Southern Health
Quality care, when and where you need it

Specialist Services Division

Occupational Therapy

1	**Definition of Occupational Therapy**
	The aim of occupational therapy is to: "Maintain or improve a client's functional status and access to opportunities for occupation and participation. The process by which this is achieved is through the maintenance, restoration or creation of a match between the abilities of the person, the demands of his or her occupations and the demands of the environment. Activity is the main medium of intervention and agent of change in occupational therapy." (Royal College of Occupational Therapy 2006)
2	**Remit and Priorities of the Service**
	The occupational therapy service recognises that occupation is fundamental to a person's wellbeing and recovery. It strives to provide a service that is person centred and encourages people to participate in a variety of activities without discrimination against any protected characteristics. Occupational therapy treatments are graded and adapted so that all service users can engage in them despite their mental state, the level of security they are living in and their leave status. The occupational therapy service aims to assess a service user's level of functioning to identify and maintain their strengths, as well as address the areas in which they may need to develop skills. This process actively encourages a good therapeutic relationship and collaborative working. Performance skills are assessed in relation to the following components: action, volition, tool handling, relationships and handling situations, task concept, product, level of supervision needed, behaviour, norm awareness, anxiety/emotional responses, initiative and effort. These components are related to the following performance areas: • Social • Personal Management • Work • Use of free time
3	**Models of Care**
3.1	**Attachment & Trauma** These theories provide an understanding of how early childhood experiences influence a person's development and presentation, including their ability to regulate emotions and develop relationships.
3.2	**Non-Violent Resistance (CAMHs Services)** NVR can be used to promote a culture within the multidisciplinary team that ensures young people's physical and emotional safety, whilst providing opportunities to develop relationships that support change.

3.3	**Recovery Approach** We incorporate the philosophy of 'recovery' recommended by the National Mental Health Development Unit (NMHDU). The recovery approach involves the support and enablement of each service user to develop the positive viewpoint of seeing their illness and recovery experience as a process of gaining restoration to a valued life and emphasises individual qualities, strengths and achievements. This approach is underpinned by the principles of hope, agency and opportunity.
3.4	**Sensory Integration** Sensory Integration (SI) is a theory developed by J.Ayres. In order to describe the process that occurs within the Central Nervous System (CNS) to take in, process and respond to sensory stimulus. Normal sensory integration is the foundation that enables a person to participate in a range of meaningful and purposeful daily occupations (Roley S, Blanche E, Schaaf R. 2001). However, deficits in processing and integrating sensory information can lead to difficulties interacting with the world around and carrying out meaningful occupations that a person needs and wants to do. The application of sensory Integration techniques can help explain some of the behavioural responses seen and to help teach service user how to regulate arousal levels by making them aware of their own sensory preferences and needs.
3.5	**Model of Creative Ability** The Model of Creative Ability is a developmental model. It examines the person's levels of motivation, range of everyday performance skills and ascertains which level they are functioning at. This level may vary across different types of performance skills. Within each level, there are 3 phases to indicate the service user's progress through the level. The term 'creativity' refers not to artistic/musical abilities, but to the capacity the service user has to engage in occupation, and the degree of participation i.e. how adaptable the service user is. Creative ability is variable across the individual's lifetime depending on circumstances, mental state, stressors etc.
3.6	**Model of Human Occupation (MOHO)** MOHO seeks to explain how occupation is motivated, patterned and performed. Within MOHO, humans are conceptualised as being made up of three interrelated components: volition, which refers to the motivation for occupation, habituation, which refers to the process by which occupation is organised into patterns or routine, and performance capacity, which refers to the physical and mental abilities that underlie skilled occupational performance. MOHO also emphasises that to understand human occupation, we must also understand the physical and social environments in which it takes place, and the opportunities and demands that environments provide. MOHO seeks to not only objectively measure functions, but to subjectively understand the service users experience and personal goals.
4	**Occupational Therapy Process**
4.1	**Referral** The occupational therapy team have a blanket referral system for all service users unless specified otherwise. On admission, service users will be assessed by the allocated occupational therapist. Initial contact will be made with the service user within 10 days of

