THIS FORM SHOULD BE COMPLETED BY THE PATIENT, WITH NURSING SUPPORT WHERE REQUIRED

FORM CP1 **(Appendix 1)**

PATIENT'S REQUEST FOR CHILD VISIT

A separate form for each child is required

Patients name:	
Ward:	
Name of Child:	
Name of Parent/Carer: **Contact Details:**	
Consent of Parent/Carer given (Y/N) **Record of direct contact** (note of telephone number called, date and time called)	
Childs Date of Birth:	**Age of child at time of visit:**
Nature of visit:	
Relationship of child to patient:	
Benefit to child:	
Parents/Guardians understanding of secure services: Yes/No	
Have they previously visited other secure placements where relatives have been detained? (Please verify)	
Copy for file: Yes/No	**Copy given to parent/guardian**: Yes/No
Name: **Job title:**	**Date:**

Signature:	

Essex Partnership University
NHS Foundation Trust

Brockfield House

Patient Information Booklet

*A booklet designed **by** patients **for** patients to help you understand where you are and what is available to you.*

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Welcome to Brockfield House

We realise this is a new and often scary experience for you and will do all we can to make your stay here as comfortable and stress free as possible.

In order to help with this patients and staff have worked together to produce this booklet, which we hope will help you understand your new environment better to make the experience less daunting.

What is Brockfield House?

Brockfield House is a secure mental health hospital located in Wickford, Essex.

There are 7 different wards at Brockfield House - 4 male wards (Lagoon, Alpine, Forest and Dune), 2 female wards (Fuji and Causeway), and a mixed pre discharge ward (Aurora).

What happens when I first arrive?

When you first arrive staff will do their best to ensure you are relaxed and at ease in your new surroundings.

Staff will discuss with you, very informally, why you are here and how we can help you get better. They will try to establish some common goals we can all work towards during your stay.

During this time you may be with a member of staff at all times – this is known as "Level 3 Observations". These observations are in place for safety reasons, it is not a punishment.

Your observation level will change during your stay at the hospital and this is discussed and agreed by your clinical team.

From the very beginning of your stay you should be discussing what needs to happen to help you get well and planning for your discharge. Within your first 12 weeks of your stay you should be given an estimated date of discharge.

The ward routine

All the wards have a routine; this is to help both patients and staff. This routine may be different from ward to ward - In your information pack you will find a leaflet with information about your ward; however the general schedule for the hospital is below.

Ward Mealtimes

Each ward has three main meal times a day, to find these times look in your ward booklet.

Business/Ward Meeting

After breakfast there is a business/ward meeting to plan the day. This meeting is attended by patients and staff and is an opportunity to discuss any ward issues. A patient leads this meeting and everything discussed is written down so staff can follow up on what has been raised.

Medication Times

There are four set medication times; however you might not be given medication during each time slot. This will be discussed and agreed in your Ward Round with your doctor and your team. Medication times are as follows:

Morning	8am – 8.30am
Lunchtime	1pm – 1.30pm
Teatime	6pm – 6:30pm
Night-time	9pm - 9:30pm

Ward Rounds

Your ward round happens once every two weeks, it includes a summary of your progress over the past two weeks and gives you an opportunity to ask the team any questions or discuss requests that you have regarding your care. If you wish to have a family member attend the ward round this may be possible following discussion with your clinical team.

Laundry Times

You will have a time where you can do your laundry. You can discuss with ward staff when there is an available slot.

Earning and Spending Money

Welfare

Welfare is a place where you can decide to keep your money. It is also where you can go to ask questions about money, including information about benefits. Welfare is open from 11 am to 12 pm for the medium secure side and 10 am to 11 am for the low secure side.

Incentive Job

You can request an incentive job on the ward, which will mean that you will have to do a task daily for £5 a week. This may include things such as cleaning tables, collecting glasses and cleaning windows etc. Please speak to your keyworker/ ward manager if you are interested in an incentive job.

The Shop

The shop is a place where you can buy refreshments such as: drinks, ice cream, chocolate and crisps. You can also buy newspapers and toiletries such as; shower gel, roll on deodorant and hair gel.

The shop is open from 10.45 am to 11.45 am for the medium secure side and 9.45 am to 10.45 am for the low secure side.

Ordering Items

If you need items that aren't in the shop you may be able to order them. You will then be required to complete a form known as an EPROC form. The form will then be discussed by your team, and needs to be signed off by your doctor before the order is placed. You can ask staff to support you with this.

Socialising and Activities

The Canteen

The canteen is a place where you can socialise with other patients and buy refreshments such as cold/ hot drinks and snacks. Groups also take part in the canteen such as Bingo and Open Mic Night.

The canteen is open at different times for both sides of the hospital. For the medium secure side the canteen is open from 3.30 pm to 4.30 pm and 6 pm to 6.30 pm and for the low secure side the canteen is open from 2pm to 3pm and 5pm to 6pm.

Gym and Sports Hall

The gym and sports hall offer a range of different sports and physical activities. The gym is open to all the wards for at least one day a week, but you are able to attend the gym more times if you wish. There is a range of sports available every day for patients to attend such as football, basketball, volleyball and badminton. These sports groups are available for anyone to attend and enjoy from all the wards.

Occupational Therapy Groups

Each ward has an Occupational Therapist and Activity Co-ordinator and there will be an activity timetable. This may include a variety of groups including creative activities, games, sports, cooking and relaxation. Speak with the OT or AC on your ward for more information.

Therapies Suites

There are different rooms in the therapies corridor in which you can go to a range of activities;

- There is an art room, and a kitchen where patients from can cook a meal of their choice under supervision.
- A workshop where activities such as wood work are carried out.
- The IT room is where patients can used the computers under staff supervision. We also have a Multi-faith Room which is used for relaxation groups, while also providing a place for patients to practice their faith if they choose to.
- There are also some large rooms where psychology groups may take place.

Psychology Sessions and Groups

Each ward has a psychologist who is assisted, sometimes, by an assistant psychologist. The psychologist will meet with you and arrange individual psychology sessions with you if this would be helpful for you, and can arrange for you to attend psychology groups.

These therapy groups are run by the psychologists and assistant psychologists and are trained to support you with a range of difficulties or problems. There are some psychology groups that you can choose to go to yourself without a referral - the details of these will be on your ward timetable.

Grounds

The grounds (courtyards) is where patients from across different wards can talk and socialise with each other. It is also where you will find the canteen, shop and the welfare office.

The grounds are open at certain times for both sides of Brockfield House.

Perimeter

The perimeter is an area which runs outside the wards and grounds; it can be used for escorted and unescorted patients to walk round the hospital and to get a bit of fresh air.

We have outside gym equipment and bikes within the perimeter that you are allowed to use when on perimeter leave.

Visiting Times

You are allowed to have family/friends visit you whilst you are in hospital. Visitors are not allowed to visit the unit during medication time or during meal times.

There is a family room available if you have young children, which is off the ward and in a separate part of the unit. All visits must be discussed and agreed with your team and organised via the social worker before the visit takes place. If a visitor turns up and it has not been pre-arranged, they will not be allowed into the unit.

Visitors can bring items into the unit for you, however all food must be sealed (so no home cooked meals) and any packaging must not contain glass, foil or cans. Any electrical items must be discussed and agreed with your team before you are allowed to have them in your bedroom. If a visitor brings an electrical item this will need to be PAT tested for safety prior to them being given to you.

Meet the staff

Responsible Clinician	*I am an NHS Consultant psychiatrist and will be your primary doctor. In association with your multidisciplinary care team I will make decisions regarding your diagnosis, medication and your treatment but will always involve you in these as much as possible.*
Senior / Junior Doctor	*I am another doctor that will be involved in your care. I will often be involved in physical health checks and reviewing medication. Also if your Responsible Clinician is away I will be available to support with your requests.*
Integrated Clinical Lead	*I am a professional member of staff involved in your care and stay at Brockfield House. I oversee the management of the ward where you are being care for, with the support of the ward sister/charge nurse.*
Psychologist	*As your Psychologist, I will help with delivering the psychological input that you need. This can mean that I help with running psychology groups that you attend, and may support you with tasks such as updating your psychology care plans or meeting with you for individual sessions if you need extra help with some of your group work.*
Social Worker	*As your Social Worker I will liaise with your family and arrange visits. I can support you with applying for and managing your benefits. I will play a role in your discharge from hospital by supporting in finding suitable accommodation to meet your needs.*
Occupational Therapist (OT)	*As your Occupational Therapist I can support you to engage in meaningful activities. There will be a group timetable on your ward consisting of various activities in which you can participate. Please speak to your OT regarding the timetable for your ward. I can also work with you in one to one sessions to develop your independent living skills e.g. cooking, budgeting, and using a computer.*

Nurse / Support Worker	*I am your first point of contact on the ward. I am able to help you with your daily living needs, administer medication and offer support and someone to talk to. Once you have been granted leave I will escort you both around Brockfield House and within the community on area leave.*
Keyworker	*I am a nurse and I will support you in preparing for you ward round including requests. I will support you in understanding your care plan and developing your behaviour support plan. I am available to offer support and guidance.*
Ward Manager	*As your ward manager, I am responsible for overseeing the staff and patients on the ward. I will also be involved in your care.*
Activity Coordinator	*As your activity co-ordinator I will offer various activities for you to attend both on and off the ward. This will also include accessing the gym and sports activities. I will also be involved in organising social events on the unit.*
Housekeeper	*I am responsible for maintaining the ward. I will be involved in cleaning the bedrooms, bathrooms, lounge, kitchen and dining room. I also organise the food.*
Spirituality	*Various spiritual leaders can come to the unit to offer support and guidance around your religious and spiritual needs. Nursing staff will be able to advise you on how to access this contact.*
Vocational and Employment Specialist	*I can support you with things related to education and work. We offer several educational courses at the unit including English, Maths and IT and you can gain a recognised qualification. I can also support you with accessing educational courses in the community or voluntary work in the community when you are ready. If you are interested in any of this please speak with OT.*
Interpreter	*If you have difficulties with English you are entitled to an*

	interpreter to support you during meetings and appointments with Therapy staff.
Advocate	*Advocates are independent of the hospital. As your advocate I can support you during ward rounds and I can be a voice for you. I can also explain your rights under the Mental Health Act. I can support you around any issues with medication and accessing tribunals. Our conversations are confidential as long as there is considered no risk to yourself or others.*
Pharmacist	*As your pharmacist I will regularly review your medication.*
Medical Secretary	*As medical secretary you will often find me in Ward Rounds and Meetings. I will take minutes of things discussed during these meetings.*
Student	*There are many of us. I may be a student nurse, psychologist or OT. I am here for my learning. Students are limited with what they can support you with but will always try their best or feedback to the team.*
Welfare Staff	I can help you with any enquires regarding your benefits. You can access your money every Monday – Friday. You are allowed to withdraw up to £40 a week, however if you require more you must complete a green form and discuss during ward round

Security Arrangements

There are a number of security arrangements at our hospital which is important to adhere to. These are in place for the safety of all patients and staff.

We are keen to make your stay as least restrictive as possible, and so rules are continually being reviewed and updated to ensure they are in place for valid reasons.

Prohibited and Restricted Items

You will find a list of Prohibited and Restricted Items in your Information Pack. This list is sometimes updated, as it often changes – you should be notified of any changes in the ward business/morning meeting.

This list will include contraband items, such as Tobacco, or items that could be used to harm yourself or others.

Room searches

Rooms will be searched monthly. However, if there is suspicion that you may be hiding some contraband items or items that you may be using to harm yourself or others, your room could be randomly searched.

Signing in and out of the ward

Every time you go onto the ward and off the ward, staff must sign you in or out. This usually happens in the airlock on the ward.

Searches at reception

Searches are in place to ensure that all patients and staff are safe. You will be searched when you return from leave to the community. This is to ensure that items that are restricted or prohibited do not enter the unit as it could cause serious harm to yourself or others.

Usually there will be two staff searching you, please speak to staff if you have any concerns about the search.

Rules and Restrictions

What about these?

You may find that when you are on the ward there is discussion about restrictions and rules. Please do not worry about this and ask staff to clarify things for you when you feel this is needed. There have to be a routine on the ward to make sure all patients and staff are safe at all times. Some rules and procedures may feel restrictive but they are in place in order to protect patients and staff to make them feel safe.

The MDT will make sure that any restriction on you will be risk assessed individually and noted in your care plan. There are times when it is necessary to have universal restrictions that apply to all patients, when this happens staff will speak to you to make sure you and the other patients know why and you will have the opportunity to ask questions about the restriction.

Why bedrooms are sometimes unavailable

You will have a bedroom allocated to you on the ward. Some wards may have set times when you have to vacate your room, for specific reasons such as to allow it to be cleaned. If so, this will be communicated to you by staff.

Why there is a medication time routine

You will be informed when you have to take your medication, and there are specific times designated to medication administration. This is to make sure that patients get medication as prescribed, i.e. morning, lunchtime, evening, to help with their mental health recovery.

If you need medication outside these designated medication times please speak to the ward staff, who will help you.

Why cigarettes aren't allowed

Legally all NHS organisations cannot allow smoking in any of their buildings. EPUT have recently agreed, however, to patients having VAPES and these are available to all patients in the shop.

Support is available to enable you to quit smoking I you wish, as is nicotine replacement therapy.

Observations

When on the ward it is still important for staff to observe your behaviour and engage with you in order to be sure you are ok.

This is for your health and wellbeing, ensuring you are coping well with being on the ward, that you are not stressed or upset. If staff observe any difficulties you are having it is easier for them to offer advice and support.

Your observation level will change during your stay at the hospital and this is discussed and agreed by your clinical team.

There are various levels of observation that staff adhere to as a minimum, and you will be placed on one of these levels depending on how well you are progressing with your treatment.

Level 1/ General observations

This is where staff will check on you once an hour even through the night.

Level 2 observations

This is where a member of staff will check on you five times an hour even through the night.

Level 3 observations

A member of staff is with you all the time. This will include when you are using the bathroom, sleeping and in the communal areas

Level 4 observations

A member of staff will be with you at all times. This member of staff will be within arm's length to make sure you are safe.

There may be times when you will be nursed by a combination of observation levels. This will be explained to you, please make sure you ask staff if you are unsure.

Discharge Planning

From the day that you arrive planning for your discharge will start. This will include practical elements, such as where you will live, but the key element is ensuring you are well enough to be discharged. This is achieved through your treatment plan.

Care Plan

A care plan will be devised and discussed with you. This plan will be unique to you and will discuss what help and support you need to get well.

Using this treatment plan an Estimated Discharge Date (EDD) will be calculated. This is the date when you will either move into a lower security level or be discharged from this hospital.

However, this date is not definite. There are many reasons why the date may be delayed, such as:

- Persistent non-attendance to treatment programmes
- Slower response to treatment than anticipated
- Non-concordance with the medication consultant prescribed
- Use of illicit substances or alcohol
- Going absent without leave (absconding)
- Aggression and violence towards staff, other patients or yourself

So please do work with the staff to help them help you get better!

Your treatment will be regularly reviewed and you are vital to ensuring it works – don't be afraid to speak up and say what you want to achieve from your treatment.

Leave

There are many types of leave here.
Regardless of the type of leave initially you will be escorted by a member of staff to ensure you are aware of your boundaries, know how to return to Brockfield House and will be safe while on leave.

Following Ground Leave, all leave will have to be agreed by your multi-disciplinary team and/or the Ministry of Justice (depending on which section you are under).

Ground (Courtyard) Leave

You will start with ground (courtyard) leave. This is when you are able to leave the ward and go to the shop, canteen or welfare.

Perimeter Leave

Perimeter Leave means that you can walk around the perimeter of the hospital and also do activities on the perimeter like CROP or Cycling.

Area Leave- Escorted

This is where are allowed outside the perimeter gates. Initially you will be escorted at all times – which means you will be with a member of staff at all times. You cannot smoke while you are being escorted.

When you are ready for unescorted leave this will happen gradually, initially with embedded unescorted. This is where you will be left alone for 15 to 30 minutes, or even an hour, while you are on Area Leave.

Area Leave- Unescorted

This means you can leave the Brockfield House perimeter by yourself.

First of all you will start with leave to Wickford then after you have had leave to Wickford for a while you will be able to venture further afield such as Basildon, Southend or even London in some cases.

Nearer the end of your stay in hospital you will probably be venturing out every day and possibly doing some volunteer work.

Home leave

In some cases service users will get special leaves such as home leave.

This is where you will be able to go home and see your family for a day. Home leave is given to patients who have permission from either the MDT or the Ministry of Justice again.

Returning to Brockfield

You must always be back on time this includes escorted and unescorted leave.

You are allowed to smoke only on **unescorted** area leave, but no alcohol or drugs are to be consumed.

Even on escorted leave there will be random searches and drug testing when you arrive back at the hospital. You will always be searched when arriving back from your unescorted leave.

What does your Section mean ?

Sometimes things happen so quickly it is hard to keep track. You may have been told why you are here, but may not fully understand.

You will only have been admitted here if you have been "sectioned". This refers to the section of the 1987 Mental Health Act under which you are detained. The section gives the hospital the legal authority to keep you here. A list of the different types of sections is given below:

Section	Description
3	If you are on a Section 3, you will have been admitted to hospital for treatment following a Mental Health Act assessment by a social worker and two doctors (one of whom must be a specialist in psychiatry). This will be for up to 6 months but can be renewed for a further period of 6 months. You can appeal against your section to an independent Tribunal (Mental Health) and to the hospital managers. Your consultant can discharge you from hospital upon completion of your treatment but a Tribunal (Mental Health) can also order your discharge.
37	If you are on a Section 37, this means that a court of law has, at the time of sentencing, ordered your detainment within hospital to receive treatment Under this section it is up to your consultant at the hospital, in discussion with your care team, to decide when it will be safe for you to have access to ground or perimeter leaves from the ward or into the community, and any conditions to the leave (e.g. if you will need to be escorted by a member of staff). Your consultant can discharge you from hospital upon completion of your treatment but a Tribunal (Mental Health) can also order your discharge.
37/41	If you are on a Section 37/41, this means that you will be detained in hospital for treatment as for section 37. The section 41 is an added 'Restriction Order'. This will have been imposed by the Judge at the time of sentencing and means that it is for the Ministry of Justice (MOJ) to decide whether and when you are allowed to have leave from hospital (and any attached

	conditions), whether you can be transferred to another hospital and when you may be discharged. However, an independent Tribunal (Mental Health) can also order your discharge. The Tribunal can also make recommendations to the Ministry of Justice for you to have leave or be transferred to another hospital.
45A	If you are on a Section 45A, this is sometimes known as a "hybrid order". It is ordered by the Court at the time of your sentencing and means that you are have been directed to hospital to receive treatment but when your mental health improves, you will be transferred to prison in order to serve the remainder of your sentence. As for other sections made by the Court you have a right to appeal to a Mental Health Review Tribunal and, successful, you will be transferred to prison to continue your sentence.
47	If you are on a Section 47, it means that, as a convicted prisoner, serving a sentence, you have developed a mental disorder that necessitates your transfer to hospital for treatment by Order of the Secretary of State. Your transfer or leave from hospital is controlled by the Ministry of Justice but you can appeal to the Mental Health Review Tribunal to be returned to prison.
48	If you are on a Section 48, it means that you are a prisoner on remand who has not yet been sentenced and who requires urgent transfer to hospital for treatment of your mental disorder. As for section 47, you have the right to appeal to a Tribunal to be returned to prison. Unlike section 47 it is most unlikely you will be allowed any leave from hospital during your stay (except for medical reasons).

49	If you are on a Section 47 or 48 this will be, in the majority of cases restricted like a section 41 but the restriction is numbered as section 49 in the Mental Health Act. Like a section 41 it means that you cannot be transferred or go on leave from the hospital or be discharged without the consent of the Ministry of Justice (Secretary of State).

A consequence of being sectioned is that you are able to be treated against your will. However, you have the right to express your opinions about your treatment to your clinical team or your doctor at all times. You will also be involved in treatment planning decisions at all stages and can provide advance choices (sometimes known as advance decisions) about any future treatment. These choices must be taken into account if you lose the capacity (as a result of your mental illness) to fully involve yourself in important treatment decisions at that time.

You also have the right to access an Independent Mental Health Advocate and to have Legal Representation for a Tribunal if you wish to challenge your section.

Your ward nurses can provide you with a list of local solicitors who specialise in mental health matters.

Patient Opportunities

There are many opportunities during your stay at Brockfield House that will assist with your recovery and also develop your skills and gain experience that could prove useful after you are discharged.

Therapeutic Activity

At Brockfield House you will have the opportunity to engage in a variety of therapies.

You can engage with psychology sessions and psychological groups to aid with recovery and to prevent relapse.

You will have the opportunity to engage with Occupational Therapy who will provide a variety of meaningful activities and groups, both at Brockfield House, and eventually within the community.

Horticultural/Gardening Opportunities

We have an allotment/poly-tunnel within the perimeter; speak to staff if you are interested in this type of opportunity.

Educational Opportunities

At Brockfield House we offer educational courses in Maths, English and Information Technology. Through attending you can receive a functional skills qualification, which you can add to your CV to support with future employment opportunities.

Vocational Opportunities

At Brockfield House we can support you in sourcing voluntary employment as part of your rehabilitation. Voluntary Jobs are varied but can include things such as working in a café, working in a charity shop, gardening and landscaping, working at the food bank, dog walking and being involved in furniture restoration.

Further Education

At Brockfield House we can support you in applying for community college courses and apprenticeships. We have an excellent education and employment co-ordinator who makes it her mission to support patients to achieve their goals.

We have patients who have successfully enrolled on plumbing and journalism courses, and commenced apprenticeships in gardening and sports coaching.

Meetings with Service User Involvement

A number of the schemes running at Brockfield House have regular meetings, usually known as Steering Groups, where the projects are discussed. Patients input and perspective is very useful in such meetings, as there is nobody better to ensure that the services developed are useful for patients.

If you would like to sit on any meetings ask a member of staff what projects are currently running and if any of them are of interest to you, ask to be a patient representative.

Interviews

When interviewing for new staff members, we like to ensure candidates meet the requirements of our patients as well as our staff.

If you would like to be on an interview panel please let a member of staff know.

Recovery College

Recovery College is an educational style programme offering various educational courses to patients. The courses offered are co-planned and delivered by both patients and staff.

The college works similar to the way a college would work in the community. You will be given a prospectus and get an idea for what courses are available and enrol on ones which you find interesting.

This scheme has a Steering Group of its own, and will always welcome new patient representation.

There should be some Recovery College prospectus' on your ward, but if you can't find one ask a member of staff to get one for you.

This will tell you lots more about the college, including feedback from past students. There are also descriptions of courses that have been run and may run again.

The timetable changes each term – this should be on your ward noticeboard, but again if you can't find it ask a member of staff to get you a copy.

Some of the courses that we have offered have international cooking, first aid, food hygiene, pet therapy, cv writing and interview techniques, football coaching by Chelsea football foundation, swimming and sports. We have also had the Fire Brigade deliver a week long "FireBreak" course, and educational one off sessions, including an educational talk about reptiles and spiders.

Also like other colleges two graduations are held each year, were certificates are awarded to all those who complete the course, as well as specialist certificates awarded to all those patients who act as a patient tutor.

If you have a special skill that you would like to share with others and would like to deliver a Recovery College course speak with the Occupational Therapist or Activity Co-ordinator.

Mental Health Jargon

CPA	This stands for Care Program Approach. Every patient will have CPA's they are basically six month reviews of your care, where your progress will be discussed. You can invite your carers/family members and solicitor to these meetings.
Ward Round	Every fortnight you have a meeting with the MDT where you discuss how you are doing and bring up any requests you have.
MDT	Stands for Multi-Disciplinary Team is made up of a psychologist, social worker, doctor and Occupational Therapist.
16.9 Form	Before you have a Ward Round you will be given a form where you write any requests you have so the MDT can discuss it.
Key Nurse	You will be allocated a key nurse, this will be a qualified nurse who will be in charge of your care on the ward.
RC	Responsible Clinician) is the primary doctor in charge of your care
Support Worker	Support workers are staff that can support your care on the ward.
OT	Stands for Occupational Therapist. OT's run groups, all patients can attend these groups once agreed by the MDT. Groups include: Maths, English, I.T, Crop group, cooking groups and many others, speak to your ward O.T to find out more.
AC	Stands for Activities Coordinators. Like OTs, ACs also runs groups, as well as the gym and sports activities.
Advocate	Advocates are independent of the hospital and are there to deal with any complaints or issues you have, you can ask them to attend your ward rounds for support if you wish.

MOJ	Stands for Ministry of Justice. If you are a sentenced prisoner or on a section 37/41 any decisions about leave or your progression must be agreed by the M.O.J.
PRN	If a patient is unwell and needs something to help calm their distress PRN can be issued. PRN is a Latin term that stands for "pro re nata" which means "as the thing is needed."
IM	Sometimes it may be necessary for medication to be given through an injection if your behaviour poses a risk to you, another patient or a member of staff.
Seclusion	Patients whose behaviour poses a risk to themselves, another patient or a member of staff may be placed into Seclusion or into the Long-Term Segregation. This will be the for the shortest amount of time.
ICS	This stands for Intensive Care Suite which is a room on some ward specifically used to help patients for a short time until the team feel it is safe for you to come out.
Section 17	This refers to leave. Whenever you go on perimeter leave or leave outside of the grounds you must a have a section 17 signed by a doctor. This includes conditions of your leave.
Green Form	When you wish to take money out of welfare over the £40 you are allowed, a green form must be completed and signed by a doctor.
Business Meeting	Every morning (Monday - Friday) after medication there is a short meeting where you say what you want to do for the day and will be told about any meetings or groups you have that day.
Recovery College	This is a scheme where groups are run by a member of staff and a patient together, this gives patients a chance to do interesting groups and gives the patient running it confidence and valuable experience.
Phlebotomist	Some medications will require you to have your blood sample taken; this is to check the level of medication in your blood.
CQC	Stands for Care Quality Commissioners. These are independent of the hospital; they are in charge of making

sure everything is running as it should. You can make complaints to them anonymously.

Ground Leave Low and Medium secure wards have different times they can go on ground leave where you can socialise with patients from other wards and visit welfare and the canteen.

Welfare This is where your money is kept, this includes your benefits or commissioners pay and any money sent to you, you can go there Monday to Friday to collect your money.

Benefits When you are detained in hospital, unless you are a transferred prisoner, you will be entitled to benefits, the amount you receive will differ from patient to patient.

Commissioners Allowance If you have been transferred from prison as a sentenced prisoner you will not be entitled to benefits but instead will receive commissioners pay which is £20.15 a week.

Incentive Job If you speak with staff you can get an incentive job to earn an extra £5 a week; it will be a small job such as wiping tables or cleaning windows.

Canteen The canteen is somewhere you can socialise with other patients from other wards. The low and medium wards have different times they can access the canteen. They sell drinks, chocolates, sandwiches and crisps. Sometimes activities are held in the canteen such as open mic nights, bingo and O.T groups.

Perimeter Leave Around the outside of the hospital there is a perimeter that once agreed by the MDT you can walk around, there is also cycling groups around the perimeter available.

Area Leave If the MDT (and Ministry of Justice if necessary) agrees, you can go out of the hospital. This will be escorted first but can build up to unescorted.

Embedded Leave When you go out on escorted leave, before you get unescorted leave it is common practice for patients to have embedded leave where the staff will leave them alone for a short time, this gives patients the chance to prove they are ready for unescorted. Those patients who wish to smoke can do so during their embedded leave.

Care Plan	Your care plan is something you will be involved in making, it is basically about deciding what support you need and how best to progress with your care.
Vitals	Every week your vitals are taken, this includes your weight, blood pressure, pulse, and temperature.
Tribunal	If you wish to apply for discharge you must have a tribunal. This will be run by the tribunal board made up of a judge, a psychiatrist and a Lay member who has knowledge of the Mental Health Act. There are certain waiting times for when you can apply for a tribunal.
Managers Hearing	As well as applying to a Tribunal for a review of your care you can also apply for a hearing by the hospital managers to review this. (Unless you are on a restriction i.e.: section 41 or section 49)
117 Meeting	Once your discharge has been agreed you will have a section 117 meeting. This will be attended by your community care team and there will be a discussion about the support you might need in the community.

Your Information Pack

We hope you have found your information pack and this booklet useful.

If you think there is anything missing or unclear please let a member of staff know so we can continue to improve the information we give to our patients.

We hope this booklet will be helpful in settling you into your stay at Brockfield House, and help you make the most of the opportunities while under our care.

This form should be completed by ward Social Worker or designated Social Worker from the inpatient social work team.

FORM CP2 **(Appendix 2)**

CHILD VISITS ASSESSMENT TOOL

The child's interest is paramount and the child's rights override the wishes of the patient and/or family.

Patient Name: _____

Date of Birth: _____

Ward: _____

Patients Legal Status: _____

Index Offence: _____

Risk to Children: YES/NO

Patient Harmed This Child: YES/NO

Patient Harmed Any Other Child: YES/NO

Nature of Harm:

Child's Name: _____

Relation to Patient: _____

Age/Date of Birth: _____

Child's Legal Status under Children Act (if applicable): _____

Type of Contact Prior to Admission (e.g. living with child, weekend contact, no contact etc):

Frequency and form of Contact (i.e.: letters, telephones, visits)

Prior to ALL child visits, the allocated Social Worker will contact the person with parental responsibility for their views regarding the forthcoming visit. The views of the child's social worker should also be sought where applicable. The views of the child should also be considered, taking into account their age and level of understanding.

Identified Local Authority Social Worker: YES/NO
(In the case of child protection)

Name: _____

Address: _____

_____

Tel. No: _____

Local Authority Social Worker Contacted: YES/NO

Outcome:

Name of Parent or person with parental responsibility: _____

Address: _____

_____

Tel. No: _____

Main Carer's Views Regarding Contact:

Child's Wishes Regarding the Visit:

Where Child Visits are to take place: _____

Tel. No: _____

NO CHILD CONTACT VISIT IS TO TAKE PLACE ON A WARD

Social Worker arranging the contact: _____

Level of Supervision (e.g. one member of staff supervising or only qualified staff to supervise): _____

Persons present during contact visit: _____

All children must be accompanied by a Responsible Adult.

Structure of Visits (e.g. 1 hour x weekly) :

Related Reports:

Signed: _____

Dated: _____

Social Workers
Name & Title: _____

Essex Partnership University
NHS Foundation Trust

SSOP 02 - Appendix 2

Robin Pinto Unit
Patient and Carer
Information






"Moving towards independance"

Welcome

The information contained in this leaflet is for you, your carers and relatives, and is about aspects of your care and treatment. Please feel free to discuss with a member of staff any concerns you may have, or anything that is not covered in this leaflet.

Robin Pinto Unit

Robin Pinto Unit is a low secure unit, not a prison. Secure units are mental health hospitals that provide specialist care to patients who require to be cared for in a secure environment. Secure units in the UK are divided into low, medium and high on the basis of security measures in place. We are a secure unit and will work with you to re-integrate you back to your chosen community.

However, in order to maintain the safety of our environment for all our patients, staff and the public, some restrictions will be placed on your freedom.

How to Contact Us

Our address is:

Robin Pinto Unit
Luton and Central Bedfordshire Mental Health Unit
Calnwood Road
Luton
LU4 0FB

The ward can be contacted directly by calling:
01582 657530
01582 657532
01582 657533

Admission Safety Check

On admission, you will be asked about any medicines you are taking and to hand over any medicines you have with you, including over the counter medicines, such as aspirin.

Any items which are not permitted will be removed for safe keeping during your stay on the ward. You will be given a receipt for these items and the items will be returned on discharge.

Restrictions

When you are first admitted, you will be restricted to the ward. After a period of assessment, and depending on progress, you will be granted leave to the local area, escorted by members of staff.

This will progress to unescorted leave within the local area. Your consultant psychiatrist will grant you leave in stages. This will be discussed with you and your care team during your regular patient reviews.

Prohibited items:

Security is important for yourself and others.
For Health and Safety reasons the following items should not be brought onto the ward by patients or visitors:

- Alcohol, Drugs (i.e. illegal street drugs or "legal highs")
- Prescribed drugs and medications
- Open drink bottles/ shop prepared food items/ toiletry items
- Open cigarette packets, plastic bags
- Mobile phones including camera phones, dictaphones
- Glass bottle/ objects
- Explosive materials/ flammable materials
- Sharp items including razors, knives/ blades, scissors, needles, etc
- Lighters, matches, lighter fluid/ petrol
- Cameras or other recording devices
- Firearms or replicas
- Tools e.g. screw drivers/ hammer
- Aerosols e.g. deodorants
- Anything in a tin e.g. food, drink, chewing gum
- Superglue, Blu-Tack, plasticine, evo-stick, solvents etc
- Personal bags, handbags, purses (in case there are prohibited items that have not been handed over)

- Sporting items e.g. cricket bats, martial arts/ self-defence items
- 18 Certificate videos, DVDs and games, pornographic material
- Any item that could be used as a weapon
- Any other item assessed by staff not to be brought onto the ward
- Items with a lead will be risk assessed before clients can have access to them

Please note: If you bring any "illegal" items on to the unit such as drugs and weapons, we will inform the police and pursue prosecution. You will be provided, upon admission, with a
full list of those items which all patients are prohibited from having in possession and those which may be restricted. These lists are also displayed on your ward notice board.

Personal Belongings

On admission, a property search for any prohibited items will be made by two members of staff. A record will be kept for any property taken from you, and a copy given to you.
Valuables such as bank cards and passports will be kept in the secure safe. A receipt will be given to you

During your stay, all items that have been taken from you will be available on request, with the exception of anything that may be considered a risk. These will be returned to you when you leave hospital

We advise against having large amount of money on you. Only £40 is allowed. Anything above that amount is to be handed to administration staff to be placed in your Trust account for safekeeping.

Electrical goods must be checked by a trust electrician. The Trust accepts no responsibility for loss or damages.
Your responsibilities during your stay in regard to your personal property and possessions, and the Trust's duties and responsibilities concerning them are outlined in a leaflet you will be given following your admission. The responsibilities are also displayed on your ward notice board.

"When staff can't do something for us then, they explain and then get back to you"

Our Ward

Robin Pinto Unit is an 18 bedded low secure male ward for patients who are experiencing enduring mental health problems.

The philosophy of the ward is to work with individuals to promote experience and learning which will empower them to develop resilience and skills to lead their lives as independently as possible.

Patients will be supported to access the community, including educational and vocational opportunities, to support them with starting to build their lives outside of hospital and facilitate transition back to the community.

Meals

Upon admission staff will ask you if you have any specific dietary needs.

- Breakfast 08:30 – 09:00 (ADL until 10 am)
- Lunch 12:00 – 13:00
- Dinner 18:00 – 19:00
- Tea and coffee, cold drinks, and snacks are available throughout the day
- Visitors may bring food and soft drinks, but these must be in manufactured sealed containers. If you want to bring food or drink in please speak to a member of staff about this. No glass bottles, cans or cooked food are allowed.

Visiting

Only two visitors per patient are allowed at any one time.

The ward visiting times are:

Weekdays:

14:00 – 17:-00
19:00 – 20:-00

Weekends and Bank Holidays:
10:00 – 11:45
13:00 – 17:15
19:00 – 20:00

If you are visiting, please check with the ward and the person whom you are visiting to make sure your visit is convenient to any therapy sessions they may take part in.
Visiting times are designed to fit in with mealtimes and the programmes of care and treatment provided on the ward, if alternatives times are needed then please feel free to ask a member of staff.

