Cornerways

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	**Good**
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We rated Cornerways as good because:

- Managers and staff shared a clear definition and vision of recovery for clients that was embedded throughout the service. Staff understood their roles in supporting clients in their recovery journey and treated them as partners in their care. Staff said they felt respected, supported and valued, and were proud of the work they did.
- The provider actively worked to reduce barriers to treatment for their clients. For example, the service had admitted clients with their pets, purchased support from domiciliary care agencies for clients requiring personal care and employed a driver who collected clients when public transport was a barrier to treatment.
- The ethos of the service was to go the extra mile for clients and put people before profits. The provider regularly provided free care to clients who had unmet needs but did not have funding available. The provider offered free aftercare for life to all clients after completion of treatment.
- Staff were motivated and inspired to offer care that was kind and promoted dignity. Staffing levels were safe and there were plans in place to cover vacancies, sickness and annual leave. There was a positive culture within the house, staff felt respected and valued as members of the team and there was support from the registered manager. Staff received the specialist training needed to carry out their work effectively. Through safeguarding training and information, staff understood how to protect clients. Staff had two-monthly supervision and yearly appraisal.
- The service was clean, well equipped, well-furnished and had good facilities. The design, layout, and furnishings of the service supported clients' treatment, privacy and dignity and there were adaptations for people with disabilities.
- The service manager proactively managed health and safety concerns. The manager completed environment health and safety checks, this included an assessment of ligature points and regular fire safety checks. The service had a de-choking device, ventilated pillows and an automated external defibrillator (AED) for use in emergencies. The provider encouraged clients to be active partners in managing their own safety and trained clients in fire safety and how to use an AED.
- The service provided a therapeutic program based on National Institute for Health and Care Excellence guidance. Both one to one counselling and group work was provided. Staff monitored and addressed physical health of clients in the house. Staff received mandatory and specialist training and they had a good understanding of the Mental Capacity Act.
- There was no waiting list for the service. The service admitted urgent referrals, in some instances, in under 48 hours. Referrals were screened and assessed for suitability although there were no documented exclusion criteria as admissions were agreed on an individual basis.

However:

- Staff did not complete comprehensive risk assessments for clients admitted to the service and there was no evidence of crisis planning. Staff did not complete individualised care plans for clients accessing the service. Staff did not document discharge plans. Staff kept a lot of information in their heads and this was not translated into the documentation. There were blanket restrictions in place.
- Medicines were not always prescribed safely due to staff not using medicines reconciliation processes as routine. This means that staff did not routinely check that the medicines they were giving were the ones prescribed by the GP.
- The service did not have sufficient governance systems in place to ensure sufficient oversight and risk management of incidents and safeguarding. Managers therefore did not monitor to look for trends, this meant that if the same incident kept on occurring then there was no oversight to look at the reasons why or for example, if there was a gap in staff training.

Summary of findings

Contents

Good

Cornerways

Services we looked at;
Substance misuse services

Summary of this inspection

Background to Cornerways

Cornerways is part of Streetscene Addiction Recovery Service. Cornerways is one of three substance misuse residential rehabilitation and detoxification services in Bournemouth and Southampton.

Cornerways has 20 beds and offers a 24-hour service for males and females. Clients receive treatment for substance misuse problems. There were 18 clients receiving treatment at the time of the inspection. The majority of the funding arrangements are through statutory organisations. However, the service does accept self-funders.

Cornerways has been registered with the Care Quality Commission since November 2006. The service is registered to provide accommodation for persons over 18 years of age who require treatment for substance misuse. There is a CQC registered manager in place.

We previously inspected Cornerways in February 2016. Cornerways was not rated at this inspection.

Our inspection team

The team that inspected the service comprised of three CQC inspectors (one with significant professional experience of working in substance misuse services).

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme to inspect and rate substance misuse services.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- Visited the location and looked at the quality of the environment and observed how staff were caring for clients
- Spoke to the registered manager
- Observed a client group therapy session
- Spoke with five members of staff
- Reviewed six client care records
- Looked at a range of policies, procedures and other documents related to running the service
- Received feedback about the service from stakeholders

Summary of this inspection

What people who use the service say

We spoke with 14 clients. All clients were given an opportunity to speak with us if they wanted to. Clients told us that the staff were kind, compassionate and caring. Clients said that staff regularly exceeded their expectations in the ways they offered support. Clients felt respected by staff and that they were treated as partners in their care. Clients thought that the therapy program was of good quality and that the counsellors instilled hope in their recovery. Clients reported that their feedback on the service was taken seriously and responded to appropriately by staff and managers. However, some clients raised that they would like more access to physical exercise earlier on in treatment.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Clients care records did not contain sufficient information around risks or their management. Risk assessments highlighted if a risk existed but did not provide detail around the highlighted risk, therefore there was little information documented to inform staff of the potential current or historical risks. Staff did not document crisis planning with clients. This meant there was no documented plan in place for staff if a client's mental health deteriorated or they left treatment early.
- Medicines were not always prescribed safely due to staff not using medicines reconciliation processes as routine. This means that support workers transcribed medicines from the boxes that clients brought in with them on admission, there was no standard double checking of the charts or routine contact with the clients GP to ensure that medicines brought in were ones that had been prescribed.
- Despite the service reviewing blanket restrictions there were still a number that remained in place. This meant that restrictions affecting someone in the house were not individually assessed, for example, access to a phone.

