The Priory Hospital
Middleton St George

Linden Ward
A high dependency (locked) rehabilitation unit
Linden Ward is a high dependency, locked rehabilitation unit for men with severe, and often treatment resistant, mental health conditions. Our aim is to help all those in our care to achieve their aspirations and full potential. We do this by working closely as a multidisciplinary team, with each patient playing a central role in their own recovery.

The ward provides a recovery orientated rehabilitation service and our patients are at the heart of everything we do. We work with the individual to develop new and existing skills and help them to understand and build on their strengths, enabling them to grow in confidence and self-belief.

Service overview

We support men with a range of mental health conditions, including:

- Psychotic illnesses, such as schizophrenia or schizoaffective disorder
- Personality disorder, either as a primary diagnosis or co-morbidity
- Additional problems, such as mild learning difficulties, autism spectrum disorders or substance misuse

We have adopted the ‘Safe Wards’ approach which is an evidence-based model (Bowers, 2014), that minimises the use of restrictive practices. This helps to reduce conflict and containment in mental health inpatient settings by re-thinking the ways in which staff, the environment and patients interact. Key to this approach is having a compassionate and motivated team that works in a flexible, patient-centred way.

Some of the ‘Safe Wards’ interventions that are used on Linden Ward include:

- Having clear mutual expectations agreed between staff and patients
- A fully collaborative approach
- The use of advanced de-escalation techniques
- Routinely saying something positive about each patient at each nurse hand-over
- Proactively supporting patients at difficult times
- Adopting an open culture
- Having daily staff and patient meetings
- Celebrating our patients’ successes, such as by commemorating their progress in ‘discharge messages’

By implementing such strategies, we are able to replace our seclusion facility with a purpose-built sensory room to help our patients during times of distress.
Our approach

We use several therapeutic models collaboratively with our patients to guide our delivery of their care. One model we use is the ‘My Shared Pathway’ framework, which anchors our care plans. In this method, patients work with staff to agree realistic goals for a successful discharge, by asking the following questions:

- Where am I now?
- Where do I want to get to?
- How do I get there?
- How can I tell how I’m doing?

Progress on this recovery journey is assessed in eight different domains:

- My mental health recovery
- Stopping my problem behaviours
- Getting insight
- Recovery from drug and alcohol problems
- Making feasible plans
- Staying healthy
- My life skills
- My relationships

- We work collaboratively with our patients to develop care plans in these domains
- They are reviewed regularly in ward rounds and care planning approach (CPA) meetings
- Our patients actively participate in risk assessment
- We use the short-term assessment of risk and treatability (START) tool, which uniquely considers strengths as well as needs
- We monitor progress using the Camberwell Assessment of Needs (CANSAS) tool, which helps us understand the health and social care needs of our patients
- For physical health management, we use the framework of the Lester Tool

Patients and carers are able to play a key role in CPA meetings, during which, progress in each of the ‘My Shared Pathway’ domains is reviewed. In addition, we always encourage patients to prepare their own CPA report, to share their successes and the progress that they have made towards their goals.
Linden Ward – a patient’s story

“For 14 years prior to arriving at The Priory Hospital Middleton St George, I had been in and out of mental health institutions. As soon as I arrived at Middleton St George, the staff team were very welcoming and they understood my illness immediately. In terms of risk management for self-harming, Linden was by far the safest ward I had ever been on.

Thanks to Priory and the staff on Linden Ward, I have made a full recovery. My psychologist was the best I had ever worked with and was partly responsible for my hard-earned recovery. The team never gave up on me, and supported me through thick and thin.

The structure of leave is really sensible and the multidisciplinary team were always fair and constructive. I would highly recommend this hospital, and particularly Linden Ward, to other people who suffer with mental health problems.”
Meet the team

Dr Steve Ramplin (Consultant Forensic Psychiatrist)
MBBS MRC-Psych MA (Philosophy and Mental Health) (Distinction)
Call: 01325 331916
Email: steveramplin@priorygroup.com

Having previously worked in both low secure and locked NHS rehabilitation, where he played a leading role in minimising restrictive practices, Dr Ramplin has considerable experience working with the patient group on Linden. His person-centred, hands-on, evidence-based approach has helped those with complex needs to achieve lasting, meaningful change.

Dr Gary Walker (Clinical Psychologist)
BSc (Hons) Behavioural Science, P.G. Dip Psy, D.Clin.Psy

Dr Walker has worked in a variety of clinical settings and with a range of clinical populations, including forensic patients, adults of working age and older people. His approach is evidence-based and emphasises understanding the individual through their experiences and interactions with others. He delivers a broad range of treatments on an individual basis.

Andrew Hodgson (Ward Manager)
RMN, BSc (Hons) Sociology
Call: 01325 331946
Email: AndrewHodgson@priorygroup.com

Since qualifying as a nurse in 1992, Andrew has gained experience in a wide variety of mental health settings including NHS secure, acute and community services, the prison service and Independent Health Care, working with young people, adults and the elderly. He has worked at Middleton St George Hospital since 2003 and was part of the team that developed the existing services.