All visiting is at the discretion of staff and will take place in the visiting room on the ward.
Visitors are not allowed anywhere else on the ward.

Children under 18 years old are not allowed onto the ward, but with prior arrangement, supervised visits can take place in a child-friendly area near the ward.

All belongings are to be placed in lockers provided prior to entering the ward, this is for the safety of both patients and visitors.

Visiting may be suspended if staff feel a disturbance on the ward will make it unsafe.

Hospital facilities

Bathroom/shower facilities:
Please inform staff when you wish to use these facilities, as they are always kept locked. Although there is a domestic on the ward who is responsible for general cleaning, all patients are encouraged to tidy up after themselves.

Laundry:
The unit has laundry facilities, which will enable you to wash, dry and iron your clothes. Please inform staff if you need these facilities as this is usually kept locked.

Multi-faith Prayer Room:
There is the use of a room for your cultural and religious requirements is available for you to meet your spiritual needs.

Chaplaincy:
There is a chaplaincy service available for all faiths.

TV Facilities:
There is a TV lounge. There are also facilities such as DVD players and free view channels.

Use of Telephones:
We provide basic 3G handsets not smartphones to enable service users to maintain contact with carers, friends and family. You can text and call but cannot use social media on them. This is now standard across all our secure units. There are payphones on the ward for incoming and outgoing calls.

Please advise your relatives or friends to not phone late at night to avoid disturbing other patients. Patients are allowed to use the ward phone should they wish to contact their social worker, solicitor, care coordinator.

Parking Facilities:
Parking facilities are available to visitors. Parking is controlled via main reception. Visitors must book visits with at least 24 hours' notice. Reception will be informed that you will be visiting the unit to allow access to the car park.

Interpreter:
Interpreters will be available for those with limited English or those with hearing difficulties.

Occupational Therapy:
As you begin to show progress on the ward it is expected for you to attend Occupational therapy sessions. Occupational therapy sessions include group and individual sessions designed to help assess and improve daily living skills such as social skills, cooking, and access to education/vocation, as well as encouraging engagement in meaningful activity. This is an important part in aiding your recovery and care. Your named nurse or the Occupational

Therapists will inform you on what sessions are available throughout the week as well as a timetable being available in the communal area.

Activity Co-ordinator

The Activity coordinator facilitates a large range of both physical and creative activities; football, badminton, computers, art, and many more. When appropriate physical fitness levels are undertaken in conjunction with risk assessments and approval of the consultant, prior to any physical activities.

Other Available Activities from OT and Psychology (list is not exhaustive)

- Access into the courtyard
- Anger management
- Anxiety management (introduction)
- Budgeting
- Cognitive Behavioural Therapy
- Community meetings
- Concordance and Engagement skills
- Creative groups
- Discharge planning
- Discussion group
- Drug and alcohol group
- Family engagement
- Football group
- Gardening group
- Gym
- Hearing voices group
- Illness education
- Multidisciplinary Team treatment and formulation review
- Relapse prevention/signature
- Relaxation
- Relaxation
- Risk assessment
- Standardised and non-standardised assessment medication review
- Symptom group (negative/positive)
- Therapeutic risk taking
- Walking group
- Weekend planning

People Responsible for your Care

Your team comprises of a consultant psychiatrist (called your Responsible Clinician under the Mental Health Act), your Care Coordinator, Named Nurse, the Occupational Therapist based on the ward, a Psychologist, Social Worker and Activity Coordinator.

Responsible Clinicians

A consultant psychiatrist is a medical doctor, who has specialist in assessing and diagnosing a range of treating mental disorders. Referred to as the Responsible Clinician (RC) they are approved clinicians with overall responsibility for the patient's care. Care includes the process of assessment and treatments. All patients subject to detention or Supervised Community Treatment have a Responsible Clinician.

Some of the main tasks of the RC is to ensure that patients are objectively assessed and whether in their opinion a patient under their care meets the statutory criteria for detention and are able to advocate their opinion to judge.

Named Nurse

During your hospital stay, you will be allocated a nurse. He or she is called your named nurse.

Your named nurse will:

- Coordinate your inpatient treatment plan
- Be available for you and your family/carer to discuss any issues with your treatment plans
- Discuss with you the level of supervision you will need whilst on the ward
- Inform you about the arrangements that are being made for your assessment, care planning, medication, therapies and activities.

If your named nurse is off duty, then please speak to the member of staff you have been allocated for the day.

When you arrive on the ward, you will be greeted and welcomed by a member of staff, offered a drink and shown around the ward. You will then be shown your bedroom and after safety checks, you will be able to pack your bags and settle in.

To help you maintain your independence, we encourage patients, as far as they are able, to put clothes away to help maintain the tidiness and cleanliness of your bedroom. Removing and cleaning cups after use and using litter bins appropriately helps the ward staff and other patients.

A member of staff will explain in more detail what happens on the ward

Forensic Social Worker Team

The Forensic Social Worker Team aims to integrate service users into their communities to the maximum level of social functioning, and link them to local agencies and facilities whenever possible. The team adhere to the principles of anti-discriminatory practice. All aspects of service users' care will be respected including their race, culture, gender, sexual orientation, religion, language age and ability. Our objective is to ensure empowerment of service users and their families through meeting individual need whilst maximising the potential for service users to live in the least restrictive environment within the context of preserving public safety as to maximise their quality of life.

The team is responsible for the care coordination of the whole patient population, ensuring that all patients have their care managed under the CPA guidelines. Advocating for the rights of patients and fair access to treatment is another aspect to the role. Social Workers provide a holistic view of patient's treatment and management and play an important role in the MDT.

The Social Worker Team also takes the lead for communication and intervention with family and carer's and is the link for the MDT regarding this aspect of a patients care. The team is also the link between our inpatient unit and the community services. This involves extensive liaison with agencies like MAPPA, Criminal Justice Mental Health Team, Community Mental Health Teams, Ministry of Justice, the Probation Services and many other agencies involved in providing input to a patient's management.

The Forensic Psychology Service

Psychology is a science based profession that studies the way people think, feel and behave in various social contexts. It aims to help people to reduce their distress and to change their behaviours and thinking patterns when necessary. Psychology provides people with a safe and confidential therapeutic space to discuss their concerns and to work towards change.

Psychologists are mainly involved in the assessment and treatment of patients who experience psychological difficulties and also work with patients to minimize their risk of harm before being discharged. They form part of every patient's multidisciplinary team and seek to enhance patients' psychological well-being. Psychologist also provide patients with one-to-one and group treatment programmes in order to help them manage a variety of problems such as depression, anxiety, anger and offending behaviours. Psychologists do not prescribe medication, but they use talking therapies to assist their patients.

The Forensic Psychology Department is made up of number of qualified psychologists who have different areas of expertise, and also employs the services of assistant psychologists.

The Role of Occupational Therapy

Occupational Therapy is aimed at developing an individual's skills so that they can function as independently as possible and have a balanced and meaningful life. Occupational Therapy looks at all areas of an individuals' life and works with them to develop their skills in areas where they may struggle. This includes looking at how an individual manages activities of daily living such as tending to their personal hygiene, laundry, and other housework, shopping, cooking, budgeting and accessing the community etc. How they manage social situations and cope with challenges, and also how people manage their leisure and free time as well their work. They will also explore how the person's environment can be adapted to support them.

When areas of difficulty are identified, the occupational therapist will help work with you to help develop your skills and put in adaptations to make the tasks easier. Occupational Therapists try hard to work with people's interests in mind so will aim to use activities which are both enjoyable and meaningful to the person to help them develop their skills and independence.

Recovery College

Recovery College is an education style resource available to patients and is not therapy. The college works in the same way that a college in the community would. You'll be able to read through a prospectus and get an idea of what courses are available every term. Then, you'll fill out an enrolment form to book onto your chosen courses. Patients are able to co-plan, co-produce and co-deliver courses with staff for patients who enrol onto various courses. You

can get more information on Recovery College from your occupational Therapist or activity coordinator.

Vocational Services

Vocational Services work closely with all disciplines but mainly with the Occupational Therapy department. As part of the Rehab team, we are responsible for the provision of the vocational programme at the unit which gives service users a chance to develop not basic skills such as literacy and numeracy, but also taking part in distance learning, college courses and in house training course such as building skills, horticulture, car valeting, juice bar, retail, newsletter publishing and nail bar. All are to an NVQ standard and can be used once the service user is discharged and read to return to the workplace.

Service users are also offered the chance to have one-to-one input with the Employment Specialist who can work closely with them in identifying skills and opportunities and any area for development to give them the best prospects when they are ready to leave us.

Local providers including Barnfield college and Luton adult learning can provide the following courses, which may be available to patients subject to MDT approval:

- Numeracy and literacy
- IT skills
- Higher education qualifications (i.e. English, Maths, etc)
- Other courses available upon request and discussion with the team

Medications

Medication may be part of your treatment plan but that is not always the case. If you are prescribed medication it is the duty of your consultant psychiatrist to discuss and explain the pros and cons of medication. You can also ask nursing staff or a hospital pharmacist for further information on medications you are prescribed.

On certain occasions, if you don't feel that you should be taking the prescribed medications, you may request the opinion of an independent psychiatrist about your medication. You will have the opportunity to meet with the psychiatrist and express your concerns. You will also have the opportunity to

discuss the effects and side effects of your medications with the pharmacist if you wish to do so.

Medication Times

- 08:00 – 09:00
- 13:00 – 14:00
- 17:00 – 18:00
- 21:30 – 22:30

Care Programme Approach

The Care Programme Approach (CPA) is an individual plan of care specifically for you to address your needs. CPA involves an all-round discussion of your mental and physical health as well as your social needs. A care plan will be reviewed with you periodically, to see that it is meeting your needs and to agree any changes. You are welcome to have carers, relatives, friends or advocate at care planning meetings and reviews. You will be asked to show your agreement by signing it. You will be given a copy. A team of mental health care professionals will support you throughout your stay in hospital.

CPA is also about your right to expect a good service in all the contacts you have with people providing services for you.

- Under the Data Protection Act you have a right to ask to see your records
- Signed documents, such as assessments and care plans, are legal documents, so you have a right to be represented accurately in them
- Where you believe statements to be inaccurate and potentially damaging to you, you should firstly discuss this with your care coordinator, or other main person providing services
- CPA declares your right to be treated with dignity and respect at all times. The right to be given available information so you can make reasonable choices in your care and support
- The CPA is about your right to information so that you are able to expect good practice

Patient Reviews (Ward Rounds)

- Your treating team will meet to review your care every two weeks. You are expected to attend these meetings. You have an important role to play in the delivery of your care
- Your named nurse will meet with you before the ward round review

- With your consent, carers and relatives can attend your care review and speak to the staff team about your care and treatment plan. They will have to contact the forensic consultant psychiatrist's secretary if they wish to attend the ward review.

Your Physical Health

Your physical health and wellbeing is just as important as your mental health.

You will continue to remain with your current GP. You can expect the same service and response you will get from your own GP, if you have any concerns you can talk confidentially.

We encourage everyone to have a regular physical health check. We will also help you to devise a plan to give up smoking, be more active, maintain a healthy weight, cook and eat healthily and look after your body.

We will also support you to visit the mobile dentist or access a local dentist if you wish.

We have a local NHS hospital which provides out of hours cover and Accident and Emergency facilities.

Continuing care in the community

Each ward has a dedicated Social Worker who has a care coordination role. Social workers are also responsible for a smooth transition of handover of care of inpatient setting to local Community Mental Health Team, where the patients will be discharged to, further ensuring that the support and follow-up is in place at the time of discharge. They also make sure that funding is available for required care packages and provide a follow-up service of up to six months after discharge. Social workers also act as a link with family and carer's/ family support group.

When you leave hospital

When you leave hospital, you will continue to receive support from members of your local Community Mental Health Team. These teams include Social Workers, Community Psychiatric Nurses and Support Workers. You will be

allocated a Care Coordinator who will be responsible for arranging all aspects of your care.

Confidentiality

All the paper and electronic information that we hold about you is protected by the Data Protection Act 1998. Confidentiality is important to us and you can be sure that only those who need to see your details can do so.

You can ask to see what information we hold about you under our 'Access to Health Records' and 'Use of Personal Information' polices. This includes access to any health record in which you are identified, such as assessments. Treatment plans and reviews. There are some items which we cannot share with you, such as information that identifies other patients or information that may result in harm to you or others. If we are unable to share information with you, we will explain why. Unless there are exceptional circumstances, we will only share information about you and your treatment with your knowledge and consent.

Patients' rights

All patients detained under the Mental Health Act have a right to appeal, to either the Mental Health Review Tribunal or the Hospital Managers. Patients have the right to go to the county court and request for a change of their nearest relative.

Advocacy

There is an advocacy service available at Robin Pinto Unit. The service is provided by PoHwer and is independent. The advocates can listen to your problems and concerns and can support you at your review. They can also help you to express your problems and wishes with regard to your treatment. Posters are available on the unit and staff can support you to access advocacy.

Aggression and Violence

Essex Partnership University NHS Foundation Trust has a Zero Tolerance Policy. We expect that all patients and visitors respect the rights of others and treat both staff and other patients and visitors with respect dignity and consideration. Violence or abuse is not tolerated. We may inform the police where necessary and charges may be brought against you.

We understand that people can sometimes be very emotional and upset, especially when someone is very ill. However, violent or abusive behaviour

whilst in hospital will not be ignored. In the case of a visitor, it may result in them not being allowed to come to the hospital. Alcohol is not permitted at any time.

The possession and use of illegal drugs is not permitted anywhere within the Hospital perimeters.

Smoking

We area no smoking Trust. Smoking is not permitted anywhere within the Hospital perimeters. You will not be allowed to smoke during escorted leave. During your stay, you will be offered Nicotine Replacement Therapy and staff will support you with Smoking Cessation if you choose.

Equality and Diversity

The trust will: "Provide an environment which extends to all its activities, where the differences between individuals (such as sex, race, ethnic origin, nationality, disability, age, religion, sexual orientation) are accepted and the benefits of diversity are valued." Please tell your named nurse if you don't feel we are meeting your equality rights.

Spirituality

We understand how important your religious and/or spiritual beliefs are to you. Please tell your named nurse if you need arrangements made to practice your faith or spiritual needs. All people of any religious denomination may request to see a religious leader. Please speak to a member of nursing staff who will arrange a meeting wherever possible.

Carers

Essex Partnership University NHS Foundation Trust values the importance of family and friends who support people who have mental health needs. The Trust has a Carers' Charter that highlights the importance of involving carers.

Who is my Carer?

This person might be a relative, a friend or even a neighbour. Some people do not see their relative or friend as a Carer, and feel that what they do is just a natural part of their relationship with that person. However, if a relative, friend or neighbour is supporting you, and without their help you might find it difficult to manage, then the law says that this person is your Carer. The help this person provides can be practical or emotional.

We recognise that people have different circumstances, and we will always respect your wishes about involving your Carer. Therefore we will always first find out from you if you want us to involve your Carer. Carers have certain rights and the law ways that Carers are entitled to an assessment of their own needs. A Carer's Assessment is not an assessment of the person's ability to care, but is to help us understand what support may help a Carer to continue in this role. If a Carer is to continue caring it is important that they maintain their own health and quality of life.

For Carers

Your Carer can ask the Named Nurse of Social Worker about how to get a Carer's Assessment. For more information on the Carers' Charter, Carer's Assessment or services available to Carers, you can talk to the Named Nurse or contact EPUT directly on 0800 0131223 or email epunft.pals@nhs.net.

Customer care standards

We want you to feel cared for and our staff to show it; we want to be 'in tune with you'.

Being in tune with you means, we promise:

- To be welcoming, courteous and listen
- To keep you informed about your services and any changes
- Not to use jargon
- To involve you in your care
- To ensure smooth handovers between services

If you want to compliment one our staff for providing excellent service, please use the pre-paid comment card on the ward or go to our website https://eput.nhs.uk/contact-us/ where you can let us know.

Our standard of care

We try to deliver the highest standard of care and we welcome comments. If you have a suggestion how we could do it better, please tell us. Equally we welcome positive feedback and compliments. It is always nice for staff to hear their efforts are appreciated. If you feel you have a serious concern or a problem then raise it with staff straight away. Often problems can be dealt with there and then.

Complaints, comments & compliments

If you or your relatives are unhappy about any aspects of your care, you can discuss this with your named nurse or any other member of staff present. If you are still not satisfied please contact the Charge Nurse or Ward Sister. If you wish to make a formal complaint, you can do in writing to:

Complaints Manager
Essex Partnership University NHS Foundation Trust
The Lodge
Runwell Chase
Wickford
Essex
SS11 7XX

Other Services:

- **Alcoholics Anonymous** **08457 697555**
- **FRANK** **0300 123 6600**
  (Free Confidential Drugs Information and advice 24 hours a day)

- **ResoLUTiONs – Luton** **0800 0546 603**
  "Drug and Alcohol Recovery Service" **Resolutions.info@cgl.org.uk**

- **Be-frienders** **01525 631323**
- **Citizens Advice Bureau** **01582 731616**
- **PALS (Patient advice & Liaison Service)** **0800 0131223**
- **Relate (Bedfordshire & Luton)** **01234 356350**
- **PoHwer – Advocacy** **01582 708188**
- **Samaritans** **08457 909090**

Patient Advice and Liaison Service

There is a Patient Advice and Liaison Service (PALS) providing information, support and advice for patients and relatives. If you want more information about how they may be able to help you, please ask a member of staff on the ward or contact them directly if you need:

- Face to face interpreters

- Document translation in other languages
- Signing (at BSL level 3)
- Document translation into Braille
- Document translation onto audio tapes
- Over the telephone translation

Contact PALS for more information on 0800 0131223 or email pals@eput.nhs.uk

This form should be completed by ward Social Worker or designated Social Worker from the inpatient social work team. This should then be shared with the Responsible Clinician and Key Nurse for their review and signature.

FORM CP3 **(Appendix 3)**

WARD NOTIFICATION INFORMING CHILD VISITS

NAME OF PATIENT: .....

NAME OF SOCIAL WORKER: .....

NAME OF RC: .....

Name of children visiting (no more than 2 at a time)	AGE/ DOB	Relation to patient	Permission for visit granted /not granted

Date of visit	Venue of visits	Level of supervision	Duration of visit	Responsible Adult

ANY OTHER IMPORTANT INFORMATION:

	RC	SOCIAL WORKER	KEY NURSE
SIGNED			
DATE			

COPY FOR FILE: YES/ NO

NHS
Essex Partnership University
NHS Foundation Trust

Welcome to Wood Lea Clinic

Low secure services for people with learning disabilities

Patient Information Booklet

"Staff are easy to talk to"

Welcome to Wood Lea Clinic. We are a 10 bedded unit for men who have a learning disability and need a low secure environment. You will have your own bedroom with washing facilities. You will be able to bring in some of your personal items. This will be explained to you in more detail on your admission.

We hope your stay here will be a turning point for you, and you will be successful in achieving a new way of thinking, feeling and living a safe and more fulfilling life.

This leaflet has been designed by patients and staff to help you know what to expect whilst you are here.

If you have any questions you can speak a member of staff at any time.

A Typical Day

Monday to Friday

By 09:00	Patients to be washed, dressed and ready. You will have the opportunity to prepare your own breakfast.
09:00 - 09:30	Community Meeting
09:30 - 10:00	Morning exercise
10:00 - 12:00	Sessions (including a break)
12:00 - 13:00	Lunch break
14:00 - 16:00	Sessions (including a break)
17:00 -18:00	Evening meal
19:00 - onwards	Leisure activities

We expect you to go to bed by 23:00 Sunday to Thursday. This will help you to be ready for a full day of activities. Friday and Saturdays are later.

Weekends are more relaxed and leisure activities are available.

Daily Activities

Structured activities are arranged for every day and a time table will be set up with you to meet your needs. Our programmes are as follows:

Understanding and Coping

Offender treatment programmes working with the whole team.

ASDAN

Offers a variety of education opportunities working towards ASDAN certificates.

Alive and Kickin'

Sessions about healthy living, opportunities for exercise, including use of our gym, rambling.

Horizons

Learning about the world and what it has to offer.

Streetwise

Education on your rights and responsibilities and safe and independent living.

Creativity

Sessions including art and craft, drama, music.

Vocation

To provide a valued role in the clinic and to prepare for future work roles, including gardening and cooking individual snacks and ward meals.

Domestic Activities

To prepare for independent living.

Leisure Activities

To prepare for a non-offending lifestyle including relaxation, karaoke, film shows, board games and much more.

"We learn new skills to help us when we leave"

Wood Lea Clinic

The Multi-Disciplinary Team (MDT)

Named Nurse

Is responsible for co-ordinating your nursing care whilst you are at Wood Lea, working with you and the MDT to develop your care and treatment plans. This means that the whole nursing team will be able to work with you.

Consultant Psychiatrist

Has responsibility for your medical and psychiatric care and treatment, they are supported by the medical team. Has overall responsibility for your care whilst you are detained under the Mental Health Act.

Occupational Therapist

Assesses your past and current lifestyle and suggests treatment to promote a healthy and non-offending lifestyle whilst you are detained and for the future.

Clinical Psychologist

Is responsible for psychological and risk assessment and is central to the treatment of your offending behaviour. They may also suggest other treatments to promote your mental health and wellbeing.

Social Worker

Will support you to maintain contact with friends and family in the community. They will help co-ordinate your transition between hospital and the community.

You may be referred to other professionals as required:

Speech and Language Therapy
Sensory
Arts Psychotherapy
Dietitian
Physiotherapy

Meetings

Admission Meeting

You will have an admission meeting within the first seven days of your stay, to discuss your care and treatment needs for the first three months of your stay.

Ward Round

You will have opportunity to attend ward round every two weeks, you will be supported by a nurse, and you will meet with the other members of the team. You may also choose to be supported by an advocate. We will discuss your care, treatment, progress and future plans.

CPA Meeting

You will have your first Care Programme Approach (CPA) meeting three months after admission then every six months (this can be sooner if needed).

A CPA meeting involves you, everyone involved in your care, and anybody else you want to invite. This may be your family, friends, solicitor or advocate. Together we will review and agree your care and treatment plan.

Community Meetings

Community meetings take place every day with other patients and staff.

They enable you to make requests and suggestions including about activities on the ward.

Contact with Family and Friends

You will be supported to maintain telephone contact as agreed in your care plan and you will have access to a payphone for this.

Visits from relatives and friends are encouraged on a Saturday and Sunday, but please ask your visitors to telephone in advance to book a visit. They will need to bring a form of identification with them.

Cultural and Spiritual Needs

You will be asked about any religious and cultural needs you may have, you will be supported in contacting a faith leader, and your dietary requirements will be met

Your Financial Support

Whilst you are at Wood Lea Clinic you will be supported to claim for any benefits you are entitled to.

Mental Health Act

You are here because you have been placed on a section of the Mental Health Act. This will be discussed with you and you will be given written information about the section you are on, and what this will mean for you.

It will also explain how and when you will be able to appeal against your section.

If you do not have a Mental Health Act Solicitor we will be able to provide you with a list of Solicitors for you to choose from.

You will be able to request the support of an advocate. This is someone who will spend time with you to find out your views and help you to make them known, for example in meetings.

Security and Safety

At Wood Lea Clinic we have a duty to protect the health, safety and wellbeing of all our patients, staff and the general public. There are some items which are not allowed on the ward and some items have restricted access. Items include the following;

- Mobile phones
- Audio and video recording equipment
- Wi-Fi enabled equipment
- Cigarettes
- Lighters and matches
- Alcohol
- Medication (any medication must be handed to staff for safe keeping)
- Illegal substances
- Solvents and flammable liquids
- Weapons
- Chewing gum
- Soap bars

To maintain security, random and routine searches will be carried out of your room and person. In addition to these, random drug and alcohol testing will be carried out. We are also regularly visited by search (sniffer) dogs. This will all be explained further to you.

Wood Lea Clinic is a non-smoking site; there is no smoking allowed on the ward or grounds. We will be able to offer you support with stopping

"Everyone is friendly and the activities are interesting"

smoking.

Ward Sister / Charge Nurse:

Wood Lea Clinic
5 The Glade Bromham Bedford MK43 8HJ
Tel: 01234 310750
Email: Woodlea.clinic@sept.nhs.uk

Patient Experience Team

If you have any concerns or need advice about accessing NHS services, you can speak in confidence to the Patient Experience Team on 0800 085 7935 or you can email epunft.pals@nhs.net

This leaflet can be produced in large print, CD, Braille and other languages on request.

Essex Partnership University NHS Foundation Trust regards equality and diversity as integral to the way it works. Our staff will ensure that everyone is treated fairly and no one is discriminated against on the basis of their ethnicity, gender, disability, age, sexual orientation and religion or belief.

Production Date: Sept 2017 EP0454

This form should be completed by the supervising professional present during the visit; Nurse or Social Worker.

FORM CP4 **(Appendix 4)**

FEEDBACK REPORT FOR CHILD VISITS

Name of patient:

Hospital Number:

Supervising Staff:

Date of contact:

Name of child:

Name of escorting Adult:

Initial contact:

Describe the greeting between child and patient. Was there any tension in this? Did the child display any anxiety about the contact? How did the child cope with the security arrangements?

Comment on the interaction between patient and child

Mention how patient and child responded to each other. Include both interactions that were positive and those of concern. Did the patient give much attention to the child? Did they play or talk much? Any discomforts noticed for both child and patient? Were any gifts exchanged between patient and child? (consider possible grooming or bribing) Did the patient attempt to hide contact with the child? (ie: whispering, talking behind open hand, hiding the child from view of supervising staff).

If any odd behaviours were noted, a detailed account of this should be given to assess the context of the situation.

Any areas of concern

If the staff supervising had to intervene, an account of the circumstances should be given and reasons for decision made, including staff having to leave the observation area. Was the accompanying adult appropriate during the contact?

After the visit

Patient's feedback/view about the visit. An assessment of their current frame of mind looking at the impact of the visit on the patient (either positive or negative). How long did the contact last? Will supervisor recommend continued visits?

SIGNED : _____

Name and Designation _____

Date: _____

This form should be completed by the ward Social Worker or Key Worker

FORM CP5 **(Appendix 5)**

VIRTUAL CHILD VISIT REVIEW

Name of patient:	
NHS Number:	
Review date & time:	
Name of child or children:	

Have the responsible Local Authority Children's Service's been contacted to identify if the child/family are known to them? **If so what was the response?**	
How frequent have the Virtual Child Visits been occurring?	

Observation of Virtual Child Visit:
Describe the interaction between child and patient. Did the child or patient display any gestures? Were there any concerns throughout the visit? Did the child appear engaged with the interaction? What was the content of the discussion/interaction?

What are the adults (Patient, Care Giver/Parent) views on how the Virtual Child Visits have been going?

What are the child's views (where applicable) on how the Virtual Child Visits have been going?

Evaluation & Recommendation for ongoing Virtual Child Visits: *How has the child/family responded to the Virtual Child Visits? Has this been positive or have there been issues that have arisen? Does the child find these visits beneficial (where applicable)?*

Signature:

Name and Designation:

Date:

Date of next review:

Essex Partnership University
NHS Foundation Trust

EDWARD HOUSE CARER'S BOOKLET

WELCOME TO EDWARD HOUSE

As part of Essex Partnership University NHS Trust, we aim to provide a safe, secure recovery service for adult males aged 18 and above.

This booklet has been designed to provide you with carer's information which should explain, in brief, various aspects of how care is organised and the various facilities available within Edward House.

Our service supports the Trust's vision 'Working to Improve Lives'. We are committed to delivering high quality care that is holistic, innovative and needs led, whilst fostering empowerment, promoting independence, dignity and respect and valuing our patients, carers and staff. We will work openly and honestly, in partnership with others, to promote and maintain optimum health and well-being, caring for others as we would want our own families to be cared for, thus creating the most positive experience.

MEET THE TEAM

Responsible Clinician
I will be the primary doctor. I will make the decisions regarding diagnosis, medication and treatment.

Integrated Clinical Lead
I am a senior manager and monitor and oversee the clinical area and management of the unit, including policy development.

Senior /Junior Doctor
I am another doctor that will be involved in the care. I will often be involved in physical health checks and reviewing medication. Also if the Responsible Clinician is away I will be available to support with requests.

Psychologist *As the psychologist I am available to offer a variety of therapies. I can explore with past experiences, difficulties with the service user's mental health and behaviour. I will support them to develop the skills to manage their mental health and future behaviour. I can be seen me in 1:1 sessions or there are a variety of groups available.*

Assistant Psychologist
As the Assistant Psychologist, I will help with delivering the psychological input that is needed. This can mean that I help with running psychology groups that service users attend, and may support them with tasks such as meeting with them for individual sessions if they need extra help with some of their group work. I cannot deliver all of the same therapies that the unit Psychologist can offer, but I will always do my best to address concerns and feed these back to the ward Psychologist.

Care Coordinator
As the Care Coordinator I can liaise with carers and arrange visits to service users. I will play a role in the future planning and discharge of service users from hospital by supporting in finding suitable accommodation to meet their needs. I am generally based in the community rather than on the unit.

Occupational Therapist (OT)
"As the Occupational Therapist I can support service users to engage in meaningful activities. There will be a group timetable on the ward consisting of various activities in which service users can participate. I can also work with service users in one to one sessions to develop their independent living skills e.g. cooking, budgeting, and using a computer. I meet with the service users every Monday morning to support them with planning their week. I also promote attendance at the Recovery College."

Nurse /Support Worker
"I am your first point of contact on the ward. I am able to help you and offer support and someone to talk to discuss any feedback and concerns you may have. I provide daily support to service users including 1:1 time."

Keyworker
"I am a nurse and I support service users in preparing for their ward rounds including requests. I will support them to understand their care plan and am available to offer support and guidance."

Ward Manager
As the ward manager, I am responsible for overseeing the staff and service users on the ward. I will also be involved in their care.

Technical Instructor
As the activity co-ordinator I will offer various activities for service users to attend both on and off the ward.

Domestic
I am responsible for maintaining the cleanliness of the unit. I will be involved in cleaning the bedrooms, bathrooms, lounge and kitchen.

Spirituality
Service users can access spiritual support by requesting this from a member of staff.

Interpreter *If service users have difficulties with English, they are entitled to an interpreter to support them during meetings.*

Advocate
Advocates are independent of the hospital. As an advocate I can support service users during ward rounds and I can be a voice for them. Conversations are confidential as long as there is considered no risk to the service users or others.

Pharmacist
As the pharmacist I will regularly review service user's medication and am available for 1:1 time to discuss this.

Medical Secretary
As medical secretary you will often find me in Ward Rounds and CPA Reviews. I will take minutes of things discussed during these meetings.

Students
There are many of us. I may be a student nurse, medical student, psychologist or occupational therapist. I am here for my learning under the supervision of qualified staff.

OUR PHILOSOPHY OF CARE

"On Edward House we aim to provide individualised care in a dignified and confidential manner identifying the physical, social and psychological needs of patients and their families/carers. The patient's right to privacy will be respected and every effort will be made to maintain this.

We will do this by working in a safe and secure environment where care needs are assessed, planned and implemented in partnership with all concerned – whilst at the same time respecting patient's rights as an individual, acknowledging individual beliefs and values, and supporting individual choices made."

ADMISSION TO THE UNIT

Edward House has 20 beds and is an all-male unit. It is located on the Broomfield Hospital site in Chelmsford. Also on this site are other mental health services including Finchingfield and Galleywood wards (adult acute), The Christopher Unit (Psychiatric Intensive Care Unit), Rainbow Mother & Baby Unit and the Crystal Centre for Older Adults.

Each patient is allocated a keyworker and co-worker who are both registered nurses. It is their responsibility with other members of the team including doctors, psychologists and Occupational Therapists to ensure a careplan is developed with the patients to support them and promote recovery throughout their stay. The keyworker will be able to discuss any concerns you may have as a carer and provide feedback in relation to the service user's care with their consent.

FACILITIES

Bedrooms

- All bedrooms have their own toilet, shower and wash basin (en-suite); these have been designed for the service user's comfort and safety. There is a window panel on the bedroom doors which can be opened by staff to check the safety of service users. This panel is set to the closed position when not in use unless service users request for it to be left open.

- Bedrooms are accessed by swipe keys only and will be issued to service users on admission. Staff members have additional access to bedrooms for reasons of safety.

- All bedrooms contain a Television aerial point and following a risk assessment by the Multi-Disciplinary Team, a Television purchased by service users may be used in the bedrooms where negotiated as safe to do so. Please speak to a member of staff if you wish to bring in any electrical items for a service user. All electrical items are required to be tested by our electricians for safety, prior to use, in line with Health & Safety regulations.

Refreshments

MEALS (Times are approximate and may vary)

- **Breakfast:** 8 a.m. – 9 a.m.
- **Lunch:** 12.15p.m. – 1 p.m.
- **Dinner:** 5.15p.m. – 6 p.m.

- Meals are served in the communal dining area. Any special diets can be discussed with the Keyworkers and referrals can be made to a Dietician for further support where required.

- Tea and coffee are available from a beverage area 24 hours per day unless for safety reasons the protective hatch needs to be closed. In these circumstances, staff members will assist with providing beverages to service users.

Personal Items

- Service users will find it helpful to have a few personal items, however, large quantities of cash and certain items (i.e. PCs and TVs) may be restricted for safety reasons. We request that you do not bring too many personal items/clothing for service users, as we have limited storage facilities on the unit and there will be limited storage space in each service user's bedroom.

- There is a safe in each ward office which can hold cash/passports etc. for service users but we are unable to hold large quantities of cash or expensive valuables on the unit.

- There is a limit to service users having a maximum of £50 on the unit at any time unless discussed and agreed with the Multi-Disciplinary Team. For service users who do not have Section 17 Leave to withdraw money, a secure account can be set up through the service and money given to service users on site. Unless handed into staff for safe keeping, we will be unable to accept liability for any lost or damaged items of personal property.

HEALTH, SAFETY AND SECURITY

General

- All staff members can be recognised by their identity badges, which have their name and role. We have a number of leads for various responsibilities on the unit including leads for Health and Safety, Safeguarding, Learning Disability and Manual Handling.

- The unit has a zero-tolerance policy towards alcohol, illegal/street drugs and dangerous weapons. In addition there are a number of prohibited/restricted items which are highlighted at the entrance area of the unit. Some prohibited/restricted items brought onto the unit such as mobile phones can be stored in a secure locker during your visit. Razors and sharp objects are restricted for safety reasons. If brought in, they must be handed to ward staff and they will be placed in a property box allocated to each service user.

- Sniffer dogs/handlers visit the wards with no warning, at which times the unit, including all patient areas are searched, this is to ensure the safety of all our service users, visitors and staff.

- We may request to search visitors if it is suspected that Prohibited/Restricted Items are being brought onto the unit for service users.

- We have a zero-tolerance policy towards bullying, either between clients, or towards and from staff.

- As a carer, we will treat you with respect at all times and expect the same from you in return. Abusive or aggressive behaviour, whether physical or verbal will not be tolerated.

Mobile Phones/Cameras and Electrical Equipment

- Personal mobile phones with Internet access/Bluetooth/Recording capabilities are not permitted on the wards at Edward House by staff, visitors or service users, for reasons of safety and security. Service user's mobile phones will be stored in their personal box in the 'hub' but may be taken out on leave following a risk assessment. There is payphone on each ward and service users may request allocation of an approved personal mobile phone provided by the unit which does not have access to the Internet/Bluetooth/Camera/Video.