However:

- The service had a de-choking device, ventilated pillows and an automated external defibrillator (AED) for use in emergencies.
- The manager completed environment health and safety checks, this included an assessment of ligature points.
- The service had trained the residents in fire safety to ensure that they understood fire procedures and the risks of smoking inside the house. The manager completed regular fire safety checks and practiced evacuation procedures.

Are services effective?

Good

We rated effective as good because:

- A range of therapeutic groups addressed the needs of the clients and supported them in their recovery journey.
- The provider followed national best practice guidelines treatment such as National Institute for Health and Care Excellence guidelines (NICE). Staff we spoke with told us they used the Department of Health drug misuse and dependence UK guidelines on clinical management (also known as the 'Orange Book').

Summary of this inspection

- Staff demonstrated an understanding of the individual needs of clients.
- Staff enabled clients to access physical healthcare including GPs, dentists, physiotherapists and hospital appointments.
- Staff had regular supervision and appraisals and attended weekly team meetings.
- Staff had been trained in and understood the Mental Capacity Act.
- The provider had provided specialist training for staff to enable them to deliver therapeutic interventions such as, cognitive behavioural therapy, harm reduction, family therapy and motivational interviewing.
- The provider employed a private psychiatrist to assess and work with clients who had symptoms of mental health illnesses in circumstances when they could not access local mental health services.

However

- While staff completed care plans they were not always individualised. Care plans were generally generic templates with names added.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- The service had a strong recovery ethos with staff devoted to ensuring that clients had excellent outcomes. The service put clients at the heart and staff consistently stated that they were there to support them and help them change their lives.
- The provider ensured that needs of clients were met, even when there was no funding in place. Bursary beds were routinely offered to clients in crisis.
- People who use services were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. Staff empowered clients to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles to delivering care.
- Feedback from people who use the service was overwhelmingly positive about the way staff treat people. Clients told us that staff go the extra mile and the care they received exceeded their expectations.
- Clients participated in a football competition called the Unity Cup set up by the company and invited local recovery services to join and bring a team. There was a volley ball tournament and barbecue in the summer and they put on a reunion where they invited over 300 ex-residents to an open evening.

Summary of this inspection

- Staff facilitated “all about me days” where clients shared their culture with each other. For example, clients chose food for the day or delivered a presentation about what it is like to be them.
- The service involved client’s families in their care and treatment. We saw examples of where family members had been involved in treatment and care plans. Carers were helped to access carers assessments to ensure that their needs were assessed and met.
- Staff hosted a graduation ceremony for clients when they completed treatment. Staff, clients, family and friends were invited to attend and celebrate their accomplishments.

Are services responsive?

Good

We rated responsive as good because:

- The service provided rapid access to treatment for clients in crisis. There was no waiting list and the service admitted urgent referrals, in some instances, in under 48 hours.
- The service provided aftercare. Clients accessed 10 days of treatment in the house following discharge to facilitate the transition from treatment back into the community. The clients also had access to lifelong aftercare through the provider’s supported housing provision.
- The provider employed a driver to collect clients on their day of admission from anywhere in the country to support clients if public transport is a barrier to treatment.
- There were no documented criteria as admissions were agreed on an individual basis. The admissions manager assessed clients and discussed with the manager before an admission was agreed.
- In the event of clients relapsing, staff tried to work around triggers for relapse or supported them to transfer to another service rather than discharging them.
- Staff gave clients information on the complaints procedure on admission. Information was available in their induction packs. Staff regularly informed clients of the complaints procedure and knew how to respond if a client complained to them.

However:

- Staff did not document discharge plans. None of the care records we reviewed contained a discharge plan.

Are services well-led?

Good

We rated well led as good because:

Summary of this inspection

- The provider had a clear aim and vision for the service. Staff understood the vision and values of Cornerways and the wider organisation. All staff understood their roles in achieving the vision and demonstrating the values.
- There was a positive culture within the service. Staff said they felt respected, supported and valued. Staff also said they felt proud working for the provider and within their team. Staff told us that the manager was compassionate and proactive about staff wellbeing. Staff discussed examples of where the manager had accommodated requests that had improved staff wellbeing.
- The service was responsive to feedback from clients, staff and external agencies. Clients had regular opportunities to give feedback about the service, including; house meetings, evaluation forms, suggestion box and a feedback book. A "you said, we did" board was kept up to date to demonstrate changes made.
- The registered manager maintained a service health and safety risk assessment that included environmental risks and necessary actions. The provider had emergency procedures in place to mitigate potential obstacles to business continuity such as loss of amenities, infection control and adverse weather.
- The provider maintained an organisational risk register was discussed at the business meeting and agreed to escalate risks to senior management and board level if needed. Staff had the opportunity to contribute to the provider's business meetings.