Nursing team
To contact any of our ward staff, please call 01325 331918

Our experienced nursing team is led by two clinical team leads, Dianne Towers and Victoria Kay.

Geoff Straughan (Advanced Nurse Practitioner)

Geoff qualified as a general nurse in 1980. He subsequently managed an occupational medical centre before completing further training as a Registered Mental Nurse (RMN). After working for six years as a ward manager for an older persons’ admission ward, he moved to the independent sector, initially working in a psychiatric intensive care unit. He has been an advanced practitioner and independent non-medical prescriber supporting the medical team at Priory since 2010.

Vicki Nesbit (Occupational Therapist)
BSc (Hons) Occupational Therapy

Vicki qualified as an occupational therapist in 2017 and has previous experience in various clinical settings, including a community mental health team, a psychiatric inpatient ward and a medium secure forensic unit. Her assessments and interventions are evidence-based, with the goal of equipping patients with the skills that are required to reach their full potential to enable independent living.

Local team care co-ordinators

We work closely with patients’ local teams throughout their stay. During the pre-admission stage, discussions take place with a patient’s care co-ordinator, and a close relationship is continued throughout admission. Representatives from local teams are invited to CPA meetings to ensure continuity and early involvement in discharge planning.

Involvement is greatest when patients move towards discharge, ensuring they receive the right support to thrive in the community.

To contact any of our team, please call 01325 333192
Our services

We take referrals from the following settings:

- Adult mental health wards
- Psychiatric intensive care units
- Low and medium secure services
- Alternative rehabilitation providers
- Prisons

Our patients are usually detained under the Mental Health Act and we take patients from all over the UK, with placements funded by Clinical Commissioning Groups (CCGs).

Pre-admission assessment

We aim to complete a multidisciplinary assessment on all referrals within three working days. This involves an initial review of documentation, followed by a detailed clinical interview by two members of the team, and the patient in their current setting. We aim to keep strong links with previous carers or the family at all times. We also begin care planning immediately.

Visits

Keeping in touch with family and friends is an important part of any recovery journey. We encourage relatives and friends to visit patients. Please contact the ward on 01325 331918 to book a visit; we aim to be as flexible as possible.

Admission and assessment – multidisciplinary care planning (up to 3 months)

On admission, the structure upon arrival will include:

- Patient is shown around the ward and introduced to the team and other patients
- Bedroom assigned which can be personalised where appropriate. All bedrooms have en-suite facilities
- Each patient is allocated a named nurse, associate nurse and nursing team
- Individual 1:1 meetings with psychiatrist, psychologist, occupational therapist, advanced practitioner, social worker and nursing staff take place

The aim is to complete a comprehensive assessment of need. The team then develops care plans collaboratively with the patient according to the ‘My Shared Pathway’ and other models.
The treatment programme

The treatment phase typically lasts for around 6 to 12 months on Linden Ward. The programme is made up of the following:

Psychiatry

- A holistic treatment plan that prioritises patient involvement
- Physical health management is a key component of treatment
- Mental health symptoms are reviewed and managed
- Rehabilitative needs are assessed and intervention plans to develop skills are implemented
- All of this is done with reference to the current best practice for each patient’s particular problems

Psychology

- Service based on individual needs to reduce psychological distress and promote wellbeing
- Symptom orientated interventions support patients in their recovery journey of re-engaging with hope, healing, empowerment and connection
- Interventions such as cognitive behavioural therapy (CBT) and dialectical behaviour informed therapy (DBT) implemented
- Neuropsychological assessments may take place to guide delivery
- Progress is evaluated routinely using various measures, such as the SCL90-R, to achieve the best possible outcomes

Occupational therapy

- Patients are regularly assessed on an individual basis, from admission to discharge
- Interventions are implemented to develop skills and ensure that any deficits are identified, with the aim of restoring as much independence as possible
- Progress is objectively assessed using the Model of Human Occupation (MOHO) tools
- Patients are supported with complex living skills such as budgeting, shopping and cooking
- Community skills assessments identify strengths and weaknesses in areas such as road safety and social integration
- A structured programme of activities runs throughout the week, including vocational roles in the hospital café, working on an allotment and volunteering at a local dog charity in the community
The treatment programme (cont).

Nursing

- The team begin by enabling patients to have more involvement and control over their conditions and promote positive links with friends and family.
- Each patient will undergo a period of assessment so that we can collaboratively plan their care, with the following considered:
  - Mental health (including mood, hallucinations, delusions, thought disorder)
  - Functioning (including memory, activities of daily living)
  - Behaviours and their triggers
  - Risks to self and others
  - Physical health
  - Effects and side effects of medication
  - Use of alcohol and misuse of prescribed or illicit substances
  - Social circumstances of the patient
  - Spiritual and cultural needs

Advanced nurse practitioner and visiting on-site GP clinics

- Comprehensive assessment takes place, which includes both a psychological and a physical review.
- Visiting on-site GP manages both acute and chronic physical health conditions.
- Works with patients to support compliance with prescribed treatments, providing advice on medication, side effects and interactions.
- Encourages health promotion and maintains the recommended physical health monitoring according to national guidance.