- The use of cameras is prohibited on hospital premises; this is to protect the confidentiality of all service users, visitors and staff.

- Visitors to the unit can store their mobile phone and other personal belongings in secure lockers near the entrance to the unit.

- Skype access is available for service user's to contact carers through a secure internet connection.

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Alarms

- **Safety Alarm**
  Edward House is equipped with an alarm system. When activated, this alarm sounds with an intermittent tone to alert nursing staff of situations that demand their immediate attention. Please keep walkways clear if this happens and follow any instructions from staff.

- **Fire Alarm**
  This alarm sounds as a continuous even tone. Please immediately follow instructions given by staff. This alarm is tested every Monday morning.

- **Nurse Call**
  In service user's bedrooms and in more isolated areas of the unit, there are 'nurse call' buttons for use if they find themselves in difficulty and need assistance.

Smoking

- Edward House is a non-smoking environment; service users, staff and visitors may not smoke on the unit, in the carpark or in the gardens. Service users will not be permitted to smoke on escorted leave, to protect staff and other service users from the effects of passive smoking.

- Rechargeable 'vapes' are not allowed on the unit and cannot be charged here, for health & safety reasons. However, safety approved 'vapes' can be purchased by service users from the reception area following an assessment of risk by the Team.

- Lighters and matches are not permitted within the building. Ward staff will hold any lighters found in the possession of clients and return these on discharge. Tobacco may not be brought onto the unit and is classed as a prohibited item.

Laundry

- Washing machines and tumble dryers are provided on the ward for service users.

CARE PROGRAMME APPROACH (CPA)

- The Care Programme Approach (CPA) and Care Plans are the processes we use to ensure service users receive properly planned and coordinated care, which they are happy with and have agreed to.

- During their stay at Edward House, service user's mental health and social care needs will be assessed. From these ongoing assessments, a plan of their treatment and care will be compiled with them and shared with family, carers or close ones, with their consent. In addition, we use a number of other ways to assess service user's progress and plan their recovery.

CPA Care Plan

- On admission to hospital, if they do not already have one, service users will be allocated a Care Coordinator from a Community Mental Health Team, who is considered most suitable for their individual needs and who is responsible for their ongoing care following discharge. The Care Coordinator is also an additional point of contact for carers.

They will:

- Make sure you have your say about what care you feel the service user should receive from us
- Be an additional point of contact if you have any questions about their care
- Work with other professionals to coordinate their care

- The Care Coordinator will set up a separate Community Care Plan which will identify ongoing interventions required once a service user is discharged from the unit. It will describe their needs and how they aim to help them meet them. It will tell the service user who will be working with them and when this will be.

- The service user's CPA Care Plan will be reviewed at least every six months, to see if it is going well or needs changing. With the service user's consent, their Care Coordinator will agree a date and time for the CPA meeting that suits you and all those involved in the service user's care. As a carer, if you require additional support, the Care Coordinator or nursing team can arrange a carer's assessment. Please speak to a member of staff to discuss this further.

Care Review

- Whilst service users are an inpatient, they will be invited to attend a care review (ward round) at least every fortnight. Carers will also be invited to attend with the service user's consent. The care review is your opportunity to meet with the Consultant, Nursing Staff, Care Coordinator and other professionals who are directly involved in the service user's care and treatment whilst at Edward House. There may be times when a service user does not wish for a carer to be involved in their care. In such cases, although the team will not be able to discuss aspects of their care due to reasons of confidentiality, they can still listen to your viewpoints and concerns.

THERAPIES

- As part of their care and treatment, service users are encouraged to attend group and individual therapeutic activities on the unit provided by Psychologists and the Occupational Therapy Team.

- These may include emotional support, understanding mental illness and medication matters, support in stopping substance use or other unhelpful behaviours, art therapy, music, dance psychotherapy and relaxation sessions, among others.

- Some activities are run to help them express their thoughts, feelings and behaviours and to assist them to develop coping strategies. Others are recreational. The weekly schedules are displayed on the ward notice boards; Occupational Therapy staff are based on the unit and will discuss activities with service users daily and each service user's week is planned every Monday morning. Any amendments to the timetables are posted on the notice board within the unit.

- There is a weekly Community Meeting which service users are invited to chair. This meeting focuses on a number of agenda topics including Reducing Restrictive Practice and enables service users to feed back their thoughts and feelings of the service, including recommendations for changes. There are additional opportunities for them to build their confidence by participating in training for staff and being on the interview panel when recruiting new staff members.

- The Recovery College is an educational style program offering various courses to patients. It is co-planned and co-produced by expert patients. It fundamentally changes the concept of treatment from just offering it to patients, to patients partnering with staff to offer recovery programmes. The college works in the same way that a college in the community would. The patient reads through the prospectus to get an idea of what courses are available then chooses the courses that suit them from that terms timetable.

Other activities include:

- Access to a Pool Table
- Table Tennis in the ADL garden
- Access to the Gymnasium, which can be accessed with a gym instructor after a health assessment
- Wii, DVD's and various games for leisure including chess etc.

There is a fairly extensive library of books for service users to access.

ADVOCACY SERVICES

- There is an advocate team available at Edward House. These include IMHAs (Independent Mental Health Advocates), One Support (for benefits/housing support), PALS (patient advice and liaison service). Please speak to the Nurse In Charge/ the Ward Secretary for information on how service users may access these services. Alternatively, information can be obtained for accessing these services online.

WELFARE AND BENEFIT

- There is a person who assists service users with their benefits. Service users can request for assistance with their benefits from a nurse and an appointment will be booked.

RELIGIOUS, SPIRITUAL AND CULTURAL NEEDS

- At Edward House, we appreciate and promote spirituality and religion in the life and recovery of our service users. As this is individual to each individual, we will work with each service user to understand and support people's specific needs. Service users can also ask their faith leader to visit them on the unit There is a multi-faith room to give service users the opportunity for reflective space and quiet time.

- Chaplaincy – Chaplains can be accessed on request for service users. Chaplaincy supports all faiths and denominations and can provide support for any faith or religion.

INTERPRETING SERVICES

- Interpreting Services are available if required. There are posters available on the ward in a range of languages which explain how to access these.

LEAVE ARRANGEMENTS

- Initially, leave from the unit will be limited and at first service users will probably have a member of staff accompany them. As their recovery continues, leave will have specific goals and purposes. This will help us understand how independent they are becoming and what the next steps could be. Any leave has to be approved by the Consultant Psychiatrist and in some cases the Ministry of Justice for service users detained under certain sections of the Mental Health Act.

- Leave cannot be accommodated for the sole purpose of smoking off the premises. Service users may not smoke in the presence of members of staff while on escorted leave, due to the negative health aspects of passive smoking.

- Following periods of leave, two staff members will request to search service users to reduce the risk of restricted or prohibited items being brought onto the unit. This is to ensure that a safe environment is maintained for all.

DISCHARGE

- Throughout their stay with us, and when they have achieved a sufficient level of safety and recovery, we will discuss the service user's discharge and future needs with you and other people important to their future support. The team will consider your views in conjunction with the service users and staff directly involved in their care, treatment and discharge plan. We will inform the GP about the service user's admission to and discharge from Edward House, and the details of any treatment and medication prescribed. A suitable level of support will be given after discharge including regular contact with their care-coordinator.

Medication on discharge

- If discharge medication is prescribed, 14 days' supply will normally be dispensed to the service user. The GP/community mental health team will then prescribe medication from this point. If a service user is transferred to another unit rather than their own accommodation then medication may be given directly to the new unit.

VISITING

- To maintain safety on the unit, visiting is by appointment only. Please telephone to arrange an appointment as the staff will need to ensure the time is free. There are various groups which run, so visiting times are restricted and we will need at least 24 hours' notice although exceptions to this can be accommodated following liaison with the ward manager.

Our normal visiting times are:

- Monday – Friday: 4 p.m. – 5 p.m. and 6.30 p.m. - 8 p.m.
- Weekends and bank holidays: 3 p.m. – 5 p.m. and 6.30 – 8 p.m.
  Visiting outside of these hours must be agreed with the Ward Manager or Nurse in charge.
- Edward House operates a protected meal time policy for all service users. Meal times are an important part of our service user's stay and having the ward free from visitors during this time allows privacy for service users to have their meals in as calm and peaceful a way as possible.
- The TV lounges and garden areas are for use by service users only. Private areas will be provided for visitors. Children under 17 visiting with friends or

relatives are not allowed into the ward areas, but this can be facilitated in another area. Please contact the ward manager if you wish to bring a young person/child to the unit.

- Visitors are not permitted to visit service user's individual rooms.
  Other rooms may be available for confidential meetings, by arrangement.
  Please contact the unit to arrange this.

Location

- Edward House is situated at Puddings Wood Drive, behind the Broomfield Hospital Site. Follow the signs to the Linden Centre, once through their barrier, turn immediately left and you will see another barrier ahead of you, which is the entrance to Edward House.
- Parking is available at Edward House for staff and visitors: please ring our barrier bell and staff will let you through. If you are registered disabled, please advise staff, as there are two places outside our reception area.
- Please be aware that we have CCTV in operation to ensure the security of our building and safety of our clients, visitors and staff. Because of this your movements may be recorded.

Infection Control

- We politely ask that you please refrain from visiting the ward if you have been unwell with any infection, especially if you have experienced diarrhoea or vomiting.

Meals/Refreshments while Visiting

While we are happy to provide you with water/tea/coffee while you are visiting the unit, we do not have any cafeteria/machines on site for food/refreshments.
The nearest venue to access café/coffee facilities is Broomfield Hospital. Staff can give you directions.

FEEDBACK

Suggestions and Complaints

- You are invited to make any suggestions about any aspect of care on the ward. If you have a concern/complaint, please discuss this with the nurse in charge/ward manager of the ward. This will enable us to try to resolve the problem smoothly and quickly.

- If however, you feel the problem has not been resolved locally, you may wish to discuss it with:
  - PALS (Patient Advice and Liaison Service) – Leaflets are available in the reception area or email you can email epunft.pals@nhs.net
  - You can speak to the Patient Experience Team on 0800 085 7935

- You can also complete a survey of your experience of the service (just ask the receptionist if you would like to complete one)

- We are inspected by the Care Quality Commission. If you would like to contact the CQC in relation to the care that is being provided the following details may be of assistance:

  By Phone: 03000 616161
  By Email: enquiries@cqc.org.uk
  Online: www.cqc.org.uk/tellus

CARER SUPPORT

- The team at Edward House will support you and can provide information in relation to various mental health conditions (we have leaflets on the unit and this can also be discussed in ward rounds or 1:1 contact with nurses or doctors). If you feel you require any support, please do not hesitate to ask as we can provide an assessment of your needs and signpost you to other organisations for further support.
- In addition, you may find the following organisations useful to gain additional support.

ORGANISATION	CONTACT DETAILS
CARERS UK A National membership charity for carers, who together call for change, seek recognition and support for those who provide care. The website and helpline offers information and advice including agencies that offer support in the local area.	www.carersuk.org Telephone helpline providing information is open on **Mondays and Tuesday between 10am and 4pm - 0808 808 7777**
RETHINK The Rethink Mental Illness Advice Service offers practical help on issues such as the Mental Health Act, community care, welfare benefits, debt, criminal justice and carer's rights. They also offer general help on living with mental illness, medication, care and treatment. They provide information about agencies in the local area.	www.rethink.org **The line is open from 9:30am - 4pm Monday to Friday. E-mail : info@rethink.org**
MIND Provides advice and support to anyone experiencing a mental health problem and campaigns to improve services, raise awareness and promote understanding. Gives practical suggestions for what a carer/family member can do and where to	www.mind.org.uk **Tel : 0300 123 3393 Monday to Friday (except for bank holidays) 09.00 – 18.00** **E-mail : supporterrelations@mind.org.uk**

go to for support.	
CARERS TRUST The Carers Trust Network supports carers locally through a UK wide network of Partner organisations/services. Their website links to a range of different organisation in the local area.	**www.carers.org** **Their head office can be contacted on : Tel : 0300 772 9600 E-mail : info@carers.org**
CARERSMART CarerSmart is a club from Carers Trust and open to carers, people with care needs, staff and volunteers across the Carers Trust network. Carers can join for free and benefit from a range of offers including: discounts on holiday and travel arrangements, cash back on shopping from numerous high street retailers, free legal advice services.	**www.carersmart.org**

Contact Information

Edward House main reception number: 01245 315850

Our full address is:

Edward House
The Linden Centre
Puddings Wood Drive
Broomfield
Chelmsford
Essex
CM1 7LF

GLOSSARY OF MENTAL HEALTH TERMS

- **Anxiety**
  Anxiety disorders range from feelings of uneasiness to immobilizing bouts of terror. Most people experience anxiety at some point in their lives and some nervousness in anticipation of a real situation. However if a person cannot shake unwarranted worries, or if the feelings are jarring to the point of avoiding everyday activities, he or she most likely has an anxiety disorder. Anxiety can be associated with depression.

- **Behavioral Therapy**
  As the name implies, behavioural therapy focuses on behaviour- changing unwanted behaviours through rewards, reinforcements, and desensitization. Desensitization, or Exposure Therapy, is a process of confronting something that arouses anxiety, discomfort, or fear and overcoming the unwanted responses. Behavioural therapy often involves the cooperation of others, especially family and close friends, to reinforce a desired behaviour.

- **Bipolar Disorder**
  Extreme mood swings with recurrent episodes of depression and mania (being high or up) punctuated by periods of generally even-keeled behavior characterise this disorder. Bipolar disorder tends to run in families. This disorder typically begins in the mid-twenties and continues throughout life. Without treatment, people who have bipolar disorder often go through devastating life events such as marital breakups, job loss, substance abuse, and suicide.

- **CTO:**
  Community Treatment Order. This is a legal order made by the Mental Health Review Tribunal or by a Magistrate. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community

- **The Care Programme Approach (CPA)**
  The Care Programme Approach is a system of assessing and looking after people with mental health problems. People can either be offered standard or enhanced CPA, and being on CPA means a patient has a care plan which they should have a copy of, and have regular review with the mental health team looking after them. CPA has four main elements:
- Assessment - Systematic arrangements for assessing the health and social needs of people accepted by the specialist mental health services.
- A Care Plan - The formation of a care plan which addresses the identified health and social care needs.
- A Key Worker and Care-Coordinator - The appointment of a Key Worker (now Care Co–coordinator) to keep in close touch with the patient and monitor care.
- Regular Review - Regular review, and if need be, agreed changes to the care plan.

- **Clinical Psychologist**
  A clinical psychologist is a professional with a degree in psychology who

specializes in psychological assessments and therapies (sometimes known as talking therapies).

- **Cognitive Therapy**
  Cognitive therapy aims to identify and correct unhelpful thinking patterns that can lead to feelings and behaviours that may be troublesome, self-defeating, or even self-destructive. The goal is to replace such thinking with a more balanced view that, in turn, leads to more fulfilling and productive behaviour.

- **Cognitive Behavioural Therapy**
  A combination of cognitive and behavioural therapies, this approach helps people change negative thought patterns, beliefs, and behaviours so they can manage symptoms and enjoy more productive, less stressful lives.

- **Community Mental Health Team**
  This is a team of mental health workers who work together in a community setting. They include Psychiatrists, Community Psychiatric Nurses, Occupational Therapists, Social Workers, Care workers, Psychologists.

- **Community Psychiatric Nurses (CPNs)**
  A CPN sees people who are living in the community. This is most often in the person's own home but it can also be in clinics based, for example, in a hospital setting. CPNs provide support to people through difficult periods of their illness. They may also see patients who are currently well to check everything is going okay and be the first point of contact if the patient starts becoming unwell again.

- **Consultant Psychiatrist**
  In a hospital a consultant refers to a specially trained doctor who has finished his training and works in one area of medicine, usually with a team of doctors in training and other professionals working with them.

- **Delusions**
  Delusions are persistent thoughts and beliefs that have no basis in reality.

- **Dementia**
  Significant loss of intellectual abilities such as memory capacity, severe enough to interfere with social or occupational functioning. Dementia is a problem in the brain that makes it hard for a person to remember, learn and communicate; eventually is becomes difficult for a person to take care of himself or herself. This disorder can also affect a person's mood and personality.

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- **Depression**
  Depression is a mood disorder characterized by intense feelings of sadness that persist beyond a few weeks. It is associated with many physical symptoms such as disturbance of sleep, appetite, and concentration. Depressed people often feel tired, guilty and can find normal life extremely difficult. Depression can be associated with anxiety.

- **Early intervention**
  A process used to recognize warning signs for mental health problems and to take early action against factors that put individuals at risk. Early intervention

can help people get better in less time and can prevent problems from becoming worse.

- **Empowerment**
  Giving people the skills, knowledge attitudes and power to allow or enable them to be more responsible for their own lives, health and care.

- **Evidenced Based (Medicine)**
  Where actions, treatment or care are based on widely accepted evidence. This evidence can be from scientific trails, or based on the collective experience of senior professionals.

- **General Practitioners (GPs)**
  Doctors who are specially trained to work in a community setting, seeing any patients for any problems they have.

- **Hallucinations**
  Hallucinations are experiences of sensations that have no source. Some examples of hallucinations include hearing nonexistent voices, seeing nonexistent things, and experiencing burning or pain sensations with no physical cause.

- **Mental Health**
  A state of emotional well-being in which an individual is able to use his or her thinking and feeling abilities, live with others, and meet the ordinary demands of everyday life.

- **Mental Illness / Ill health**
  A state where the person's mental health is disrupted so that their thinking, emotions or behaviour are affected to an extent that it has an effect on their daily life.

- **Mental Well-being**
  A good or satisfactory condition of thinking, feeling and living; a state characterized by health, happiness, and prosperity. It is a broader term than mental health and includes the wider aspects of a person's life, not just how they feel.

- **MHT:**
  Mental Health Tribunal. This is an independent tribunal which can order the discharge of a patient. Can also make other recommendations. Sometimes referred to as First Tier Tribunal

- **Multi-Disciplinary Team**
  The Multi-Disciplinary Team includes Psychiatrists, Nurses, Occupational Therapists, Care-Coordinators and GPs. Together with the service user, they plan their ongoing care needs and interventions.

- **Obsessive Compulsive Disorder (OCD)**
  Obsessive Compulsive Disorder is a chronic, relapsing illness. People who have it suffer from recurrent and unwanted thoughts or rituals. The

obsessions and the need to perform rituals can take over a person's life if left untreated. They feel they cannot control these thoughts or rituals.

- **Occupational Therapists (OTs)**
  An occupational therapist can have many different roles. They help people to adapt to their environment and to cope with their daily life.
  OTs may work in hospitals or in the community. They supervise and assess a person's ability to look after themselves, e.g. self-care, cooking and housework. This may be done in purpose-built occupational therapy departments in hospitals or in the patient's own home.
  OTs work with both individuals and groups. They can set goals for individuals with depression to encourage them to achieve more than they have been able to do while ill. They may get patients involved in specific job-related training schemes to improve their decision making and planning about the future. Group work is often aimed at increasing people's social interactions.
  OTs become involved in rehabilitation work to help them reintegrate back into life outside hospital.

- **Panic Disorders**
  People with panic disorder experience heart-pounding terror that strikes suddenly and without warning. Since they cannot predict when a panic attack will seize them, many people live in persistent worry that another one could overcome them at any moment.

- **Paranoia and Paranoid Disorders**
  Symptoms of paranoia may include feelings of persecution and an exaggerated sense of self-importance. The disorder is present in many mental health problems and it is rare as an isolated mental illness.

- **Person Centered Care**
  Puts the patient at the heart of diagnosis and treatment. Patient centered care explores the main reason for the consultation, seeks an integrated vision of the patient’s world, finds common ground and creates a mutually agreed management plan, enhancing health promotion, and providing a solid basis for the long term doctor patient relationship. Patient centered care is therefore based on the patient’s problems, the patient’s needs, their feelings and beliefs and the skills and support they already have to combat their problems.

- **Phobias**
  Phobias are irrational fears that lead people to altogether avoid specific things or situations that trigger intense anxiety. Phobias occur in several forms, for example, agoraphobia is the fear of being in any situation that might trigger a panic attack and from which escape might be difficult; social phobia is a fear of being extremely embarrassed in front of other people.

- **Recovery**
  This may not mean cure, but does include not only a significant reduction in symptoms but also an improvement in the ability of the individual to lead a normal life including work, home life and leisure. Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

- PRN:A Latin phrase meaning “ProReNata”,to describe medication given as necessary, in reaction to a symptom, i.e. painkillers.

- **S17:**
  Section17,the legal document stating when, where and how often a patient can leave the hospital.

- **Schizophrenia**
  Schizophrenia is a mental disorder characterized by "positive" and "negative" symptoms. Psychotic, or positive, symptoms include delusions, hallucinations, and disordered thinking (apparent from a person's fragmented, disconnected and sometimes nonsensical speech). Negative symptoms include social withdrawal, extreme apathy, diminished motivation, and blunted emotional expression.

- **Self Management**
  Where a patient develops the knowledge and experience which enables them to be able to monitor their condition and modify their treatment with the full support of health care professional.

- **Severe and Enduring Mental Illness**
  This term is used to describe a group of illnesses which can cause more severe mental health problems. It includes schizophrenia, bipolar affective disorder (manic depression) and other psychotic illnesses.

- **Social Inclusion**
  Ensuring the marginalised and those living in poverty have greater participation in decision making which affects their lives, allowing them to improve their living standards and their overall well-being.

- **Stigma**
  Stigma is discrimination, based upon societies fear and ignorance about an illness or a problem. It causes peoples to be marginalized and mistreated, and therefore leads to social isolation, health inequalities and many forms of discrimination. It is derived from the term used to describe the marks burnt onto Roman slaves.

- **Ward Round**
  This is where the Multi-Disciplinary Team meets a patient, asks them questions about their problems and arranges investigations. The main objectives are to try and understand what the problems are and what is causing them, understand what the patient thinks and feels about them, and work out a plan of action that the doctor and patient can agree on.

Essex Partnership University

NHS Found at ion Trust

EDWARD HOUSE SERVICE USER BOOKLET

WELCOMETOEDWARD HOUSE

As part of Essex Partnership University NHS Trust, we aim to provide a safe, secure recovery service for adult males aged 18 and above.

This booklet has been designed to provide you with information which should explain, in brief, various aspects of how care is organised and the various facilities available within Edward House. There is a glossary towards the end of the booklet which can be used as a reference guide for some of the terms used throughout the booklet.

Our service supports the Trust's vision, "To be the leading health and wellbeing service in the provision of mental health and community care". We are committed to delivering high quality care that is holistic, innovative and needs led, whilst fostering empowerment, promoting independence, dignity and respect and valuing our patients, carers and staff. We will work openly and honestly, in partnership with others, to promote and maintain optimum health and well-being, caring for others as we would want our own families to be cared for, thus creating the most positive experience.

MEET THE TEAM

Responsible Clinician
I will be the primary doctor. I will make the decisions regarding diagnosis, medication and treatment.

Integrated Clinical Lead
I am a senior manager who monitors and oversees the clinical area and management of the unit, including policy development.

Senior /Junior Doctor
I am another doctor that will be involved in the care. I will often be involved in physical health checks and reviewing medication. Also, if the Responsible Clinician is away I will be available to support with requests.

Psychologist
As the Psychologist I am available to offer a variety of therapies. I can explore past experiences, difficulties with your mental health and behaviour. I will support you to develop the skills to manage your mental health and future behaviour. I can be seen in 1:1 sessions or there are a variety of groups available.

Assistant Psychologist
As the Assistant Psychologist, I will help with delivering the psychological input that is needed. This can mean that I help with running psychology groups that service users attend, and may support you with tasks such as meeting for individual sessions if you need extra help with some of the group work. I cannot deliver all of the same therapies that the unit Psychologist can offer, but I will always do my best to address concerns and feed these back to the Psychologist.

Care Coordinator
As the Care Coordinator I can liaise with your carers and arrange to visit you. I will play a role in your future planning and discharge from hospital by supporting in finding suitable accommodation to meet your needs. I am generally based in the community rather than on the unit.

Occupational Therapist (OT)
As the Occupational Therapist I can support you to engage in meaningful activities. There will be a group timetable on the ward consisting of various activities in which you can participate. I can also work with you in one to one sessions to develop your independent living skills e.g. cooking, budgeting, and using a computer. I meet with the service users every Monday morning to support them with planning their week. I also promote attendance at the Recovery College.

Occupational Therapy Technician [OTT]
As part of the Occupational Therapy team I will work with you to identify your strengths and talents through a variety of meaningful activities, with an emphasis on Education, and an opportunity to gain an In-house award focusing on personal development [The Phoenix Award]. I can also help and support your journey gaining links into the community via employment, volunteering projects, or college courses.

Dance Movement Psychotherapy
As the Dance Movement Psychotherapist I will move with you and support you to notice your body's physical sensations and how these may connect to your emotions and difficult issues you may be struggling with. Each session will have time for you to explore your own natural movements and express yourself with your body and any emotional feelings that are present. Movement Props can be used to support your movement expression, such as balls, stretchy cloth, percussion instruments. There will be time to talk and reflect about the experience of moving and any emotional feelings that arise.

Nurse/Support Worker
I am your first point of contact on the ward. I am able to help you and offer support and someone to talk to and discuss any feedback and concerns you may have. I provide daily support to service users including 1:1 time.

Keyworker
I am a nurse and will support you in preparing for your ward rounds including requests. I will support you to understand your care plan and am available to offer support and guidance.

Ward Manager
As the ward manager, I am responsible for overseeing the staff and service users on the ward. I will also be involved in their care.

Domestic
I am responsible for maintaining the cleanliness of the unit. I will be involved in cleaning the bedrooms, bathrooms, lounge and kitchen.

Spirituality
Service users can access spiritual support by requesting this from a member of staff.

Interpreter
If service users have difficulties with the English language, they can be provided with an interpreter to support them during meetings.

Advocate
Advocates are independent of the hospital. As an advocate I can support you during ward rounds and I can be a voice for you. Conversations are confidential as long as there is considered no risk to you or others.

Pharmacist
As the pharmacist I will regularly review service user's medication and am available for 1:1 time to discuss this.

Medical Secretary
As medical secretary you will often find me in Ward Rounds and CPA Reviews. I will take minutes of things discussed during these meetings.

Students
There are many of us. I may be a student nurse, medical student, psychologist or occupational therapist. I am here for my learning under the supervision of qualified staff.

OUR PHILOSOPHY OF CARE

"On Edward House we aim to provide individualised care in a dignified and confidential manner identifying the physical, social and psychological needs of patients and their families/carers. The patient's right to privacy will be respected and every effort will be made to maintain this.

We will do this by working in a safe and secure environment where care needs are assessed, planned and implemented in partnership with all concerned – whilst at the same time respecting patient's rights as an individual, acknowledging individual beliefs and values, and supporting individual choices made."

ADMISSION TO THE UNIT

Edward House has 20 beds and is an all-male unit. It is located on the Broomfield Hospital site in Chelmsford. Also on this site are other mental health services including Finchingfield and Galleywood wards (adult acute), The Christopher Unit (Psychiatric Intensive Care Unit), Rainbow Mother & Baby Unit and the Crystal Centre for Older Adults. The unit is separated into two wards, each with a garden. In between the two wards there is a middle "Atrium" area, from which other others of the service can be accessed including the Therapies' suites and kitchen.

You will be allocated a keyworker and co-worker who are both registered nurses.

It is their responsibility with other members of the team including doctors, psychologists and Occupational Therapists to ensure a careplan is developed with you to support you and promote recovery throughout your stay.
Most of the patients under our care are transferred from the prison service or stepped down from Medium Secure care, although occasionally patients come to us directly from home or mental health units such as PICU.

In addition, patients will usually meet the following criteria:

- Presence of a mental disorder which is of a nature and/or degree warranting detention in hospital for medical treatment under the Mental Health Act.
- Patients predominantly present a significant risk of harm to others and to manage this risk requires specialist risk management procedures and specialist treatment interventions.
- Prisoners suitable for transfer to low secure inpatient care will generally be charged with, or have been convicted of, a specified violent or sexual offence as defined in Schedule 15 of the Criminal Justice Act 2003 or another serious offence, such as arson.
- Patients may be accepted without criminal charges pending, where there is clear evidence of a significant risk to others in the context of mental disorder. There will generally be a pattern of assaults and escalating threats
- Potential to benefit from the treatment/assessment provided or to prevent deterioration
- The patient is not safely managed in a non-secure environment
- Patient may present a risk of escape
- Patients with a mental disorder directed to conditions of low security by the (MoJ).

Prior to admission to the service patients will receive an assessment from members of our MDT. Where appropriate, carers may also be contacted for their views.

FACILITIES

Bedrooms

- All bedrooms have their own toilet, shower and wash basin (en-suite); these have been designed for your comfort and safety. There is a window panel on the bedroom doors which can be opened by staff to check on your wellbeing. This panel is set to the closed position when not in use unless you request for it to be left open.

- Bedrooms are accessed by swipe keys only and will be issued to you on admission. Staff members have additional access to bedrooms for reasons of safety.

- All bedrooms contain a Television aerial point and following a risk assessment by the Multi-Disciplinary Team, a Television purchased by you may be used in the bedrooms where negotiated as safe to do so. Please speak to a member of staff if you wish to bring any electrical items onto the unit. All electrical items are required to be tested by our electricians for safety, prior to use, in line with Health & Safety regulations.

Refreshments and Meals

MEALS (Times are approximate and may vary)

- **Breakfast:** 8 a.m. – 9 a.m.
- **Lunch:** 12.15p.m. – 1 p.m.
- **Dinner:** 5.15p.m. – 6 p.m.
- **Supper:** 8.30p.m. – 9 p.m.

- Meals are served in the communal dining area. Any special diets can be discussed with the Keyworkers and referrals can be made to a Dietician for further support where required.

- Tea and coffee are available from a beverage area 24 hours per day unless for safety reasons the protective hatch needs to be closed. In these circumstances, staff members will assist with providing beverages to you.

Personal Items

- You will find it helpful to have a few personal items, however, large quantities of cash and certain items (e.g. PCs) may be restricted for safety reasons. We request that you do not bring too many personal items/clothing, as we have limited storage facilities on the unit and there will be limited storage space in your bedroom.

- There is a safe in each ward office which can hold cash and bank cards for you but we are unable to hold large quantities of cash or other valuables in these safes.

- There are lockers located in the Atrium area which you can store personal belongings in such as electronic equipment (which can also be charged in the locker) and valuable items. You can access the locker in the presence of a staff member.

- If there are concerns that prohibited items are being stored in your locker, staff may need to access the locker to check for these. For added security the lockers are in full view of CCTV cameras.

- There is a limit to service users having a maximum of £50 on the unit at any time unless discussed and agreed with the Multi-Disciplinary Team. If you do not have Section 17 Leave to withdraw money, a secure account can be set up through the service and money given to you on site.

- We will be unable to accept liability for any lost or damaged items of personal property.

Other Facilities

- There is a Gymnasium on site which can be used under supervision from staff.

- A kitchen is available under supervision and following a risk assessment for patients to prepare meals and for storage of patient's own food and drink.

- We can provide access to the internet following an assessment of risk.

- There is a garden on each ward: access to the garden is available 24 hours per day.

- There is an additional garden available in the middle of the unit which can be used under supervised access.

- Computer access is available following an assessment of risk.

HEALTH, SAFETY AND SECURITY

General

- All staff members can be recognised by their identity badges, which have their name and role. We have a number of leads for various responsibilities on the unit including leads for Health and Safety, Safeguarding, Learning Disability and Manual Handling.

- The unit has a zero-tolerance policy towards alcohol, illegal/street drugs and dangerous weapons. In addition, there are a number of prohibited/restricted items which are highlighted at the entrance area of the unit. Some prohibited/restricted items brought onto the unit such as Smart mobile phones can be stored and charged in your locker throughout your stay but

may not be used on the unit. Razors and sharp objects are restricted for safety reasons. If brought in, they must be handed to ward staff and they will be placed in a property box located in the clinical room for safe storage.

- Sniffer dogs/handlers visit the wards with no warning, at which times the unit, including all patient areas are searched; this is to ensure the safety of all our service users, visitors and staff.

- We may request to search service users and visitors if it is suspected that Prohibited/Restricted Items are being brought onto the unit.

- We have a zero-tolerance policy towards bullying, either between clients, or towards and from staff.

- As a service user, we will treat you with respect at all times and expect the same from you in return. Abusive or aggressive behaviour, whether physical or verbal will not be tolerated.

- We will maintain confidentiality throughout your stay. During your admission we will check with you who you are happy for us to share information with and what type of information. A leaflet is available on the ward outlining confidentiality in the service.

Mobile Phones/Cameras and Electrical Equipment

- Personal mobile phones with Internet access/Bluetooth/Recording capabilities are not permitted on the wards at Edward House by staff, visitors or service users, for reasons of safety and security. Your mobile phone can be stored in your personal safe in the Atrium and may be taken out on leave following a risk assessment. An approved personal mobile phone provided by the unit, which does not have access to the Internet/Bluetooth/Camera/Video, can be requested.
  The use of cameras is prohibited on hospital premises; this is to protect the confidentiality of all service users, visitors and staff.

- Visitors to the unit can store their mobile phone and other personal belongings in secure lockers near the entrance to the unit.

- Video calling access is available for you to contact carers through a secure internet connection.

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Alarms

- **Safety Alarm**
  Edward House is equipped with an alarm system. When activated, this alarm sounds with an intermittent tone to alert nursing staff of situations that demand their immediate attention. Please keep walkways clear if this happens and follow any instructions from staff.

- **Fire Alarm**
  This alarm sounds as a continuous even tone. Please immediately follow instructions given by staff. This alarm is tested every Monday morning.

- **Nurse Call**
  In your bedroom and in more isolated areas of the unit, there are 'nurse call' buttons for use if you find yourself in difficulty and need assistance.

Smoking

- Edward House is a non-smoking environment; service users, staff and visitors may not smoke on the unit, in the carpark or in the gardens. Service users will not be permitted to smoke on escorted leave in the company of staff, to protect staff and other service users from the effects of passive smoking.

- Rechargeable 'vapes' are not allowed on the unit and cannot be charged here, for health & safety reasons. However, safety approved 'vapes' can be purchased by service users from the reception area following an assessment of risk by the Team. Service users who wish to purchase their own disposable vapes for use on community leave can store these in the personal lockers. We also provide Nicotine Replacement Therapy (NRT) including Patches, Lozenges and Inhalators.

- Lighters and matches are not permitted within the building. Ward staff will hold

any lighters found in the possession of service users and return these on discharge. Tobacco may not be brought onto the unit and is classed as a prohibited item.

Laundry

- Washing machines and tumble dryers are provided on the unit.

CARE PROGRAMME APPROACH (CPA)

- The Care Programme Approach (CPA) and Care Plans are the processes we use to ensure you receive properly planned and coordinated care, which you are happy with and have agreed to.

- During your stay at Edward House, your mental health and social care needs will be assessed. From these ongoing assessments, a plan of your treatment and care will be compiled with you and shared with family, carers or close ones, with your consent. In addition, we use a number of other ways to assess your progress and plan your care.

CPA Care Plan

- On admission to hospital, if you do not already have one, you will be allocated a Care Coordinator from a Community Mental Health Team, who is considered most suitable for your individual needs and who is responsible for your ongoing care following discharge. The Care Coordinator is also an additional point of contact for carers.

