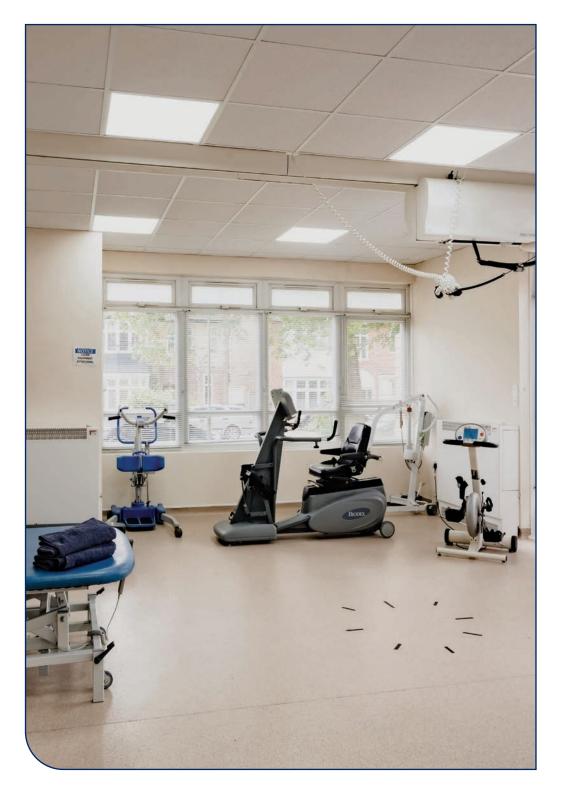


Your Clinical Pathway to Wellbeing at Barclay House





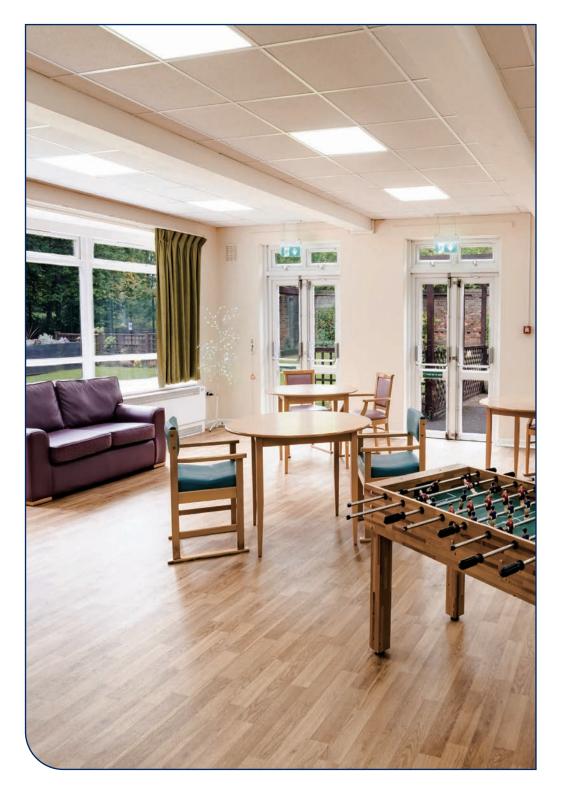


Barclay House provides a safe and therapeutic environment in which a dedicated team will support you on your Brain Injury Rehabilitation journey.

Acquired brain injury (ABI) refers to any type of brain damage that occurs after birth. It can include damage sustained by infection, disease, lack of oxygen or a blow to the head.

We recognise that you should only be in inpatient services for the minimum amount of time necessary and we will engage with your community team to support a safe discharge into the community.

We aim to put you at the centre of your rehabilitation, supporting you to live as independently as possible.



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Clinical Model

Slow Stream Rehabilitation

Our Multi-disciplinary Team are highly specialised in the assessment and treatment of service users in slow stream rehabilitation pathway. The nature of this pathway enables therapist who are BOBATH trained to complete an in-depth complex assessments. The depth of this assessment ensures service users have the opportunity to explore all of their potential. The therapists work collaboratively to ensure a tailor made rehabilitation program steering service users towards both their short and long term goals. Service users are placed at the centre of their rehabilitation journey to empower them to take control of their recovery from admission to discharge. The service users & family network are kept regularly up to date by the team, with progress and expected longer term outcomes explained and liaison with external agencies. Service users will have the opportunity to experience a graded discharge to make the transition into the community setting as smooth and stress free as possible. This allows therapists to problem solve any issues that arise early to address them and allows the Service user & Family to emotionally prepare for discharge with our support.



Hospital Services

Uniquely set within a broader pathway enabling continuity of care and reducing delayed discharges into community services. Providing a safe and therapeutic environment for those detained under the Mental Health Act. Your safety and immediate needs will be met and a formulation of your rehabilitation needs will be commenced.

Specialist neurobehavioural rehabilitation, for those with an acquired brain injury (ABI), including traumatic brain injury (TBI) and stroke, or a progressive neurological condition (PNC).

