

Title	Therapy Unit Operational Policy. V.1
Asset number	952
Rights of access	Public
Type of paper	Policy
Category	Clinical
Document purpose/summary	Operational policy describing the function of the Therapy Unit neurological outpatient service
Author	Amanda Eddy, Team manager and Clinical Specialist Physiotherapist
Ratification date and group	28th March 2017 CUCS Managers Team Meeting.
Publication date	11th May 2017
Review date and frequency	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 All copies must be destroyed when replaced by a new version or withdrawn from circulation.
Name & Job title	Amanda Eddy, Team manager
Target audience	Staff employed to work in at the Therapy Unit, other stakeholders
Circulation	Electronic: Livewell Southwest (LSW) intranet and website (if applicable) Written: Upon request to the PRG Secretary on ☎ 01752 435104. Please contact the author if you require this document in an alternative format.
Stakeholders	Staff within Livewell Southwest, external agencies and service users
Consultation process	Working group including staff, service users and carers. Draft policy discussed with all staff and comments received.
References/sources of information	National Service Framework for Long term neurological conditions (DH 2005). Five Year Forward View (2014) NICE guidance: Multiple sclerosis: Management of multiple sclerosis in primary and secondary care, 2003 The NHS Improvement Plan, 2004 NICE guidelines: Parkinson's disease: Diagnosis and management in primary and secondary care, June 2006 National Stroke Strategy, 2007 Our NHS Our Future – NHS Next Stage Review, 2007 BSRM Standards for Rehab Services Mapped on to the NSF

	for LTC 2009 National Guidelines: Spasticity in adults: management using botulinum toxin, 2009 RCP National clinical guideline for stroke Fourth edition, Sept 2012 NICE guidelines: Stroke rehabilitation: Long-term rehab after stroke, June 2013 Equality & Diversity Policy v2:4 Livewell SouthWest Equality Act 2010
Equality analysis checklist completed	Yes
Is the Equality and Diversity Policy referenced	Yes
Is the Equality Act 2010 referenced	Yes
Associated documentation	N/A
Supersedes document	New document
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 2017	Team manager	New document
1	Minor changes	April 2017	Team Manager	Ratified

Therapy Unit Operational Policy

1 Introduction: Overview of Service

1.1 The Therapy Unit (TU) is located within the Community Urgent Care Services. It offers specialist outpatient assessment and treatment to people over 16 with a neurological diagnosis. It can also offer one-off home visits to address specific goals/problems.

1.2 The aim is to provide a multidisciplinary goal orientated approach to recovery for people who have complex neurological conditions with holistic individualised care. The team focus is on recovery, prevention of deterioration and/or self-management.

1.3 The service consists of physiotherapists, occupational therapists, therapy support workers and administration support. Regular contact is made with other services, including falls service, Stroke Early Supported Discharge, psychology, speech and language therapy, medical support from rehabilitation consultants, orthotics, wheelchair services, community teams, dieticians. If a person's goals are best met at home, they will be referred to the community therapy teams. In-reach can be arranged to ensure smooth transfer of care for inpatients at Mount Gould Hospital (MGH) with first appointments made prior to discharge.

1.4 The service has an office base in the Beauchamp Centre at Mount Gould Hospital. Clinically patients are treated at the Therapy Unit Gym and splinting room in the Local Care Centre.

2 Purpose

2.1 The aims of the Therapy Unit are as follows:

- To provide a specialist multi-disciplinary rehabilitation outpatient service for assessment and treatment of people with a neurological diagnosis (including facial paralysis) whether recovering from a one-off episode, or living with a long-term condition. The team focus is on recovery, prevention of deterioration and/or self-management.

- To provide multi-disciplinary, holistic assessment, treatment and advice and to promote self-management, education, independence and improved quality of life.