They will:

- Make sure you have your say about what care you feel you should receive from us
- Be an additional point of contact if you have any questions about your care
- Work with other professionals to coordinate your care

- The Care Coordinator will set up a separate Community Care Plan which will identify ongoing actions needed once you are discharged from the unit. It will describe your needs and how they aim to help you meet them. It will tell you who will be working with you and when this will be.

- Whilst an inpatient, the team will work with you to develop an individualised “My Shared Pathway” Careplan which will aim to determine your needs and the interventions required to meet them.

- Your “My Shared Pathway” Careplan will be reviewed at least every six months, to see if it is going well or needs changing. We will agree a date and time for the CPA meeting that suits you and all those involved in your care. If your carer/family members require additional support, the Care Coordinator or nursing team can arrange a carer’s assessment. Please speak to a member of staff to discuss this further.

- As part of your careplan, future plans regarding discharge will be discussed. Depending on your needs, there may be different options for what happens after discharge in terms of where you stay and what continuing support you will receive. Soon after admission, you will receive a date for your estimated date of discharge, based on how long the MDT feel you will need to remain in hospital.

Care Review

- Whilst you are an inpatient, you will be invited to attend a care review (ward round) at least every fortnight. Carers will also be invited to attend with your consent. The care review is your opportunity to meet with the Consultant, Nursing Staff, Care Coordinator and other professionals who are directly involved in your care and treatment whilst at Edward House. There may be times when you do not wish for a carer to be involved in your care. In such cases, although the team will not be able to discuss aspects of their care due to reasons of confidentiality, they can still listen to your carer's viewpoints and concerns.

THERAPIES

- As part of your care and treatment, you will be encouraged to attend group and individual therapeutic activities on the unit provided by Psychologists and the Occupational Therapy Team.

- These may include emotional support, understanding mental illness and medication matters, support in stopping substance use or other unhelpful behaviours, art therapy, music, dance psychotherapy and relaxation sessions, among others.

- Some activities are run to help you express your thoughts, feelings and behaviours and to assist you to develop coping strategies. Others are recreational. The weekly schedules are displayed on the ward notice boards; Occupational Therapy staff are based on the unit and will discuss activities with you daily and your week is planned every Monday morning. Any amendments to the timetables are posted on the notice board within the unit.

- There is a daily Community Meeting held every evening which you are invited to chair. This meeting focuses on a number of agenda topics including Reducing Restrictive Practice and enables service users to feed back their thoughts and feelings of the service, including recommendations for changes. There are additional opportunities for you to build your confidence by participating in training for staff and being on the interview panel when recruiting new staff members. There is also a Service Improvement Meeting held every 3 months which you are invited to attend to have input into the service.

- The Recovery College is an educational style program offering various courses to service users. It is co-planned and co-produced by service users. It fundamentally changes the concept of treatment from just offering it to service users, to service users partnering with staff to offer recovery programmes. The college works in the same way that a college in the community would. The service user reads through the prospectus to get an idea of what courses are available then chooses the courses that suit them from that terms timetable.

Other activities include:

- Access to a Pool Table
- Table Tennis in the ADL garden
- Access to the Gymnasium, which can be accessed with a gym instructor after a health assessment
- Wii, DVD's and various games for leisure including chess etc.

There is a fairly extensive library of books for you to access.

SUPPORT SERVICES

- There is an advocacy team and other means of support at Edward House. These include IMHAs (Independent Mental Health Advocates), One Support (for benefits/housing support), PALS (patient advice and liaison service). Please speak to the Nurse in Charge/ the Ward Secretary for information on how you may access these services. Alternatively, information can be obtained for accessing these services online or reading the leaflets on display.

- You can also request to have a second opinion regarding your care while here. Please let the staff know if you wish to do this.

WELFARE AND BENEFIT

- There is a person who can assist you with your finances. You can request for assistance with your benefits from a nurse and an appointment will be booked.

RELIGIOUS, SPIRITUAL AND CULTURAL NEEDS

- At Edward House, we appreciate and promote spirituality and religion in the life and recovery of our service users. As this is individual to each individual, we will work with each you to understand and support your specific needs. You can also ask for your faith leader to visit you on the unit. There are quiet rooms on the unit to give you the opportunity for reflective space and quiet time. We can provide reading materials in relation to your spiritual needs.

- Chaplaincy – Chaplains can be accessed on request for service users. Chaplaincy supports all faiths and denominations and can provide support for any faith or religion.

INTERPRETING SERVICES

- Interpreting Services are available if required. There are posters available on the unit in a range of languages which explain how to access these. Alternatively, your care team will be able to arrange these.

LEAVE ARRANGEMENTS

- Initially, leave from the unit will be limited and at first you will probably have a member of staff accompany you. As your care continues, leave will have specific goals and purposes. This will help us understand how independent you are becoming and what the next steps could be. Any leave has to be approved by the Consultant Psychiatrist, and in some cases, the Ministry of Justice for service users detained under certain sections of the Mental Health Act.
- Leave cannot be accommodated for the sole purpose of smoking off the premises. You may not smoke in the presence of members of staff while on escorted leave, due to the negative health aspects of passive smoking.
- Following periods of leave, two staff members will request to search you to reduce the risk of restricted or prohibited items being brought onto the unit. This is to ensure that a safe environment is maintained for all.

DISCHARGE

- Throughout your stay with us, and when you have achieved a sufficient level of safety and recovery, we will discuss your discharge and future needs with you and other people important to your future support. The team will consider your views in conjunction with your carers and staff directly involved in your care, treatment and discharge plan. We will inform the GP about your admission to and discharge from Edward House, and the details of any treatment and medication prescribed. A suitable level of support will be given after discharge including regular contact with your care- coordinator.

Medication on discharge

- If discharge medication is prescribed, 14 days' supply will normally be dispensed to you. The GP/community mental health team will then prescribe medication from this point. If you are transferred to another unit rather than your own accommodation then medication may be given directly to the new unit.

VISITING

- To maintain safety on the unit, visiting is by appointment only. Visitors will need to arrange an appointment as the staff will need to ensure the time is free. There are various groups which run, so visiting times are restricted and we will usually need at least 24 hours' notice (although exceptions to this can be accommodated following liaison with the Ward Manager).

Our normal visiting times are:

- Monday – Friday: 4 p.m. – 5 p.m. and 6.30 p.m. - 8 p.m.
- Weekends and bank holidays: 3 p.m. – 5 p.m. and 6.30 – 8 p.m.
  Visiting outside of these hours must be agreed with the Ward Manager or Nurse in charge.
- Edward House operates a protected meal time policy for all service users. Meal times are an important part of our service user's stay and having the unit free from visitors during this time allows privacy for service users to have their meals in as calm and peaceful a way as possible.
- The TV lounges and garden areas are for use by service users only. Private areas will be provided for visitors. Children under 17 visiting with friends or relatives are not allowed into the ward areas, but this can be facilitated in another area. Please contact the Ward Manager if you wish to bring a young person/child to the unit as arrangements can be made to facilitate this.
- Visitors are not permitted to visit service user's individual bedrooms.

Location

- Edward House is situated at Puddings Wood Drive, behind the Broomfield Hospital Site. Follow the signs to the Linden Centre, once through their barrier, turn immediately left and you will see another barrier ahead of you, which is the entrance to Edward House.
- Parking is available at Edward House for staff and visitors: please ring our barrier bell and staff will let you through. If you are registered disabled, please advise staff, as there are two places outside our reception area.
- Please be aware that we have CCTV in operation to ensure the security of our building and safety of our service users, visitors and staff. Because of this your movements may be recorded.

INFECTION CONTROL

- We politely ask that visitors refrain from visiting the ward if they have been unwell with any infection, especially if they have experienced diarrhoea or vomiting.

PROHIBITED AND RESTRICTED ITEMS

We have listed items which are Prohibited or Restricted at the end of this booklet.

FEEDBACK

Suggestions and Complaints

- You are invited to make any suggestions about any aspect of care on the ward. If you have a concern/complaint, please discuss this with the nurse in charge/ward manager of the ward. This will enable us to try to resolve the problem smoothly and quickly.

- If, however, you feel the problem has not been resolved locally, you may wish to discuss it with:
  - PALS (Patient Advice and Liaison Service) – Leaflets are available in the reception area or email you can email epunft.pals@nhs.net
  - You can speak to the Patient Experience Team on 0800 085 7935
  - You can also complete a survey of your experience of the service (just ask the receptionist if you would like to complete one)

- We are inspected by the Care Quality Commission. If you would like to contact the CQC in relation to the care that is being provided the following details may be of assistance:

By Phone: 03000 616161
By Email: enquiries@cqc.org.uk
Online: www.cqc.org.uk/tellus

CARER SUPPORT

- The team at Edward House will support carers and can provide information in relation to various mental health conditions (we have leaflets on the unit and this can also be discussed in ward rounds or 1:1 contact with nurses or doctors). If your carer feels they require any support, please do not hesitate to ask as we can provide an assessment of their needs and signpost them to other organisations for further support.

- We hold a carer's group every last Friday of the month between 6-7pm for carers to meet with staff members and provide support. There are also other carer' groups and ways in which you can become involved in the development of the service which we will contact you about.

- In addition, carers may find the following organisations useful to gain additional support.

ORGANISATION	CONTACT DETAILS

CARERS UK A national membership charity for carers, who together call for change, seek recognition and support for those who provide care. The website and helpline offers information and advice including agencies that offer support in the local area.	www.carersuk.org **Telephone helpline providing information is open on Mondays and Tuesday between 10am and 4pm - 0808 808 7777**
RETHINK The Rethink Mental Illness Advice Service offers practical help on issues such as the Mental Health Act, community care, welfare benefits, debt, criminal justice and carer's rights. They also offer general help on living with mental illness, medication, care and treatment. They provide information about agencies in the local area.	www.rethink.org **The line is open from 9:30am - 4pm Monday to Friday. E-mail: info@rethink.org**
MIND Provides advice and support to anyone experiencing a mental health problem and campaigns to improve services, raise awareness and promote understanding. Gives practical suggestions for what a carer/family member can do and where to go to for support.	www.mind.org.uk **Tel : 03001233393 Monday to Friday(except for bank holidays) 09.00 – 18.00** **E-mail : supporterrelations@mind.org.uk**
CARERS TRUST The Carers Trust Network supports carers locally through a UK wide network of Partner organisations/services. Their website links to a range of different organisation in the local area.	**www.carers.org** **Their head office can be contacted on: Tel: 03007729600 E-mail: info@carers.org**
CARERSMART CarerSmart is a club from Carers Trust and open to carers, people with care needs, staff and volunteers across the Carers Trust network. Carers can join for free and benefit from a range of offers including: discounts on holiday and travel arrangements, cash back on shopping from numerous high street retailers, free legal advice services.	**www.carersmart.org**

Contact Information

Edward House main reception number: 01245 315850

Our full address is:

Edward House The
Linden Centre
Puddings Wood Drive
Broomfield
Chelmsford
Essex
CM1 7LF

The managers and doctors can also be contacted by calling the above phone number.

If you would prefer to email the team, this can be sent to:

epunft.carersrelativessupportgroup@nhs.net

GLOSSARY OF MENTAL HEALTH TERMS

- **Anxiety**
  Anxiety disorders range from feelings of uneasiness to immobilizing bouts of terror. Most people experience anxiety at some point in their lives and some nervousness in anticipation of a real situation. However if a person cannot shake unwarranted worries, or if the feelings are jarring to the point of avoiding everyday activities, he or she most likely has an anxiety disorder. Anxiety can be associated with depression.

- **Behavioural Therapy**
  As the name implies, behavioural therapy focuses on behaviour- changing unwanted behaviours through rewards, reinforcements, and desensitization. Desensitization, or Exposure Therapy, is a process of confronting something that arouses anxiety, discomfort, or fear and overcoming the unwanted responses. Behavioural therapy often involves the cooperation of others, especially family and close friends, to reinforce a desired behaviour.

- **Bipolar Disorder**
  Extreme mood swings with recurrent episodes of depression and mania (being high or up) punctuated by periods of generally even-keeled behaviour characterise this disorder. Bipolar disorder tends to run in families. This disorder typically begins in the mid-twenties and continues throughout life. Without treatment, people who have bipolar disorder often go through devastating life events such as marital breakups, job loss, substance abuse, and suicide.

- **Carer**
  A carer involved in your care may be a family member, friend or other close individual.

- **CTO:**
  Community Treatment Order. This is a legal order made by the Mental Health Review Tribunal or by a Magistrate. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community

- **The Care Programme Approach (CPA)**
  The Care Programme Approach is a system of assessing and looking after people with mental health problems. People can either be offered standard or enhanced CPA, and being on CPA means a patient has a care plan which they should have a copy of, and have regular review with the mental health team looking after them. CPA has four main elements:
- Assessment - Systematic arrangements for assessing the health and social needs of people accepted by the specialist mental health services.
- A Care Plan - The formation of a care plan which addresses the identified health and social care needs.
- A Key Worker and Care-Coordinator - The appointment of a Key Worker (now Care Co–coordinator) to keep in close touch with the patient and monitor care.
- Regular Review - Regular review, and if need be, agreed changes to the care plan.

- **Clinical Psychologist**
  A clinical psychologist is a professional who specialises in psychological assessments and therapies (sometimes known as talking therapies).

- **Cognitive Therapy**
  Cognitive therapy aims to identify and correct unhelpful thinking patterns that can lead to feelings and behaviours that may be troublesome, self-defeating, or even self-destructive. The goal is to replace such thinking with a more balanced view that, in turn, leads to more fulfilling and productive behaviour.

- **Cognitive Behavioural Therapy**
  A combination of cognitive and behavioural therapies, this approach helps people change negative thought patterns, beliefs, and behaviours so they can manage symptoms and enjoy more productive, less stressful lives.

- **Community Mental Health Team**
  This is a team of mental health workers who work together in a community setting. They include Psychiatrists, Community Psychiatric Nurses, Occupational Therapists, Social Workers, Care workers, Psychologists.

- **Community Psychiatric Nurses (CPNs)**
  A CPN sees people who are living in the community. This is most often in the person's own home but it can also be in clinics based, for example, in a hospital setting. CPNs provide support to people through difficult periods of their illness. They may also see patients who are currently well to check everything is going okay and be the first point of contact if the patient starts becoming unwell again.

- **Consultant Psychiatrist**
  In a hospital a consultant refers to a specially trained doctor who has finished his training and works in one area of medicine, usually with a team of doctors in training and other professionals working with them.

- **Delusions**
  Delusions are persistent thoughts and beliefs that have no basis in reality.

- **Dementia**
  Significant loss of intellectual abilities such as memory capacity, severe enough to interfere with social or occupational functioning. Dementia is a problem in the brain that makes it hard for a person to remember, learn and communicate; eventually is becomes difficult for a person to take care of himself or herself. This disorder can also affect a person's mood and personality.

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- **Depression**
  Depression is a mood disorder characterized by intense feelings of sadness that persist beyond a few weeks. It is associated with many physical symptoms such as disturbance of sleep, appetite, and concentration. Depressed people often feel tired, guilty and can find normal life extremely difficult. Depression can be associated with anxiety.

- **Early intervention**
  A process used to recognize warning signs for mental health problems and to

take early action against factors that put individuals at risk. Early intervention can help people get better in less time and can prevent problems from becoming worse.

- **Empowerment**
  Giving people the skills, knowledge attitudes and power to allow or enable them to be more responsible for their own lives, health and care.

- **Evidenced Based (Medicine)**
  Where actions, treatment or care are based on widely accepted evidence. This evidence can be from scientific trails, or based on the collective experience of senior professionals.

- **General Practitioners (GPs)**
  Doctors who are specially trained to work in a community setting, seeing any patients for any problems they have.

- **Hallucinations**
  Hallucinations are experiences of sensations that have no source. Some examples of hallucinations include hearing non-existent voices, seeing non-existent things, and experiencing burning or pain sensations with no physical cause.

- **Mental Health**
  A state of emotional well-being in which an individual is able to use his or her thinking and feeling abilities, live with others, and meet the ordinary demands of everyday life.

- **Mental Illness / Ill health**
  A state where the person's mental health is disrupted so that their thinking, emotions or behaviour are affected to an extent that it has an effect on their daily life.

- **Mental Well-being**
  A good or satisfactory condition of thinking, feeling and living; a state characterized by health, happiness, and prosperity. It is a broader term than mental health and includes the wider aspects of a person's life, not just how they feel.

- **MHT:**
  Mental Health Tribunal. This is an independent tribunal which can order the discharge of a patient. Can also make other recommendations. Sometimes referred to as First Tier Tribunal

- **Multi-Disciplinary Team (MDT)**
  The Multi-Disciplinary Team includes Psychiatrists, Nurses, Occupational Therapists, Care-Coordinators and GPs. Together with the service user, they plan their ongoing care needs and interventions.

- **Obsessive Compulsive Disorder (OCD)**
  Obsessive Compulsive Disorder is a chronic, relapsing illness. People who have it suffer from recurrent and unwanted thoughts or rituals. The

obsessions and the need to perform rituals can take over a person's life if left untreated. They feel they cannot control these thoughts or rituals.

- **Occupational Therapists (OTs)**
  An occupational therapist can have many different roles. They help people to adapt to their environment and to cope with their daily life.
  OTs may work in hospitals or in the community. They supervise and assess a person's ability to look after themselves, e.g. self-care, cooking and housework. This may be done in purpose-built occupational therapy departments in hospitals or in the patient's own home.
  OTs work with both individuals and groups. They can set goals for individuals with depression to encourage them to achieve more than they have been able to do while ill. They may get patients involved in specific job-related training schemes to improve their decision making and planning about the future. Group work is often aimed at increasing people's social interactions.
  OTs become involved in rehabilitation work to help them reintegrate back into life outside hospital.

- **Panic Disorders**
  People with panic disorder experience heart-pounding terror that strikes suddenly and without warning. Since they cannot predict when a panic attack will seize them, many people live in persistent worry that another one could overcome them at any moment.

- **Paranoia and Paranoid Disorders**
  Symptoms of paranoia may include feelings of persecution and an exaggerated sense of self-importance. The disorder is present in many mental health problems and it is rare as an isolated mental illness.

- **Person Centred Care**
  Puts the patient at the heart of diagnosis and treatment. Patient centred care explores the main reason for the consultation, seeks an integrated vision of the patient’s world, finds common ground and creates a mutually agreed management plan, enhancing health promotion, and providing a solid basis for the long term doctor patient relationship. Patient centred care is therefore based on the patient’s problems, the patient’s needs, their feelings and beliefs and the skills and support they already have to combat their problems.

- **Phobias**
  Phobias are irrational fears that lead people to altogether avoid specific things or situations that trigger intense anxiety. Phobias occur in several forms, for example, agoraphobia is the fear of being in any situation that might trigger a panic attack and from which escape might be difficult; social phobia is a fear of being extremely embarrassed in front of other people.

- **Recovery**
  This may not mean cure, but does include not only a significant reduction in symptoms but also an improvement in the ability of the individual to lead a normal life including work, home life and leisure. Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

- **PRN:**
  A Latin phrase meaning “ProReNata”, to describe medication given as necessary, in reaction to a symptom, i.e. painkillers.

- **S17:**
  Section17, the legal document stating when, where and how often a patient can leave the hospital.

- **Schizophrenia**
  Schizophrenia is a mental disorder characterized by "positive" and "negative" symptoms. Psychotic, or positive, symptoms include delusions, hallucinations, and disordered thinking (apparent from a person's fragmented, disconnected and sometimes nonsensical speech). Negative symptoms include social withdrawal, extreme apathy, diminished motivation, and blunted emotional expression.

- **Self-Management**
  Where a patient develops the knowledge and experience which enables them to be able to monitor their condition and modify their treatment with the full support of health care professional.

- **Severe and Enduring Mental Illness**
  This term is used to describe a group of illnesses which can cause more severe mental health problems. It includes schizophrenia, bipolar affective disorder (manic depression) and other psychotic illnesses.

- **Social Inclusion**
  Ensuring the marginalised and those living in poverty have greater participation in decision making which affects their lives, allowing them to improve their living standards and their overall well-being.

- **Stigma**
  Stigma is discrimination, based upon societies fear and ignorance about an illness or a problem. It causes peoples to be marginalized and mistreated, and therefore leads to social isolation, health inequalities and many forms of discrimination. It is derived from the term used to describe the marks burnt onto Roman slaves.

- **Ward Round**
  This is where the Multi-Disciplinary Team meets a patient, asks them questions about their problems and arranges investigations. The main objectives are to try and understand what the problems are and what is causing them, understand what the patient thinks and feels about them, and work out a plan of action that the doctor and patient can agree on.

Prohibited and Restricted Items

Please could we ask visitors not to bring any contraband items onto the ward/unit as these will be confiscated. The lists below detail the restricted items for visitors and patients.
Other items, though not allowed to remain within patients' possession, can be accessed and used by patients, either under staff supervision or under specific circumstances if approved by the care team.

Restricted items include:
• Alcohol based aftershaves, perfumes, polishes, toiletries etc.
• plasticine, Play-Do and clay
• polythene and plastic bags
• mobile phones
• electronic or chargeable vapes
• toiletries in glass bottles
• DVD's, games or CD's with an over 18 certificate
• adhesives and adhesive tape
• hobby equipment / tools
• musical instruments and their accessories
• wire, cord, rope, string or plastic ties (with the exception of electrical flexes which may be shortened if felt to pose a risk)
• binoculars and magnifying glasses (unless required for medical reasons)

• pressurised aerosol containers
• heating devices e.g. hair dryers, tongs or crimpers
• tins or metal canisters
• driving licences, cheque books, credit, debit or cash cards, bank pass-books, National Insurance cards, etc. (these items must be given to welfare for safekeeping)
• "top shelf" or "soft" pornography

The above list of restricted items is not exhaustive.
Please could we ask visitors not to bring any contraband items onto the ward as these will be confiscated. The lists below detail the prohibited items for visitors and patients.
Prohibited items cannot be retained by patients under any circumstances. Certain articles which are prohibited within the secure facility for their use whilst on the ward, may be held securely for patients, if agreed by the individuals care team.

Prohibited items include:
• hospital security equipment e.g. security pass keys, radios, staff personal ID's/name badges
• keys to wards, storerooms, other patient's rooms or property
• confidential papers and documentation except for their own personal documents
• illicit drugs including 'psycho active substances
• medicines (unless agreed that the patient can hold such medication) or medical equipment e.g. stethoscopes and tourniquets
• protein and other nutritional supplements unless prescribed by a doctor
• energy drinks or drink high in caffeine content

• alcohol (and any liquid containing alcohol)
• Super Glue or similar epoxy / thiocyanate based adhesives
• chewing gum, Blu-Tac, or any ply able similar substances
• knives, bladed articles, firearms and other weapons including replicas and home made or manufactured items
• satellite dishes and receivers
• passports
• scissors including rounded nose type.
• cash exceeding the amount specified in Trust Policy
• torches
• radios, which exceed 150 MHz at maximum volume, electrical surveillance equipment
• covert listening devices, recording equipment or transmitting devices, e.g. dictaphones or small stereo
• electronic pagers / cameras
• equipment that allows the patient access to the Internet
• Survival equipment which could be used to assist in an escape
• 'hard core' pornography or media
• glass in picture frames or mirrors
• lighters, matches, tobacco and tobacco products
• explosives, inflammable liquids or substances or other ignition sources

The Derwent Centre

A guide for Friends and Family

Welcome to Chelmer Ward

Chelmer ward is a female acute mental health ward. The ward provides 24 hours treatment and care in a safe and therapeutic setting for up to 18 patients at any time.

There is a multidisciplinary team who work together to provide care and treatment for your loved one, including nursing, psychology, occupational therapy and medical staff.

Recovery is promoted from the beginning of admission in order to limit amount of time spent away from friends/family and community living. Therapy team on the ward provides weekly program including occupational therapy groups, psychology groups and exercises.

Each patient receives an individualised care plan which focuses on their needs and is regularly reviewed.

Welcome to Chelmer Ward

Nursing Bay

Lounge Area

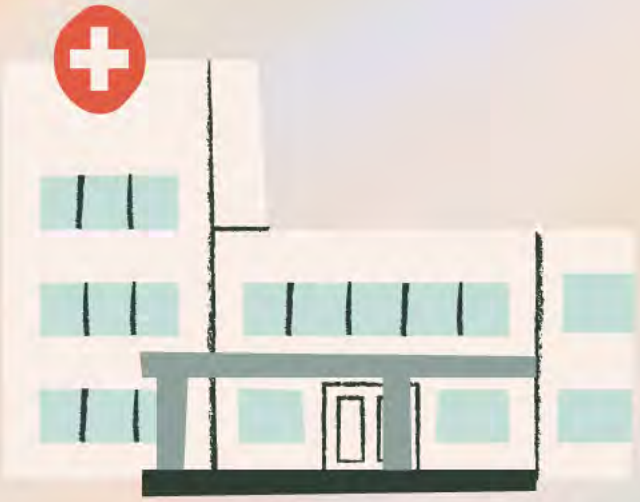
Welcome to Chelmer Ward

Lounge Area

Patients Notice Board

Corridor and recovery tree

Ward Contact Details:



Chelmer Ward
Derwent Centre
1 Hamstel Road
CM20 1QX
Tel: 01279 967145/46

Visiting days:

Please contact reception or ward to arrange a visit in advance: 01279 967302

Ward Review days:

Mondays and Wednesdays
Ward clerk works with the Consultant to allocate the times and will email the invites with times and log in details for you

Feedbacks:

We really value feedback from family and carer's of people who use our services. If you have any concerns or compliments, please email us at: epunft.derwentcentre@nhs.net

Visit and delivery guideline:

We understand that you would like to send essential items for your loved ones when they are under our care. Please could we ask you not to bring any contraband items onto the ward for safety reasons. Any contraband items will be confiscated.

Items include:

- pornography
- drugs
- alcohol
- any sharp items
- smoking paraphernalia (lighters)
- plastic bags
- any food that are not in a sealed manufacturers packaging
- chewing gum
- blue tack
- caffeinated drinks
- electronic devices capable of videoing/ recording

Please ask a member of staff if you are unsure of whether an item can be brought onto the ward.

Useful websites and phone numbers for carers support:

Samaritans:

This services offer emotional support 24 hours a day, in full confidence.

Tel: 116 123/ **E-mail**: jo@samaritans.org

Mind Infoline:

Mind provides information on a range of mental health topics to support people in their own area

(9am- 6pm; Monday to Friday)

Tel: 0300 123 3393/ **E-mail:** info@mind.org.uk

Rethink Advice and Information Service:

Rethink provide specific solution-based guidance

Tel: 0300 5000 927/ **E-mail**: advice@rethink.org

Essex Partnership University
NHS Foundation Trust

CHILD VISITING PROTOCOL for the SECURE SERVICES - SSOP16

POLICY NUMBER:	SSOP16
VERSION NUMBER:	1.7
AUTHOR:	Secure Services Policies & Procedures Group
IMPLEMENTATION DATE:	May 2008
AMENDMENT DATE(S)	September 2009, April 2013, July 2014 September 2020 March 2021
LAST REVIEW DATE:	September 2020
NEXT REVIEW DATE:	September 2023
APPROVAL BY SERVICE MANAGEMENT TEAM:	Changes implemented in March 2021, ratified on 19th April 2021

The Director responsible for monitoring and reviewing this policy is:

The Director of Specialist Services

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CHILD VISITING PROTOCOL for the SECURE SERVICES

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CHILD VISITING POLICY for the SECURE SERVICES

1.0 INTRODUCTION

1.1 The Secure Services will ensure that all children who visit any of the secure services' units are safeguarded at all times. Our priority is to be proactive in the protection of children in all aspects of our care, management and practice. In response to COVID-19; measures have been put in place to protect all those present during child visits, whilst ensuring the environment remains child centred. Measures and restrictions will be reviewed in line with Government Guidelines.

1.2 This Protocol sets out the principles and procedures for children to safely visit patients detained in our services and, where appropriate, to maintain contact with family members, wherever possible

1.3 The purpose of this Protocol is to provide instruction and assign responsibility for the visiting of children to the Secure Unit, taking into consideration the guidance issued by Revised Code of Practice (1999), the Children Act (2004), the Fallon Report (1999), Child Protection Guidance for Senior Nurses, Health Visitors and Midwives (1991), Guidance to Hospital Managers and Local Authorities, Social Services Departments on the Sex Offenders Act (1997), Child Protection Medical Responsibilities (HMSO) and Local Authority Social Services Letter (LASSL) 2005 – Identification of individuals who present a risk to children– (Every Child Matters).

2.0 OBJECTIVES

2.1 To assign responsibility and provide instruction for the visiting of all children (persons under the age of 18) to Brockfield House, Robin Pinto Unit, Wood Lea Clinic and Edward House.

2.2 To prevent those patients who may pose a risk of causing significant harm to children from making contact with or being visited by any child.

2.3 This procedure is applicable to all patients in Brockfield House, Robin Pinto Unit, Wood Lea and Edward House who request to have a visit from a child. It also applies to any patients who are considered to pose a risk to children with particular reference to:

- Individuals who, by reason of their offence history, pose a continuing risk to children (appertaining to those convicted of one or more offences against children - as set out in the Children and Young Persons Act, 1933).

- Those whose mental disorder, by its nature, suggests that they may pose a risk to children.

2.4 It is the responsibility of the Social Worker, Ward Manager and the Integrated Clinical Leads, to ensure that this procedure is followed.

2.5 The principle that the welfare of the child is paramount must override all other considerations. This includes the child's physical safety and emotional welfare.

2.6 No assumption can or should be made that people with mental health problems constitute a risk to children simply by virtue of being diagnosed with a mental illness or a personality disorder.

2.7 All child visits to the unit, or contact with children by patients outside the unit (including assessments prior to such contact or visits) will follow these procedural guidelines.

2.8 No changes to this procedure shall be undertaken without the authorisation of the Secure Services Policies & Procedures Group and the Secure Service Management Board.

3.0 REVIEW AND MONITORING

3.1 By the Secure Services Policies & Procedures Group every three years.

4.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

4.1 Visitors' Policy – SSOP 28.

4.2 Trust and Local Safeguarding Board procedures.

5.0 PROCEDURE

5.1 **Circumstances of the Child Visit**

5.2 Arrangements for child visiting will be included in the Ward Information leaflet which is given to all patients upon admission to the unit.

5.2.1 A child will only be allowed to visit a patient if the latter has direct parental responsibility or responsibility for the child or has a significant relationship with the child which is in the child's best interest to maintain and develop. Where this pertains the visit can only take place when consent to the visit has been given by the person with parental responsibility for the child (or the Local Authority, where the child is subject to a Care Order). Notice of the consent must be documented in Appendix 1. The responsible adult accompanying the child must agree to adhere to COVID-19 measures as part of the visit to protect themselves and the child. This may include but is not limited to; hand washing, wearing a mask or gloves and neither consuming nor bringing food or drink items into the visit. It is the responsibility of nurses on the ward to ensure these measures have been followed.

5.2.2 No child will visit any of the secure units without the agreement of the patient's MDT. This agreement should be documented in the ward round minutes of the patient

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5.2.3 The patient's key- nurse, ward Social Worker or designated Social Worker from the Inpatient Social Work team should explain fully to the patient (and his/her carers) the child visiting procedure inclusive of safety measures in place regarding COVID-19, prior to any visit, and where it will take place (i.e. a designated room off the ward). This must be evidenced by making a note in the patient's electronic record. Only the medium secure wards have access to commissioned in-patient social work support. Therefore, on the secure services' low secure wards, it will fall to the patient's key-nurse (or, by mutual agreement, the patient's community care coordinator or Social Worker) to take on the responsibility of carrying out the functions of the Social Worker in regard to sections 5.1.2, 5.2.3 and 5.2.6 of this protocol. Social Workers within the secure services should be contacted and offer advice and support to the key-nurse, if required, in these circumstances.

5.2.4 The timing of all child visits, and their duration, will be pre-arranged, by agreement between the ward Social Worker on medium secure wards and by collaboration between the key- nurse, MDT and community Social Worker (or care-co-ordinator) for the low secure wards.

5.2.5 The visit will take place in a designated contact suite area away from the ward. At least one member of unit staff must be in attendance at all times. All child visits must take place in a room designated for this purpose which must lie outside clinical areas. At Brockfield House this is the family room whose entrance is in the rear reception lobby. For Robin Pinto this is the staff or conference room which is adapted to be conducive for child visits. For Wood Lea child visits will take place in a designated room on the non-secure side of the unit. For Edward House they will take place in the multi faith room / MDT room outside of the clinical area.

5.2.6 All child visits must be pre-booked in a diary. Without the requisite permission children will be refused entry into the Unit.

5.2.7 During their visit, children will not be allowed at any time to enter any of the secure wards.

5.2.8 All children under the age of 18 must be accompanied by a 'responsible adult' in order to gain entry to the unit. The 'responsible adult' should be approved by the patient's clinical team. If the 'responsible adult' does not have parental responsibility for the child, the person with parental responsibility must give written consent for that person to accompany and supervise the child during the visit. (See Appendix 1)

5.2.9 When patients are transferred from High Security Hospital and placed in medium secure units on trial leave, any conditions attached to the leave are at the discretion of the Responsible Clinician (RC). The RC responsibility will continue to reside with the RC from the high security hospital for the entire

duration of the period of trial leave and this includes any approval (or refusal) for child visits.

5.3 **Risk Assessment – The patient**

5.3.1 Any patient wishing to receive a visit from a child will be requested to complete form CP1 (Appendix 1) giving details of their relationship to the child and why they would like to receive a visit from them. The assessment process for child visits should be explained to the patient, including the requirement for contact with the person with parental responsibility and why enquiries with the Local Authority Child Protection Team should take place.

5.3.2 The patient's MDT will consider the request for a child visit after the team Social Worker (or key-nurse / allocated care coordinator in the community in the case of low secure wards) has carried out a thorough assessment as to the appropriateness of the visit which should be presented to the MDT for discussion. This assessment will include the following:

- Establishing the patient's relationship to the child, as in 5.1.2 above.

- Contacting the person with parental responsibility to inform them that a request for a child visit has been made. The assessment process should be explained, including the need for enquiries with the Local Authority Children's Services. Should the person with parental responsibility refuse permission for those enquiries to be made, no child visits can take place and the request for the visit will be denied.

- The Local Authority Child Protection Team appropriate to the child's home address should be contacted to inquire if the child (or the child's family) is known to them. This will include a request to check the Paris, Remedy and/ or Mosaic Computer Programme (or other Local Authority system) and to give relevant information and the name of any Social Worker allocated with a contact address and telephone number.

- Establishing if the child is subject to any childcare orders, such as a Statutory Care Order, or whether the child is on the Child Protection Register, or has a Child Protection Plan in place, and what contact provisions or restrictions are in place.

- Establishing if the patient has been identified as a person presenting a risk or potential risk to children (Code 3 in prison coding which means they have been convicted of neglecting or carrying out a physical or sexual offence against a child). The social services safeguarding team must be informed, before discharge from hospital, if any patient so identified could return to live with a child or children.

5.3.3 Where there is doubt or disagreement within the MDT, the allocated Social Worker should make contact with the Children's Social Work team pertaining to the family's area of residence to seek their views as to whether contact is

in the child's best interest and if any special measures or restrictions need to be in place during a proposed visit.

5.3.4 If appropriate, a professionals meeting will be held involving the RC and other members of the MDT, the team Social Worker and the childcare Social Worker to discuss the case more fully before a decision is taken as to whether to allow the visit. A copy of these procedural guidelines will be given to the childcare Social Worker, upon request.

