The Corner House

Quality Report

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Date of inspection visit: 14 December 2015
Date of publication: 26/04/2016

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

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 the Corner House as **requires improvement because**:

- Following the review of a serious incident in April 2015, the service identified that the physical intervention approach used was not compatible with the technique agency staff used. This left staff vulnerable in challenging situations and a further incident occurred in October 2015. The service had not yet implemented an alternative approach although plans were in place to train staff in January 2016.
- Corner House had used 58 different agency staff in the last three months to fill vacancies and support patients who needed increased levels of observation.
- A patient had missed three doses of his psychoactive medication. Internal processes were not followed which led to the failure to provide sufficient stocks of medication.
- The psychologist was unable to introduce positive behavioural support plans for patients in line with the latest guidance or facilitate group therapy sessions. This was due to staff vacancies and a lack of stability within the staff group.
- The service provided a limited choice of meaningful activities and group therapy sessions due to the occupational therapist and psychology assistant vacancies. This meant that patients did not receive individualised tailored activities to promote independence. The activities coordinator and the service user involvement worker provided group activities and engagement.
- Patient discharge plans were variable. This was because the service distinguished between a discharge plan and a discharge pathway. If staff had identified that a patient was ready for discharge they completed their discharge plan. Otherwise, patients remained on the discharge pathway with a discharge plan that did not identify what steps the patient needed to take to achieve independence.
- There was a lack of local leadership, which contributed to low staff morale. The service manager was often away from the site promoting the service and the organisation. The clinical lead had recently left. The service had temporarily promoted a permanent member of staff to fill this post. The clinical team did not feel supported by the service manager when they tried to introduce changes to clinical processes.
- The service had carried an occupational therapist vacancy since April 2015. They had recently been unsuccessful in recruiting to this position due to poor coordination during the recruitment process.
- Nursing staff morale was low. Permanent staff felt stressed when they worked a shift with agency staff, particularly when there was only one permanent member of staff on duty to three agency staff. This was because patients were reluctant to engage with unfamiliar agency staff and agency staff looked to permanent staff, whatever their grade, for direction.
- We requested information from the service during the inspection. When the service sent this to us electronically, they breached data protection.

However:

- The service was clean and well maintained. The housekeeper undertook regular infection control audits and supported patients to keep their bedsits clean and tidy.
- Patient risk assessments and risk management plans were comprehensive and of good quality. Staff reviewed these on a regular basis or as risks changed.
- We observed staff interacting with patients during the course of the inspection. They treated patients with kindness and compassion and clearly had good relationships with them.
- Four patients had a discharge timeline displayed in their rooms. The service had developed these in an easy read format so that the patient could understand them and showed what goals they had to achieve to move along the timeline.

Summary of findings

- Staff handover at the end of each shift was multi-disciplinary, identifying patients' needs, and focusing on individual risks and safeguarding issues. This meant staff had a clear picture of the care and treatment they needed to provide to their patients.
- All patients had access to information about their care and treatment in an easy read format. The service displayed this information in the reception area where patients tended to congregate.

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Background to The Corner House

The Corner House is an independent, purpose built 12 bedded locked rehabilitation unit located in a residential area on the outskirts of Rotherham. The service provides rehabilitation to men with a learning disability who also have mental health needs or challenging behaviours. The Corner House is provided by Turning Point and has a registered manager who is also the controlled drugs accountable officer. The service is registered to provide the following regulated activities:

- accommodation for persons who require nursing or personal care
- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- treatment of disease, disorder or injury.

On the day of our visit, there were 10 patients allocated to the unit, of which nine were detained under the Mental Health Act (1983) and one was subject to Deprivation of Liberty Safeguards.

We have inspected The Corner House twice before. An inspection took place in January 2014 and met the required standards. The Mental Health Act review in January 2014 identified actions in respect of patient risk assessments and renewal of detention forms. We found the service had addressed all these actions. This was the first time we have inspected Corner House using our new method of inspection.

Our inspection team

Team leader: Jacqui Holmes, Care Quality Commission.

The team that inspected the service comprised two CQC inspectors, one occupational therapist and a Mental Health Act reviewer.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

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 service, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with four patients who were using the service
- spoke with a carer
- spoke with the registered manager
- spoke with 10 other staff members; including doctors, nurses, health care assistant, service user involvement worker, activity coordinator, psychologist and housekeeper
- attended and observed one hand-over/ multi-disciplinary meetings
- looked at four care and treatment records of patients

Summary of this inspection

- carried out a specific check of the medication management on the ward
- looked at policies, procedures and other documents relating to the running of the service

What people who use the service say

The four patients we spoke with were happy with the care they were receiving. They said staff were kind and supportive towards them. One patient told us they would miss the staff when they left the unit.