	admission where the role of occupational therapy will be explained and the service leaflet will be offered.
4.2	**Assessment** The occupational therapist will complete an initial contact within 10 day of admission and this will be documented on RiO in a progress note specifically detailed 'Initial Contact'. A mix of assessment, observation and engagement in occupational therapy sessions, are used to gather information about the goals, interests and functional ability of the service user. This is completed prior to the first CPA and throughout the admission. Once assessments have been completed they will be documented on RiO and/or stored on the shared drive. Verbal feedback of the outcomes will be given to the MDT at progress review. Standardised and non-standardised assessments may be used periodically as appropriate. If the service user is too unwell to be assessed in all areas, or they refuse to engage with the assessment process, this will be documented on RiO and the MDT informed at progress review.
4.3	**Bathing/Showering Assessments** In accordance with the protocol for the safe bathing and showering of people with epilepsy (SHCP 190) all service users with epilepsy will require a bathing/showering assessment. In addition, from June 2019 any service user with a health condition which may make bathing difficult or dangerous will also be assessed. Once the Occupational therapist has been made aware at admission (following clerking in) or during a progress review, that a service user has epilepsy or a physical health condition that put them at risk of harm whilst bathing, they will arrange an assessment. This may include: • Reading the service user's notes • Speaking to nursing staff • Speaking to the service user • Conducting a physical bath/showering assessment The assessment will be documented on Rio in progress notes with the heading "bathing assessment". A separate care plan will be written by the Occupational therapist and filed in care plans on RiO. The outcome of the assessment and the care plan will be discussed with the service users' primary nurse who is responsible for ensuring that it is followed in practice. If a hard copy of the bathing assessment is completed this can be uploaded into 'clinical documentation' on RiO or summarised in the progress notes.
4.4	**Treatment Plan** The occupational therapist will work with the service user to identify and agree on treatment goals and a provisional treatment plan within 14 days of admission.

	The treatment plan will be discussed with the MDT at the service user's progress review. This discussion will cover areas of risk and, in particular, whether the team agree to the service user being involved in the suggested treatment activities. Interventions may be individual or group and may take place on the ward, in high care, in Education and/or in the community. Once a treatment plan has been drafted, the occupational therapist will offer the service user a copy to read, will offer to read it to them or summarise it for them. If a service user is unable to manage this the occupational therapist will presume consent to work on the treatment goals through their attendance in treatment sessions. The treatment plan is then finalised and stored on RiO under 'Clients care plans', 'OT Input'. It should be documented if they consent to the treatment plan or not, and why.
4.5	**Interventions** Occupation focused/ meaningful to the person working towards identified treatment goals. Interventions may conducted on an individual basis with the service user or be in a group format. Examples of individual interventions include: • Practising personal, domestic, community and vocational daily living skills such as maintaining personal hygiene, preparing meals, using the bus and time-management • Exploring identity and interests • Using sensory items to help regulate emotions Examples of group interventions include: • Practising communication and social skills through shared interests/activities
4.6	**Review / CPA** Service users are reviewed regularly (frequency depends on the individual service) in progress reviews by the MDT. A summary of the service user's progress in occupational therapy sessions and their aims is verbally reported by the occupational therapist. All service users will be seen and reviewed by their occupational therapist as a minimum on a ***monthly*** basis. This includes those service users currently not engaging in occupational therapy. Service users are also reviewed on a regular basis in occupational therapy clinical meetings and during clinical supervision. Any changes to the service user's programme will be documented in their notes. Each service user is reviewed in detail by the multi-disciplinary team as part of the Care Programme Approach (CPA). Prior to the CPA, the occupational therapist will review the service user's progress by: • reading their occupational therapy continuation notes. • talking to the service user about their progress and future goals. • talking to the service user's primary nurse and other occupational therapy staff, who have worked with them.

	Occupational therapists may also use the range of standardised outcome measures, so the occupational therapist can see at a glance where the service user is functioning in relation to the last assessment. It can help with the formulation of the CPA report produced by occupational therapists. Assessment results are recorded on RiO. Following information gathering the occupational therapist will then write a formal CPA report, summarising the service user's assessment results, progress, strengths, needs and agreed goals for the next review period. This report is saved on the S:drive and other professionals/outside agencies have access to it in CPA minutes, sent via the medical secretaries or ward admin. Following each review the occupational therapist will update the service user's treatment plan which they will discuss with the service user. The MDT care plan will also be updated after each CPA by a member of the MDT.
4.7	**Discharge** Service users are only usually discharged from occupational therapy if they are discharged from the unit, which is a decision made by the MDT (occasionally service users may decline to attend occupational therapy, but their case is left open, as staff continue to encourage them to attend). When the service user is discharged from occupational therapy, the Occupational Therapy Practitioner will prepare a discharge report which may include: • Date occupational therapy intervention commenced • Aims of occupational therapy intervention } Included in • Type of occupational therapy intervention } the attached <u>final</u> • Service user's achievements } CPA/Case Conference Report • Reason for discharge • Where service user is discharged to • Any other recommendations / plans • Standardised assessment •
5	**Service Evaluation & Review**
5.1	The occupational therapy staff strive to provide an excellent service which is based on the principles of clinical governance and evidence based practice. Evaluation and review of the service takes place through the following.
5.2	**Governance** An occupational therapist must be registered with the Health Care Professionals Council (HCPC) and all the occupational therapy staff maintain an up to date portfolio of professional development activities. Occupational therapists must comply with the Royal College of Occupational Therapy (RCOT) Standards of Practice, Code of Ethics and other relevant strategies such as Career Development Framework and the Getting My Life Back and Unlocking Potential publications. Locally occupational therapists have developed a divisional strategy and the profession is also linked into clinical governance which is underpinned by standards for better health. The occupational therapy team will be represented at the local monthly Clinical Governance, Learning from Incidents, Environment and Patient Safety, and Physical