However:

- The service did not have thorough governance systems in place to ensure good oversight and risk management of incidents and safeguarding. Managers therefore did not monitor to look for trends, this meant that if the same incident kept on occurring then there was no oversight to look at the reasons why or for example, if there was a gap in staff training.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The service had a policy on the Mental Capacity Act. Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The service did not accept clients who were subject to Deprivation of Liberty Safeguards (DoLS). Staff had a good level of understanding of the Mental Capacity Act and how it related to their role.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Substance misuse services	Requires improvement	Good	Outstanding	Good	Good	Good
Overall	Requires improvement	Good	Outstanding	Good	Good	Good

Good

Substance misuse services

Safe	Requires improvement
Effective	Good
Caring	Outstanding
Responsive	Good
Well-led	Good

Are substance misuse services safe?

Requires improvement

Safe and clean environment

- Cornerways was visibly clean and there were arrangements in place to ensure the service was kept clean and tidy. Clients staying at the service were taught by staff and peers to clean and tidy the communal areas of the house as well as their own bedrooms. This meant that clients learned valuable skills that they could take with them when they completed treatment. These were called 'therapeutic duties' and were required to be completed daily. Staff assisted with the cleaning and did daily checks to ensure that therapeutic duties had been completed. There was a weekly deep clean of the house and a manager walk round to ensure that standards were high. The house was well maintained and furnishings were of a high standard.
- Clients had a bedroom and bathrooms were shared. Staff admitted a client into a shared bedroom if they were having an assisted withdrawal. An assisted withdrawal is a period where a client is prescribed medication to help them safely withdraw from a substance. Staff moved clients into single rooms as their treatment progressed.
- The manager completed environment health and safety checks, this included an assessment of ligature points. A ligature point is anything which could be used to attach a cord, rope or other material for hanging or strangulation. Steps had been taken following the audit, such as locking bedrooms that were not being used, to ensure the safety of the environment. Staff walked round the house daily to check the safety of the environment, for example that cords were safely tucked away and windows and lights were working.
- Staff adhered to infection control principles such as hand washing and disposing of clinical waste. Hand washing signs were clearly displayed around the service and there were hand gel signs prompting people to clean their hands when they entered the building. There was no hand washing sink available in the clinic room. However, antibacterial gels and wipes were available and hand washing sinks were available in other parts of the building.
- There was an automated external defibrillator (AED) within the building. An AED is a lightweight, battery-operated, portable device that checks the heart's rhythm and sends a shock to the heart to restore a normal rhythm. At the previous inspection in February 2016 there was no AED at Cornerways so we advised the service that they should get one. Both staff and clients had been trained in using the AED.
- The service had a de-choking device in the dining room, for use when debris cannot be removed by usual methods. The service had also purchased ventilated pillows for client's bedrooms who were at risk of a seizure or for use if a client had a seizure face down to prevent suffocation and head injuries.
- The service had trained the residents in fire safety to ensure that they understood fire procedures and the risks of smoking inside the house. The manager completed regular fire safety checks and practiced evacuation procedures.

Safe staffing

- Staffing levels were safe and there were plans in place to cover vacancies, sickness and annual leave. There was

no use of agency staff as they had their own bank staff to cover shortfalls in staffing. The manager of the service felt that it was not guaranteed that agency staff would share their approach and ethos of recovery.

- Volunteers and recovery champions were part of the team. Recovery champions were volunteers who were in recovery from addiction that staff encouraged to support and mentor clients. All staff demonstrated a very high level of knowledge and skill in safety around the management of alcohol and substance misuse.
- Staff were up-to-date with their mandatory training. Mandatory training included Mental Capacity Act, safeguarding adults and children, infection control and addictions training which included withdrawal from alcohol and drugs. When staff needed to renew their mandatory training, there were dates booked in.