We aim to reduce challenging behaviour, optimise functional skills and promote quality of life for all of our patients. We offer an initial 12-week assessment with goal-focused rehabilitation and support from admission.



Long Term Nursing Services

We recognise that some individuals require longer term placements due to complex health and social care needs and in some cases it may be concluded that they would have their needs met best at Barclay House. Our long term nursing service can support those with long term health conditions and high dependency nursing needs, requiring careful and skilled monitoring in an environment they have become familiar with. Those who stay in our long term pathway have the advantage of rapid access to the therapy team and gym facilities, should their presentation change. Residents will be supported to maintain their leisure based interests both within the service and in the community.

Outpatients Therapy Clinic

The outpatients services are set within the designated therapy suite at Barclay House. The therapy suite has its own dedicated entrance and exit to the facility.

We are able to continue to support those people discharged from our in patient service as well as take direct referrals from the community

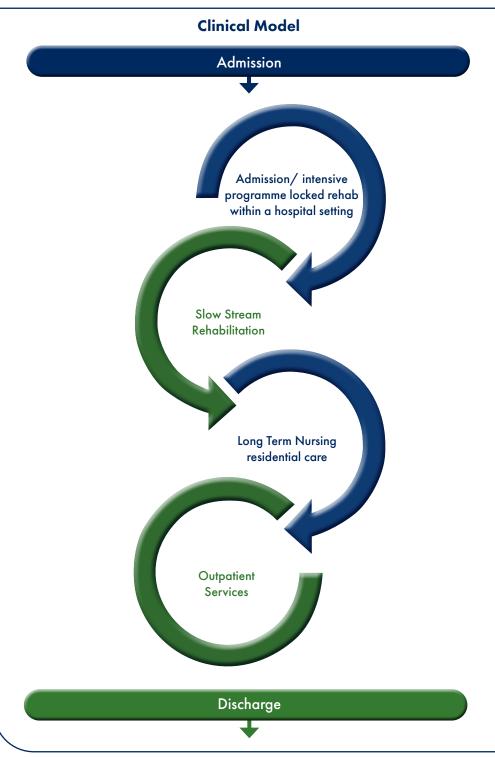
We aim to respond to referrals within 72 hours therefore reducing community wait times.

Full list of outpatient therapies available:

- Psychiatry
- Psychology
- Physiotherapy
- Occupational Therapy
- Speech & Language Therapy







Care Pathway

Stage 1 (Within 24 Hours)

- You will be introduced to your core team and be orientated to the unit
- Your safety and immediate needs are met along with discussions regarding your discharge destination
- We will establish youir goals to enable you to leave the service safely



Stage 2 (Within 7 Days)

- Initial assessments will be completed
- Baseline outcome measures will be assessed, such as GAS goals
- Your presentation will be monitored and you will be given regualr feedback
- Your Positive behaviour support plan will be developed with you where applicable
- Your discharge planning will be discussed with you



Stage 3 (Within 28 Days)

- You will have a full assessment from each relevant MDT discipline (Psychiatry, Nursing, Physio, OT, Psychology and SaLT) and a clear, person centred, therapeutic plan will be in place to support your rehabilitation
- The MDT will review and analyse the information and feedback to you to establish a more formal discharge plan including a predicted discharge date



Stage 4 (Within 12 weeks)

- A full evaluation will be conducted against your rehabiliation goals
- Any changes to the treatment plan will be made where required
- Your external team will be involved
- Assessment/ home visit will be completed in prepartion for discharge and your discharge plan adapted accordingly



Stage 5 (6 Months and Beyond)

- You will be updated regularly about your progress with your goals being regularly reviewed which will directly correleate with your discharge plan
- The team will work closely with external agencies to ensure a smooth transition to your discharge destination



Discharge

- As you approach discharge you will be informed of a final predictive date of discharge.
- Referrals will be made to follow up services for on-going therapy as required.
- Every patient is an individual, the length of stay may vary for each person

The following tables describe each disciplines role in your care.

Who	What	What this means for the Service User
Nursing Team	 The Nurses will complete physical observations e.g., pulse, heart rate, respiration, blood pressure, weight and height and monitor these regularly. We will administer any medication required and support you to understand your prescriptions. We will commence a physical health history if possible including recognising allergies We carry out drug and alcohol screening, where required. We will complete a risk assessment that will cover nutrition (MUST), skin integrity (Waterlow), falls and *VTE. We will formulate a 72-hour nursing care plan which includes a risk assessment. The nurse in charge will explain your rights including under the MHA 1983(2007) if applicable. You will be registered with the GP and any other specialties in order to ensure that appropriate physical health care is provided. You will meet your named nurse and they will explain how they can help you and work with you on achievable goals for each area of need identified. We will provide you with information about Activities, how to complain and Advocacy. We will contribute to compiling your outcome measures and your discharge plan. We will support you to access therapy and activities available promoting engagement. 	 We can monitor and quickly react to your mental and physical health needs to maintain your wellbeing. We can keep you and others safe. We can ensure you have access to the correct health professionals. You will receive care and support which is effective to you in times of crisis/high arousal. The provision of information in an understandable format to promote healthy living You have appropriate information in order to make informed choices/ in relation to your care and treatment You are included as much as possible in the planning of care and treatment. You are fully aware of your rights and that any detention is legal. Interagency working will formulate the most effective package of care for you assessed to reduce the risk of future deterioration and admission.