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:

- Agency staff did not assist with physical interventions as they had not had the same training as permanent staff. Plans were in place during January 2016 to train permanent staff in a technique that matched with agency staff and met the services' needs.
- The service failed to maintain sufficient stock of a patient's medication. This led to the patient missing three doses of his psychoactive medication.
- The high use of agency staff meant that permanent staff felt stressed during shifts. This was because patients were reluctant to engage with unfamiliar staff and agency staff looked to permanent staff, whatever their grade, for direction.

However:

- The service was clean and well maintained. The housekeeper undertook regular infection control audits and supported patients to keep their bedsits clean and tidy.
- Patient risk assessments and risk management plans were comprehensive and of good quality. Staff reviewed these on a regular basis or as risks changed.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- The psychologist was unable to introduce positive behavioural support plans or group therapy sessions due to a lack of stable and consistent staff.
- Patient care plans were several pages long and staff had written them using language that was not easily understandable by the patient.

However:

- Each patient had "Daily Living Support Plans". These plans described the level of support required by the patient for each element of their care. This meant that patients received a consistent level of support from all staff.

Summary of this inspection

- Staff ensured that patients had good access to physical healthcare and encouraged them to join a local GP practice. Staff met patients' physical health care needs by carrying out daily / weekly checks on blood sugar levels, weight and blood pressure.
- Multi-disciplinary shift handovers ensured all staff knew how each patient was presenting, pending discharges, patient relationships and reminder of individual risks.

Are services caring?

Good

We rated caring as **good** because:

- We observed staff interacting with patients during the course of the visit. They treated patients with respect and kindness and clearly had good relationships with them.
- The service user involvement worker encouraged patients to be involved in their care and treatment using information in a format they could easily understand.

Are services responsive?

Requires improvement

We rated responsive as **requires improvement** because:

- The service provided a limited choice of meaningful activities and group therapy sessions due to the lack of occupational therapist and psychology assistant.
- Staff told us that patients were sometimes not motivated in a morning to attend activity sessions. Information recorded about activity attendance supported this.
- Discharge plans were not clearly present in patients' notes. This meant that the plan did not identify what steps the patient needed to take to achieve to independence.

However:

- The activities co-ordinator arranged group activities for patients. They held a daily activities meeting with patients to discuss activities arranged for the next day and any specific future activities that patients requested.
- Four patients had a discharge timeline displayed in their rooms. These were in an easy read format so that the patient could understand them and showed what goals they had to achieve to move along the timeline.
- All patients had access to illustrated, easy to read information about treatments, local services, their rights and how to complain. The service displayed this information in the reception area where patients tended to congregate.

Summary of this inspection

Are services well-led?

Requires improvement 

We rated well-led as **requires improvement** because:

- There was a lack of local leadership. The service manager often worked away from the site. The service had a high turnover of staff and the clinical lead had recently left.
- Nursing staff morale was low, permanent staff did not feel supported by the organisation and felt stressed when they worked with agency staff.
- The service did not fill vacancies in a timely fashion and the recent unsuccessful recruitment to the psychology assistant role was poorly coordinated.
- We requested information from the service during the inspection. When the service sent this to us electronically, they breached data protection.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

The service had nine patients detained under the Mental Health Act. The system for recording patient leave was thorough and patients were aware of how much leave they could take.

Staff regularly explained to patients their rights under section 132 and recorded their understanding.

Patients were receiving treatment authorised by the appropriate certificate. We saw that copies of the certificates were stored with the patients' prescription cards. In each case, an assessment of the patient's capacity to consent to the treatment had been recorded.

Copies of the patients' detention papers and the reports by the approved mental health professionals were mainly in order. However, the authorisation of one patient's restricted detention could not be located on the unit.

The service used an advocacy service and all patients engaged with an advocate.

Mental Capacity Act and Deprivation of Liberty Safeguards

The service had a Mental Capacity Act (MCA) policy in place and 84% of staff had undertaken some form of MCA training. They had made one application for a Deprivation of Liberty Safeguard in the last six months and were awaiting authorisation.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

The Corner House was a locked rehabilitation unit. The main entrance to the site was through an air lock, controlled by staff. An airlock strengthens security by providing an additional locked room that all staff, visitors and patients have to pass through to gain entrance or exit from a building. Staff did not have clear lines of sight to all areas due to the layout. Bedrooms were located either on the first floor or along a corridor on the ground floor. Staff managed the risk to clients by effective handovers and through observation. CCTV was available in the communal areas. Staff used this to review incidents.