Assessing and managing risk to clients and staff

- Staff did not complete comprehensive risk assessments for clients admitted to the service and there was no evidence of crisis planning. We reviewed five care records for clients at Cornerways and there was a lack of detail to inform staff of risks. The templates used were generic which meant that a client's name was added to a pre-populated template that was the same for every client. The templates used were dependent on whether staff ticked the risk in the initial assessment. For example, if a client had a history of suicidal thoughts or self-harm then the corresponding risk assessment/ highlighted need template was used. Staff told us that they kept a lot of client information in their heads.
- We discussed the use of the templates with staff who said that the assessment acted as a disclaimer for clients to sign to say they would not self-harm and would adhere to the therapeutic agreement. The templates did not provide detail around the highlighted risk, therefore there was little information documented to inform staff of the potential current or historical risks. However, staff demonstrated that they were aware of clients risks and their treatment when we spoke with them.
- Staff responded safely to a deterioration in client's health or behavioural change. Staff explained how they responded to changes in mental health and behaviour, for example, by using their observation policy to increase support from staff or to do 'walking therapy' where they went for a walk locally while they talked. We heard that there was a good relationship with the local GP and with community mental health teams, staff used A&E when needed for both physical health problems and mental health deterioration they could not manage in house.
- The service provided clients with a clear list of banned items to keep the house safe, for example, substances.
- Staff supported clients to exit treatment safely if they wanted to leave early. Staff discussed with clients in their admission assessment where they would go if they left unexpectedly and documented early exit plans with clients when they arrived in treatment. The service had a policy of not discharging immediately, for example, if they were intoxicated, so instead put clients up in a bed and breakfast at the expense of the service. Staff said that they tried their best to stop clients leaving the service early if there was a risk of relapse.
- Despite the service reviewing blanket restrictions there were still a number that remained in place. Wi-Fi had been opened for all clients to access. However, access to mobile phones had been reviewed so they were allowed on the secondary stage of treatment but they continued to have access restricted on the primary stage. We also heard that staff prohibited phone calls in private during their first week of treatment. Staff did not review restrictions according to the stage of treatment on an individual basis, however, the length of the stage of treatment was negotiated according to the progression of the client.

Safeguarding

- Staff had good knowledge of safeguarding procedures that helped them protect vulnerable adults from abuse. Staff received training in safeguarding and appointed a safeguarding staff member each day to respond to any safeguarding concerns. When a client was further on in their treatment, staff approached them to have safeguarding responsibilities so that if they became aware of an incident then they could bring that concern to staff to deal with. The safeguarding policy stated that if staff identified a safeguarding concern, they should tell a manager who would make the referral. However, staff demonstrated knowledge of how to raise a safeguarding alert and stated that they would do so if a manager was not available. Cornerways had good a relationship with the local authority.

Staff access to essential information

- Staff used paper records to store essential information related to the care of clients staying at the service. These were kept in a folder and stored safely in a lockable cabinet.

Medicines management

- Medicines were not always prescribed safely due to staff not using medicines reconciliation processes as routine. Medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated. We reviewed all medicine record charts in the house and spoke to staff who dispensed and managed medicines. Support workers transcribed medicines from the boxes that clients brought in with them on admission, there was no standard double checking of the charts or routine contact with the clients GP to ensure that medicines brought in were ones that had been prescribed. This meant that staff risked writing a prescription chart for a medicine that was not prescribed by the clients GP. National Institute for Health and Care Excellence (NICE) guidance on medicines optimisation recommends clear communication around medicines within 24 hours of a client moving from one care setting to another in order to have a complete and accurate list of prescribed medicines to maintain safety.
- Clients accessing the service to have an assisted withdrawal received assessment and a reducing regime of medication to help them safely withdraw from drugs or alcohol. There was a dedicated doctor in charge of the assessment and prescribing of medication for assisted withdrawal. Care records clearly showed the assessment prior to detox commencing. However, medical summaries from the client's GP were not routinely sought as part of this process. This means that potentially vital information could be missed as part of the assessment process.
- All medicines kept in the cabinet were in date. Staff had accurately checked and completed the controlled drugs register. Emergency medicine to be administered in the event of an opiate overdose was present and in date. Staff audited medicines on a daily and weekly basis to count tablets and check for omissions, they received audits from the external pharmacist. Staff recorded fridge and room temperatures to ensure that medicines were stored at a safe temperature.
- Clients progressed onto self-medication regimes to help them manage their own physical and mental health medication. This was risk assessed prior to starting to ensure that the client was appropriate for the step.

Track record on safety

- Cornerways reported 15 serious incidents in the 12 months leading up to the inspection. These included clients being taken to hospital and medication errors.

Reporting incidents and learning from when things go wrong

- Staff knew what to report as incidents and how to report incidents. Staff reported incidents on a paper record and met together to discuss and learn from incidents. Staff described a supportive team around incidents and that they felt confident in managing incidents such as rule breaking or violence and aggression. The manager held a record of all incidents that occurred in the house however it was not clear if learning from incidents was cascaded to the wider team, for example if a staff member was not at work to have the de-brief and immediate learning.
- Managers demonstrated that they were aware of the duty of candour in relation to incidents. The duty of candour puts responsibility on the provider to be honest when things go wrong.