5.3.5 If a visit is anticipated, a request should be made to the child's Social Worker to organise a joint visit with the team Social Worker to the child and the person with parental responsibility at their place of residence to seek their views.

5.3.6 In doubtful or disputed cases where no Local Authority childcare team is involved, the team Social Worker (or named nurse / external care co-ordinator in low secure wards) should arrange a home visit to assess the situation and feed-back to the MDT before a decision is reached in regard to the benefits of the proposed visit to the child.

5.3.7 The outcome of such an assessment process will be fed back in a written report to the RC and MDT. A child visits assessment tool - CP2 (Appendix 2) will also be completed. The patient must be informed of the outcome of the assessment and, if visits are refused, the reasons set out and explained.

5.3.8 When a child visit is agreed the arrangements for the visit, including the need and extent of supervision, will be agreed by the MDT and recorded in the case notes by the team Social Worker and form CP3 completed (Appendix 3). The visit will only be undertaken within the boundaries agreed.

5.3.9 If there are concerns that the visit will be detrimental to the child by virtue of the mental state of the patient, the visit will be postponed. The carers / parents of the child should be informed as soon as possible to minimise any distress this postponement may cause to the child.

5.4 Managing Risk – Arrangements for Visits

5.4.1 An up-to-date comprehensive list of all approved visits from children must be kept on each ward on Form CP 3 (Appendix 3).

5.4.2 Clinical Teams must review these lists, together with an account from the key worker of the course of visits, on a three monthly basis, or sooner, if deemed necessary.

5.4.3 The identity of the responsible adult accompanying the child on the visit should be agreed in advance, and their name should be entered on Form CP3 (Appendix 3). The responsible adult must bring satisfactory proof of identity in accordance with the Visitors' policy – SSOP 28.

5.4.4 The responsible adult accompanying the child must contact the ward immediately prior to the visit, in order to ascertain that it is appropriate for the contact to take place on that day. The final decision as to whether the visit can proceed on that day will be made by the Ward Manager or Nurse in Charge. Contact between patients and a child in the hospital grounds is not permitted.

5.4.5 At Brockfield House, so as to avoid inadvertent contact between patients legitimately using the rear reception lobby and child visitors the pre-discharge ward (Aurora) must be notified of the dates and times of all child visits. Additionally, before any patient leaves the pre-discharge ward it is essential that Aurora staff call the main reception office to ensure that a child is not in the rear reception lobby.

5.4.6 The Code of Practice makes it clear that the rooms designated for child visits in each unit should be welcoming and child- friendly and should contain equipment such as books, non-toxic crayons and safe toys. In order to protect and minimise the risk of COVID-19, only age-appropriate equipment and toys will be available during the visit.

5.4.7 Under no circumstances must a child come into contact with any patient/s other than the person whom he, or she, is approved to visit. If this occurs, an incident form must be completed by the Nurse in Charge.

5.4.8 Under no circumstances must a child or group of children be allowed into the unit to participate in any group or social event.

5.4.9 No patient will have contact with a child during a home visit unless authorised and assessed in line with this policy. If an unauthorised child is found to be unexpectedly present at the home visit, on arrival, then the escorting staff must give consideration to immediately terminate the visit.

5.5 Managing Risk – Supervision of Visits

5.5.1 Unless there are exceptional circumstances, each visit should last no longer than one hour. After the initial two visits, there will be a review by the MDT before any further visits are planned.

5.4.2 No more than two children will be allowed to visit at any one time and visitors accompanying the child/children will be restricted to two adults. At least one of these should be the child's parent, foster-parent, a person with parental responsibility or a responsible adult acting with the written permission of a person with parental responsibility.

5.4.3 Supervision of patients during a child visit should be carried out by members of staff (nursing or social work) who know the patient and who are familiar with the Trust's Engagement and Formal Observation procedural guidelines (CLP 8 and CLPG8). This person will be responsible for cleaning the room, toys and equipment before and after the visit.

- Where the child is subject to a Statutory Care Order, a qualified Social Worker from the Local Authority, or their designated deputy, must supervise the visit.

5.4.4 All staff supervising a patient's contact with children will need to be able to recognise and respond to abusive behaviour towards a child and have knowledge of abusive adult/child relationships. In the event of any abuse towards the child from either the patient or the visitor (be it verbal/physical), the visit must be terminated at once and the patient returned to the ward.

5.4.5 Any concerns regarding the visit must be reported to the Nurse in Charge immediately and recorded accurately in the nursing/social work notes. The RC and MDT must also be informed as soon as possible. In cases of serious concern, the Nurse in Charge or RC must consider immediately informing the duty Social Worker of the responsible Local Authority.

5.4.6 The nurse or other appropriate professional accompanying the patient for the visit must record an account of the visit - CP4 (Appendix 4). This should include any observations with regard to the interaction between the patient and the child, including any concerns which arise during the visit.

5.4.7 The following issues should be recorded, on form CP4 (Appendix 4), in the appropriate social work case file and nursing process: initial contact, patient / child interaction, areas of difficulty or concern, patient's account of the visit (see Appendix 4).

5.4.8 The team Social Worker will request an invitation to attend any statutory childcare reviews or child protection case conferences, if applicable, to give and receive information about the visits and the child's circumstances.

5.6 Training

5.6.1 In the course of their work with adults, mental health professionals may receive disclosures of abuse towards a child / children. In such events, all staff will need to be aware of their responsibilities under The Children Act 1989 and 2004, and should be familiar with the Trust and Local Safeguarding Board procedures.

5.6.2 All staff responsible for supervising child visits will receive appropriate Child Protection and Safeguarding training.

5.7 Appendices

5.7.1 Appendix 1 should be completed by the patient & staff nurse for support.

5.7.2 Appendix 2 should be completed by ward Social Worker or designated Social Worker from the inpatient social work team.

5.7.3 Appendix 3 should be completed by ward Social Worker or designated Social Worker from the inpatient social work team. This should then be shared with

the Responsible Clinician and Key Nurse for their review and signature.

5.7.4 Appendix 4 should be completed by the supervising professional present during the visit; Nurse or Social Worker.

6.0 Virtual Child Visits

6.1.1 All virtual visits carried out via AccuRx and Skype should be treated as formal child visits.

6.1.2 If a patient requests a virtual visit to be organised with family, Nursing Staff should enquire as to whether children will be present and confirm with the Social Worker or Key Worker that the child has been screened. Where a child has not been screened and is likely to be present no virtual visit should be facilitated until this has been completed.

6.1.3 The MDT should encourage discussions of family or child virtual visits within the patient ward round to ensure there is oversight.

6.1.4 As per SSOP35 Smart Phone Use on Perimeter Leave; there should be no virtual child visits taking place.

6.1.5 The ward Social Worker or designated Key Worker should complete a bi-annual review of the virtual child visits, ensuring that they are positively contributing to the contact between, patient, parent and child. They should observe 1 virtual visit where this review should take place using form CPG5.

6.1.6 Only the Appendices named below should be used in relation to virtual visits.

6.1.7 Appendix 4 Form CP4 should be completed by the supervising staff member following all virtual child visits.

6.1.8 Appendix 5 Form CP5 should be completed by the ward Social Worker or designated Key Worker as part of the review of Virtual Child Visits.

7.0 REFERENCES

- The Children Act (1989)(2004)
- Revised Code of Professional Practice (1999)
- Child Protection: Clarification of Arrangements between the NHS and other Agencies (Department of Health 1985)
- Child and Young Persons Act 1933

- Framework for the Assessment of Children in need and their Families (2000), (Department of Health and Department for Education, HMSO, London).
- Local Authority Social Services Letter (2005) – Every Child Matters
- Working together to Safeguard Children (2006) – HM Government

END

Rainbow Mother and Baby Unit
The Linden Centre
Puddingwood Drive
Broomfield
Chelmsford
Essex
CM1 7LF

Dear…….

Receiving this letter is a result of your loved one and child coming into The Rainbow Unit for treatment in alleviating mental health concerns. Rest assured, Mother and baby will be well taken care of in this time and we will aim to have them home as soon as possible once medically ready.

We understand that this will be a difficult time for yourself and wanted to reach out to you to ensure you are supported through this process. You will be a vital part in beginning the recovery process for your partner and we hope to support your family as a whole.

That being said, **how are you?**

Please take this opportunity to speak with us regarding your thoughts and feelings around this time and how this situation is affecting you. Hopefully by now the team will have been able to speak with you or will have tried to contact you but we would like to ensure that you are aware of the support and are welcome to call the ward when you feel the need. We aim to ensure your thoughts are being taken into account throughout this admission.

We can help in giving you some information regarding your partners diagnosis, offering regular updates on baby's progress on the ward and keeping you well informed of the future goals your partner is striving towards with the medical team. Your partners keyworker while on Rainbow unit is …… and the allocated nursery nurse is……

To ease your mind for what happens now with partner and baby, some of the following are the first steps we take when someone is newly admitted to the ward:

1. Clerk in by the medical team: This will include having some physical examinations such as blood pressure, blood tests and having a psychological assessment which focuses on current and historical information to help us assess the best start of treatment.

2. Rights and Observation levels: Your partner will be advised of their rights as a patient receiving treatment within our care and will be nursed on observation levels that minimise risk to your partner, your baby or others on the ward and are allocated to offer the right support.

3. Baby will be body mapped: This is to note anything on baby such as birth marks, rashes or new markings to monitor for improvement/decline. This is a standard procedure for all baby's admitted to Rainbow Unit and is performed on admission and return from leave periods.

4. Therapeutic engagement: This is time spent with your partner, baby and the team in getting to know each other and devising a care plan going forward.

We appreciate that this may be a very difficult time for you all so please don't hesitate to get in touch any time for support or if you have any questions

Kind regards

Rainbow Mother and Baby unit

From: FOI (ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST)
To: FOI (ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST)
Date: 23 May 2023 13:10:44

Visitors:
Partners are welcome at all times for a booked visit (dependant on Mothers mental health needs) however we ask that you respect the needs of all mothers and the importance of resting well during the night.
Close family are also welcome out of the normal visiting times provided it has been prearranged with the nurse in charge.
All other visitors are welcome during visiting hours
Monday – Friday 4p.m – 8p.m
Saturday, Sunday & public holidays 10a.m – 8p.m

If you are not familiar with the area or are planning to stay nearby and need assistance in finding local facilities, please speak to a member of the team who will be happy to provide you with a list of local accommodation options.

Rainbow unit is a 24hr, 7 day a week service, if you have any queries or concerns please do not hesitate to contact us.

Contact details

Rainbow Mother and Baby unit
The Linden Centre
Puddingwood Drive
Broomfield
Chelmsford
Essex
CM1 7LF

Nursing office number: 01245 315629 or 01245 315630

Rainbow Mother and baby unit

Partner and carers

Having a baby can be a time of great joy but it can also be a time of stress and huge change for both body and mind from daily living to relationships, which in all parents creates changes in feelings and emotions.

The Rainbow Mother and Baby Unit is a specialist 6 bedded unit providing mental health care and treatment to women during the third trimester of pregnancy and up to one year after delivery.

The aim of Rainbow unit is to:
Deliver the highest quality of care to Mother and baby in a safe, friendly and supportive environment.
Maintain the safety of Mother and baby whilst treating the Mother's mental illness.
Offer support to the families and carers involved in Mothers/baby's care.
Sustain and facilitate the developing relationship between Mother, baby and other family members.
On Rainbow unit we recognise the importance of delivering holistic care that promotes privacy and dignity in a safe and secure environment.

The service is family focused and designed around Mum and baby's needs.
We encourage Fathers/partners to spend as much time on the ward as they wish to support active involvement in both Mother and baby's recovery (dependant on Mothers mental health needs) but do ask that you consider the therapeutic timetable when planning visits

The dedicated team work to ensure all patients privacy and treat all information as confidential within the team however, in the event that the team are concerned in regards to immediate safety of Mum or baby they may share relevant information with outside professionals to ensure comprehensive cover of Mum and baby's care needs.

All patients will be allocated a Keyworker within 24hrs of admission, the Keyworker will lead in Mums care and agree with her a CPA Care Plan which is a record of what is agreed together and an outline of the care and treatment.
These care plans are reviewed regularly and will reflect what is agreed in the care review.

Care reviews are held at least once a week and partners/carers are welcome to attend (dependant on Mum's mental state and wishes).
Rainbow team recognise that the impact of suffering from Mental Health issues is not only felt by Mum it can be a time that causes great emotional and physical stress to their loved ones who often report feelings of confusion and helplessness. The team are here to also support partners and carers to the best of their ability and the Keyworker would be happy to speak to partners/carers on a 1:1 basis if requested.

Support:
We understand as a partner/carer you may also have many uncertainties and questions and may yourself require some support, all partner's/primary carers are able to access a carer's assessment, please speak to a member of staff if you would like further information on this. Upon admission, we will make a support call to yourself within 24 hours to answer any questions or queries and offer support.

Below are some Web links to useful sites covering mental health issues that you may find helpful to view.

https://pandasfoundation.org.uk/how-we-can-support-you/

http://apni.org/advice-for-carers/

http://www.fatherhoodinstitute.org/

http://www.nct.org.uk/parenting/dads-view-parenting

http://www.familylives.org.uk/

http://www.home-start.org.uk/

http://puerperalpsychosis.org.uk/site/help/partners.html

[redacted]

Rainbow

Mother and Baby Unit

Having a baby can be a time of great joy but it can also be a time of stress and huge change for both body and mind from daily living to relationships, which in all parents creates changes in feelings and emotions.

The Rainbow Mother and Baby Unit is a specialist 6 bedded unit providing mental health care and treatment to women during the third trimester of pregnancy and up to one year after delivery.

The aim of Rainbow unit is to:

Deliver the highest quality of care to Mother and baby in a safe, friendly and supportive environment.

Maintain the safety of Mother and baby whilst treating the Mother's mental illness.

Offer support to the families and carers involved in Mothers/baby's care.

Sustain and facilitate the developing relationship between Mother, baby and other family members.

On Rainbow unit we recognise the importance of delivering holistic care that promotes privacy and dignity in a safe and secure environment.

Family focused

The service is family focused and designed around you and your baby's needs. There is a ward routine but this has flexibility to fit around you and your baby's needs rather than the other way around.

We encourage Fathers/partners to spend as much time on the ward as they wish to support active involvement in both Mother and baby's recovery (dependant on Mothers mental health needs)

Visitors:

Partners are welcome at all times (dependant on Mothers mental health needs) however we ask that you respect the needs of all Mothers and the importance of resting well during the night.

Close family are also welcome out of the normal visiting times provided it has been prearranged with the nurse in charge.

Other adult visitors are welcome during visiting hours however this should be prearranged with the nurse in charge. It is not possible for children, other than your own to visit the unit.

Monday – Friday 4p.m – 8p.m

Saturday, Sunday & public holidays 10a.m – 8p.m

In line with local and government guidelines due to COVID 19 pandemic visiting is not currently supported as above. Please speak to the team to find out current practice and availability

Unit Environment

The unit comprises of six single inpatient beds all with en-suite facilities, each bedroom is fully equipped with a cot and baby changing facilities, allowing Mothers to continue caring for their babies during a vulnerable period whilst receiving specialist treatment and support from our dedicated team.

We have a fully equipped nursery and milk kitchen that can be used by all Mothers and family. Our dedicated nursery nurses are available to offer advice, support and education on baby's development and needs.

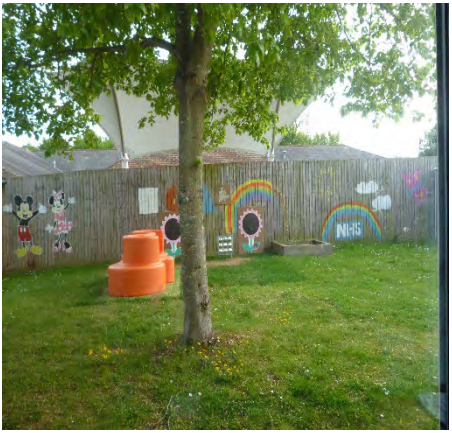
There is a fully equipped 'activities of daily living' kitchen which provides opportunities for Mothers to cook for themselves and their babies.

The lounge/diner provides a large, bright multi-purpose room where Mothers can relax, eat, watch some TV or engage in the ward activities.

We provide a range of toys and activities suitable for all stages of baby development.

There is an activities room which can be accessed from the lounge at any time. The activities room is used for some of the therapeutic groups, offers a private space for visiting and is where you will be invited to attend your care reviews.

We have a private enclosed garden that can be accessed throughout the day, allowing us to offer a safe and secure environment to carry out activities or just relax when the weather permits. For security the door is kept locked when the garden is not being used however, please speak to a member of staff any time you wish to access the garden



Our Team

The Rainbow Mother and Baby team includes

- Doctors
- Registered Mental Health Nurses
- Psychologists and other Therapists
- Associate Practitioners
- Nursery Nurses
- Support Workers
- Occupational Therapist
- Ward secretary

We also work closely with:

- Health Visitors
- Midwives (including a specialist midwife in mental health)
- The trust Safeguarding team
- Social services
- Paediatricians
- Advocacy services
- Chaplaincy

Your care

All patients will be allocated a Keyworker within 24hrs of admission, your Keyworker will agree with you a CPA Care Plan which is a record of what you agree together and an outline of your care, treatment and recovery goals. These care plans are reviewed regularly and will reflect what is agreed in your care review.

Activities offered can vary depending on need but may include:

Baby yoga
Art and Craft
Walking group
Cookery
Art Therapy
Indoor and outdoor sensory
Messy play
Rhyme and sign
Baby development
Coffee morning

This is not an exhaustive list

Confidentiality

The Rainbow team work to ensure all patients privacy is respected and treat information provided by you as confidential. When referring to confidentiality this means that information you provide will only be shared within the Rainbow team and your own extended professional team i.e your care coordinator, social worker. However, in the event that the team are concerned in regards to immediate safety of you or your baby they may share relevant information with outside professionals to ensure comprehensive cover of your care needs. The team will only share information about you with your family members after obtaining your consent, although will provide information in regards to baby to baby's second parent where appropriate. In the event of an emergency if it has not been possible to obtain consent the team may make a decision to share information based on your best interests, if this were to happen only information relevant to this would be disclosed.

Security

Any mains electrical appliances (e.g. hairdryers, steam sterilisers, hair straightners) you bring in from home will need to be checked by the hospital electricians before use for safety checks.

To ensure safety on the unit some items may not be kept loose in bedspaces, you would be informed of any items that you are unable to keep on you and these would be locked away by staff who will be happy to assist if you need access to these items.

The unit is secure with entry only by a staff operated video intercom system. Each Mother is issued with a card to access her own room.

The use of cameras and video recording devices are not allowed on inpatient wards however, the use of these on Rainbow is permitted following discussion with ward staff.
Under no circumstances are you allowed to take photographs of other patients or their babies and staff may remove phones/cameras if used inappropriately.

The unit is a no smoking area and tobacco products are not permitted within the building. Staff will work with you to develop a personalised care plan to address support and products that may help you to manage any needs.

Parking and Transport

There is public parking on site, there is a public transport route to Broomfield general hospital which is the hospital site we are based on.

For more information about getting to Broomfield Hospital please visit.

www.meht.nhs.uk/new-hospital/getting-to-broomfield-hospital/

Disabled access

All our buildings and services are accessible for people with disabilities.

Compliments and Complaints

We hope you find your admission to us beneficial and strive to support you in your recovery. However, should you be unhappy with the care you receive or have a concern or complaint that you would like to raise please request to speak with the ward manager to discuss these issues or alternatively contact our patient experience, compliments and complaints team:

Epunft.complaints@nhs.net

01268 407817

Your rights to:

If you do not agree with decisions made by your allocated consultant you can request a second opinion by placing your request in writing to the attention of the ward manager, they will then make arrangements for you to see an alternative consultant.

If you wish to have access to your medical records please place your request in writing and pass to the ward manager who will then forward your request to the relevant team for action.

Thank you's from past Mums on Rainbow

"Thank you so much for all the support and peace that everyone gave me. I will never forget what you have done for me. Baby now has a stronger mummy".

"A big thank you for helping us, were grateful that the unit is there".

"Thank you so much for all your support and for helping me on my road to recovery".

"Thank you for your kind assistance, guidance and advice during my recent stay with you".

"You're a wonderful bunch of people! Thank you so much for all your support and encouragement especially on the bad days. Thank you for all the advice and constant positivity. It has helped me so much and put me on the path to recovery".

"I firmly believe that this unit has provided me with the best possible opportunity to move on in life. I have endless gratitude to all the staff for all the encouragement and support"

Rainbow Mother and Baby Unit

The Linden centre

Pudding Wood Drive

Chelmsford

Essex

CM1 7LF

Office telephone number: 01245 315629 or 01245 315630

RAINBOW MOTHER AND BABY UNIT OPERATIONAL POLICY

POLICY NUMBER:	
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The Director responsible for monitoring and reviewing this policy is:
The Director of Specialist Services

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ESSEX PARTNERSHIP UNIVERSITY TRUST

MOTHER AND BABY UNIT OPERATIONAL POLICY

1 INTRODUCTION

1.1 The Rainbow Mother and Baby Unit is a 6 bedded facility based at The Linden Centre, Chelmsford and provides specialist inpatient services for Mothers who either experience severe post/peri-natal mental illness, have a severe and enduring mental health illness and experience a deterioration in late pregnancy or are at a high risk of experiencing an acute relapse and for whom appropriate and safe care would be better managed in hospital. Mothers can be admitted during their third Trimester of pregnancy (from 28 weeks) until their baby is aged up to 12 months to receive the appropriate treatment for themselves whilst maintaining the close Mother/child relationship.

1.2 The unit will primarily provide inpatient care through specialist commissioning to patients from the East of England. However, referrals can be accepted from anywhere within the UK and beds will be allocated dependent on appropriateness, need and risk.

1.3 Referrals will only be accepted for the purpose of a Mental Health admission and therefore should be made by a Mental health Professional. Rainbow unit does not conduct parenting assessments and therefore will not accept referrals on the basis of a social care need.

2 PHILOSOPHY OF SERVICE

2.1 The Rainbow Mother and Baby unit seeks:

2.1.1 To provide consistent high quality care in line with evidence based practice to women during pregnancy and the post-natal period who have current or previous severe mental illness.

2.1.2 To facilitate multi-disciplinary working to undertake holistic assessments of not only the Mother's needs but those of her baby, other dependents, partners/carers and the impact of the wider social network as part of the assessment of Mother's situation.

2.1.3 To ensure Mothers and their partners/carers receive support and treatment which is delivered with respect, honesty, empathy and compassion.

2.1.4 To work alongside Mothers in an empowering way, promoting mental wellbeing and social inclusion.

2.1.5 To facilitate partnership working with colleagues across health and social care.

2.1.6 To enable staff within the service to be supported by colleagues to reflect and enquire, to value everyone's contribution, to be accountable, creative, innovative and to share best practice.

3 COMMON SERVICE OBJECTIVES

3.1 The need/safety of the child is paramount.

3.2 Ethnicity and diversity will be respected and information/guidance will be made available in a language or form that is accessible and recognises the full range of ethnic and cultural differences.

3.3 Services provided will conform to the Mental Health Act 1983, The Mental Capacity Act 2005 and The Children's Act 1989, 2004. The Trust's Mother and Baby Facilities only offer an 'open' environment. Where Mothers require secure care, admission to the Mother and Baby unit would not be appropriate.

3.4 When Mothers are admitted to the unit, staff will work closely with other key professionals and agencies i.e Care Co-ordinator, Perinatal key worker, community consultant, social care, primary health care to ensure effective co-ordination and smooth transition of the Mother's care pathway between services.

3.5 To commence early discharge planning to support safe discharge from hospital using the CPA process.

3.6 To provide telephone advice and support to Mothers, partner/carer and family in addition to providing support for other professionals involved in their care.

3.7 Mothers where mental state allows will be encouraged and expected to take responsibility for the care of their babies.

3.8 To actively involve Mothers and their families by obtaining feedback from them throughout their stay, to inform the on-going development of the service. Staff will also engage with Mothers to obtain patient reported outcomes in regards to their clinical recovery.

4 ELIGIBILITY

4.1 This service is for:

4.1.1 Women who either experience severe post/peri-natal mental illness, have a severe and enduring mental health illness and experience a deterioration in late pregnancy or are at a high risk of experiencing an acute relapse and for whom appropriate and safe care would be better managed in hospital and are requiring support with Mother/infant relationship.

4.1.2 Mothers can be admitted during their third Trimester of pregnancy (from 28 weeks) until their baby is aged up to 12 months to receive the appropriate treatment for themselves whilst maintaining the close Mother/child relationship.

4.1.3 All women (with exception of those detailed within exclusion criteria) who require psychiatric admission during their third trimester of pregnancy or following childbirth will be offered admission to the specialist Mother and Baby unit, together with their baby where it is deemed safe and appropriate by the unit.

4.1.4 In cases of dual diagnosis (substance misuse, learning disability, personality disorder or eating disorder) the Mother and baby unit will liaise with other relevant services and leads identified within joint protocols and individual care plans to assess the most appropriate admission area for the Mother dependent on individual risks and needs whilst also considering the needs and best interests of the infant.

4.1.5 **Exclusion Criteria** – Mothers with a diagnosed personality disorder, who have a significant problem with substance misuse, gambling or exhibit anti-social behaviour, will be considered on an individual basis.

Mothers who have marital or relationship problems or are meeting life crises but who have no mental disorder or Mothers whose problems are solely alcohol or drug related will not be accepted by the Service.

Mothers who require admission for the purpose of a parenting assessment or where there is a plan to remove the child or felt that the Mother would not be able to independently parent the child following admission/treatment will not be accepted by the service.

Rainbow Mother and Baby unit is an acute Mental Health unit, Babies are admitted under the status of dependent guest. Therefore due to the skill set of the staff it is not possible to admit Mothers whose baby requires enhanced physical care needs or who are in poor physical health.

5 ACCESS and AVAILABILITY

5.1 Referral Pathway into Rainbow Mother and Baby Unit:

5.1.1 Referral to the Mother and Baby Unit can be made during the service user's pregnancy if there is an anticipated need for the service user to receive in-patient care, however admission could only be facilitated from the third trimester of pregnancy.

5.1.2 Rainbow unit is accessible 24 hours per day, 365 days a year by contacting the team directly on 01245 315629 or 01245 315630.

5.1.3 Referrals can only be directly accepted from Mental Health professionals to ensure that mental state and the need for Mental Health inpatient admission is appropriately assessed.

5.1.4 All referrals should first be made to the patients most local MBU who have primary responsibility of screening the referral for appropriateness. If a referral is felt appropriate but the local MBU does not have capacity to admit they should state by return to the referrer that they support an MBU admission so this can be forwarded to alternate MBU placements.

5.1.5 Referrals received in relation to East of England patients will be prioritised however patients outside the region will be offered admission if there is capacity, support of the need for MBU admission should be sort from the local MBU prior to accepting.

5.1.6 On receiving a call the ward will request an initial verbal handover of information which will be logged within the ward referral book and give advice based upon this information. Referrer will be asked to complete the 'universal referral form' (attached to nhsWebbeds) with full details and email this to the team email account epunft.rainbowmbu@nhs.net The team will make every effort to acknowledge new referrals within 1hr and aim to provide outcome from the screening or request additional information if needed within 4hrs. The Nurse in charge of the shift will lead in the screening of referrals (If the nurse in charge is in doubt this will be discussed with the appropriate manager and/or perinatal consultant psychiatrist)

5.1.7 Where possible all admissions to the unit should be planned, giving the ward staff time to prepare to receive the service user and for the Mother and others in her family to make personal arrangements for the admission. However, emergency admissions will be accommodated where clinically indicated and safe to do so.

5.1.8 Where Mothers are previously known there should be a joint care package between mental health services, the midwifery team and primary care during the pregnancy to ensure assessment of risk and child safety.

5.1.9 If appropriate for admission and a bed is available unit staff will email the IPPA, Commissioner funding form to the referrer for completion prior to formal acceptance of the patient. Ward staff will submit the completed funding form to NHSE via email admin.providercollaborative@cpft.nhs.uk and liaise with referrer, patient and relative if appropriate to arrange admission time. However, where this is in relation to an emergency admission completion of IPPA should not delay the patient being accepted/admitted but should be completed as soon as possible after.

5.1.10 If the referral is received in relation to an East of England patient and is felt appropriate for admission but a bed is not available at the time, ward staff will provide the referrer with alternative MBU details, starting with an alternate MBU within the region and direct to Webbeds www.nhswebbeds.co.uk. Ward staff will confirm by email that they support admission to an MBU but are unable to facilitate at this time due to bed occupancy. Ward staff will continue to liaise with relevant placement with a view of transferring to Rainbow if agreed by patient once a bed becomes available.

5.1.11 Where a patient resides out of area but makes a specific request to be admitted to Rainbow due to support network, despite a more local MBU having availability this can be considered and Rainbow may become the patients 'local' MBU based on the planned discharge support plan. Therefore an out of area patient can be given priority if their family/friend support and planned discharge support is within the region.

5.1.12 Women who require PICU care in the first instance will be admitted to a PICU without the baby prior to MBU admission. For those very ill and disturbed women, not requiring PICU level care, every effort will be made to ensure staffing arrangements are made to allow admission of Mother and baby if a bed is available and it is deemed safe to care for Mother within an MBU setting.

5.1.13 Full disabled access is available on the unit for Mothers, visitors and children. Should a Mother be admitted with her own personal mobility aid to the unit, the appliance must be safety tested prior to use on the unit.

5.1.14 Rainbow unit has 1 bedroom that can accommodate the needs of women requiring bariatric equipment however additional needs of the patient must be assessed by the team in regards to appropriateness due to limitations in the use of mechanical aids in the room.

5.1.15 In the event of a referral being received that is deemed inappropriate to the unit this will be explained to the referrer and advice given by return email.

5.1.16 In the event of a referral being made but not accepted by the unit and the referrer is dissatisfied with this outcome and strongly disagrees the referrer can request a further clinical assessment of the referral by another MBU. Rainbow unit staff will then liaise to obtain a further opinion from an alternate MBU within the region. Where there are unresolvable differences in clinical opinion on the appropriateness of admission, the patients home specialised Commissioning team should be contacted.

6 PRE-ADMISSION

6.1 Risk assessment must be carried out prior to Mother's admission to determine if it is safe and in the best interests of the child to accompany the Mother to the psychiatric Mother and Baby unit.

6.2 For those women who have an identified mental illness or are deemed at risk of developing mental illness, clinicians should consider any existing advance directives or advance decisions made by the Mother. Where a pregnant woman is admitted prior to giving birth and is deemed as having capacity, she should be encouraged to record her wishes for her future care and treatment both in respect of her birth plan and psychiatric care. These should be documented on the appropriate forms – MCA 10 and shared with the Obstetric Team and Midwives as appropriate.

6.3 Ward staff will offer where appropriate to speak to all new admissions or family members to advise regarding what to expect/bring for admission.

6.4 The unit is happy to accommodate visits to the unit to allow Mothers and their partners (where appropriate) an opportunity to view the environment and speak to staff about any questions or concerns prior to an admission however, these visits must be pre planned with the nurse in charge and can only take place if clinically safe and appropriate on the day.

7 RECEPTION

7.1 Rainbow Unit has its own separate entrance so Mothers and visitors should not report to the main reception at The Linden Centre. Please follow the sign and press the appropriate intercom system to be let in. Staff will meet Mother or visitor in the reception area and escort onto the unit.

7.2 If the nurse in charge of the unit is in any doubt regarding an admission or visitor, this must be discussed with the Manager (in hours) and the clinical on-call (out of hours) or the perinatal consultant if available to clarify clinical need.

8 ADMISSION PROCESS

8.1 Discussion and decision to admit will be based on risk assessment and clinical need.

8.2 The Mental health Practitioner wishing to make a referral for admission must discuss the patient with the Mother and Baby unit before offering admission to the patient. Referrers should ensure that the Mother is consenting to an MBU admission where appropriate and that all parents with legal PR (Parental Responsibility) have consented to the baby being cared for within the MBU, unless there are legal or safeguarding reasons to prevent this.

8.3 Every effort should be made to arrange admissions during the working week and in hours.

8.4 All patients at the point of admission along with any property bought onto the unit will be searched in accordance with the trust search policy and any inappropriate or higher risk items removed, given to relative to take back home or placed/locked in an appropriate place.

8.5 A full nursing, medical and risk assessment of Mother will be carried out on admission which must include risk to self, others and baby. A body map and handover regarding baby will also be taken. The senior nurse on the unit is responsible for ensuring that the

Trust Risk Assessment Policy is adhered to and that any risks identified are highlighted and appropriate action taken.

8.6 All risk assessments must be recorded on the trust electronic patient records (Paris).

8.7 The referrer should ensure that the baby/children are well on day of admission.

8.8 Medical responsibility for the Mother during admission will be with the designated perinatal Consultant Psychiatrist. Medical Responsibility for the baby remains with the Mother's GP until the baby is registered with the GP in it's own right following registration of the birth

8.9 Mothers will be provided with a Welcome pack on admission with key information regarding their admission and process' on the unit and a member of staff will explain this to them.

8.10 Ward staff will liaise closely with partners/carers where appropriate and offer support. Formal carers assessment can be offered and this should be undertaken where necessary by relevant community team

8.11 Mothers will be allocated a Keyworker and Co workers to lead in their care whilst on the unit. Mothers/babies will be allocated a Nursery Nurse who will work with Mothers to support and guide on baby's care and needs.

8.12 Baby's legal status while on the unit is as 'dependent guest' and therefore is not admitted as a patient. Baby's daily progress report will be entered under a separate heading within Mothers electronic health care record however Baby's individual records e.g health checks, weight, baby care plan will be held within a file on the ward within the nursing office.

8.13 New admissions will be assessed by the ward doctor or on call doctor if out of hours within 4 hours of arriving on the unit and will be reviewed by the perinatal consultant within 1 working day.

8.14 It is accepted that the full admission and care planning process may take several days to complete, depending on the mental state of the Mother and her ability to receive and give information.

8.15 The key worker or nurse in charge must ensure that the Mother has a basic understanding of what will happen in the facility, her responsibilities for her baby and herself and is orientated to the environment. The keyworker or nurse in charge will need to ensure that any medication prescribed for the Mother is administered in accordance with the agreed In-Patient procedures while considering the current feeding arrangements for baby, i.e. breast/bottle.

8.16 All Mothers will be referred to and supported by the units link perinatal midwife or health visitor as appropriate. All expectant Mothers will be referred within 1 working day to local midwifery service and will be seen by the units link midwife and registered for maternity care at Broomfield Hospital.

9 ACCESS TO ADVOCACY

9.1 The Mother has a right to independent advocacy.

9.2 Ward staff will refer to advocacy services if requested by the Mother or as a best interests decision if Mother lacks capacity. All patients will be provided information in regards to advocacy and can contact directly if they prefer.

9.3 Information will be given to the Mother on the way in which the service will provide support during and after the inpatient stay and include a process for responding to stated preferences.

10 CARE OF BABIES DURING ADMISSION OF MOTHER

10.1 Babies accompanying Mothers on admission to the Mother and Baby unit will be regarded as a dependent child/guest.

10.2 All babies during the admission process will have an identification strap placed around their ankle.(Appendix 16, Form 6)

10.3 A dependent child is not classified as a patient, but is recognised as a child who has health and care needs, which cannot be met entirely by his/her Mother (who is the patient). The Mother and Baby Unit staff have a responsibility to ensure these needs are met during the period of the Mother's admission but the primary parenting responsibility remains with the Mother wherever possible.