	Health meetings. The representative must ensure that they are prepared for each meeting, familiarising themselves with the minutes of the previous meeting and providing a progress update on any standard agenda items and actions. Following the meeting, the representative must also cascade any important information and new actions to the rest of the team.
5.3	**Service User Involvement** The occupational therapy service is committed to involving service users in evaluating and developing the service. The Occupational Therapy Specialist Practitioners facilitate or co-facilitate the service user involvement forums in each hospital: The forums provide an opportunity for 2-way communication, with service users sharing their views and experiences, raising concerns and recommending quality improvements, and receiving feedback regarding the matters raised at previous meetings. The occupational therapy team representative is responsible for sharing the minutes of the local service user involvement forums in the local Clinical Governance and Clinical Effectiveness meetings, and for communicating any response to the Specialist Practitioner to feed back into the next forum. The occupational therapy team involves service users in the interview process for new occupational therapy staff.
5.4	**Clinical Effectiveness Meeting** The occupational therapy team will be represented at the local monthly Clinical Effectiveness meeting. The meeting is a multidisciplinary forum which ensures that the hospital delivers high quality, evidence-based, person-centred interventions.
5.5	**Away Days** Each year the occupational therapy department has a divisional and a service away day which focuses on the divisional strategy, and then allows staff time to consider and discuss identified gaps in the service and plans for development. New government or Royal College of Occupational Therapy directives will be considered in planning, as well as the results of service user surveys and research of good practice at other units and/or evidence based practice. Another action plan is then written and reviewed throughout the year.
5.6	**Evidence Based Practice** The occupational therapy team uses evidence based practice to underpin all new treatment interventions. The Occupational Therapy Team Manager and Advanced Clinical Practitioner facilitate a monthly CAMHS CPD event and the Head of Occupational Therapy facilitates a quarterly divisional CPD event, which occupational therapy staff are invited to attend. The occupational therapy teams are encouraged to share/present literature reviews, outcome data, learning from training, conferences and articles, and reflect on service user's feedback in team meetings.

5.7	**Clinical Supervision, Line Management, Appraisal, Competencies and Job Planning** In line with Trust policy, occupational therapy staff must participate in an annual appraisal with their line manager within the mandated timeframe. The appraisal should be considered the 12th supervision session of the year. As well as the Trust appraisal document, Band 3, 5, 6 and 7 occupational therapy staff have been issued with a competency document, underpinned by the Career Development Framework, which they will use to self-assess and discuss their competence in the role. Occupational therapy staff must participate in either combined or separate monthly clinical and line management supervision. Occupational therapy staff must ensure that they are prepared for supervision sessions and their annual appraisal by completing the appropriate documentation in advance, familiarising themselves with the notes of the previous session and providing a progress update on any actions.
5.8	**Audit** The occupational therapy department is involved in division and service wide audits as well as those of its own. RCOT Standards of Practice are audited regularly to ensure that the department is providing good standards of care.
5.9	**Research** A divisional research group meets every six weeks. The purpose of this group is to: • Identify potential research opportunities within Specialist Services • Highlight and critique research, applying the findings where relevant • Disseminate information back to respective teams and wider management structure • Identify national research priorities and link in with those • Develop and engage with own research projects • Support conference abstract preparation and article writing • Raise awareness amongst research group of work currently being undertaken within Specialist Services
5.10	**Outcome Measures** The occupational therapy department has access to a variety of outcome measures to evidence service user's progress during their admission. The MoHO Screening Tool (MoHOST), Activity Participation Outcome Measure (APOM) and Assessment of Motor and Process Skills (AMPS) can all be used prior to and at intervals during treatment to provide evidence of progress, evaluate the effectiveness of interventions and to inform future treatment planning. APOM data is included in CPA reports.