Are substance misuse services effective?
(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Staff ensured that there were plans of care in place however they were completed on generic templates. We looked at five care records including recovery and medical care plans. The care plans were holistic, however not personalised. The templates were generic

with fields where clients` names could be added rather than creating a care plan that reflected the individual. This meant that all clients had the same care plans in place despite having very different presentations.
- Staff completed medical care plans that described detoxification regimes, actions to take in an emergency and monitoring of withdrawal symptoms.
- Staff took clients' physical health needs into consideration. Physical care plans were in place and were comprehensive and detailed. We saw examples of physical health issues that had been planned for and were being monitored.

Best practice in treatment and care

- The provider followed national best practice guidelines treatment such as National Institute for Health and Care Excellence guidelines (NICE). Staff we spoke with told us they used the Department of Health drug misuse and dependence UK guidelines on clinical management (also known as the 'Orange Book'). The registered manager told us that there was one hard copy of the Orange Book available for staff to refer to on site.
- The provider used the '12 step' model to support clients who were on detoxification treatment. The 12-step model is focused on interaction within a group support structure as opposed to individual counselling and medical intervention. Whilst counselling and medical intervention were also part of addiction recovery, it was the 12-step model that participants go through that provided a bridge between past behaviours and an addiction-free future.
- The provider provided individual counselling to clients. Staff delivered daily groups based on the 12-step program and cognitive behavioural therapy principles.
- The provider submitted data to the National Drug Treatment Monitoring System (NDTMS) as a means of monitoring the effectiveness of the therapeutic program. Staff evaluated the effectiveness of treatment and clients' progress by using an in-house tool called entry and exit questionnaire. These were reviewed to inform improvements.
- Staff used the clinical institute withdrawal assessment of alcohol scale (CIWA-Ar) and clinical opiate withdrawal scale (COWS) to identify and monitor withdrawal symptoms. Staff were aware and able to identify withdrawal symptoms by observations and when reported by clients. Staff acted promptly by monitoring and seeking medical advice if required. The GP did not routinely prescribe PRN for detoxification regimes but would provide verbal prescriptions over the telephone if extra doses were required. Staff described good practice around receiving verbal prescriptions. However, staff did not always clearly document communication with the GP.
- The provider employed a private psychiatrist to assess and work with clients who had symptoms of mental health illnesses in circumstances when they could not access local mental health services. Psychoactive medications are used to treat a variety of mental health conditions. Although Cornerways followed a 12-step treatment model, which traditionally does not support medical treatment of mental health problems, this facility enabled clients to access support for their mental health problems should this deteriorate whilst being at Cornerways.
- Staff ran therapeutic groups five days per week for around an hour. We attended one of these groups and staff used cognitive behavioural therapy techniques which is appropriate for use with this client group. Clients appreciated the therapeutic groups as they said the groups addressed their needs and helped them in their recovery journey.
- Records showed staff enabled clients to access the physical healthcare they needed including dentists, GPs, hospital appointments and other specialists such as physiotherapists. The provider also weighed clients weekly if they were concerned about weight loss.
- The service catered for clients who had specific dietary requirements. For example, one client was on a low sugar diabetic diet plan and staff were providing a diet plan to support the client.
- The provider did not supply take home naloxone to all clients or carers of people who were discharged after opiate rehabilitation. This is an essential injectable medication that can reverse opiate overdose. However, staff were signposting clients to a local service that issued take home naloxone.

Skilled staff to deliver care

- The multidisciplinary team comprised of counsellors, support workers, a registered manager and a team lead.
- There were professionally qualified staff working in the service such as counsellors. The support workers had relevant qualifications and training for their role.

Good

Substance misuse services

- Staff were provided with specialist training in approaches that were recommended for substance misuse rehabilitation providers, such as, cognitive behavioural therapy, relapse prevention, harm reduction and motivational interviewing.
- The provider gave training for staff in the treatment model and they were issued with a copy of the treatment model book.
- Staff had access to regular supervision and annual appraisals. Staff supervision were conducted every two months using a standard form and were delivered by an external supervisor. Staff were involved in their appraisals such as their self-appraisal meeting or review and their yearly appraisal. In staff records we reviewed, staff had personal development plans. All staff had had an appraisal within the past 12 months and completed an induction program at the start of employment.

Multi-disciplinary and inter-agency team work

- There was a multidisciplinary team meeting every week with individual clients reviewed every week. The support workers and counsellor team attended the meeting. Staff always invited the clients care manager for clients who were from other areas and counties but they were not always able to attend.
- Clients records showed good joint working between the support workers and counsellor teams. Staff attended these team meetings weekly.
- Staff completed a handover at the beginning and end of each shift. An additional handover took place in the morning where the counsellors and support workers handed over and shared information. Staff had daily process meetings where they reflected on the day and put in place any necessary changes to the program or client's individual treatment.
- Managers told us they had effective working relationships with other organisations such as social services and a local GP practice.