10.4 In the event that a Mother lacks capacity to make decisions in regards to their baby staff will ensure that any other party holding PR (baby's father, local authority) are kept up to date and involved as much as possible in any care decisions.

10.5 In the event of an emergency or urgent care need/decision staff will act in view of the best interests of the baby.

10.6 All babies are roomed with their Mother unless requested otherwise by Mother or it is necessary due to risk for baby to be cared for or sleep in the nursery. If a baby is placed within the nursery due to a clinical decision or lack of capacity of Mother, ward staff will make every effort to inform any other party holding PR, this will be maintained for the shortest time possible dependent on risk and will be clearly documented within Mothers clinical notes.

10.7 All babies are body mapped on admission and a baby care plan developed collaboratively with Mother around the needs, routines of baby. If Mother lacks capacity to work with staff initially on this staff will consult relatives if appropriate and make an initial care plan based on best practice. (Appendix 1 & 2)

11 DUTY OF CARE TO THE DEPENDENT CHILD

11.1 The safety and wellbeing of the child is paramount at all times.

11.2 All staff on the unit have a duty of care to the child to ensure his/her safety and wellbeing.

11.3 In all cases, care of the child will be shared between the Mother and unit staff.

11.4 While the Mother remains the primary carer of her child, her illness may compromise her ability to provide appropriate care, and to ensure her child's wellbeing. Staff will support with this role and where necessary make decisions in regards to the baby's wellbeing.

11.5 The extent of care provided by staff will depend on the level of the Mother's capacity, mental state and behaviour, this will be clearly documented in the electronic records.

11.6 The unit will respect the right of Father's and other family members to have contact with the child, and will endeavour to ensure that this is maintained, taking into account the Mother's wishes, the safety and wellbeing of the child, and any instruction from the local authority, Children & Families Services or advice from the Trust Safeguarding team along with clear understanding of the legal status of the baby and who holds legal PR.

11.7 All staff will work in accordance with current legislation and guidance on safety and welfare of children, seeking advice from the Trust safeguarding team or Social Care where appropriate. Staff will escalate any safeguarding concerns as appropriate to the Trust Safeguarding team and Social care as necessary and in line with The Trust safeguarding policy and procedure.

11.8 Staff will act at all times to appropriately care for and protect any child/infant on the unit. However, if a concern is raised or witnessed in relation to the care or treatment of a child staff will liaise with the trust safeguarding team immediately and follow the LADO process (Appendix 18)

12 PROCEDURES TO ENSURE CHILD CARE NEEDS ARE MET

12.1 As part of the admission process, staff will identify who has legal parental responsibility for the dependent child, and will endeavour to work closely with them to ensure the child's safety and wellbeing, and to take into account their wishes with regard to child care.

12.2 All initial assessments (in accordance with the Trust Safeguarding Children, Safeguarding Adults and CPA Policies) must identify who lives in the same household as the Mother

12.3 As part of the admission and ongoing assessment process, all babies will be assessed with regard to:

12.3.1 Evidence of current illness
12.3.2 Evidence of injury or inadequate care
12.3.3 Status regarding registration of birth
12.3.4 Immunisation status
12.3.5 Developmental stage, feeding and sleeping routines
12.3.6 Social care needs.
12.3.7 Other Matters may also be assessed where deemed appropriate by staff.

12.4 The Mother's mental state will have an ongoing assessment specifically regarding risk of harm or neglect in relation to her child on the unit.

12.5 The child's basic health care needs (including prescribing and administration of medications where appropriate) will be met by unit staff, at a level commensurate with their training and competence.

12.6 Day to day baby care is documented in Mothers electronic records. All babies also have developmental milestones and healthcare records which are held in a separate folder in the nursing office. (Appendix 4)

12.7 Procedures will be in place to ensure effective communication of any child protection issues to relevant health and social care professionals on an ongoing basis and as part of the child's discharge plan.

13 PHYSICAL HEALTH OF THE CHILD

13.1 The baby's primary clinician will remain as the GP throughout the stay on the unit. The baby's status while on the unit is as a dependant guest. However, staff will have a duty of care towards the baby.

13.2 Unit staff receive training on infant BLS (Basic Life Support) and the unit has a child 'Grab bag' located in the clinic room to support this.

13.3 The unit is supported in their care of babies by a specialist perinatal midwife and link Health visitor who visit the ward regularly and as needed. The unit also has links with the paediatric ward 'Phoenix' at Broomfield General Hospital and ward doctors can liaise and directly refer to Phoenix if required.

13.4 Unit staff receive basic training in recognising an unwell baby 'common disorders' however would refer for any necessary treatment as staff are not qualified in paediatric medicine, therefore the unit cannot accept any baby that is receiving an enhanced level of care or is in poor physical health.

13.5 If staff are concerned about the health of any baby they will contact the ward doctors in hours or on call doctor out of hours.

13.6 For guidance around potential presentations and concerns please see appendix 13, 14 & 15.

14 CLINICAL PRACTICE

14.1 All bedrooms have full facilities for baby to be nursed in Mother's room, however the sleeping arrangements for the Mother and the baby can be reviewed by the MDT taking into consideration any clinical risk assessment outcomes, cultural needs of the family and Mothers preference.

14.2 The principal tasks of the team are observation, assessment and treatment. The allocated nurse is required to write in the Mother's health and social care record documenting their observations and clinical interactions about the Mother's behaviour, mood, mental state and response to her baby on each shift. The allocated nurse with support from the team is also responsible for documenting the care given to the baby.

14.3 Staff should have access to specialist knowledge on perinatal psychiatry, including mother-infant relationship, interaction, attachment and child development. The Trust Pharmacist can provide advice on the use of medication during pregnancy and lactation. CAMHS consultation is always available as is Safeguarding Advice and a Safeguarding Clinic is held at least monthly on the unit. All staff working on Rainbow unit as registered and non-registered clinicians must complete Safeguarding Children training within 6 months of commencing work on the unit.

14.4 If in an acute phase of her illness, a Mother is not able to tend to her baby's care, all care given to the baby by clinicians should be done wherever possible, dependent on risk assessment at the time in the presence of the Mother. The team should offer reassurance to the Mother that she will be able to tend to the baby later on and ensure all reasonable support measures are put in place to accommodate this.

14.5 All Mothers will have a comprehensive risk assessment as part of the admission process which must consider any perceived risk to Baby. Mothers observation levels will be based upon this risk assessment however all new admissions should be nursed on at least Level 2 observations (4 checks within the hour) for the first 48hrs to ensure

a heightened level of monitoring and support. If a Mother and Baby is admitted from an alternative MBU observation levels should be assessed individually considering care package, parenting ability and risk already demonstrated/assessed within an MBU setting.

14.6 Nursing staff may utilise a combined observation level meaning that observations may vary dependant on when the Mother is or is not with her baby or giving direct baby care dependant on risk.

14.7 Babies will be monitored in line with the Mothers observation levels but must be checked a minimum of hourly. The purpose of observations/checks of the baby are purely to observe obvious safety, whereabouts and wellness of baby in line with staff competency. Rainbow unit is an Adult Mental Health inpatient environment and therefore the MDT does not include paediatric staff. Babies 'whereabouts/wellness' check will be documented on the Mothers observation recording form.

14.8 The multidisciplinary team's risk assessment may stipulate the conditions under which a Mother may be alone with her baby and leave it to the nurse in charge and/or junior doctor to decide when those conditions have been met. These decisions should always be recorded in the service user's health and social care records. The Unit encourages Fathers/partners to be as involved in their child's care as possible unless clinicians have concerns in them doing so.

14.9 It is the clinician's responsibility to ensure that the Father of the baby recognises the legal responsibility of the facility for the well being and safety of the baby.

14.10 CPA (Care Programme Approach) provides a framework for care coordination and communication and is fundamental to the provision of a person-centred mental health service. The care plan objectives are delivered in a coordinated approach within an integrated partnership between primary care, secondary care, voluntary services and nominated family and friend's of the individual Mother receiving an inpatient service.

14.11 The assessment evaluates the Mother's individual strength's, taking into consideration what coping strategies have worked in the past and identifies areas of need including finance, housing and occupation. Risk management is key in forming part of the plan.

14.12 Individualised care plans will be developed with Mothers and the multi disciplinary team. Interventions will include one to one protected time with staff, attendance of individual or group therapies for Mother, attendance of individual or group Mother/Infant activities/therapies, child care (Appendix 3), use of medication and discharge planning.

14.13 It is expected that the local mental health service and Primary Health Care Teams will maintain close contact with Mothers whilst they are in the unit.

14.14 Should a patient's illness or behaviour threaten the safety of other patients, their own safety or safety of babies, then an assessment will be conducted to review the most appropriate, safest environment for treatment to continue. Due to level of risk it may be deemed necessary for a period of treatment within an alternate setting including possible transfer to a psychiatric intensive care unit, subject to the availability of a bed. In these instances alternative child care arrangements may need to be made with the family or local authority.

14.15 Any Mother whose child is subject to a plan through the local authority CP, CIN (Child Protection, Child In Need) or a legal order i.e ICO (Interim Care Order) will be given

support from ward staff to access help to specialist advisors to ensure that they fully understand their rights and the implication for them and their child.

14.16 Any Mother whose child is subject to Care proceedings under the Children Act (1989, 2004) will be provided with support to understand these proceedings by Social Care and the unit will work closely with Social Care to ensure the wellbeing of the child.

14.17 The ward has a separate nursery where babies can sleep and be cared for if necessary or appropriately requested by Mother. The Nursery is generally an open door policy to Mothers however if baby was deemed to be at immediate risk due to Mothers mental state or behaviour ward staff are able to activate the locking mechanism to switch the door to Fob only access meaning that staff would have to open the door to allow entry.

14.18 Due to the nature and purpose of the unit it is not possible to have Mother or baby on the unit independently therefore if Baby is removed from Mothers care either by the local authority or baby's father (providing he has PR) refusing to have baby on the unit then alternative arrangements for Mothers admission should be made immediately by liaising with the local adult acute inpatient unit.

14.19 The unit works closely with partner agencies. All Mothers will be supported/monitored by the units link midwife or health visitor as appropriate. All Women admitted during pregnancy will be booked to deliver at Broomfield Hospital however this can be transferred back to the local area at any point if needed. The unit has a contract with a local GP surgery, The Laurels, Boreham to offer care in line with National screening i.e post natal follow up, immunisations to Mothers and babies that are not able to access their own GP while on the unit.

14.20 The unit has a separate Milk Kitchen which is used for the preparation and storage of infant formula/breast milk. Each Mother with the support of staff as needed and appropriate will record the sterilisation of baby equipment and baby feeding chart. (Appendix 5)

14.21 EPUT is a strictly non smoking environment. Any Mothers admitted affected by this will receive support to utilise Nicotine Replacement Therapy as per Trust guidelines.

14.22 Any exceptions to the operational guidelines should be escalated for discussion with Ward Manager and Perinatal consultant or on call manager and on call Doctor.

15 RISK AWARENESS - SEPERATION/REMOVAL OF THE BABY FROM THE MOTHER

15.1 All concerns regarding the Mother's ability to look after her baby safely must be documented.

15.2 There are a number of reasons why the MDT may consider the Mother is a risk to her baby or that admission to the Mother and Baby unit may not be the most appropriate place for admission to continue. The decision to separate a baby from his/her Mother may be based on one serious event or an accumulation of less serious events.

15.3 Factors to consider when assessing safety and best interests of the baby –

15.3.1 The impact of multiple carers for the baby (nursing staff) for more than one week, with the Mother having little or no input.

15.3.2 The overall interaction and development of baby if baby is being cared for in a separate area ie remaining in the nursery due to risk

15.3.3 If the Mother is unable to co-operate with staff eg observational levels, care of baby

15.3.4 If the Mother's behaviour is considered to be having a detrimental impact upon the baby – ie the baby is distressed / passive/delay in developmental milestones.

15.3.5 If the Mother requests separation from the baby in order for her to be treated.

15.3.6 If the standard of care given to the baby, physical and emotional, may be compromised in some way.

15.3.7 If the Mothers behaviours place baby in unnecessary risk, even if non direct harm

15.4 If the risk to baby is felt to be immediate the baby should be removed and cared for separately from the Mother by staff and arrangements made for baby to be placed with identified carers i.e. father, family or local authority.

15.5 A decision may be made through the court or police via the local authority to remove baby from Mother, if the unit is informed of such a decision they must act to ensure safety of both Mother and Baby. Staff should assess each situation independently with a constant focus of risk, acknowledging the trauma such a decision is likely to have on the Mother and ensure increased support is available. Staff should also consider increased observations and the possibility of removing baby to the nursery if necessary due to Mother's reaction and potential risk. In these circumstances staff must liaise with any other relevant professionals involved in Mothers care and inform the local adult inpatient unit so the Mother can be transferred to continue her treatment without baby. Staff must ensure that a clear handover highlighting the likely increased risk following removal is given to the accepting unit.

16 LEAVE ARRANGEMENTS

16.1 The unit acknowledges that there may be circumstances where it is not possible to predict or pre plan an episode of leave however, the unit will work to ensure that all leave is pre planned and agreed with the MDT and exceptions to this should only be under exceptional circumstances.

16.2 The unit will ensure that community teams and other agencies i.e GP, Health visitor, midwife, social care are informed of all planned periods of leave as necessary and relevant.

16.3 During any period of extended leave (more than 72hrs) staff will negotiate with the patient and relevant community services to facilitate contact with the Mother during her leave period either by a visit or telephone contact dependant on appropriateness and agreement with patient.

16.4 All patients prior to departing on leave will have a leave plan and risk assessed as per Trust Policy/Procedure.

16.5 Staff will ensure that all patients and partners/carers (if appropriate) have the contact details of the unit prior to departing on leave and are made aware they can contact the unit at any time for advice/support.

16.6 All patients and their property will be searched on return from each period of leave as per Trust search policy.

16.7 Due to the nature of the unit leave beds will not be used for other patients to ensure the unit is never over established due to risk factors associated if a Mother and baby need to return from leave unplanned.

17 LEGAL ISSUES

17.1 The Trust will have a legal duty of care towards Mother's, children and visitors to the unit.

17.2 Every admission must document:

17.2.1 The reasons for admission of Mothers or Mothers-to-be.
17.2.2 Who has made the decision
17.2.3 Identify key worker responsible for the care and safety of Mother and Baby.
17.2.4 Confirm the Capacity of the Mother to consent to admission. Where a Mother may lack capacity to consent to admission, the Mental Capacity Act must be followed and where appropriate use of the Mental Health Act must be considered.
17.2.5 Legal status of each Mother i.e informal or detained and ensure procedures around the Mental Health Act are followed and documented and all patients are aware of their rights.

17.3 Full records of Baby must be maintained covering all aspects of the Baby's care. All involved with primary and community care of the Baby to be informed of 'admission' and progress to discharge stage. The Baby is a visitor to mental health services and is not a service user in their own right.

17.4 Parental Rights and Responsibilities

17.4.1 The parental rights of adults involved in each case must be established and recorded at the earliest point, with evidence sought and verified where necessary.

17.4.2 Admissions will be determined by the clinical team.

17.4.3 In most cases a child may be accepted to the facility only if the Mother expresses a wish to care for the child in hospital. All Mothers have a right to refuse MBU admission and can be cared for on an alternative inpatient setting without baby if they prefer.

17.4.4 If both parents hold 'Parental Responsibility' the Father of the baby has a right to refuse for baby to accompany Mother for admission, this right must be upheld unless over ridden by law.

17.4.5 If parents both with PR are of conflicting opinions in regards to whether baby accompanies Mother for admission advice should be sought from Social care and the best interests of the baby must be a priority.

17.5 Parental Responsibility

17.5.1 The concept of parental responsibility is one of the main principles of the Children Act 1989, 2004. It can be held by either the parents or, in certain circumstances, by other people or bodies, in some circumstances PR may be shared between the Parents and the local authority. The question of who has parental responsibility is dealt within S.2 of the Act, whilst the term itself is defined by S.3 of the Act.

17.5.2 The principles of identifying Parental Responsibility where there is not a legal order in place are:
Mothers automatically have PR from giving birth.
Fathers hold PR if the couple are married at the time of the baby's birth or if the Father is on the baby's birth certificate

17.5.3 On admission, confirmation will be sought as to who holds Parental Responsibility; (both parent's names will be recorded on the birth certificate). It is important to clarify who holds PR as Mother's may have a new partner since conceiving a child; the new partner would not hold PR.

17.5.4 More than one person may have parental responsibility for the same child at the same time.

17.5.5 Where more than one person has parental responsibility for a child, each may act alone to meet that responsibility, except where any legislation requires the consent of more than one person in a matter affecting that child.

17.5.6 The fact that a person has parental responsibility for a child does not entitle that person to act in a way that would be incompatible with any order made in respect of that child under the Children Acts, 1989, 2004.

17.6 Meaning of Parental Responsibility

17.6.1 The Children Act 1989, 2004 clarifies that parental responsibility means all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to that child and the child's property.

17.6.2 A person who does not have parental responsibility for a particular child but has care of that child may (subject to provisions within the Act) do what is reasonable in the circumstances for safeguarding or promoting the child's welfare.

17.6.3 Other persons who are not parents but have an interest in, or connection to, the child (eg a grandparent) may acquire parental rights and responsibilities by making an application to a court under Section 44 of the Children Act 1989, 2004 for an Emergency Protection Order.

17.6.4 The Mother's wishes as to family involvement should be respected unless in conflict with legal decisions

17.6.5 The MDT must consider, with legal advice if necessary, what can be enforced, respecting the Mother's wishes as to the involvement or otherwise of the extended family.

17.6.6 Where doubts exist regarding a Mother's capacity to make such decisions, an MCA2 assessment of capacity must be completed.

17.6.7 Should a child already be the subject of a supervision order, then a review should be requested in order to name the unit as a place of residence, where this is in the child's best interests.

17.6.8 A Father with full parental rights and responsibilities can remove the child from the unit, in the absence of any statutory orders being in force affecting the exercising of his parental rights and responsibilities. However staff would meet with Mother and Father to negotiate what is best for the child and parents.

17.6.9 A Baby can only be removed from the unit by an appropriate person with legal responsibility for the baby, if baby is needing to be removed for example at Mothers request and she is the only person with Parental Responsibility staff must liaise with the local authority immediately and cannot hand over care of the baby to another family member without the local authorities agreement.

17.6.10 There may be occasions where consideration is given to a Child Protection Order to protect a child from other family/extended family members. If a parent with PR is wanting to care for baby at home but there are concerns regarding the Baby's safety with that parent, staff should act in the best interests of the Baby and liaise with the Local authority and police if needed and appropriate to ensure Baby's safety.

17.6.11 In the event of an emergency in regards to baby's safety and preventing a person with PR from leaving the unit with baby due to concerns over risk staff must contact police immediately via (9)999 as police are the only agency with the power to enforce an immediate protection order without the need to attend court. (PPO, Police Protection Order)

17.6.12 It is difficult to have protocols or guidance for all possible situations. Skills of dialogue and negotiation are essential in complex situations. Again, the staff's duty of care to the child, particularly where they may have concerns in relation to harm to the child, should take precedence. Advice is available from the Trust Safeguarding Team, however staff should always take action to protect the child and seek senior advice as necessary.

18 DISCHARGE PLANNING

18.1 The principles of CPA apply to all Mother and Baby admissions.

18.2 Discharge planning should start at the point of admission.

18.3 All discharge plans will incorporate multi-agency involvement, including midwifery, health visiting and social care as appropriate. Staff will ensure that all agencies and relevant family members (with patient consent) involved in the Mother and Baby's care are made aware of and invited to the weekly care reviews and any discharge planning meetings. In the event that it is not possible for community services to attend the meetings staff will liaise and inform services via telephone and/or email of any relevant outcomes.

18.4 Referral for community support will be made within the week of admission. Every effort will be made by the unit to ensure allocation of an appropriate community-based clinician to lead on planned transition arrangements between the inpatient Mother and Baby unit and community-based care.

18.5 Discharge planning will consider the comprehensive needs of the Mother and baby and may include referral or sign posting to other agencies and voluntary sector services.

18.6 All patients upon discharge will have been given information explaining to them who to contact in an emergency or should they need support. Every effort will be made by the ward staff to ensure that all Mothers discharged from the service have an allocated care coordinator who they have met prior to discharge however the unit acknowledges that this may not be possible due to local area arrangements.

18.7 All relevant parties must be informed of the patients discharge. (Appendix 9)

18.8 All patients discharged from the Mother and Baby unit are informed and invited to contact the Mother and Baby unit post discharge for support should they wish.

18.9 At the point of discharge all patients are given an initial (24hr) discharge summary, the ward must also scan and email a copy of this to the GP using their secure nhs.net email account.

18.10 In the event that a patient wishes to self discharge against medical advice, staff must ensure the trust policy/procedure is followed. Staff must also consider any risk factors to the Mother and/or Baby should they do this and any Safeguarding concerns. Staff must take any appropriate action taking into consideration The Mental Health Act, Mental Capacity Act and Children's Act and ensure this is comprehensively documented on the electronic patient record.

18.11 If a Mother wishes to self discharge with her baby and it is not felt appropriate to use The Mental Health Act, staff must consider any child protection/safeguarding concerns, if no formal order is in place in regards to The Children's Act but staff feel that baby would be at risk if they left this should be explained to the Mother wherever possible and consultation should take place immediately with Social Care, staff should not allow the baby to leave until plans are in place. If it is felt that the baby is or would be at immediate risk staff must call police for assistance via (9)999 for consideration of a PPO (Police Protection Order)

19 MEDICATION/PRESCRIBING

19.1 Mothers may be prescribed medication, and the administration of medication is to be carried out in accordance with Trust policies and procedures.

19.2 All Mothers will be given information in regards to risk:benefit of taking medication during pregnancy or while breastfeeding as needed to allow them to make an informed decision. Medication would only be enforced during pregnancy or breastfeeding in exceptional circumstances and if believed that the risk of not medicating was greater than the risk of medicating and would only be given in accordance with The Mental Health Act or Capacity Act.

19.3 Method of baby feeding (breast/bottle) should be considered when prescribing medication as breast feeding may be contra indicated. Breast feeding should be supported and assisted in Mothers who chose this option wherever possible and medication should be adjusted where possible to facilitate this. The Method of baby feeding must be documented on the front of the Mothers medication card and baby's if applicable.

19.4 Any baby requiring medication during admission should have a separate medication chart which is prescribed for them in their own right, all medication administration should be done in accordance with the Trust policy and procedures.

19.5 All medication charts should have a photo attached of the person to whom the chart is for to assist in identification. Staff must seek consent to take the patient photo, completing and processing the consent form prior to any photo being taken in accordance with trust protocol, should a patient refuse to have their photo taken 'Refused' must be documented on the front of the medication chart.

19.6 Mothers should be asked to consent to Baby's photo being taken for this purpose however in the event that Mother refuses another party who holds PR can consent to the baby's photo being taken. If Mother lacks capacity to consent and no other party holds PR a best interest decision can be taken.

20 PHYSICAL INTERVENTION

20.1 All ward staff are trained in TASI (Therapeutic and Safe Interventions) attending initial training and subsequent updates in accordance with trust procedure.

20.2 Physical intervention should only take place when all reasonable steps have been taken to avoid its use. If the patients behaviour remains unmanageable despite the efforts of verbal de-escalation and there is a risk associated with the behaviour staff may need to utilise physical intervention.

20.3 Physical intervention should not be used for any longer than is necessary, to minimise the risk of injury to the individual or others.

20.4 Women in pregnancy or up to 6wks postnatal will automatically be manual handling RAG rated as Amber until they have received their 6-8wk post natal check and clearance, during this time under no circumstances can the Mother be placed in Prone position and any physical intervention should be to a seated or kneeling position only, staff should utilise the use of the safety pod wherever possible. If the Mother during this time throws herself to the floor staff should immediately release any holds in place and ensure an immediate medical review takes place.

20.5 The use of seclusion should be avoided and only undertaken in exceptional circumstances. If seclusion is used, this must be for the minimum time and in line with the Trust's Seclusion and Long Term Segregation Procedure. A contingency plan for the care of the baby must be in place. The seclusion of the Mother should prompt an urgent MDT review in relation to the possible increased risks and future management.

20.6 Following any physical intervention staff will offer the patient a debrief to allow them time to discuss the incident, explore any contributing factors and offer reassurance and support. If necessary and appropriate this will also be offered to other patients on the unit that may have been affected.

21 MOTHER AND BABY PHYSICAL INTERVENTION

21.1 There are no national guidelines/technique in regards to physically separating a Mother and child. In the event that a Mother is holding her baby and makes threats to harm her baby or is acting in a way that could endanger the baby's safety, the person negotiating with the Mother in an attempt to keep the baby safe should continually assess the risk and call for assistance by activating the alarm. De-escalation skills - talking and listening - should be the first line of approach and continue throughout, where possible staff should encourage the Mother to sit in order to minimise the height of the baby and physical motion.

21.2 If de-escalation and negotiation with the Mother is breaking down and the Mother continues to refuse to give the baby to the clinician and there is concern for the baby's safety, staff should only approach with a minimum of a three-person team, 2 staff to support and limit the Mothers hand and arm movements and 1 staff to support the baby. Staff should call for police assistance where needed and indicated by risk via (9)999

21.3 As soon as possible, the baby must be examined by a doctor.

22 CONTROLLED ACCESS, EXIT AND SECURITY

22.1 The safety of the unit, Mothers and Baby's is paramount. To ensure and assist in the management of this all entrance and exit points require staff to access.

22.2 The unit main entrance is operated by a fob and code system to restrict the ability of people accessing the unit inappropriately or a vulnerable patient or baby exiting the unit unplanned.

22.3 The unit has a non recording intercom with camera located at the main entrance for visitors to inform staff of their arrival, staff can view through an intercom located in the main nursing office. There is also an internal door leading directly onto the unit which is fob only access.

22.4 Staff should ensure that they allow entrance through the main door via the intercom only if the visitor is known and expected by the unit, staff will then attend the reception area to greet any visitors and escort onto the ward.

22.5 All ward staff will have trust photographic identification badges which will be worn at all times. Staff will ensure they check the identification of any person visiting the unit and view professional ID's as relevant.

22.6 All patients will be informed of their legal rights and how to request and exit the unit.

22.7 The unit will assess and discuss any requests made giving consideration to legal status of the Mother, baby and Mothers capacity

22.8 The unit acknowledges that there may be occasion where Mothers have the legal right to leave but it may not be possible for them to leave with baby due to baby's legal status or due to safeguarding concerns.

22.9 The team will act to safeguard the baby at all times while also ensuring that they respect Mothers wishes where safe and possible but taking appropriate action in line with Mental Health Act, Mental Capacity Act and Children's Act when needed.

22.10 The risk of child abduction and subsequent management of an abduction or attempted abduction is covered in Appendix 16.

23 VISITING

23.1 All visiting is at the discretion of the Nurse in Charge. The Nurse in charge can delay or prevent a visitor from entering the unit temporarily if clinically necessary due to risk.

23.2 Patients admitted to other Mental Health in patient wards are not permitted to visit a Mother while on the ward.

23.3 Partners and or baby's Father are welcomed on the unit and encouraged to visit as much as is reasonable and wanted dependant on Mothers wishes and providing there are no safeguarding issues or legal orders to prevent this. However, staff will request that they are mindful and respectful of others on the unit in regards to the timing of visits.

23.4 Mother's children and or baby's siblings are also welcomed onto the unit at all times dependant on clinical risk at the time and Mothers wishes. Staff should also consider in conjunction with the family the best interests of the Children and any potential impact the visit may have.

23.5 Due to the size and nature of the unit other children are not permitted to enter the unit and visiting should be restricted to up to 3 people at a time with the exception of a Mother with more than 3 children.

23.6 All other visitors should visit within visiting times:
Monday – Friday: 15:00 – 17:00hrs & 18:00 – 20:00hrs
Saturday, Sunday and Bank Holidays: 10:00 – 12:00hrs, 13:00 – 17:00hrs & 18:00 – 20:00hrs

23.7 No visitors are permitted to remain on the unit overnight**.**

23.8 In the event of an unwanted visitor attending the unit, staff will attempt to engage if safe to do so, offering reasons around why the visit cannot be supported and negotiate the person/s leaving

23.9 Any visitor that presents in an aggressive manner will not be allowed access to the unit to ensure that the unit safety is maintained.

23.10 If any unwanted visitor refuses to leave staff should request support from colleagues, on site security and the site coordinator. Staff will contact the police if any risk is posed.

23.11 If any visitor refused to leave the unit once on and presents with any risk to the unit or an individual staff will request police support, via (9)999 where appropriate. In this circumstance the team will move patients and babies away from the area and support elsewhere on the ward.

23.12 If it is known by the unit that an identified individual may attend the unit and there are known risks surrounding this, the team will notify the ward manager and liaise with safeguarding and LSMS as appropriate to implement an agreed response.

24 STAFF

24.1 Rainbow units core team consists of Perinatal Consultant Psychiatrist, Team Doctors, RMN's, Associate Practitioners, Senior Healthcare Assistants, Nursery Nurses and Occupational Therapist however is also supported by alternate therapists such as Art psychotherapy, Dance and Movement psychotherapy, Gym and Fitness instructor and Psychologist.

24.2 All staff complete mandatory training in line with Trust guidelines.

24.3 Staff on the unit are trained in psychological therapies and complimentary therapies and work to deliver a comprehensive 7 day therapeutic programme to all patients.

24.4 All substantive staff receive regular supervision in line with trust guidelines and yearly appraisals

24.5 All staff working on the unit receive a local ward orientation and induction including the commencement of ward specific competencies in regards to baby care. (Appendix 6, 7 & 8)

24.6 All staff receive training on infant BLS and work with external colleagues i.e Midwife, Health visitor to share knowledge and training on Mental and Physical Health. (Appendix 10, 11 &12)

NHS
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Appendix 1

CPA CLINICAL/SPECIALIST INITIAL BABY CARE PLAN
Service: InPatient Nursing

Service User's Name: **DoB:** **NHS No:**

This care plan is for Baby: **DoB:** **NHS No:**

Assessed Need	Plan/Goal	Implementation/Action Required	Clinical Rationale for Planned Intervention	Evaluation Date
Feeding the baby	To ensure that the baby is feeding regularly.	Being held in a safe manner whilst being fed, closely,safely,securely and makes eye contact. Staff to advise the importance of bringing up babies wind during and after feeds. Follow sterilisation guidelines when making up feeds. Ensure feeds are made up following milk preparation instructions.	So that the baby continues to thrive and grow given the right nutrients and is not at risk of neglect. To minimise discomfort for baby after feeds, help to reduce reflux. To maintain the baby's safety and so the baby is less likely to choke.	Weekly

Baby's overall health	For the baby to be healthy and continue to thrive whilst safety is maintained at all times.	When baby is placed in a rocking chair/bouncer baby is to be strapped in at all times. Both Mother and staff are to promote a good level and quality of sleep for baby.Baby not to sleep in Mothers bed or bouncy chair.Baby put to sleep on their back and with their feet at the bottom of the cot. Only cotton celular blankets to be used. Baby not to be left unattended including in the communal lounge, unless if asleep in their cot. Mother to inform staff should she need to leave baby to attend to other things, so that a member of staff is present at all times with baby. Ensure that baby is not being excessively handled by different people (staff included) on the ward. Identify when attendance for all the appointments for immunisations are due and all	To maintain baby's safety and general well being.	Weekly

		check ups (according to baby's red book). Follow advice and guidence regarding baby not being too close to the television, to protect baby's eyes. Baby is dressed appropriatly.		
Baby's routine	Promote and establish a routine.	Feed/change baby regularly. Establish a bedtime routine. Allow sufficient time for floor play with appropriate aged toys. Play with baby regularly to encourage attachment and bonding.	By establishing a routine it will help baby to feel secure and settled. Regular stimulation is important for baby's growth and development. Allowing time throughout the day for play and interaction can encourage mother and baby attachment and bonding.	Weekly
Baby's Hygiene	Baby's hygiene to be maintained at a high standard.	Baby is to be bathed 2-3 times a week, unless clinically advised not too (this may be due to skin conditions etc). When baby is not being bathed, they should be top and tailed every day. Baby's nappy should be checked before or after a feed and changed when very wet or soiled. Nappies should be changed	To adhere to infection control and to reduce the risk of infection for baby's well-being.	Weekly

		regularly throughout the day and documented on the feed charts. Any prescribed creams for skin conditions should be applied as per instructions.		
Skin care for the baby.	Baby is to have healthy skin and to stop any development of rash or dry skin.	Baby's nappy to be changed regularly and application of any nappy cream if nappy rash is evident. The nappy area should be washed once per day and at other times use cotton wool and water. Make sure that baby's skin is dry all over after washing including skin folds.	Keeping the baby comfortable. To stop any rashes developing.	Weekly
Attachment		To communicate with baby by talking, singing, making eye contact. To respond and anticipate baby's needs. To hold baby safely, securely, caress and speak lovingly to baby.	To develop a secure Mother and baby attachment.	Weekly

Clinician (print name):

Clinician's Designation: Nursery Nurse

Clinician's signature:

Discussed and Shared with Mother:

Date:

Discussed/Shared with Father: (if applicable/appropriate)

Rainbow Mother and Baby unit

Baby Care Plan

My Symbol 

Baby's name: **D.O.B:** **NHS number:**
Mother's name: **D.O.B:** **NHS number:**
Parental responsibility held by:
ALLERGIES: **MEDICATION:**

My Support Bubble	**Who do I live with?** **Social care involvement?** **Other care givers**
Feeding	**How much do I have?** **What do I have?** **When do I have it?** **How is it given to me?** **Where do I have it?** **Safety surrounding feeding**

Physical Health	**Allergies** **Medication/creams** **Red book/immunisations up to date** **Upcoming appointment's** **Any medical investigations** **Medical Conditions**
Sleeping	**What is my sleep routine?** **Do I have comforters?** **Safe sleeping policy** **Where do I sleep**
Development and play	**Where am I in terms of movement and development?** **Appropriate equipment and safety** **What do I like to play?** **What are my next steps**
Personal care	**Nappy changes** **Bath routine/top and tailing** **What cleaning products/creams do I use?**

	What equipment is used in my personal care? **My likes and dislikes**

Nursery nurse name and signature:
Mum given copy:
Dad given copy: (delete if inappropriate)
Date:
Review due:

Appendix 3

CPA Mother and Baby assessment

Service User's Name: **DOB:** **NHS No:**

Baby's Name: **DOB:** **NHS No:**

Date of assessment: _____ **Assessors name and signature**
_____

Feeding	Comments (Please circle or add Risk)
• Holds baby closely, safely, securely and makes eye contact.	Avoidance Hostile Menacing Glancing Appropriate
• Brings wind up appropriately.	Yes No
• Sterilises bottles correctly? • Follows guidelines?	Yes No Yes No
• Follows milk preparations instructions?	Yes No
Baby's health	
• Is Mum aware of safety issues? I.e. strapped in to bouncer or highchair?	Yes No
• Does Mum allow baby to sleep?	Yes No Where?
• Does Mum leave baby unattended inappropriately?	Yes No
• Aware of safe sleeping?	Yes No
• Cares for baby if able? (doesn't pass baby to staff/ others unnecessarily)	Yes No With or without support?
• Attends baby's health appointments and immunisations?	Yes No Red book on unit? Last immunisations?
• Is baby dressed appropriately?	Yes No
Baby Routine	
• Do Mum and baby have an established routine?	Yes No
• Allows time for play and interaction?	Yes No
• Do Mum and baby have a bond (secure attachment)	Yes No Positive? Negative?
Baby's hygiene	
• Is baby top and tailed or bathed appropriately?	Yes No
• Are nappies changed regularly?	Yes No
• Is the nappy area cleaned thoroughly and appropriately? (i.e. Girls cleaned front to back, cream applied as required)	Yes No Aware of nappy rash?
• Is skin cared for appropriately? i.e. dry skin, rashes, eczema	Yes No
Attachment	
• Does Mum acknowledge baby?	Yes No
• Does Mum communicate with baby?	Yes No Appropriate? Inappropriate?
• Does Mum respond/anticipate baby's needs?	Yes No
• How does Mum hold baby?	Relaxed Safe Anxious Tense Refusal Too tight Willing but unsafe Distant Caresses baby Minimal Rough Harmful

Appendix 4

Development Matters Checklist

Baby's Name

Date of birth **Age on admission**

Development matters	Date my baby achieved this
Personal, social and emotional development	
• Enjoys the company of others and seeks contact with others from birth.	
• Gazes at faces and copies facial movements. e.g. sticking out tongue, opening mouth and widening eyes.	
• Responds when talked to, for example, moves arms and legs, changes facial expression, moves body and makes mouth movements.	
• Recognises and is most responsive to main carer's voice: face brightens, activity increases when familiar carer appears.	
• Responds to what carer is paying attention to, e.g. following their gaze.	
• Likes cuddles and being held: calms, snuggles in, smiles, gazes at carer's face or strokes carer's skin.	
• Seeks to gain attention in a variety of ways, drawing others into social interaction.	
• Builds relationships with special people.	
• Is wary of unfamiliar people.	
• Interacts with others and explores new situations when supported by familiar person.	
• Shows interest in the activities of others and responds differently to children and adults, e.g. may be more interested in watching children than adults or may pay more attention when children talk to them.	
• Laughs and gurgles, e.g. shows pleasure at being tickled and other physical interactions.	
• Uses voice, gesture, eye contact and facial expression to make contact with people and keep their attention	
• Enjoys finding own nose, eyes or tummy as part of naming games.	
• Learns that own voice and actions have effects on others.	
• Uses pointing with eye gaze to make requests, and to share an interest.	
• Engages other person to help achieve a goal, e.g. to get an object out of reach	
• Is comforted by touch and people's faces and voices.	
• Seeks physical and emotional comfort by snuggling in to trusted adults.	