- To prevent hospital admission

- To facilitate earliest possible hospital discharge from Derriford Hospital, Plym Neuro Unit and the Stroke Rehab Unit within Mount Gould Hospital as an in-reach system if appropriate to ensure smooth transfer of care for inpatients at

Mount Gould hospital with first appointments being made prior to discharge.

2.2 The objectives of the Therapy Unit are as follows:

- To provide a specialist outpatient neurological service providing Occupational Therapy and Physiotherapy assessment and treatment in an appropriate setting. This should usually be the gym environment but one-off home visits can also be arranged to address specific goals/problems. If the person's needs are best met by treatment at home in the long term, they will be referred to the Community Therapy Team (CTT).

- To set time-limited, functional goals with each patient.

- To provide advice, education and information to promote self-management.

- To coordinate discharge in a timely way, with onward referral where appropriate

2.3 Expected Outcome of the Therapy Unit:

- To meet patient-led functional goals within a reasonable time period.

- To see all patients within priority settings (see section 7).

- To meet patients' expectations of the service provided, measured by the Friends and Family test.

3 Definitions

3.1 ESD Early supported discharge team

MGH Mount Gould Hospital

TSW Therapy Support Worker

TU Therapy Unit

Mdt Multi Disciplinary Team

LCC Local Care centre

GP General Practitioner

4 Duties & responsibilities

4.1 The **Chief Executive** is ultimately responsible for the content of all policies, implementation and review.

4.2 Responsibilities of **Director(s)** are to assist the Chief Executive in delivering this policy by ensuring its implementation within their services across all localities.

4.3 Responsibilities of the **Locality/Deputy Locality Managers** are responsible for the day-to-day compliance with this policy and to work with the team managers to make any changes to the policy as necessary.

4.4 Responsibility of **line managers** is to update this policy as necessary and ensure that the operational policies are adhered to, and to ensure that any deficiencies found in the audit process are acted upon.

4.5 Responsibility of all **staff** to be aware of and work in accordance with this policy.

5 Staff Team

5.1 The Therapy Unit team is managed by the team lead. The team also includes Physiotherapists, Occupational Therapists, Therapy Support Workers and Administration staff. Workforce planning and skill mix reviews are on-going and integral to the safety and cost effectiveness of the service.

5.2 Physiotherapists

Provide specialist assessment by analysing movement and function. Treatment includes physical therapeutic modalities, home exercises, education and advice to improve and maintain function and independence.

This includes:

- Neurological therapy
- Strengthening, maintaining joint range of movement and improving sensation
- Assessment and management of muscle tone
- Reducing pain and swelling
- Acupuncture for pain
- Advice and exercises for facial paralysis
- Improving balance and gait
- Assessment and provision of appropriate walking aids
- Strength and balance group
- Taping
- Assessment for functional electrical stimulation

- Signposting to other appropriate services
- Advice regarding posture and seating

5.3 Occupational Therapists

Provide specialist assessment of occupational performance skills, environment and cognition, enabling patients to develop and maintain independence in personal, domestic and vocational living skills.

This includes:

- Specialist functional assessments including wheelchair, seating, cognitive, perceptual testing
- Specialised treatment including splinting, joint protection and daily living skills
- Home visiting for the purpose of assessment and appropriate resettlement
- Provision and training in the use of rehabilitation and specialist equipment
- Environmental assessment and the provision of, and recommendation for, adaptations
- Driving assessment
- Rehabilitation of upper limb movement and function
- Vocational rehabilitation
- Fatigue management

5.4 Therapy Support Workers

Support therapists in the application of a treatment plan in order to achieve patient goals relating to function, mobility and activities of daily living

This includes:

- Joint treatment sessions with therapists
- Carrying out a treatment plan according to referral
- Progression of exercise programmes in discussion with qualified therapist
- Meeting regularly with appropriate therapist to review episode of care, goals and treatment plan
- Identifying when referral to other agencies would be appropriate
- Assessment for and ordering aids and equipment (including for home environment)
- Maintenance of therapy environment
- Walking aid clinic
- Practice and development of strategies for memory loss
- Implementation of strategies for fatigue management/pacing
- Updating/maintain information for patients/therapists eg: community groups, exercises classes, pool access
- Organisation of orthotics clinics

- Organisation of splinting review system

5.5 Additional contact with the multi-disciplinary team occurs when required in accordance with specific patient needs via phone contact, email and face to face meetings. There is also a monthly MDT meeting to discuss patients with consultants and psychology staff.

