Priory

Learning Disability Service

Male Rehabilitation and Recovery Services

Philosophy of Care – Lombard House and Lombard House Flats 2022

Mission statement:

To work in partnership with individuals to achieve their optimum level of functioning, to maximise their quality of life by building on their existing strengths, facilitating the gaining of new skills and promoting personal development. To enable them to live in the least restrictive environment possible, while maintaining the safety of themselves and others.

Introduction

Priory Healthcare are the leading provider of behavioural care in the UK. Within Learning Disability Services, we strive to be a centre of excellence and to be at the forefront of evidence-based practice.

The Rehabilitation and Recovery Service at Lombard House provides a step-down pathway for adult males with primary diagnosis of intellectual disability or autistic spectrum condition. We accept service users with comorbid mental illness such as psychotic or personality disorders who present with behaviours that challenge, not requiring restraint and seclusion.

The service is committed to tackling health inequalities commonly found in people with Learning Disabilities and provide specialist support through person centred care to reduce barriers and enable individuals to live a fulfilling life. Positive Behaviour Support provides a framework for the nursing team, their values and objectives.

Lombard House is located in the rural Norfolk village of Little Ellingham surrounded by farms. There are walking paths within a short walk from the house surrounded by wildlife and nature. Staff escort patients for walks within the quiet community on a regular basis. Attleborough is the closest town centre, which has all essential shops and Norwich is only a 30 minute drive from the house at the busiest time of the day.

Our rehabilitation services are provided within a seven bed main house, used for admission, assessment, treatment and rehabilitation. It has a shared kitchen, dining room and living area. A further two beds are provided in a flat which is based within the grounds of the house. These two beds continue the pathway within secure rehabilitation services, whilst creating a less restrictive environment for the patients who progress from the house to the flat.

We have a multi activity centre where patients can play and the large garden where they can engage

in rehabilitation activities such as walks, exercise and gardening.

The MDT consists of a psychiatrist, nurses, psychologists, occupational therapists, speech and language therapist, basic skills teacher and healthcare support workers.

Patient referral & criteria

We expect patients who are referred to us to be detained under the civil or forensic section of the Mental Health Act 1983 at the time of admission to our service. We accept patients from acute and secure services. Service users who stepdown from secure services, will have completed their assessment and core treatment within the secure Assessment and Treatment (A&T) hospital service. Service users who are referred to us from acute services, we complete a further assessment and provide appropriate therapy in order to help improve their mental wellbeing.

Criteria:

- **Male**
- **Age 18 and above**
- **Detained under the Mental Health Act 1983**
- **Diagnosis of intellectual disability or autistic spectrum disorder**
- **IQ score on WAIS–IV or equivalent of mild severity of intellectual disability**
- **Co-morbid diagnoses of other developmental disorders, personality disorders and mental illnesses.**
- **Patients with forensic history, sexual offending, fire setting or other violence**

If a person has a physical disability, an assessment will be made to identify the needs of the individual and the extent of which they can be met.

Referrals can be made in writing, emailed to the Rehabilitation and Recovery Services MDT. Further detailed information can be provided upon request.

Patient engagement

All patients have a 12 weekly timetable of planned meaningful and therapeutic activity, with a minimum of 25 hours planned activity. Patients are actively involved in developing and reviewing these timetables.

All activities are positively promoted to develop, support and maintain positive self-esteem, a sense of self-worth and independence in addition to developing existing skills while learning new skills within a supportive environment.

Patients are encouraged to participate in the daily tasks of the unit such as cooking and cleaning and are supported to attend to their own laundry to develop and maintain practical skills. Assisting with the unit shopping develops social and practical skills and offers the staff the opportunity to continually assess the patients within a community setting, the outcome of which can be used in the planning of future care needs.

Psychology, life skills, education and vocational opportunity service (LEVOS)

Although it is anticipated that patients will have undertaken the intensive therapeutic work associated within assessment and treatment care pathways, it is appreciated that ongoing session work and support may be required for individual patients. Psychological treatments, individual or follow on group work, focused on specific interventions that are individually tailored to patients' needs will be available.

The Occupational Therapy Service and interventions are underpinned by the 'Model of Human Occupation' (MOHO) which incorporates a number of standardised and non-standardised assessments.

Assessments are completed by the MDT team to provide each patient with an individualised programme that promotes engagement in a range of activities and supports the patients to develope and/or maintain their current abilities.

This includes psychological interventions, communication therapy and educational skills on an individual basis or as group work.

Measurement of change

The Rehabilitation and Recovery service has an in-built audit trail to demonstrate that its standards of care have full compliance with the guidelines from bodies such as Care Quality Commission (CQC), National Institute of Health and Clinical Excellence (NICE) and the Mental Health Act Commission (MHAC).

Audit findings are monitored closely through the clinical governance framework for continuous improvement of the quality of care. Lombard House works closely with Clinical Audits and Contractors Co-ordinator.

Care programme approach

All patients within the service are cared for and treated within the framework of the Care Programme Approach (CPA) to ensure involvement of the patients in all aspects of their care.

Rehabilitation and recovery service, patients have a care co-ordinator allocated to them. The care co-ordinator will ensure that the patient's views on treatment are communicated to the staff and that aspects of the treatment programme go as planned. All patients will be involved in, and have access to, their documented care

plan. Carers can attend the patient's CPA and aftercare planning meetings with the consent of the patient.

Risk management

The assessment and management of risk is seen as an essential component of treatment within the Rehabilitation and Recovery Service. Patients often present with very complex risks and we see it as important to identify how these may be best minimised and managed, not only for the well-being of the patient, but also for the benefit of the community. Risk must be subject to frequent review, which occurs at each Risk Formulation Meeting. (Monthly MDT meeting)

Family contact

We recognise our geographical distance from the home areas of many of our patients. We are committed to maintaining our patient's links with family and friends, and their local community. This is facilitated by regular home visits where appropriate. Patients within the rehabilitation and recovery service have the opportunities to access Video Calling and some patients have the use of their own personal mobile phones or the use of the house smart phone.

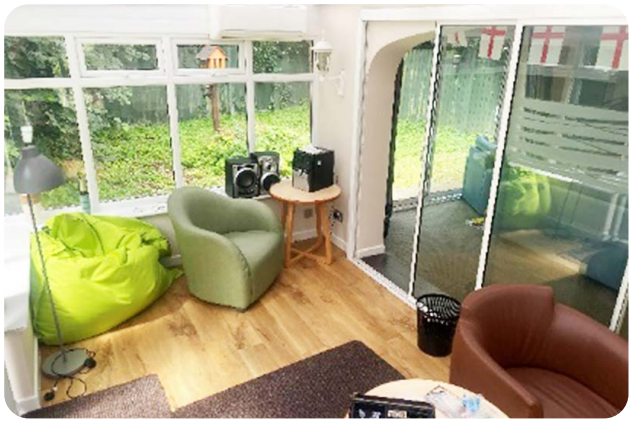
Advocacy

An external Advocacy Service called POhWER will provide formal advocacy for the patient group to deal with specific issues raised by patients within the hospital. In addition, an Independent Mental Health Advocate and Independent Mental Capacity Advocacy service is available upon request.

Discharge and transfer

Patients will have their care pathway and future service planning discussed at Section 117 meetings within the CPA procedure, or discharge planning meetings for those patients who are not subject to S117.

To assist the patients external professional network in future service planning, the MDT will complete a pre-discharge profile. The profile fully outlines the patient treatment pathway and outcomes since admission. It endeavours to identify their future individual needs, risk management, and service recommendations.



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