Good practice in applying the Mental Capacity Act

- All staff had completed training in the Mental Capacity Act.
- Staff had a good level of understanding of the Mental Capacity Act and the guiding principles.
- The provider had a policy on the Mental Capacity Act including Deprivation of Liberty Safeguards that staff could refer to.

Are substance misuse services caring?

Outstanding ☆

Kindness, privacy, dignity, respect, compassion and support

- Feedback from people who use the service was overwhelmingly positive about the way staff treat people. Clients told us that staff go the extra mile and the care they received exceeded their expectations. Clients praised the staff in helping them open up and talk about areas of their life they had previously kept to themselves. They were taught to be truthful and honest as well as being taught to take care of themselves physically and emotionally. Clients felt respected by staff and they understood changes of emotion such as getting angry and wanting to leave. There were adaptations to normal therapy such as doing walking therapy to help get the best out of the clients.
- The service had a strong recovery ethos with staff devoted to ensuring that clients had excellent outcomes. Staff were hard working, caring and committed to delivering a good quality service. They spoke with passion about their work and were proud of what they did. The service put clients at the heart and staff consistently stated that they were there to support them and help them change their lives.
- The provider ensured that the needs of clients were met. Bursary beds were routinely offered to clients in crisis, clients who needed to remain in treatment longer or who did not have accommodation to return to when treatment had finished. The ethos of the organisation was to ensure that all vulnerable clients were cared for, irrespective of the funding received.
- Clients gave us numerous examples of where staff had supported clients out of hours or provided support to former clients.
- Staff recognised and respected the totality of the client's needs. They always took client's personal, cultural, social and religious needs into account. Staff also told us that the established good relationship with the local Jewish community which supplied the house with Kosher products when required. Staff were keen to promote a culture of respect and assured clients that they were safe to raise any allegations of discriminatory behaviour.

Good

Substance misuse services

- Staff attitudes and behaviour when interacting with patients showed they were discreet, respectful and responsive. Staff said that there was an open culture where they could always raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients without fear of consequences.
- Staff maintained the confidentiality of information about clients and supported them to make choices about sharing information.

Involvement in care

- Clients participated in a football competition called the Unity Cup set up by the company and invited local recovery services to join and bring a team. There was a volley ball tournament and barbecue in the summer and they put on a reunion where they invited over 300 ex-residents to an open evening at a hotel. Ex-residents shared their experience and their recovery. The service had also put on a gala to raise money to pay for clients that had no funding but needed treatment, we found that a lot of free treatment was given away.
- People who use services are active partners in their care. Staff are fully committed to working in partnership with people and making this a reality for each person. Staff empowered clients to have a voice and to realise their potential. They show determination and creativity to overcome obstacles to delivering care. Client's individual preferences and needs were always reflected in how care is delivered.
- Staff collected formal client feedback quarterly and on discharge and held weekly house meetings for clients to raise any issues. Clients told us that staff always responded to issues raised and explained the reasons for decisions made.
- Counsellors met with clients weekly to discuss their care and review treatment plans. Clients told us that feedback about their treatment was listened to and that they developed plans collaboratively with their counsellors.
- The service involved client's families in their care and treatment. We saw examples of where family members had been involved in treatment and care plans. Family members were encouraged to visit and there were no set visiting hours. Carers were helped to access carers assessments to ensure that their needs were assessed and met.
- Staff hosted a graduation ceremony for clients when they completed treatment. Staff, clients, family and friends were invited to attend and celebrate their accomplishments.
- Clients were involved in decisions about the services they used. Staff involved them as panel members when they held interviews for new staff. Clients and carers had been included in discussions about the house developments.
- Staff ensured that clients had access to advocacy and included the advocate in meetings as appropriate. This was important to help ensure clients had their voice heard.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- There was no waiting list for the service. The service admitted urgent referrals, in some instances, in under 48 hours. The manager gave an example where a previous client telephoned in crisis and was admitted the next day.
- Referrals were screened and assessed for suitability. The admissions manager assessed clients and discussed with the manager before an admission was agreed. There were no documented exclusion criteria as admissions were agreed on an individual basis. The manager worked with external agencies to safely offer places to clients that had difficulty accessing residential treatment elsewhere.
- The provider employed a driver who collected clients from anywhere in the country and drove them to the service to facilitate admission.
- In the event of clients relapsing, staff tried to work around triggers for relapse or supported them to transfer to another service rather than discharging them. Discharging clients immediately following relapse is often normal practice within many substance misuse services.