5.6 The Clinical team are supported by a senior Management structure. This includes a Matron who is accountable to a Deputy Locality Manager/Locality Manager for Community Urgent Care Services.

6 The Environment

6.1 The team office is based at the Beauchamp Centre, Mount Gould Hospital, Mount Gould Road, Plymouth, PL4 7QD shared with the ESD service.

6.2 The team clinical area is based in the Therapy Unit on the ground floor of the Local Care Centre, Mount Gould Hospital, Mount Gould Road, Plymouth, PL4 7QD. This area consists of the main therapy gym which is shared with the LCC wards, a splinting/occupational therapy room and a shared office.

7 Day to Day Operations and Referral Process

7.1 The Therapy Unit operates from 8am to 5pm Monday to Friday, excluding bank holidays

7.2 TU accepts referrals for people registered with a Plymouth GP and those with facial paralysis from Plymouth, Devon and Cornwall. People with a GP in South Hams and West Devon can be seen on a case by case basis if the rehabilitation teams in that area do not have sufficient neurological skills to manage their needs.

7.3 Patients are seen as outpatients in the Therapy Unit, Local Care Centre, as a one-off in their own homes, or shortly before discharge from an inpatient unit. Patients may also be seen as a one-off in a community location such as sports facility, or swimming pool, in order to meet their specific needs.

7.4 Referrals can be made via the community therapy referral email (Livewell.therapyreferrals@nhs.net). The CTT referral form (Appendix 1) must be fully completed for the referral to be accepted and attached to the email.

7.5 Referrals can be made by other Allied health Professionals, GPs, Adult Social Care, District Nurses, other Community Therapy Teams including ESD, Psychologists, Consultants, Specialist Nurses, Derriford Hospital, voluntary

sector and secondary care. There is currently no service provision for self-referral.

7.6 Referrals received in the CTT inbox are sent to the Therapy Unit inbox and triaged three times per week by therapists within the Therapy Unit team. All referrals will be triaged to identify urgency, therapy input needed and the most appropriate setting for assessment.

7.7 Referrals are prioritised on clinical need and risk regardless of diagnosis according to the following criteria:

- As soon as possible (within 5 days):
  - Supporting patients being discharged from hospital
  - People who are having increased frequency of falls compared to normal and at heightened risk due to issues such as dizziness
  - Botulinum toxin injection requiring further therapy management to maximize treatment effectiveness

- Priority 1: within 2 weeks
  - Person whose long term condition has showed rapid significant deterioration and as a result are at high risk of falls
  - Neurological splinting due to risk of loss of range of movement
  - Person requiring facial therapy assessment and management

- Priority 2: within 3 weeks
  - Mobility and transfer assessment and progression
  - Functional assessment
  - Wheelchair/routine seating assessment
  - Splinting assessment and provision
  - People experiencing mechanical falls
  - Walking aid clinic
  - Deterioration of long term condition

- Priority 3: within 4 weeks
  - Driving assessment
  - Vocational rehabilitation
  - Referral related to personal/daily activities of daily living
  - Fatigue management

8 Inclusion Criteria

8.1 Eligibility criteria include:

- Over 16 years of age
- New neurological diagnosis or neurological diagnosis with new needs

- Needs are best met in outpatient setting
- Person can travel to Mt Gould Hospital
- Has specific rehabilitation goals and can participate in a rehabilitation programme
- Requires Neurological Physiotherapy or Occupational Therapy input
- Facial paralysis living in Devon, Cornwall, or Plymouth

