Elysium Healthcare

Three Valleys

Specialist Mental Health Rehabilitation Service

2 Burley Court, Steeton, Keighley, BD20 6TU

T: 01535 657350

Email: **referrals@elysiumhealthcare.co.uk**

Overview of the Service

At Three Valleys we provide a safe and supportive environment for up to 43 men and women with complex mental health issues, including our specialist 9 bed dementia service. Three Valleys Hospital provides a clear care pathway, with four distinct rehabilitation services, and three community houses complementing our rehabilitation pathway.

Environment

With easy access to Keighley and excellent transport links to the surrounding area, the Three Valleys is ideally located for safe, structured and gradual reintegration into the local community.

All bedrooms have en suite facilities and the communal areas are spacious with a warm, homely feel.

- **Oldfield and Steeton:**
  an 18 bed male rehabilitation service, incorporating a six bed unit for older men
- **Ingrow and Winfield:**
  a 16 bed female rehabilitation service, incorporating a four bed step down unit
- **Oakworth:**
  a nine bed male specialist Dementia service

Treatment Philosophy

The philosophy of care at Three Valleys is based on encouraging social and community integration. A strong emphasis is placed on collaborative goal-focused rehabilitation. Skills development is actively encouraged, and support is given to achieve optimum functioning. We support individuals to develop confidence and the ability to live in a community setting.

RAID

Staff have a clear & effective philosophy of care which not only supports challenging behaviours when they occur, but also encourages the development of a positive approach to preventing these behaviours from occurring. This philosophy of care provides a clear sense of purpose and a positive, empowering environment for both staff and service users together.

Service Aims

The hospital strives to support service users with severe and enduring mental health difficulties, who require ongoing rehabilitation in a safe, therapeutic environment. We place high emphasis on maximising quality of life and supporting our patients to optimise their engagement in rehabilitation and recovery.

We provide a safe and supportive environment for those who may have suffered repeated placement breakdowns, offering continuity and stability. We aim to support individuals through periods of mental health fluctuations, by managing relapse and thus preventing re-admission to acute services. The hospital team work with challenging behaviours and look to reduce indents through pro-active management and a real understanding of our service users' therapeutic needs.

The hospital team work together to develop personalised, recovery focused programmes within the care pathways. By adopting an enabling approach and social care model, the team can support service users to achieve and maintain optimum functioning.

There is a comprehensive range of therapies and activities to meet all service user needs, often delivered through bespoke and creative care packages.

Multidisciplinary Team

The unit is led by an effective multidisciplinary team, experienced in rehabilitation, recovery and caring for service users with complex needs. The team includes:

- Consultant psychiatrists
- Psychologist and psychology assistants
- Registered mental health nurses and healthcare assistants
- Occupational therapist and activity co-ordinators,

Full access and registration with the community GP service is available, in order to optimise and maintain the physical health of the individual.

Services Offered

- An initial assessment is carried out within 48 hours of receipt of the referral information
- An initial care plan is formulated prior to admission and continues upon admission once the multidisciplinary team have completed a full assessment
- A full Care Programme Approach (CPA) begins within three months of admission and six monthly thereafter unless other arrangements are agreed
- A holistic approach, meeting personalised treatment goals to maximise the opportunity for community living
- Supporting individuals with complex co-morbidities
- Close links with local support groups, education and real life work opportunities, to facilitate community reintegration
- Continuity of care across the whole care pathway from a dedicated multi-disciplinary team
- Comprehensive and regular risk assessments are undertaken in collaboration with the service user
- Development and maintaining of social networks that are important to the individual.

Inclusion criteria:

- Males and females aged 18 or over
- Service users admitted either informally or detained under the Mental Health Act
- Service users who have complex needs, with a diagnosed severe and enduring mental illness
- Services users who present with behaviours that challenge

Elysium Healthcare

To discuss rehabilitation and step down services, to arrange a visit or to make a referral, please contact:

referrals@elysiumhealthcare.co.uk

24hr referral line 0800 218 2398

To view our video tour, please visit **www.elysiumhealthcare.co.uk**

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