• Calms from being upset when held, rocked, spoken or sung to with soothing voice.	
• Shows a range of emotions such as pleasure, fear and excitement.	
• Reacts emotionally to other people's emotions, e.g. smiles when smiled at and becomes distressed if hears another child crying.	
• Uses familiar adult to share feelings such as excitement or pleasure, and for 'emotional refuelling' when feeling tired, stressed or frustrated.	
• Growing ability to soothe themselves, and may like to use a comfort object.	
• Cooperates with caregiving experiences, e.g. dressing.	
• Beginning to understand 'yes', 'no' and some boundaries.	
Communication and language	
• Turns toward a familiar sound then locates range of sounds with accuracy.	
• Listens to, distinguishes and responds to intonations and sounds of voices.	
• Reacts in interaction with others by smiling, looking and moving.	
• Quietens or alerts to the sound of speech.	
• Looks intently at a person talking, but stops responding if speaker turns away.	
• Listens to familiar sounds, words, or finger plays.	
• Fleeting Attention – not under child's control, new stimuli takes whole attention	
• Moves whole bodies to sounds they enjoy, such as music or a regular beat.	
• Has a strong exploratory impulse.	
• Concentrates intently on an object or activity of own choosing for short periods.	
• Pays attention to dominant stimulus – easily distracted by noises or other people talking.	
• Stops and looks when hears own name.	
• Starts to understand contextual clues, e.g. familiar gestures,	

words and sounds.	
• Developing the ability to follow others' body language, including pointing and gesture.	
• Responds to the different things said when in a familiar context with a special person (e.g. 'Where's Mummy?', 'Where's your nose?').	
• Understanding of single words in context is developing, e.g. 'cup', 'milk', 'daddy'	
• Communicates needs and feelings in a variety of ways including crying, gurgling, babbling and squealing.	
• Makes own sounds in response when talked to by familiar adults.	
• Lifts arms in anticipation of being picked up.	
• Practises and gradually develops speech sounds (babbling) to communicate with adults; says sounds like 'baba, nono, go-go'.	
• Uses sounds in play, e.g. 'brrrm' for toy car.	
• Uses single words.	
• Frequently imitates words and sounds.	
• Enjoys babbling and increasingly experiments with using sounds and words to communicate for a range of purposes (e.g. teddy, more, no, bye-bye.)	
• Uses pointing with eye gaze to make requests, and to share an interest.	
• Creates personal words as they begin to develop language.	
Physical development	
• Turns head in response to sounds and sights.	
• Gradually develops ability to hold up own head.	
• Makes movements with arms and legs which gradually become more controlled.	
• Rolls over from front to back, from back to front.	
• When lying on tummy becomes able to lift first head and then chest, supporting self with forearms and then straight arms.	
• Watches and explores hands and feet, e.g. when lying on back lifts legs into vertical position and grasps feet.	
• Reaches out for, touches and begins to hold objects.	
• Explores objects with mouth, often picking up an object and holding it to the mouth.	
• Sits unsupported on the floor.	
• When sitting, can lean forward to pick up small toys.	
• Pulls to standing, holding on to furniture or person for support.	
• Crawls, bottom shuffles or rolls continuously to move around.	
• Walks around furniture lifting one foot and stepping sideways (cruising), and walks with one or both hands held by adult.	
• Takes first few steps independently.	

• Passes toys from one hand to the other.	
• Holds an object in each hand and brings them together in the middle, e.g. holds two blocks and bangs them together.	
• Picks up small objects between thumb and fingers.	
• Enjoys the sensory experience of making marks in damp sand, paste or paint.	
• Holds pen or crayon using a whole hand (palmar) grasp and makes random marks with different strokes	
• Responds to and thrives on warm, sensitive physical contact and care..	
• Expresses discomfort, hunger or thirst.	
• Anticipates food routines with interest	
• Opens mouth for spoon.	
• Holds own bottle or cup.	
• Grasps finger foods and brings them to mouth.	
• Attempts to use spoon: can guide towards mouth but food often falls off.	
• Can actively cooperate with nappy changing (lies still, helps hold legs up).	
• Starts to communicate urination, bowel movement.	

Appendix 5

Rainbow Mother and Baby Unit Milk Feed and Sterilisation Chart

Please use a new sheet for each day

Date:

Breast/Formula:

Baby's Name: **Mum's Name:** **Amount of feed:**

Time bottles sterilised:	Time Feed Finished:	Amount of feed taken	Feed By:	Solids Taken	Nappy Change Soiled (S) Wet (W) Dry (D)	Comments
		Total ounces:				

Appendix 6

MOTHER AND BABY FACILITIES

'WORKING WITH BABIES' – CORE COMPETENCIES

The following competencies equate with NVQ Level 2 'Working with Babies'. However, they are expected to be met by all grades of staff working on the ward who provide care for Mothers and their Babies.

Feeding Babies

Sterilisation of Feeding Equipment

- The principles of sterilisation and different methods of sterilisation
- The differences between sterilisation and social cleanliness
- Methods of cleaning feeding equipment other than sterilisation

Making Up Formula Feeds for Babies

- The typical feeding requirements of babies at different stages – birth to 6 months
- Typical patterns of feeding for babies – birth to 6 months
- The different types of milk required for cultural, religious or medical reasons
- The storage properties of made up feeds
- The adverse effects if feeds are not properly made up
- Different methods of heating made up feeds

Bottle Feeding a Baby

- The importance of a suitable environment for feeding
- The importance of interaction/communication with babies before, during and after feeding
- The importance of winding and settling the baby after feeds
- Why some babies have difficulties with feeding and how to overcome common difficulties
- Specialised equipment for babies with special needs and how and where to obtain it
- Dangers and problems associated with feeds

Spoon Feeding a Baby

- The process of weaning and current medical advice on when weaning should be started
- Methods of food preparation and associated hygiene and safety requirements
- What constitutes a balance diet for babies up to 6 months and how and when to introduce new foods

General Baby Care – Development and Stimulation

- A basic knowledge of the growth and development of babies – birth to 6 months
- The needs and requirements of young babies in relation to physical care and how these needs can be met
- Effective ways of handling babies both for safety and encouraging interaction
- The way that caring for babies may vary with different cultures
- The importance of communication and stimulation to the development of babies up to 6 months

- The importance of a safe, clean environment for babies

Bathing a Baby

- The general health and safety requirements when bathing babies from birth to 6 months
- Why different parts of the body are bathed separately
- Why particular attention is paid to creases and folds in the skin
- The importance of bathtime as a sensory and pleasurable experience for babies
- How babies react to water at different ages
- The range and suitability of bathing equipment and toiletries

Changing Nappies

- The common skin conditions and variations in bowel and bladder action which need to be reported
- Different types of nappies and how to apply them
- Importance of regular nappy changing
- Range, application and suitability of toiletries

Child Protection

- Awareness of Child Protection issues
- Awareness of the Trust policies in relation to Child Protection

Recognising the Sick Baby

- Signs and symptoms of a sick baby
- Action to be taken if the baby appears unwell
- Basic paediatric resuscitation skills

Appendix 7

GUIDELINES – BABY HYGIENE

Have everything you need to hand in advance of bathing baby – towel, toiletries, clean nappy and clothes. It is not safe to leave a baby or toddler alone in water for even a second.

Put cold water in the tub first and then hot. This reduces the chance of scalds. Test the water with your elbow ***before*** you put the baby in the tub (as hands can bear very high temperatures). The water should feel comfortably warm.

Step-by-Step Bathing

- Undress the baby.
- Lower the baby feet first into the water, supporting their head and neck at all times.
- With your free hand, gently splash water over the baby's body.
- Keep talking to the baby for reassurance and to let them know they are safe.
- When you have finished, take the baby out of the tub, wrap them in a towel and then dress them.

If the baby is upset or is clearly not enjoying the bath, stop and try again a few days later.

You can use a mild soap or a baby bath liquid. For newborns, no soap is necessary.

Washing Hair

If the baby has lots of hair, it helps to use a jug to rinse the water through. You can use a mild baby shampoo as it is good for the scalp, but soap will do for the amount of hair they have. Be careful not to get the soap/shampoo in the baby's eyes.

The baby does not 'need' to bath in the first weeks (see 'Top and Tail Cleaning' below).

Top and Tail Cleaning

Top and tailing is an alternative to bathing for the very young baby.

You need –

- Cotton wool swabs or two cloths
- Bowl of warm water
- Fresh nappy and clean clothes, if necessary
- Bin or bucket for waste

Step by Step Top and Tailing

- Undress the baby, but leave the nappy on.
- Wipe the baby's face, neck and ears with a damp cloth or damp cotton wool you have made wet with the water in the bowl. Dry with cotton wool or the other cloth.
- Wipe the baby's hands and under their arms in the same way.
- Remove the nappy.
- With a newborn baby, wash any discharge from the cord stump.
- Wash the bottom and the genitals well (wipe girl's from front to back to avoid spreading infection from the bottom to the vagina).
- Dry the baby.
- Put a clean nappy on the baby and replace their clothes.

Appendix 8

ESSEX PARTNERSHIP UNIVERSITY TRUST

'WORKING WITH BABIES' – CORE COMPETENCIES ATTAINMENT RECORD

Name (printed)	

Unit	***Title***	***Underpinning Knowledge***	***Practical Observation***	***Practical Performance***
1	Sterilisation of Feeding Equipment	Signature ……. Date ……	Signature ……. Date ……	Signature …… Date……...
2	Making Up Formula Feeds for Baby	Signature ……. Date ……	Signature ……. Date ……	Signature ……. Date ……
3	Bottle Feeding a Baby	Signature ……. Date ……	Signature ……. Date ……	Signature ……. Date ……
4	Spoon Feeding a Baby	Signature ……. Date ……	Signature ……. Date ……	Signature ……. Date ……
5	General Baby Care –Development and Stimulation	Signature ……. Date ……	Signature ……. Date ……	Signature ……. Date ……
6	Bathing a Baby	Signature ……. Date ……	Signature ……. Date ……	Signature ……. Date ……
7	Changing Nappies	Signature ……. Date ……	Signature ……. Date ……	Signature ……. Date ……
8	Child Protection	Signature ……. Date ……	Signature ……. Date ……	Signature ……. Date ……
9	Recognising the Sick Baby	Signature ……. Date ……	Signature ……. Date ……	Signature ……. Date ……
10	Safe sleeping	Signature ……. Date ……	Signature ……. Date ……	Signature ……. Date ……

Appendix 9

ESSEX PARTNERSHIP UNIVERSITY TRUST

MOTHER AND BABY UNIT
PRE DISCHARGE CHECKLIST

Mother's name	
Baby's name	

Mother's admission address	
Mother's admission date	

DISCIPLINE & ADDRESS	*INFORMED (✓)*	*DATE & METHOD*	*COMMENTS*
General Practitioner			
Health Visitor			
Midwife			
Social Worker			
CPN			
Other			

Mother's discharge date	
Mother's discharge address	

Appendix 10

NICE CLINICAL GUIDELINE 37

LIFE-THREATENING CONDITIONS IN WOMEN		
Possible Sign/Symptom	***Evaluate For***	***Action***
Sudden or profuse blood loss, or blood loss and signs/symptoms of shock, including tachycardia, hypotension, hypoperfusion, change in consciousness.	Postpartum haemorrhage	***EMERGENCY ACTION***
Offensive/excessive vaginal loss, tender abdomen or fever. If no obstetric cause, consider other causes.	Postpartum haemorrhage/ sepsis/other pathology	***URGENT ACTION***
Fever, shivering, abdominal pain and/or offensive vaginal loss. If temperature exceeds 38ºC repeat in 4-6 hours. If temperature still high or other symptoms and measurable signs, evaluate further.	Infection/genital tract sepsis	***EMERGENCY ACTION***
Severe or persistent headache.	Pre-eclampsia/ eclampsia	***EMERGENCY ACTION***
Diastolic BP is greater than 90 mm Hg and accompanied by another sign/symptom of pre-eclampsia.	Pre-eclampsia/ eclampsia	***EMERGENCY ACTION***
Diastolic BP is greater than 90 mm Hg and no other sign/symptom, repeat BP within 4 hours. If it remains above 90 mm Hg after 4 hours, evaluate.	Pre-eclampsia/ eclampsia	***EMERGENCY ACTION***
Shortness of breath or chest pain.	Pulmonary embolism	***EMERGENCY ACTION***
Unilateral calf pain, redness or swelling.	Deep vein thrombosis	***EMERGENCY ACTION***

EMERGENCY ACTION: Life threatening or potentially life-threatening situation.

URGENT ACTION: Potentially serious situation, which needs appropriate action

Appendix 11

COMMON HEALTH PROBLEMS IN WOMEN	
Health Problem	***Action***
Baby blues	If symptoms not resolved after 10-14 days, assess for postnatal depression and, if symptoms persist, evaluate further. ***URGENT ACTION***
Perineal pain, discomfort, stinging, offensive odour or dyspareunia	Offer to assess the perineum. Evaluate for signs of infection, inadequate repair, wound breakdown or non-healing. ***URGENT ACTION*** Advise use of topical cold therapy and paracetamol (in not contra-indicated), but if neither are effective consider oral or rectal non-steroidal anti-inflammatory drug. ***NON URGENT ACTION***
Dyspareunia	In cases of perineal trauma, offer to assess the perineum (see row above). Advise use of water-based lubricant. If problem persists, evaluate further. ***NON URGENT ACTION***
Headache	Advise women who have had epidural/spinal anaesthesia to report severe headache. For tension/migraine headaches, offer advice on relaxation and avoiding factors associated with headache. For mild headache follow local protocols.
Persistent fatigue	Ask about general well-being and offer advice on diet, exercise and planning activities. If it affects a woman's care of herself or baby, evaluate underlying cause. Measure haemoglobin level and, if low, treat according to local policy.
Backache	Manage as general population.
Constipation	Assess diet and fluid intake. If changes in diet are ineffective advise use of a gentle laxative.
Haemorrhoids	If haemorrhoids are severe, swollen or prolapsed, evaluate. ***URGENT ACTION*** Otherwise advise dietary measures to avoid constipation and manage according to local protocol.
Faecal incontinence	Assess severity, duration and frequency. If symptoms don't resolve, evaluate further. ***URGENT ACTION***
Urinary incontinence	Teach the woman to do pelvic floor exercises and, if symptoms don't improve or get worse, evaluate.
Urinary retention (within 6 hours of birth)	Advise methods of assisting urination such as taking a warm bath or shower. If this doesn't work, assess bladder volume and consider catheterisation. ***URGENT ACTION***

URGENT ACTION: Potentially serious situation, which needs appropriate action

NON URGENT ACTION: Continue to monitor and assess

Appendix 12

COMMON BREASTFEEDING CONCERNS	
Concern	**Action**
Cracked or painful nipples	Assess attachment and positioning. If pain persists, consider thrush.
Engorged breasts	Advise frequent unlimited feeding, breast massage, hand expression, analgesia and that the woman has a well-fitting bra.
Mastitis	Offer assistance with attachment and positioning and advise woman to continue breastfeeding/hand expression, gently massage affected breast(s), take paracetamol and increase fluid intake. Advise woman to contact you urgently if it lasts more than a few hours.
Mastitis lasting more than a few hours	Consider antibiotics. ***URGENT ACTION***
Inverted nipples	Give extra breastfeeding support.
Breastfeeding concerns despite review of attachment and positioning	Evaluate for ankyloglossia. ***URGENT ACTION***
Perceived breastmilk insufficiency	Reassure woman, review attachment and positioning and evaluate baby's health.
Sleepy baby	Advise skin-to-skin contact or massage of baby's feet. If no improvement, assess general health.

URGENT ACTION: Potentially serious situation, which needs appropriate action

Appendix 13

GUIDELINES – UNWELL BABY

How to Tell if a Baby is Unwell

Sometimes it can be difficult to know what is wrong if a baby seems unwell or distressed. Here are some signs that can be important to look for –

- The baby is not responding normally
- When awake, the baby may seem unusually drowsy or not interested in looking at you
- The baby may not be interested in feeding
- The baby feels floppy or limp (perhaps when cuddled)
- The baby's cry seems different (perhaps moaning, whimpering or shrill) and soothing doesn't help

If you think you notice these in the baby, seek further advice and talk to a senior nurse. If you are already worried and then notice other problems too (such as those in the list below), medical advice must be sought.

- If the baby looks very pale
- If the baby seems irritable and does not like being touched
- If a new rash starts to appear
- If the baby's skin looks bruised or discoloured
- If the baby seems hot (feverish or has a high temperature)
- If the baby seems breathless or is breathing much faster than usual
- If the baby starts being sick (vomiting)
- If the baby's nappies are not wet or they are less wet than normal
- If the baby is drooling excessively instead of swallowing their own saliva
- If the baby is three months old or younger or was born prematurely
- If the baby has a tense or bulging soft spot on the head (fontanelle)

Babies and young children often have minor illness which you do not need to worry about. Make sure the baby drinks plenty of fluids and is not too hot.

If may be difficult to judge whether an illness is more serious, requiring medical attention.

If the baby has any of the following symptoms, there may be a serious illness –

- A high pitched or weak cry, is less responsive, is much less active or more floppy than usual.
- Looks very pale all over, grunts with each breath, has obvious dips in the upper thoracic upper medical aspect (upper centre of chest) or between the ribs as they breath.
- Takes less than a third of usual fluids, passes much less urine than usual, vomits green fluids or passes blood in their nappy. Infants should have at least three wet nappies per day (24 hour period).
- Has a high fever with sweating.

Seek medical advice early and quickly.

Appendix 14

HEALTH PROBLEMS IN BABIES	
Health Problem	**Action**
Jaundice in first 24 hours	***EMERGENCY ACTION***
Jaundice in babies aged 24 hours or more	Monitor, record jaundice and overall well-being, hydration and alertness.
Jaundice in babies starting aged 7 days or lasting longer than 14 days	***URGENT ACTION***
Significantly jaundiced or unwell babies	Evaluate serum bilirubin.
Jaundice in breastfeeding babies	Advise frequent breastfeeding, waking the baby to feed if necessary; routine supplementation is not recommended.
Thrush	Offer information and guidance on hygiene. If symptoms are causing pain to the woman or baby, treat with antifungal medication.
Nappy rash	Consider hygiene and skin care, sensitivity, infection (for example, thrush).
Persistent painful nappy rash	Consider antifungal treatment. If it doesn't resolve, evaluate further. ***NON URGENT ACTION***
No meconium in first 24 hours	***EMERGENCY ACTION***
Constipation in formula fed baby	Evaluate feed preparation, quantity, frequency and composition. ***URGENT ACTION***
Diarrhoea	Evaluate. ***URGENT ACTION***
Excessive inconsolable crying	Reassure parents and assess general health, antenatal and perinatal history, onset and length of crying, nature of stools, feeding, woman's diet if breastfeeding, family allergy, parent's response, factors making crying better/worse. ***URGENT ACTION***
Colic	Advise parents that holding their baby during the crying episode and peer support may be helpful. Dicycloverine should not be used.
Colic in formula fed babies	Consider use of hypoallergenic formula.
Unwell baby	A full assessment, including physical examination, should be undertaken. Take temperature and if it is above 38ºC, evaluate cause. ***EMERGENCY ACTION***

EMERGENCY ACTION: Life threatening or potentially life-threatening situation.

URGENT ACTION: Potentially serious situation, which needs appropriate action

NON URGENT ACTION: Continue to monitor and assess

Appendix 15

Fever in under 5's
Clinical guideline CG160

This guidance is based on an abstract from the above NICE guidelines.

Feverish illness in young children usually indicates an underlying infection and is a cause of concern for parents and carers. Feverish illness is very common in young children, with between 20 and 40% of parents reporting such an illness each year. As a result, fever is probably the commonest reason for a child to be taken to the doctor. Feverish illness is also the second most common reason for a child being admitted to hospital. Despite advances in healthcare, infections remain the leading cause of death in children under the age of 5 years.

Fever in young children can be a diagnostic challenge for healthcare professionals because it is often difficult to identify the cause. In most cases, the illness is due to a self-limiting viral infection. However, fever may also be the presenting feature of serious bacterial infections such as meningitis or pneumonia. A significant number of children have no obvious cause of fever despite careful assessment. These children with fever without apparent source are of particular concern to healthcare professionals because it is especially difficult to distinguish between simple viral illnesses and life-threatening bacterial infections in this group.

- **Management by the non-paediatric practitioner**
- If any 'amber' features are present and no diagnosis has been reached, provide parents or carers with a 'safety net' or refer to specialist paediatric care for further assessment. The safety net should be 1 or more of the following:
    - providing the parent or carer with verbal and/or written information on warning symptoms and how further healthcare can be accessed (see section 1.7.2)
    - arranging further follow-up at a specified time and place
    - liaising with other healthcare professionals, including out-of-hours providers, to ensure direct access for the child if further assessment is required. **[2007]**

The following table is to assist practitioners in assessing the infant and as a guide to potential seriousness:

All staff with any concern regarding a babies level of wellness will record the baby's temperature and contact the ward doctor in hours or duty doctor out of hours. It is recognised that the unit and unit staff do not have all necessary training or equipment to conduct all appropriate tests therefore the doctor will liaise with paediatric department as needed.

NICE National Institute for Health and Care Excellence

Traffic light system for identifying risk of serious illness

	Green – low risk	Amber – intermediate risk	Red – high risk
Colour (of skin, lips or tongue)	• Normal colour	• Pallor reported by parent/carer	• **Pale/mottled/ashen/ blue**
Activity	• Responds normally to social cues • Content/smiles • Stays awake or awakens quickly • Strong normal cry/not crying	• Not responding normally to social cues • No smile • Wakes only with prolonged stimulation • Decreased activity	• **No response to social cues** • **Appears ill to a healthcare professional** • **Does not wake or if roused does not stay awake** • **Weak, high-pitched or continuous cry**
Respiratory		• Nasal flaring • Tachypnoea: – RR >50 breaths/ minute, age 6–12 months – RR >40 breaths/ minute, age >12 months • Oxygen saturation ≤95% in air • Crackles in the chest	• **Grunting** • **Tachypnoea: RR >60 breaths/minute** • **Moderate or severe chest indrawing**
Circulation and hydration	• Normal skin and eyes • Moist mucous membranes	• Tachycardia: – >160 beats/minute, age <12 months – >150 beats/minute, age 12–24 months – >140 beats/minute, age 2–5 years • CRT ≥3 seconds • Dry mucous membranes • Poor feeding in infants • Reduced urine output	• **Reduced skin turgor**
Other	• None of the amber or red symptoms or signs	• Age 3–6 months, temperature ≥39°C • Fever for ≥5 days • Rigors • Swelling of a limb or joint • Non-weight bearing limb/not using an extremity	• **Age <3 months, temperature ≥38°C*** • **Non-blanching rash** • **Bulging fontanelle** • **Neck stiffness** • **Status epilepticus** • **Focal neurological signs** • **Focal seizures**

CRT, capillary refill time; RR, respiratory rate
*Some vaccinations have been found to induce fever in children aged under 3 months

This traffic light table should be used in conjunction with the recommendations in the NICE guideline on Feverish illness in children.
See http://guidance.nice.org.uk/CG160

'Feverish illness in children', NICE clinical guideline 160 (May 2013)

Appendix 16

RISK MANAGEMENT
POLICY FOR THE PREVENTION OF BABY ABDUCTION
In patient only

POLICY STATEMENT

This Policy addresses the prevention of baby abduction for babies who are residing in the Mother and baby unit, the suspicion of baby abduction and actual abduction. This policy applies to all staff working within the Rainbow unit. It also includes clinical staff in adjacent units, communications staff, Trust Executive, corporate and senior clinical staff attending the unit.

Infant/child abduction is a criminal offence and therefore, the police will have overall authority and assume responsibility for the investigation and management of the incident and recovery of the child. On arrival on the scene the Senior Police Officer will assume the role of Incident Co-ordinator and direct events from this time.

SCOPE

1. To ensure that systems are in place to reduce the risk of baby abduction.
2. To ensure that, should the preventative measures fail, systems are in place to assist the police to apprehend the abductor.
3. To ensure that the parents and their families are given maximum support and information.
4. To ensure that the remaining Mothers, their babies and families are supported and their environment remains secure.
5. To ensure that communication channels are effective and consistent. (Form 3)
6. To ensure that in the event of any attempted/actual abductions security measures are reviewed.

1. **PREVENTION**

1.1 Mothers

All mothers must be given information regarding baby security measures within the Unit.

a) The Baby identification Policy (Form 6)
b) That the safety of the baby is maximised if s/he is in the Mother's bedroom.
c) All persons in contact with her or her baby must be either known to her, eg family or friend or wearing a valid ID badge.
d) If neither of these conditions apply, she must alert the staff.

1.1.2 Clinical Staff

a) All clinical staff and healthcare professionals attending the unit must adhere to the identification of babies Policy (Form 6)
b) The ward staff must not allow other Trust employees or outside contractors onto the

ward unless they are wearing a valid ID badge.

2. SUSPICION OF, OR ACTUAL BABY ABDUCTION

General Principles

Time is critical - It is essential that all staff utilise their personal alarm system to raise the alarm in the event of an abduction incident at the earliest opportunity.

There is controlled access via Access Control System to all doors allowing access and egress from the Mother and baby unit.

2.1 THIS IS A SERIOUS INCIDENT AND ALL STAFF MUST RESPOND IMMEDIATELY.
2.2 After an initial check with the mother , the senior member of staff on the ward must immediately ring 9-999 and inform them of a 'BABY ABDUCTION'.
2.3 The Senior nurse in charge of the unit where baby has been abducted must liaise with the ward manager and co-ordinate a thorough search of the immediate area and stop the flow of all traffic. (Form 1, Form 2). CCTV coverage to be utilised. (Clinical Manager must be informed of incident)
2.4 The Police must be informed immediately if the search is negative (flow chart)
2.5 Once an abduction is confirmed, the seminar room must be utilised as an initial Incident Room
2.6 The unit must be secured by clinical staff and all entrances monitored. (Form 4)
2.7 The Ward or Clinical Manager must arrange for the Mother/ parents to transfer to a designated area away from other patients
2.8 If false alarm, cancellation of the process must be by the Ward Manager or senior manager. (Form 1)
2.9 The Ward Manager must contact safeguarding lead and Director of specialist Services (on call Director out of hours).

3. REVIEW PROCEDURES

3.1 Reviews of security must be carried out annually including the lockdown procedure.
3.2 Reviews must be carried out by the Clinical Manager, Associate Director of Corporate Governance and Risk Management and Trust Security Adviser.

Form 1

Ward Manager /Out of hours Duty Manager Duties

1. The Nurse in charge of the Unit must co-ordinate the initial search whilst Ward manager contacts support staff

2. The Ward Manager must inform Area Director or their deputy of the possibility of abduction.

3. Out of hours the Duty Manager must be informed and must act until the Clinical manager arrives.

4. If a negative search results, the Manager must activate raise the alarm and ensure all relevant staff are alerted as soon as possible

5. The Ward or Clinical Manager must establish the initial Incident Room within the Linden centre.

6. The Ward or Clinical Manager must liaise with other Managers, Personnel and Police on arrival.

7. The Ward or Clinical Manager must receive update reports from Security that unit is secure and that visual vetting is being conducted and recorded at all entrances.

8. The Clinical Manager must liaise with the Director of Nursing and Quality and the Police regarding publicity.

9. The Communications team will be asked to arrange an initial rendezvous point for press.

10. The Ward or Clinical Manager must ensure that after the initial search a second and more exacting search is undertaken.

11. The Ward or Clinical Manager must retain all staff until they are dismissed by Police.

12. The Ward and Clinical Manager must ensure the continued smooth running of the Unit and consider counselling for the staff and other Mothers.

13. In the event of a false alarm, the process must be cancelled by the Clinical Manager in consultation with the relevant Director.

Form 2

SECURITY NURSE

1. Security Nurse will be designated to secure doors and stop flow of traffic in line with Lockdown procedure.

2. The immediate area where the abduction occurred must remain secure until Police have released the area back for clinical use.

3. If a negative search results:

- Use all available staff to secure Mother and Baby Unit
- Direct one competent person to review CCTV footage and scrutinise visitors log. Contact Trust Security Adviser in relation to this.
- Liaise with Police and deliver appropriate video tapes.
- Organise personnel deployment at all entrances, exits and car park barriers (in and out) for visual inspections of all persons and vehicles. Ensure details are recorded on the 'Baby Abduction Log Sheet'. (Form 5)

Form 3

Communication's Officer Duties

In the event of the communications officer being unavailable, the duties must be assumed or delegated by the Trust Executive Manager.

1. Any release of information concerning an infant should be jointly planned and agreed upon by the Trust and the police, and issued through the Communications Officer/ Director of Nursing with the consent of the family.

2. Care should be taken to keep the family fully informed.

3. The Communications Officer/Director of Nursing must contact the local media and invite them to come to a designated media room/area within the Trust premises.

4. The media should be provided with accurate information about the incident and asked to co-operate by requesting the assistance of the public in recovering the infant. They should also be requested to respect the privacy of the family.

5. Only information agreed and approved between the Trust and the police will be released.

6. The Communications Officer must prepare a written response which the contact centre may use to outside callers, including anxious parents who have a baby in the unit.
   In exceptional circumstances, particularly anxious parents can be put through to the Duty Manager.

7. The Communications Officer must produce information for circulation to other hospitals, GP surgeries and Registry Offices or anywhere where the abductor may take the child in an attempt to register the birth, or have the baby examined or obtain any benefits.

8. Once an initial statement has been made to the media, updates should be given at regular intervals in the designated media room. Consider the possibility of a press conference as media interest is likely to be quite intense and thus generate maximum publicity.

Form 4

SUSPECTED BABY ABDUCTION PROCEDURE
SECURITY ACTION PLAN

On the alarm being raised that there is a suspected abduction an initial internal search of immediate units and grounds must have been completed by all available staff where the abduction occurred. Staff from adjacent wards may be asked to conduct the search of a designated area.
Your role will be to establish and maintain communications, secure the unit, examine vehicles and occupants leaving that area, maximise CCTV coverage and review recordings.

WARD or CLINICAL MANAGER - CONTROL ROOM OFFICER DUTIES – ABDUCTION

1.The clinical manager must ensure that the front entrance and the vetting of people entering and leaving – this should be recorded using the baby abduction log sheet Form 5.

2. All relevant actions and deployments must be clearly printed on a dry wipeboard.

3. As incident room liaison officer, every assistance must be given to the duty On call Manager.

4. Alert Service Director (on call Director out of hours) and request additional personnel to report to control room for deployment and radio issue as appropriate.

Form 5

BABY ABDUCTION LOG SHEET

You are not required to search people beyond a visual examination.

Date		**Time**		**Location**	
Name					
Address					
Description of Outer Clothing					
Reg No		**Colour**		**Make**	
Other					

Date		**Time**		**Location**	
Name					
Address					
Description of Outer Clothing					
Reg No		**Colour**		**Make**	
Other					

Date		**Time**		**Location**	
Name					
Address					
Description of Outer Clothing					
Reg No		**Colour**		**Make**	
Other					

Date		**Time**		**Location**	
Name					
Address					
Description of Outer Clothing					
Reg No		**Colour**		**Make**	
Other					

Form 6

POLICY FOR THE IDENTIFICATION OF BABIES

INTRODUCTION

It is essential that all babies within the Unit are clearly identified from admission until discharge in order to:

- ensure the Mother cares for and is discharged with her own baby.
- to prevent erroneous treatment of the baby by clinical staff.

SCOPE

1 To ensure clear identification of the baby.
2. To ensure the baby is clearly identified throughout its stay in the Unit.
3. To ensure the Mother is discharged with her own baby.
4. To prevent erroneous treatment of the baby.

POLICY STATEMENT

This policy applies to all staff working within the Mother and Baby unit, to ensure babies are clearly identified.

1. **Mother and Baby unit**

1.1 The Nurse in charge responsible for the admission must ensure that the baby has a name tag which should be secured to the Baby's ankle to prevent accidental harm.

The registered nurse must securely attach one to the ankle. This must be done on admission. Department of Health (1994)

1.2 The label must show:

- Mothers name
- Baby's name
- Baby's sex
- Baby's NHS number
- Baby's date of birth

Example: M - Sue Bloggs
B – Lucy Bloggs (F)
NHS – 00000000000
DOB – 01/02/19

1.3 This procedure must be recorded in the Remedy record for the Mother (including the name of the nurse when appropriate) who has checked the labels.

Procedure for the Management of babies accidentally dropped in hospital

Procedure statement

This procedure has been devised in relation to the NHSI patient safety alert for 'Assessment and Management of Babies accidentally dropped in Hospital' and is written to guide all staff working within Rainbow Mother and Baby unit on appropriate actions to take in the event of a Baby being accidentally dropped whilst residing on the unit.

"The risks of accidentally dropping a baby are well known, particularly when a parent falls asleep while holding a baby, or when a parent or healthcare worker holding the baby slips, trips or falls. However, despite healthcare staff routinely using a range of approaches to make handling of babies as safe as possible and advising new parents on how to safely feed, carry and change their babies, on rare occasions babies are accidentally dropped".