9 Exclusion Criteria

9.1 Exclusion criteria include:

- Not registered with a Plymouth GP. Patients from South Hams and West Devon can be seen if the rehabilitation teams in that area do not have sufficient neurological skills to manage the needs of the service user
- Under 16 years of age
- Unable to travel, therefore needs best met in home environment
- If the person's primary problem would be best addressed by another service
- Inpatients
- Self-referral
- Primary need is for equipment
- Primary need is for minor or major adaptations
- Requiring replacement of walking aids
- Requiring maintenance/repair of existing equipment

10 Discharge criteria and planning

10.1 Patients are discharged from the Therapy Unit when they meet the following criteria:

1) All agreed goals have been met
2) The patient is not achieving goals and is unlikely to do so
3) The patient is admitted to hospital
4) The patient has longer term rehabilitation needs which are best met by referral to another service

10.2 The discharge planning process starts at assessment, when treatment plan and SMART goals are agreed. Goals are discussed with the patient and their carer/family as appropriate within the first 2 treatment sessions and documented within the notes. Treatment is goal directed and time limited and this is discussed with the patient at the time of setting goals. Patients can also be given a copy of their goals. Once this timescale is reached, the goals should be reviewed together and either re-set if there are outstanding therapy needs, or the patient should be discharged at this stage.

10.3 Caseload management is carried out with all staff via their line manager, particularly reviewing those patients who have been seen for more than 6 weeks, providing support for therapists making decisions regarding discharge.

10.4 Plans for discharge will be discussed with the patient and anyone who attends with them.

10.5 Onward referral will be made, with the patient's consent (or in the patient's best interests' if consent cannot be obtained), to other appropriate services.

10.6 Once discharge has been agreed, a discharge report is sent to the referrer, GP, the patient if required and any other services involved.

11 Patient and Carer Information

11.1 The Therapy Unit actively promotes patient independence and self-management. Patients are strongly encouraged to maximise their function and fitness in order to manage their condition successfully at home and maintain their own wellbeing as far as possible.

11.2 Patients will be signposted to condition-specific organisations, expert patient programmes and support groups to support them with managing their condition. Information regarding the PALS service is provided where appropriate.

11.3 Patients and their carers are given contact details for services/groups, website addresses and leaflets relating to their specific needs. These may include: MS Society, Parkinsons UK, Age UK, MS Trust, Stroke Association, National Osteoporosis Society, Headway, Scope, Spinal Injuries Association, local exercise groups, Social Services and local support groups.

12 Communication

12.1 Monthly team meeting- this is held on the first Wednesday of each month to discuss clinical and non-clinical issues within the team, including service development plans and matters directly related to the operation of the Therapy Unit team including patient feedback, risk management and safeguarding alerts raised.

12.2 MDT Clinical Meetings- These are held on the last Wednesday of the month to review patients on the team caseload with consultants, psychologists and other members of the MDT also involved with the patient to discuss goals and plans for treatment. New referrals are discussed and decisions made regarding the outcome.

12.3 Waiting list review meetings- held weekly to review the waiting list, spaces in the exercise group and new patient appointments being offered on a weekly basis. Urgent new patient referrals can also be discussed to ensure that they are allocated in a timely manner.

12.4 Service meetings- The Manager/deputy or other staff may attend meetings within the organisation, feedback to other staff within the team and action any points from this meeting.

13 Training implications

13.1 On appointment all staff should receive a corporate and local induction

13.2 Each staff member is allocated a line manager who takes responsibility for regular line management supervision, caseload management supervision and annual appraisal. Additionally the Organisation supports staff to engage in 1-1 clinical supervision in line with policy.

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

13.4 All staff are expected to engage with Continued Professional Development and should keep a record of the training, reflection and supervision that they have participated in. All staff are expected to maintain their professional competencies using the ratified documents to support this.

13.5 Local clinical in-service training is also provided alongside other neurological teams within Livewell Southwest on a fortnightly basis. Staff are expected to attend where possible.