Physical health clinics and physical wellbeing opportunities

- Ensure the best physical health of our patients.
- Monitoring for potential physical health conditions, including weight gain, diabetes, high blood lipids and hypertension in our monthly rolling physical health clinic.
- We adopt the Lester Tool (Shiers et al, 2014), an intervention framework for people with psychosis and schizophrenia, based on the principle ‘don’t just screen, intervene’.
- Key principles of this framework involve assistance with smoking cessation (like many private and NHS hospitals, ours is now a ‘no smoking’ site), lifestyle advice, weight management and the treatment of any identified conditions, such as diabetes.
- We engage our patients in this process by presenting information visually, including body mass index (BMI) and QRisk scores.
- To help our patients to maintain their physical health we have a small ward gym, a larger hospital gym, regular on and off-site walking groups and an all-weather outdoor football pitch.
The treatment programme (cont).

Social work

- Engages with patients to assist in their rehabilitation and recovery
- Provides a link between the home and multidisciplinary team
- Provides a link with patients’ social supports (carers, family members, friends)
- Promotes carer engagement in patients’ treatment as appropriate
- Enables visits that are supportive and beneficial to patients
- Ensures that child visits are in the best interests of the children involved, which relies on correct risk assessment before approval
- Acts as a lead in multi-agency contact relating to matters of safeguarding and as an appropriate adult for potential police interviews
- Supports MAPPA/MARAC needs and identifies potential discriminatory structures and practices

Discharge management (up to three months)

- Progress against ‘My Shared Pathway’ care plans will indicate readiness for discharge
- At this stage, a CPA meeting will usually be organised to finalise plans for moving on from Linden Ward
- Typically, this will involve a period of time in the community on an unescorted basis before integration to an identified community placement
- This would be supported by the patient’s care coordinator and community mental health team
- Often a patient will require a community treatment order (CTO), which will also require an assessment by an approved mental health practitioner from that patient’s home area locality
- We liaise closely with home teams, to ensure that all of the necessary support is implemented prior to discharge
- Where possible, discharge meetings take place in a patient’s home area, as by that stage, that should be the main location of their care
Measuring quality

We are committed to ensuring a very high quality of care and are working hard to develop ways to measure this.

- We adhere to National Institute for Health and Care Excellence (NICE) guidelines
- We follow the Mental Health Act Code of Practice
- We take the rights of our patients as individuals detained under the Mental Health Act very seriously
- All staff in our team are familiar with the principles of the act, including that care should be delivered in the least restrictive way possible at all times
- We always treat all of our patients with dignity and respect and we actively empower our patients by involving them in all aspects of their care
- We do not have seclusion facilities, preferentially utilising de-escalation and a positive behavioural support informed approach
- We routinely abide by good prescribing practice – avoidance of poly-pharmacy and minimising the use of high dose antipsychotic treatment
- We also minimise the use of discretionary and sedative medication

Objective quality measures

- We routinely use objective rating scales to assess progress and treatment response
- These include diagnosis specific measures (such as the brief psychiatric rating scale for those patients with severe mental illnesses like schizophrenia) and side effect rating scales
- We objectively measure improvements in function, for example using the Health of the Nation Outcome Survey (HoNOS) and Global Assessment of Functioning (GAF) tool
- Analysis of our 2017 GAF data showed an improvement in function for the majority of our patients
- Other outcome measures used include the Camberwell Assessment of Needs and the Model of Human Occupation
Safeguarding

We take our safeguarding responsibilities very seriously indeed. Our patients are classed as vulnerable adults, because of their needs and because they are usually detained under the Mental Health Act. Moreover, some have parental responsibilities, or have regular contact with children. Therefore in such cases, their mental health problems can have a major impact on any children involved too. Linden Ward adheres to the highest possible safeguarding standards to ensure that everyone involved is supported to the highest degree.

All of our safeguarding policies and procedures are up-to-date and all of our staff complete mandatory adult and children safeguarding training. The hospital’s senior management team meet every working day, reviewing all incidents and highlighting any issues related to safeguarding. They liaise closely with Darlington Local Authority and patients’ home area local authorities, escalating any concerns if required.

We also regularly audit our safeguarding practices and all of this helps to ensure that, as far as possible, we maintain the safety of our patients and any children with whom they have contact with, on and off our site.

Training

To help maintain quality, all staff receive regular supervision, undertake regular mandatory training (which is audited) and are supported in continuing professional development.
References


• My Shared Pathway www.recoveryandoutcomes.org/my-shared-pathway/how-it-works.html

• Webster et al (2009), Short-Term Assessment of Risk and Treatability (START).

Our location

The Priory Hospital Middleton St George, Middleton St George, Darlington, County Durham, DL2 1TS

Contact us

For more information on the services offered at The Priory Hospital Middleton St George, or if you have an enquiry about Linden Ward, please contact us today:

Call: 01325 333192 (reception)
Email: middletonstgeorge@priorygroup.com
Visit: www.priorygroup.com/middletonstgeorge

Alternatively, if you would like to make a referral into Middleton St George, please contact Lorraine Mason on the following secure contact details:

Call: 01325 333192
Email: loraine.mason@nhs.net
Visit: www.priorygroup.com/professionals/make-a-referral