"A search of the National Reporting and Learning System for a recent 12 month period identified: 182 babies who had been accidentally dropped in obstetric/midwifery inpatient setting, 66 babies accidentally dropped on paediatric wards and two in mother and baby units in mental health trusts" (eight with significant reported injuries, including fractured skulls and/or intracranial bleeds). Almost all of these incidents occurred when the baby was in the care of parents or visiting family members.

This procedure is to be followed in the event of a baby being dropped/falling from any height but does not cover falls at ground level, where a baby trips, falls at ground level local assessment and management should be followed.

1. **Initial stabilisation, assessment and management**

   In the event of a baby being dropped staff should respond to the incident immediately, summoning assistance from ward colleagues pending assessment

   It is likely that in the event of a baby being dropped while in Mother or family members care that they will of instinctively picked baby up, staff should immediately check if baby is conscious

   If baby is conscious and appears alert staff should assess for obvious signs of injury considering cuts, bruising, bleeding, clear fluid from the ear or nose, vomiting, swelling of the fontanel. The lead staff member should instruct a colleague to contact the ward/on call doctor immediately for an urgent attendance

Staff in consultation with the doctor should request an ambulance.

If baby is unconscious or presents in an altered state staff should place baby on a stable surface and follow Paediatric Basic Life support assessment and intervention as per local policy. Staff should summon immediate assistance by activating the internal emergency alarm system. Staff should contact emergency services via (9) 999 to request ambulance response and call the ward/on call doctor for immediate attendance and assistance

Staff will lead in the care of baby recognising the impact this will likely have on Mother/extended family and should ensure that a member of staff is allocated to support Mother throughout

It is recognised that spinal protection is largely unmanageable with an infant however staff should ensure that movement of the baby is limited as much as possible and enhanced consideration of baby's head and neck are given at all times, holding baby in a secure manner that prevents sudden movements

A suitably qualified member of staff (as deemed by the Nurse in Charge) should be allocated to remain with the baby throughout

Where possible a member of staff should be allocated to documenting a timeline through the incident making note of items such as time of fall, time ambulance called, doctor called, baby becoming unresponsive, commencing CPR, time ambulance arrived

On arrival of the ambulance staff will hand over lead role to paramedics in attendance once they have confirmed they are ready to intervene but will remain in support

2. Further management and transportation

All baby's following a fall from any height should be referred to Broomfield Hospital for formal medical review

Due to the complexities of conducting a full assessment or monitoring of an infant, all neurological assessment and observations must to be conducted by an appropriately trained and experienced practitioner in infant neurology, therefore it is inappropriate for any infant to remain on Rainbow Mother and Baby unit for monitoring following a fall

In all events following a baby falling from any height the baby should be transported to Broomfield hospital by ambulance to minimise risk of exacerbating any injury

The ward/on call doctor should make every effort to liaise with Broomfield Hospital to make them aware of the transfer, circumstances around the incident and management

thus far either by telephone or sending a written account with staff member dependant on time frame

Every effort should be made for Mother to accompany baby to hospital with the support of ward staff. Staff will remain with Mother and Baby throughout the assessment and any observations to offer support and monitoring of Mothers mental state

In the event that Mother is not able to attend hospital with baby due to mental state or refuses to go with baby staff will escort and remain with baby acting in the best interests of baby (Referring to statutory obligations under Children's Act) until an alternative person with PR (Parental Responsibility) arrives

If Mother is unable or unwilling to attend hospital with baby and is the only legal guardian for the baby staff will liaise with social care to inform them of the situation and that staff are escorting to act in best interests of the baby

3. **Following transfer for medical review**

Ward staff will contact and inform the second parent of baby where applicable and appropriate considering any safeguarding concerns

A comprehensive nursing entry must be entered into the Mothers records

Datix must be completed with a full outline of events and measures taken

Rainbow Mother and Baby unit link Health visitor/midwife as appropriate will be informed of the incident as soon as is practical

Ward staff will inform the allocated social worker ensuring a clear handover of events and keep them updated in regards to monitoring/treatment

Ward staff will raise as a new safeguarding concern if appropriate/applicable

Escorting staff will remain in contact with the unit as much as is possible to ensure clear communication and update is received by the unit

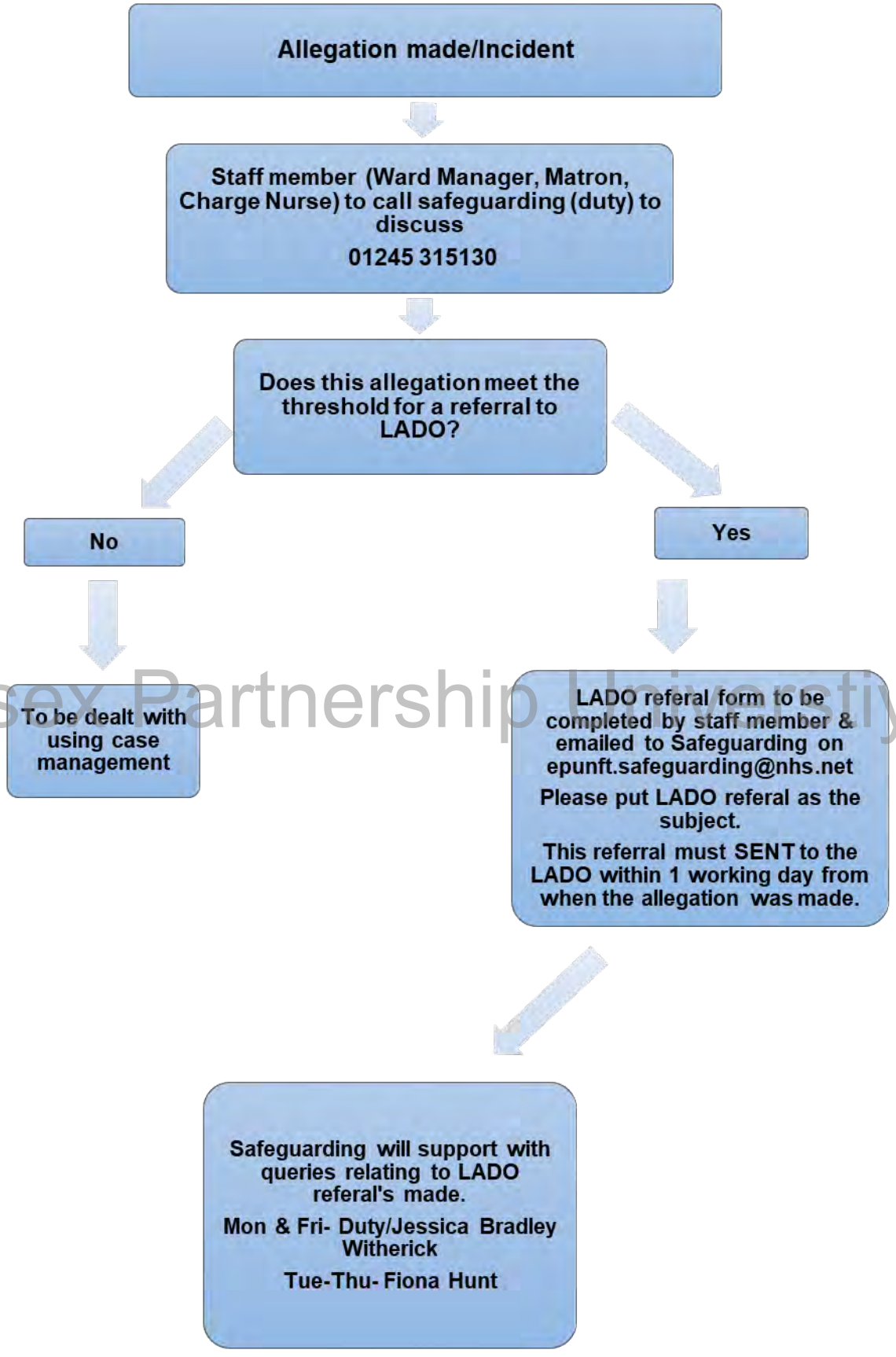
4. **Return to the unit**

If baby is deemed medically fit following attendance to Broomfield Hospital baby and Mother should be escorted back to Rainbow Mother and Baby unit by ward staff

Staff must ensure they have a clear and comprehensive discharge summary from Broomfield Hospital with clear documentation of the fall, investigations and findings prior to returning to the unit.

Staff must ensure they are always working within the remit of their experience and skill set and therefore should not accept a returning baby if baby requires any further monitoring. Any concerns in regards to this should be escalated to the ward/on call doctor and manager on call if needed.

LADO Referral Process



Essex Partnership University
NHS Foundation Trust

VISITING PROTOCOL for the SECURE SERVICES

POLICY NUMBER:	**SSOP 28**
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The Director responsible for monitoring and reviewing this policy is:

The Director of Specialist Services

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

VISITING PROTOCOL for the SECURE SERVICES

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SCOPE

Services	Applicable	Comments
Secure Services Essex	√	
Secure Services Bedfordshire & Luton	√	

VISITING PROTOCOL for the SECURE SERVICES

1.0 INTRODUCTION

1.1 The purpose of this protocol is to provide staff with detailed guidance on the processing and management of visitors to the Secure Services Directorate.

1.2 For the purposes of this protocol a visitor is defined as someone seeking entrance to the secure area who is neither a patient of the secure unit, nor a member of staff employed within the Secure Services Directorate.

1.3 Visitors are divided into the following categories:

1.4 Official Visitors (must be aged 18 years or over)

(i) Employees of the Trust not permanently employed on site who may, as part of their duties, have a regular need to access the secure areas of the Directorate.

(ii) Representatives of official bodies with a mandate to inspect the systems or facilities of the secure unit (this includes MHAC, Hospital Managers, Fire Services, Care Quality Commission etc.).

(iii) Other official visitors (including representatives of statutory organisations e.g. MHRT, other NHS staff, representatives of recognised agencies such as social services departments, probation service, GPs, police service, etc.) who may require occasional and specific access to the secure unit for clinical reasons or for purposes of other business..

(iv) Official visitors attending the secure unit for academic sessions.

(v) Legal representatives (and those instructed by legal representatives), advocates, and spiritual advisors to patients.

(vi) Contractors.

(vii) Students, trainees and researchers.

(viii) Media personnel (where permitted by the Communication Department).

1.5 Social Visitors

Social visitors aged 18 years and over to patients **(see also: CHILD VISITING PROTOCOL for the SECURE SERVICES - SSOP16).**

N.B. Social visitors to staff are not permitted.

2.0 OBJECTIVES

2.1 To ensure appropriate and managed access to clinical areas within the Secure Services Directorate by visitors while maintaining the security of the environment and information held within the directorate; observing the privacy, wellbeing, dignity and safety of patients, staff and visitors alike.

2.2 To uphold statutory responsibilities, national guidance and best clinical practice will be followed.

3.0 REVIEW AND MONITORING

3.1 All secure services staff have a responsibility to ensure that this protocol is followed. Monitoring of the implementation of this protocol is the responsibility of the unit clinical managers and, at Brockfield House, the charge nurse for security.

4.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

4.1 This protocol should be read in conjunction with other protocols in use within the Secure Services Directorate, in particular:

- **Child Visiting Protocol (SSOP16)**
- **Reception Office Protocol (SSOP 27)**
- **Admissions Protocol (SSOP 2)**
- **Storage and Recording of Patients' Property and Possessions (SSOP 37)**
- **Searching of Patients, Property, Areas and Visitors Protocol (SSOP 22)**
- **Key Suiting Protocol (SSOP 6)**
- **Pinpoint Protocol (SSOP18)**
- **Estates and External Contractors Protocol (SSOP 23)**
- **Unit Co-ordinator Protocol (SSOP 30)**
- **Protocol for Non-Trust Clinical Staff (SSOP38**

5.0 PROCEDURES

5.1 All visitors will be treated with dignity, courtesy and respect and welcomed within the directorate. The following procedural guidelines only apply to adult visitors (i.e. visitors over the age of 18). Child visits are managed according to a separate protocol, SSOP16.

5.2 It is the responsibility of all staff to ensure that no visitor is made to feel unwelcome. Staff members who are escorting visitors within clinical areas (e.g. wards and courtyards) must ensure they accompany the visitor at all times. If it has been agreed that the visit to the patient can be unsupervised by staff, contact between the visitor and the escort or security nurse must resume immediately upon completion of the unsupervised interval.

5.3 Notification to Security/ Reception

5.3.1 All staff will give prior notification to Reception of expected visitors by telephone. Staff arranging visits will also advise visitors of the need to produce photographic identification at the initial visit and any other appropriate information e.g. that the bringing in of certain items is prohibited or restricted and that visitors and their property may be subject to a search before being allowed to enter the facility. People wishing to make social visits to patients must agree an arrangement with the ward at least 24 hours in advance and the ward will subsequently notify reception.

5.4 Visiting Times

5.4.1 In general, social visits will only occur at the following times:

Brockfield House : between 18.00 and 20.00 hours (week days) and from 10.00 to 20.00 hours (weekends and bank holidays, but excluding protected meal-times).

Edward House: between 16.00 and 17.00 hours and 18.30 and 20.00 hours (week days) and between 15.00 and 17.00 hours and 18.30 and 20.00 hours (weekends and bank holidays)

Wood Lea Clinic: between 16.00 and 19.30 (week days) and between 10.00 to 19.30 hours (weekends and bank holidays, but excluding protected meal times).

Robin Pinto Unit: between 14.00 and 20.00hrs (week days) and 10.00 to 20.00 (weekends and bank holidays, but excluding protected meal times)

5.4.2 There may, at times, be particular circumstances which dictate that a visit should occur outside of these hours. If this is deemed necessary, then this can be arranged with the ward manager in consultation with the security team.

5.4.3 The general guideline is that the visit duration should not exceed one hour but, where there are justifiable reasons (for example, where the visitor can only visit infrequently or has travelled a long distance) this can be extended with the agreement of the multi-disciplinary team (MDT) and the ward charge nurse / sister / nurse in charge.

5.4.4 Patients will only be allowed to have more than **three** visitors at any one time if requested in advance of the visit and with the agreement of the MDT / nurse in charge. Such an arrangement must be documented.

5.5 Suitable Forms of Identification

5.5.1 All visitors to the secure services at each site will be asked to produce acceptable photographic identification (such as employer's identification or passport or photo-driving licence) upon their first visit to the facility. Where such a form of identification cannot be produced the person/s may be allowed to visit provided they can produce two alternative forms of identification containing their name and current address (e.g. utility bill, bank statement, council tax invoice, etc.) and at the discretion of the Head of Security/Integrated Clinical Leads or Unit Co-ordinator. Without any proof of identity a visitor will only be allowed entry to Brockfield House if they can be positively identified by a permanent member of staff and cleared by the Head of Security and Integrated Clinical Lead or, out of hours, the Unit Co-ordinator. At Wood Lea Clinic, Robin Pinto Unit and Edward House the person delegated with these clearance responsibilities is the charge nurse / sister or nurse in charge.

5.6 Visitor Badges (Brockfield House)

5.6.1 With the exception of EPUT staff (and NHS/ Local Authority/ emergency services personnel who possess their own professional photo ID badge to wear during the visit), all new visitors to Brockfield House will have their photograph taken by reception at the point of their initial visit. This, along with their details, will be held and maintained in a database at reception. Visitors will be expected to wear, at all times whilst visiting Brockfield House, either their service ID badge or the visitors' photo badge they have been issued (see Reception Office Protocol – SSOP 27).

The only exception to this rule is when a ward nurse requests that badges be removed due to the risks on the ward. This can only occur after the security nurse on the ward has seen the badge and is satisfied that the person on the ID badge is the person entering the ward.

5.7 Prohibited Items and Restricted Items

5.7.1 All visitors will be asked by a member of the reception staff to read the list of prohibited and restricted items and will be requested to leave any such items in one of the lockers provided in the reception area for this purpose. Prospective visitors will also be briefed of this requirement, at the time of organising the visit and will also be advised that they may be subject to a pat-down body/clothing search, a search of any belongings and/or metal detector sweep, before entering the secure area. Similarly, visitors should be made aware of this, before the visit. (se Searching of Patients, Property, Areas and Visitors Protocol (SSOP22).

6.0 PROFESSIONAL VISITORS

6.1 **At Brockfield House and Edward House, some EPUT employees not permanently employed on site, and certain other regularly visiting professionals who have a frequent need to access the secure areas of the Directorate (e.g. police liaison officers, dental and primary care practitioners, mental health care advocates, spiritual advisers)** may be issued with keys and alarms subject to the agreement of the senior charge nurse, security and after undertaking the unit's security training. They will be expected to comply with security protocol pertaining to all permanent employees of the unit. **At Robin Pinto Unit,** only permanent staff working at the unit will be issued with keys. At **Wood Lea clinic** only unit-based staff (nursing, therapist and reception personnel) will be allowed keys.

6.2 **Representatives of official bodies with a mandate to perform inspection and regulatory functions within the secure services (including the Care Quality Commission, Hospital Managers, the Fire Service, SOAD doctors and First Tier (Mental Health) Tribunal members etc.)** should be asked to provide official identification and their details should be noted in the record held at reception. Access should be given at any reasonable time for the purposes of exercising inspection and regulatory functions. In the event of an unannounced inspection by such bodies, the service assistant director (or his/her nominated deputy) must be advised immediately by the reception staff of the unit concerned. The nurse in charge (or the unit co-ordinator, out-of-hours) will take responsibility for facilitating the inspectors' access to any clinical area/s visited. These visitors must be attended by a member of staff at all times who will be responsible for conducting them elsewhere in the building. They will not be issued with keys or alarms.

6.3 **Some professional visitors (including representatives of statutory and voluntary agencies, e.g. social services departments, probation and police services) will require *occasional* access to the facility.** Such visits will be made by prior arrangement with a member of staff within the directorate who will be responsible for identifying and establishing the legitimate interest of the visitor and for informing reception and other relevant personnel (e.g. Ward charge nurse/sister) of the time and date of the visit. The secure services directorate staff member will arrange the use of a clinical room, if this is needed. Visitors should be advised to bring and to show appropriate photographic identification. Their details must be noted in the record held at reception. It is a requirement that these visitors be attended by a member of staff at all times during their visit and an identified member

of staff will be responsible for escorting them in the building throughout their visit. They will not be issued with keys but will be offered an alarm if entering patient areas (Refer to Pinpoint Protocol (SSOP18).

6.4 **Visitors attending the secure unit for academic / training sessions, job interviews and similar events.** Where academic, training or other sessions are to be held in the secure unit and are open to attendance from people not employed within the secure services directorate, the person organising the event will ask those who express an interest in attending to indicate, in advance, their attendance. The event organiser is responsible for informing all those attending to bring with them legitimate identification in accordance with 1.3 above. The event organiser will advise reception, in writing, of the event no less than three days prior to it. The event organiser is responsible for putting in place arrangements to escort visitors from main reception to the event venue and for dealing with any latecomers or those wishing to leave the unit before the end of the session. All such visitors will, at no time, be left unaccompanied anywhere in the building. They will not be issued with keys or alarms. All academic and training sessions will be held in non-patient areas and will not involve direct patient contact. Any extension of such visits to ward areas will be at the entire discretion of the ward manager and should be regarded as exceptional. Where such visitors are permitted to visit the wards/patient areas the number in an individual party should not exceed five plus escorts. Wherever possible, patients will be consulted and offered the opportunity not to take part in any meetings with such visitors. These visitors must be attended by a member of staff at all times whilst visiting patient areas. In the case of prospective employees, the extension of visits to ward areas will only usually be considered appropriate for candidates who have been made an offer of employment.

6.5 Legal representatives

6.5.1 Solicitors and other legal executives should be asked, whenever practicable, to make appointments in advance through the relevant ward manager. These visitors will be allowed privacy with the patient at the discretion of the ward manager and clinical team and having regard to the current risk assessment of the patient. A member of staff will be responsible for conducting them within the directorate's premises at all times. They will not be issued with keys. At **Robin Pinto unit** they will be issued a personal alarm at the discretion of the ward charge nurse/sister when entering clinical areas. At **Brockfield House, Edward House and Wood Lea Clinic** such visitors will be offered a personal alarm by main reception staff on entering the site. (See Protocol for Non-Trust Clinical Staff (SSOP38) and Use of Personal Alarms in Secure Services Protocol (SSOP 18)

6.6 Contractors and Facilities/Maintenance Operatives

6.6.1 There are separate protocols, with regard to drawing keys and escorting requirements, for retained maintenance personnel, approved and any other contractors who work within the secure service sites. In some cases they will be required to undergo induction (security) training and will be issued with keys and alarms (for further details, please refer to: *Management of Retained Maintenance Personnel and External Contractors protocol – SSOP 23*)

6.7 Students, Trainees and Researchers

6.7.1 Those students, trainees and researchers undertaking short-term (i.e. less than a total of six days or sessional equivalent) or one-off placements/work within the secure service will be treated as professional visitors under 2.4 above.

6.7.2 All other students, trainees and researchers will be allocated to a supervisor from the permanent staff of the Secure Services Directorate. The supervisor will be responsible for ensuring that the person is suitably qualified and has legitimate interest in undertaking the work placement or research. The supervisor should ensure that proper protocols such as Ethics Committee approval for research are in place, if required. References and a valid Enhanced **DBS** disclosure will usually be required before trainees and researchers can be accepted on placement in the Directorate. Any possible exceptions should be discussed with the senior charge nurse security (or in his or her absence the director or nominated deputy) prior to the proposed start date. (see Non-Trust Clinical Staff Protocol (SSOP38).

6.7.3 The supervisor must also notify the senior charge nurse and security, in writing and at least 28 days prior to the start of the placement/ work, the full name of the student/trainee/researcher, duration and nature of their work, intended office position and must confirm that they are the responsible person for the student/ trainee/researcher throughout the placement/work. The supervisor is additionally responsible for ensuring that the student/ trainee/researcher submits appropriate identification and attends the mandatory security training. The supervisor must ensure that the student/ researcher/trainee return all Trust property (including any Trust identification badge) at the end of the placement/work.

6.8 Media

6.8.1 All proposed visits to the Secure Services Directorate by members of the media (e.g. journalists, documentary researchers, representatives of television, radio or film crews) must be discussed and approved by the senior charge nurse security and the assistant director/clinical director in collaboration with the Trust's Head of Communications.

7.0 SOCIAL VISITORS

7.1 Social Visitors (18 years and over) to Patients

7.1.1 Upon admission to the Directorate, all patients will be asked to provide brief details of anyone that they would like to visit them during their admission. These details will include full name and address of the proposed visitor, contact telephone number and the nature of the relationship (e.g. parent, brother, partner, friend, etc.).

7.1.2 The rationale for this list is to ascertain the identity of visitors, to make certain that the patient is agreeable to contact with a visitor, to ensure the clinical appropriateness of the visit and to have a mechanism for contacting visitors if a scheduled visit has to be altered or cancelled.

7.1.3 The information on proposed visitors will be collated by the allocated social worker who will establish contact with the prospective visitor to confirm the information supplied by the patient, and inform them of the Visiting Protocol and Procedure including restricted items and random searches (see Section 11 below). This will subsequently be reviewed by the clinical team. The clinical team will, in a timely way, approve all visits where there are no grounds to exclude the proposed visitors

(see 8.0 to 10.0 below). Where there are concerns, not amounting to grounds for exclusion, the team may elect to authorise supervised visits and will document these concerns in the patient record, including the nature (and any other conditions) of the supervision deemed necessary. Any initial visit should also be supervised unless deemed unnecessary by the clinical team.

7.1.4 Once agreed or reviewed by the MDT, the information on all permitted social visitors to a patient will be held on the patient's record and main reception will be notified of their names. The responsibility for notifying and updating this list to reception staff lies with the patient's social worker and key nurse. Where a decision is taken to exclude a visitor, this information must also be held on the patient's notes and passed to reception staff. In these circumstances the Responsible Clinician will need to take certain additional steps, as outlined below.

7.1.5 It may be important and desirable that a visit occurs early in the patient's admission prior to there being an opportunity for full clinical team discussion. Where the visitor's application is being considered under this 'fast track' discretion, the social worker must ensure, following collation of information on the proposed visitor, that the application is discussed with the Responsible Clinician and appropriate nursing team member. If approved, the visit must be supervised. The details of the visitor/s will be noted on the appropriate form/s and brought to the next clinical team forum for full discussion.

7.1.6 A patient may withdraw or make changes to requests to receive visitors at any time during their admission.

7.1.7 Remote Social Visits (Video-Conferencing)

7.1.8 Where a patient has approval for social visits but has difficulty visiting the family due to restraints such as distance, the MDT may approve virtual visits by the use of video calling facilities such as Skype or AccuRx to contact family/significant others. All protocols to do with facilitating social visit requests will have to be followed by the MDT before approving such requests (ID checks, supervision during the visit etc.).

7.1.9 Before patients are permitted to use Skype or AccuRx for appropriate virtual visiting, patients must first obtain MDT approval and must sign the 'Use of AccuxRx Video Call between Patient and Family within Secure Services' (Appendix 1).

7.1.10 All Skype and AccuRx calls must be supervised by a member of staff.

7.2 Visits by Former Patients of the Directorate

7.2.1 The following protocol must take place before former patients are permitted to visit Brockfield House or other units within the directorate.

7.2.2 Where a former in-patient requests to visit a current in-patient, (whether socially or as a carer or relative) this needs to be raised with the clinical team responsible for the inpatient concerned. The team should consider whether it is in the patient's best interests to meet with the ex-patient and decide whether (with the visitor's consent) to access their clinical record and/or discuss the matter with relevant clinical personnel to ascertain more information about the proposed visitor's mental condition and any possible risks that might present.

7.2.3 Particular consideration should be given to establishing the nature and quality of the relationship between the patient and the ex-patient including any known historical

tensions or risks. Therefore, as part of good practice, effective liaison should also occur with the ex-patient's previous clinical team. Attention should additionally be given to the possibility of incidental contact with others in the course of the proposed visit and any risks or tensions that might arise from this. In situations of uncertainty it may be considered prudent to authorise supervised visits away from the ward, at least in the first instance

7.2.4 Where an ex-patient is to visit in another capacity (e.g. voluntary worker or service user representative) this should be brought first to the attention of the clinical team, along the lines indicated above. Before the decision to allow a visit is sanctioned it should be referred to the assistant director who will ensure that additional safeguards such as a current **DBS** clearance are in place and that views are sought from that individual's current clinical team in the community and from the Trust's Patient and Public Involvement (PPI) department.

7.2.5 The final decision as to whether the ex-patient can visit as a voluntary worker or representative will rest with the, Head of security at Brockfield House (or equivalent member of staff at the other units).

7.3 Social Visitors Invited to Attend Meetings

7.3.1 When visitors are invited to attend meetings, such as a CPA, every effort should be made for the meeting to start and finish on time and visitors made comfortable during the period of waiting.

8.0 EXCLUSION OF VISITORS

8.1 *This section mirrors the Trust's Restrictions of Visitors to Detained Patients in Hospital Policy (MHA29).*

8.2 Chapter 11 of the Mental Health Act 2015 Code of Practice emphasises the right of all detained patients to receive visits subject to limited exceptions (see Code of Practice Section 11.4). In implementing this Visiting Protocol, clinical teams and individual members of staff must be mindful of this principle and of the possibility of legal challenge should visits be refused or unreasonably delayed except on the grounds set out in the Code of Practice.

8.3 Proposed visitors may only be refused on one (or both) of the following grounds:

8.4 Restriction or Exclusion on Clinical Grounds *(Code of Practice 11.1)*

8.4.1 From time to time, the patient's Responsible Clinician may decide, after assessment and discussion with the multi-disciplinary 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, impose reasonable conditions, or if necessary exclude the visitor. In any of these cases the reasons for the restriction should be recorded and explained to the patient and the visitor, both orally and in writing (subject to the normal considerations of patient confidentiality).

8.5 Exclusion on Security Grounds *(Code of Practice 11.15 & 11.16)*

8.5.1 The behaviour of a particular visitor may be disruptive, or may have been disruptive in the past, to the degree that exclusion from the hospital is necessary as a last resort. Examples of such behaviour include: incitement to abscond; smuggling of illicit drugs or alcohol into the hospital or unit; transfer of potential weapons, unacceptable aggression; and attempts by members of the media to gain unauthorised access. A decision to exclude a visitor on the grounds of their behaviour should be fully documented and explained to the patient orally and in writing. Where possible and appropriate, the reason for the decision should be communicated to the person being excluded (subject to the normal considerations of patient confidentiality and any overriding security concerns).

8.6 Monitoring by Hospital Managers (*Code of Practice 11.17 & 11.18)*

8.6.1 Hospital managers should regularly monitor the exclusion from the hospital of visitors to detained patients. Restricting visitors could amount to or contribute to a deprivation of liberty in breach of Human Rights legislation and may indicate that an authorisation under the deprivation of liberty safeguards of the Mental Capacity Act 2005 may need to be sought.

8.6.2 Whernever a visitor is excluded the Responsible Clinician will copy to the Mental Health Act Administrator their letters of explanation or a copy of the clinical record of the discussion in circumstances where a letter has not been sent to the patient and visitor. The Mental Health Act Administration will log and monitor exclusions and make this information available to the hospital managers.

9.0 UNSUPERVISED VISITS

9.1 The term 'unsupervised' should not be taken to denote a total absence of staff supervision. It is important that general good observational and security practices are observed. On each ward a room should be designated as a room for visits. The room must have a vision panel in the door so that non-intrusive observations are possible. Part of the visit may take place in communal areas (e.g. internal gardens, courtyards and cafeteria) subject to MDT agreement which must be documented. Visitors are not permitted to enter the following ward areas:

- Patient bedrooms
- Treatment rooms
- Ward, administration or other offices

10.0 SUPERVISED VISITS

10.1 In the case of concerns or reservations not amounting to grounds for exclusion, the Responsible Clinician, in consultation with the clinical team, may decide that a visit should be supervised. The nature of the supervision should be specified on the visitor form and in the patient's notes.

10.2 In the absence of clear information to the contrary it should be assumed that the term 'supervised visit' will imply that the member of staff is present in the room throughout the visit and is party to the conversation between patient and visitor. Where the language used in the visit is likely to be unfamiliar to the supervising member of staff, consideration should be given to the additional use of an interpreter. Occasionally, it may be necessary for more than one member of staff to supervise a visit.

10.3 The ward charge nurse / sister or senior duty nurse may also make a judgement, on a one-off basis, that a visit should be supervised because of particular

circumstances pertaining to the patient, the visitor, or the ward environment. They will refer the matter to the next available multi-disciplinary meeting for further discussion.

10.4 Supervised visits may also be indicated where, by reason of specific vulnerability (e.g. elderly or disabled visitors), it has been determined that a visitor should not go onto a ward or clinical area.

10.5 Visits by children must always be supervised and comply with the Child Visiting Protocol (refer to Child Visiting Protocol, SSOP 16)

11.0 INFORMATION TO PATIENTS AND VISITORS

11.1 The Secure Services Directorate provides information booklets for patients and their visitors, which includes details about visiting times and the Visiting and Child Visiting protocol. The information will be available in the main reception area, on the wards and posted by the social worker to visitors upon confirmation of their application to visit

11.2 Social visitors will also be offered the booklets upon their first visit and patients will be given them upon their arrival. The patient's key nurse will ensure that patients and their visitors understand this information. This may on occasion require the information to be translated or interpreted. Where this is necessary it should be conducted as soon as practicable by a Trust registered interpreter.

12.0 EXCLUDED VISITORS

12.1 In exceptional circumstances visitors who have previously been on a patient's approved visitors list may be excluded following a decision by the patient's multi-disciplinary team. Such actions would be instituted as per 8.0above.

12.2 Reception must be informed in writing by the Responsible Clinician or social worker of those individuals who are excluded from the unit. It is the responsibility of reception staff to maintain an up to date record of all such excluded visitors.

12.3 Excluded visitors may attempt to visit after the exclusion has been imposed. If such an individual refuses to leave, the police should be called to remove them.

12.4 Excluded visitors should be reviewed at regular, monthly intervals at multi-disciplinary meetings to consider if the grounds for the exclusion still pertain.

END

The Derwent Centre

A guide for Friends and Family

Welcome to Stort Ward

Stort ward is a male acute mental health ward. The ward provides 24 hours treatment and care in a safe and therapeutic setting for up to 18 patients at any time.

There is a multidisciplinary team who work together to provide care and treatment for your loved one, including nursing, psychology, occupational therapy and medical staff.

Recovery is promoted from the beginning of admission in order to limit amount of time spent away from friends/family and community living. Therapy team on the ward provides weekly program including occupational therapy groups, psychology groups and exercises.

Each patient receives an individualised care plan which focuses on their needs and is regularly reviewed.

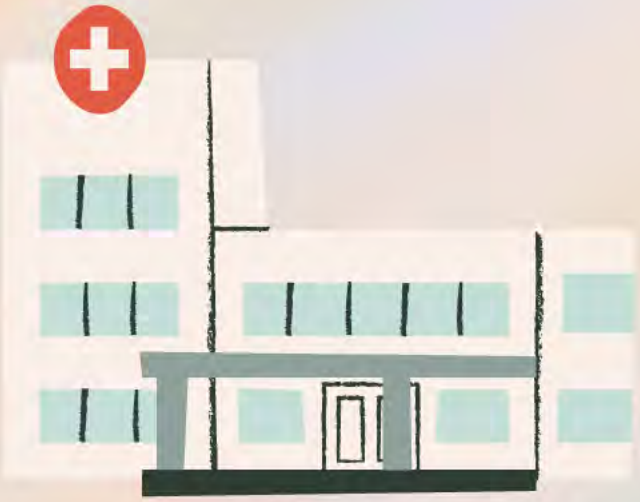
Welcome to Stort Ward

Lounge area

Lounge area

Nursing Bay

Ward Contact Details:



Stort Ward
Derwent Centre
1 Hamstel Road
CM20 1QX
Tel: 01279 967160/61

Visiting days:

Please contact reception or ward to arrange a visit in advance: 01279 967302

Ward Review days:

Mondays and Wednesdays (subject to change)
Ward clerk works with the Consultant to allocate the times and will email the invites with times and log in details for you. Please contact the ward to confirm.

Feedbacks:

We really value feedback from family and carer's of people who use our services. If you have any concerns or compliments, please email us at: epunft.derwentcentre@nhs.net

Visit and delivery guideline:

We understand that you would like to send essential items for your loved ones when they are under our care. Please could we ask you not to bring any contraband items onto the ward for safety reasons. Any contraband items will be confiscated.

Items include:

- pornography
- drugs
- alcohol
- any sharp items
- smoking paraphernalia (lighters)
- plastic bags
- any food that are not in a sealed manufacturers packaging
- chewing gum
- blue tack
- caffeinated drinks
- electronic devices capable of videoing/ recording

Please ask a member of staff if you are unsure of whether an item can be brought onto the ward.

Useful websites and phone numbers for carers support:

Samaritans:

This services offer emotional support 24 hours a day, in full confidence.

Tel: 116 123/ **E-mail**: jo@samaritans.org

Mind Infoline:

Mind provides information on a range of mental health topics to support people in their own area

(9am- 6pm; Monday to Friday)

Tel: 0300 123 3393/ **E-mail:** info@mind.org.uk

Rethink Advice and Information Service:

Rethink provide specific solution-based guidance

Tel: 0300 5000 927/ **E-mail**: advice@rethink.org