Who	What	What this means for you
Visiting Consultant / Medical Team	 You will be "clerked" in and an assessment of your mental state completed. An initial assessment of your physical health will be carried out. Out of hours support will be provided by an on-call consultant. We will assess your capacity to consent. We review medications or immediately prescribed medications and provide you with information about these by talking to you and providing you with written information. We will assess your capacity to consent to medication. You will have an initial review of your legal status and ensure that there is a valid consent to treatment form in place if you require this. We will consider access arrangements and potential leave. 	 We can monitor and quickly react to your mental and physical health needs to maintain your wellbeing. We can keep you and others safe. We can ensure you have access to the correct health professionals. You will receive care and support which is effective to you in times of crisis/high arousal. The provision of information in an understandable format to promote healthy living You have appropriate information in order to make informed choices/in relation to your care and treatment You are included as much as possible in the planning of care and treatment. You are fully aware of your rights and that any detention is legal. Interagency working will formulate the most effective package of care for you assessed to reduce the risk of future deterioration and admission. You are not restricted unnecessarily form places and things that matter to you.

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Who	What	What this means for you
Therapies Team	The Physiotherapist will complete an assessment with you and discuss goals to formulate a treatment plan. The Occupational Therapist will meet with you to explain their role and begin to get to know you. The Speech & Language Therapist will assess where applicable and initially advise on the most effective ways to support communication and any swallow moderating diets. This will be done in conjunction with a rehabilitation plan to optimise recovery. You will meet with the Psychology team, who will Assess your readiness for change (Joint assessment with Assistant Psychologist and Clinical Psychologist) We will gather and triangulate information from internal and external sources This information will be used along with the therapists' assessments to develop care plans to enhance care and develop person centred goals.	Make you as comfortable as possible. You have access to food that you like or need.

Who	What	What this means for you
House- keeping and Support Services	 Will make a room for you based on the clinical teams assessment of where you need to be. Chef will ask you or the staff looking after you what you like to eat based on your choice, religion, culture or physical health. Offer to clean your room daily. Change your linen and launder your clothes at your request/need. Chef will provide questionnaires or speak to you to ensure you are having the food and drink you like/need. 	Make you as comfortable as possible. You have access to food that you like or need.

If English is your second language

We offer translation services and information in your first language on request. This can also include written information in braille, or the use of sign language if you require it. Your named nurse will help to ensure this is provided for you if you need it.

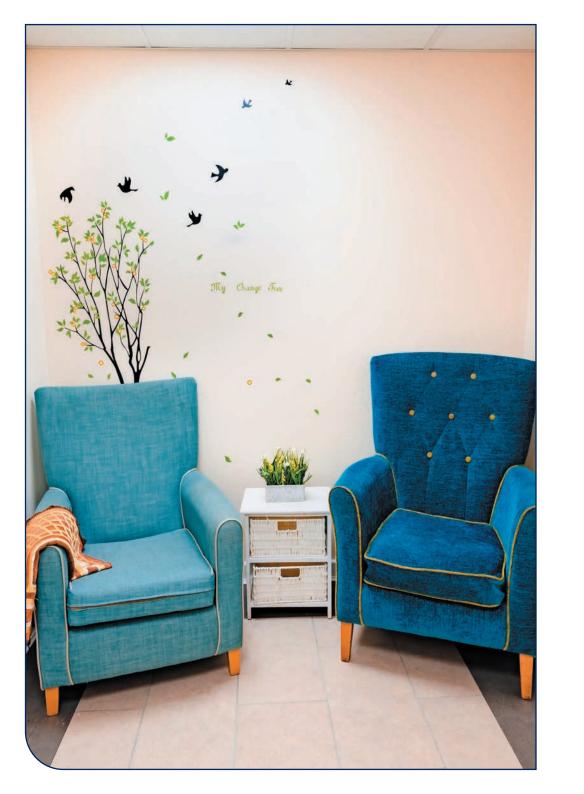
Referrals

We consider referrals from the following:



We accept referrals from a variety of funding streams, for more information you can contact us at:

0116 2541092 / 0116 2553039 info@plans4rehab.com Plans 4 Rehab, Barclay House, 165 Barclay Street, Leicester, LE3 0JE



0116 254 1092

www.plans4rehab.com

Plans 4 Rehab, Barclay House, 165 Barclay Street, Leicester, LE3 OJE