14 Management responsibility

14.1 The Therapy Unit Manager has responsibility for the unit during working hours supported by the deputy and all other members of the team, and is responsible to the Matron for Neurological Services who in turn is accountable to the Community Urgent Care Services Locality Manager.

15 Service user involvement

15.1 Service Users are involved in all aspects of their care, along with carers as appropriate, and are assisted to access resources as required. Service user questionnaires are completed on discharge and on an annual basis.

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

16 Clinical Governance

16.1 Services are monitored for compliance against Care Quality Commission Standards. These are reviewed on an on-going basis and evidence is kept on a shared drive. The Current Key Lines of Enquiry focus on the service being Safe, Effective, Caring, Responsive and Well Led.

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

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

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

17 Information Governance

17.1 The service provides visual information displayed within the waiting area around SystmOne and use of information, Confidentiality, Data collection and Compliments, Complaints and Concerns procedure.

17.2 All staff are responsible and must adhere to policies, procedures and systems that are in place to ensure that confidentiality of information is maintained.

17.3 All staff receive training around confidentiality and sharing of information.

17.4 Information Governance incidents are routinely monitored across Livewell Southwest and discussed at Locality level and at Team Meetings.

18 Managing safety and risk

17.1 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.

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

17.3 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. All staff attending a home visit should use the Skyguard in accordance with the loan worker policy.

17.4 If there is a known risk in visiting any service user then appropriate safeguards should be put in place according to the Loan Worker Policy.

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

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

18 Monitoring compliance

18.1 Compliance with this policy is monitored through patient feedback via the Friends and Family test, local audits of documentation, regular line management and appraisal of all staff, NICE guidance review and monitoring service statistics and waiting lists. Results of these are reviewed by managers and deputies and shared with the team to monitor team performance.

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: Michelle Thomas, Director of Operations

Date: 10th May 2017

Appendix 1

Community Therapy

Tel: 01752 434195 for PL1, PL2, PL5 (West) Tel: 01752 435346 for PL7, PL9 (East)
Tel 01752 434171 for PL3, PL4 (South) Tel: 01752 435441 for PL5, PL6 (North)
Email: LIVEWELL.therapyreferrals@nhs.net

Referral form will be returned if all sections are not completed and clear

GP name and address: **GP tel. no:** **Date last seen by GP *(if known)*:** **Relative/Carer contact details:** **Permission to contact the relative/carer:**	**Person's name:** **NHS no:** **Date of birth:** **Address *(include permanent address if temporary):*** **Post Code:** **Tel:**

Referred by: Position:

Tel. no: Location: Date of referral:

Confirm person has consented and agreed to referral:
Patient lacks capacity and referral completed in best interest

GP informed of referral?

Diagnosis/current history:

Date of onset:
Relevant medical history:

Medication:

What is the person's perceived problem/need?

Reason for referral *(referrer's expectation, aim or goal of the intervention):*

Previous therapy/treatment *(include dates and outcome if known):*

Please consider attaching the following additional information:

Drug chart

GP summary

Discharge summary

Goals and treatment plan *(essential if referring to a Therapy Support Worker)*

Health Needs Assessment

Is there a risk to staff visiting this person?

Comments:

Visiting alone **Yes** _____

Environmental **Yes** _____

Access **Yes** _____

Infection **Yes** _____

Pets **Yes** _____

Smoking **Yes** _____

Other **Yes** _____

If no/unknown please ☑

Prioritising degree of urgency *(Please delete as appropriate)*:

Would intervention help prevent a hospital or care home admission?

Would intervention facilitate discharge?

Is the person medically able to participate?

Is the person's immediate safety compromised?

Does the person live alone?

Can the person travel to Mount Gould?

(Please note that this should be ability to travel rather than patient choice)

Comments regarding urgency:

_____

_____

_____

_____

_____

Is the person willing for information gained during this episode of care to be shared with other agencies as appropriate? Yes