- The service transferred clients to other houses within their organisation if they could not meet the client's needs. The service also supported clients to access treatment and accommodation outside of the organisation.
- The provider offered supported living which clients could move onto after successful completion of treatment.
- The service provided aftercare to support clients with their recovery after completion of residential treatment. Clients accessed 10 days of treatment in the house following discharge to facilitate the transition from treatment back into the community. The clients also had access to lifelong aftercare through the provider's supported housing provision.
- Staff did not document discharge plans. None of the client care records we reviewed contained a discharge plan. However, staff discussed good practice around planned and unplanned discharges and transferring clients to other services.

The facilities promote recovery, comfort, dignity and confidentiality

- The service had a range of rooms for clients, including living rooms, a large dining room and a multi-faith room. There were other rooms for group and individual therapy. The living rooms were bright, spacious and well maintained.
- Bedrooms were individual and shared rooms. Clients undergoing a medical detoxification slept in a shared bedroom with a client further along in their treatment to provide night time support and alert staff if there was a problem. All other clients had their own bedrooms.
- Bathrooms were communal. There were gender specific bathrooms on the ground floor and mixed bathrooms on the first floor. However, most client's bedrooms were situated on the first floor and would have to pass bedrooms of the opposite gender to access a bathroom.
- Clients had private spaces to make telephone calls from. There was a payphone in a private location and some clients used their mobile telephones in their bedrooms. However, clients in their first week of treatment were expected to make all telephone calls in the office in the presence of staff.

Clients' engagement with the wider community

- Staff supported clients to access and attend external support groups such as Alcoholics Anonymous.
- Clients had limited access to the community within the first phase of treatment. Clients were required to take a volunteer with them when accessing the community. However, specific requests were considered by staff and planned for with the clients and access to the community was more flexible in the second phase of treatment.
- Staff supported clients to access suitable voluntary work and education opportunities.
- The service organised day trips for all the clients. For example, trips, ice skating or for a walk in the countryside.

Meeting the needs of all people who use the service

- The ground floor was wheelchair accessible. There were bedrooms and bathrooms on the ground floor. There were no mobility aids in the bedrooms or bathrooms requiring clients to be able to transfer independently. However, we were told that mobility aids were accessible if required.
- When clients had additional care needs, such as personal care, the provider used a domiciliary care agency to provide this support to enable the client to remain in treatment.
- Staff provided access to spiritual support on and off site. Clients accessed faith groups in the community and had a multi-faith room on site.
- Staff understood the clients' needs, encompassing their different social and cultural needs including those with protected characteristics such people from the lesbian, gay, bisexual and transgender community.

Listening to and learning from concerns and complaints

- Cornerways received 0 complaints in the 12 months prior to our inspection.
- Staff escalated complaints to their manager. Serious complaints were referred to the board of directors for investigation and response. Other complaints were dealt with by the manager.
- Staff gave clients information on the complaints procedure on admission. Information was available in their induction packs. Staff regularly informed clients of the complaints procedure in house meetings. Clients could also raise concerns informally through a feedback book, house meetings and in client evaluation surveys.

Good

Substance misuse services

Are substance misuse services well-led?

Good

Leadership

- Cornerways had a dedicated registered manager and a clinical team lead for the counselling team. Leaders and managers were visible and experienced in working in substance misuse. Managers were active in-service delivery and participated in providing front line care.
- Staff spoke positively of the leadership shown by the registered manager. Staff said that the manager was approachable and accessible.
- The provider supported managers to complete management training. The manager had completed leadership qualifications.
- The chief executive officer (CEO) and the board of directors provided clear direction and clinical leadership.

Vision and strategy

- Management and staff shared a clear definition of recovery that was embedded throughout the service. Managers and staff were committed to putting clients first. This was evident in the way that staff spoke about the clients and in interactions we observed between staff and clients.
- Staff understood the vision and values of Cornerways and the wider organisation. All staff had a job description and understood their roles in achieving the vision and demonstrating the values. Managers used a values-based interview process to ensure that staff held the organisational values.
- Staff had the opportunity to contribute to the provider's steering meetings. Staff felt that members of the steering group welcomed their input and always fed back after meetings.
- The service was committed to ensuring money was available where it was most needed, for example in providing clients with healthy food choices over decorative issues that could wait to be corrected.

Culture

- There was a positive culture within the service. Staff said they felt respected, supported and valued. Staff also said they felt proud working for the provider and within their team. Staff told us that although there were pressures particularly around completing paperwork, the workload was manageable and there was not much stress within the team.
- Staff were aware of how to raise concerns including the whistle-blowing process and felt they could do so without fear of retribution.
- The registered manager told us that they dealt with poor performance when needed. We saw personal development plans and action plans in staff supervision and appraisal records.
- Staff told us that the manager was compassionate and proactive about staff wellbeing. Staff discussed examples of where the manager had accommodated requests that had improved staff wellbeing.
- The provider had mechanisms in place to ensure staff were appraised and counsellors received regular supervision through an external supervisor. This ensured staff had received the necessary specialist training they needed to support the client group and deliver the treatment programme. The provider ensured staff updated their mandatory training.

Governance

- Policies were in place to guide staff within their work. Some of these had been created from previous learning within the organisation, for example, the policy of referring a client to the local mental health service prior to admission if they had mental health support in their home town.
- Managers and staff conducted audits of notes within the house and in other houses in the organisation. This allowed practice to be reviewed and any shortfalls to be picked up.
- Managers evaluated the effectiveness of client treatment. Clients completed feedback questionnaires every quarter and on discharge. Treatment outcome profiles (TOPS) were completed and submitted to National Drug Treatment Monitoring System (NDTMS). The provider also gauged the effectiveness of the service through contacts they received from previous clients such as phone calls and Christmas cards.
- The service did not have sufficient governance systems in place to ensure sufficient oversight and risk management. Incidents were not logged centrally or analysed for trends and themes. However, there was no analysis of incidents over a period to look for trends, this

meant that if the same incident kept on occurring then there was no oversight to look at the reasons why or for example, if there was a gap in staff training. Safeguarding governance was not as robust as expected

- The manager did not have access to up to date data about the service, for example retention in treatment or successful discharges. Data was reported to the National Drug Treatment Monitoring System (NDTMS) and reports generated annually. The latest information available to manager was almost a year old.

Management of risk, issues and performance

- The registered manager maintained a service health and safety risk assessment that included environmental risks and necessary actions.
- The provider maintained and discussed the organisational risk register at the business meeting and agreed to escalate risks to senior management and board level if needed. We saw evidence of this in the minutes of these meetings.
- The provider had emergency procedures in place to mitigate potential obstacles to business continuity such as loss of amenities, infection control and adverse weather. The plan did not cover what the provider would do if all the staff were sick at the same time. When staff were on leave, other staff covered for them as extra bank shifts and there were no agency staffing arrangements.
- Managers monitored staff performance within their teams. Performance management plans were in place where they were needed.

Information management

- The paper care records system was accessible to staff and were stored in a way that maintained clients' confidentiality.
- Staff had access to relevant policies which were access via the computer on the intranet. There were enough computers and staff had access to equipment to help them provide care to clients.
- The manager discussed learning from individual incidents and complaints with staff via emails, in team meetings, during supervision or to individual staff.

Engagement

- Staff told us feedback from clients were collected through satisfaction surveys.
- The manager maintained a "you said, we did" board with examples of feedback received and the actions taken by the service.
- Clients had regular opportunities to give feedback about the service, including; house meetings, evaluation forms, suggestion box and a feedback book. The provider also gauged client's opinion the service through self-evaluation forms during and on completion of treatment.

Learning, continuous improvement and innovation

- We found no specific examples of programs or processes to facilitate learning, continuous improvement or innovation.

Outstanding practice and areas for improvement

Outstanding practice

- The provider actively worked to reduce barriers to treatment for their clients. For example, the service had admitted clients with their pets, purchased support from domiciliary care agencies for clients requiring personal care and employed a driver who collected clients when public transport was a barrier to treatment.
- The ethos of the service was to go the extra mile for clients and put people before profits. The provider regularly provided free care to clients who had unmet needs but did not have funding available. The provider offered free aftercare for life to all clients after completion of treatment.
- The provider worked with staff and clients to minimise harm if a medical emergency occurred. For example, clients were trained in using an automatic external defibrillator (AED) and delivering cardio-pulmonary resuscitation (CPR). The provider had purchased a de-choking device and ventilated pillows to prevent suffocation during a seizure.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff follow safe medicines prescribing and management procedures. (Reg 12)
- The provider must ensure that risk assessments reflect all risks for clients using the service. (Reg 12)

Action the provider SHOULD take to improve

- The provider should ensure that restrictions are individually assessed.
- The provider should ensure that there are effective care plans in place that are personalised.
- The provider should ensure that managers have robust oversight of incidents and safeguarding procedures.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Clients care records did not contain sufficient information around risks or their management. Risk assessments highlighted if a risk existed but did not provide detail around the highlighted risk, therefore there was little information documented to inform staff of the potential current or historical risks. Staff did not document crisis planning with clients. This meant there was no documented plan in place for staff if a client's mental health deteriorated. Staff did not routinely obtain GP summaries prior to starting detoxification regimes. Staff did not clearly document medical decisions, instructions or conversations with medical professionals. There was no process in place to ensure that client's medication was checked against the most up to date list of prescribed medication. Community staff sent a medication list, up to four weeks prior to admission. Clients brought in 28 days of medication with them and this was checked against the potentially inaccurate medication list. Support workers transcribed medicines onto drug charts on a client's admission. There was no standard double checking of these charts by another member of staff or a prescriber. This was a breach of regulation 12(2)(a)(b)(g)