There was a yearly environmental risk audit carried out, which included the ligature risk audit and management plan. Patients had individually programmed fobs to gain access to their bedrooms and the courtyard area. Staff kept areas that contained ligature risks locked to minimise the risk to patients, for example, the assisted bathroom.

The service was well maintained and very clean throughout with good standards of hygiene and infection control. There were effective systems in place to reduce the risk and spread of infection The housekeeper carried out regular infection control audits and supported clients to keep their rooms tidy and clean.

The clinic room had emergency equipment and equipment necessary to carry out physical examinations. A pharmacy technician carried out a weekly audit of the clinic room.

Corner House had a contract with the local pharmacy, which supplied medications. We noted that life support equipment and medications were in date and that nurses monitored the temperature of the clinical fridge on a daily basis. Nursing staff were responsible for ensuring that equipment and medications were in order and safe to use on a daily basis.

All rooms had nurse call points for use by service users and staff. In addition, staff carried personal alarms, which linked into an infra-red sensor system covering all parts of the building. This meant staff could summon immediate assistance from any part of the unit if required. The patients we spoke with told us they felt safe.

Safe staffing

The service employed 32 staff in total, including seven whole time equivalent qualified nurses and 14 support workers. The number and grades of clinical staff had been decided when the unit first opened and was not based on any specific tools. The service operated a shift pattern of one qualified nurse and three support workers, covering three shifts a day. The shift rotas showed that this was the minimum of staff employed on a daily basis.

Sickness rates for the service over the last 12 months were low at 1.5%. Staff turnover for this period was 25%. The service had vacancies for four support workers, a psychology assistant, a clinical lead and an occupational therapist. The clinical lead had left recently and a permanent nurse had temporarily filled the vacancy. The service had appointed an agency nurse to the vacant nursing position. Following a recruitment drive, the service

had recently appointed three support workers, two were going through pre-employment checks and one had started recently. However, the occupational therapist role remained vacant and had been since April 2015.

At the time of our inspection, one patient was on section 17 leave to the general hospital due to physical health needs and another patient required two to one levels of observation following a decline in their mental health. The service manager adjusted the number of staff on duty to account for increased levels of observation required. All agency staff were required to complete an induction checklist before their first shift at the service.

Due to the level of staffing vacancies and need for increased observations, the service relied heavily on agency staff. We looked at staffing rotas for the 12-week period leading up to and including the inspection. The rotas showed that 227 out of 252 support worker shifts required agency staff in order to meet the minimum establishment levels. The service used agency nurses to fill 76 out of the 252 qualified nurse shifts, 49% of these being night shifts. On nine shifts, there was only one permanent staff on duty and an additional three shifts comprised of all agency staff. In total, the service used 44 different agency support workers and 14 different agency nurses during this period.

This meant that patients were not familiar with and did not build up a therapeutic relationship with agency staff. Permanent staff told us that patients preferred to engage with them rather than agency staff. They were also concerned that agency staff sought direction from permanent staff whatever their grade. The service had recognised the impact this was having on patients. They had recently changed their agency recruiting process to develop a core group of agency staff that were familiar with the patients and service. Although the service adjusted staffing levels to cover shifts, the agency staff used did not have the same training in physical interventions as permanent staff. This meant they did not assist when the need arose.

We checked permanent and agency staff recruitment files and found the service had carried out the necessary pre-employment checks. These included identity checks, educational certificates and satisfactory disclosure and barring service clearance.

Staff and patients told us that they rarely cancelled any escorted leave. Patients told us they received one to one sessions with either their named nurse or a member of staff every day. We saw permanent staff frequently engage in conversations with their patients.

In April 2015, the Corner House made a contract with the local NHS mental health trust to supply a clinical team to strengthen and improve clinical processes. This team consisted of a part time psychologist, consultant and a full time doctor. Out of hours, the service had access to an on call psychiatrist and emergency services for physical health need.

All staff were required to attend mandatory training. Corner House had a target compliance rate of 100%. The service was currently achieving 92% for mandatory online training courses. Staff struggled to attend the face-to-face training because the provider held the training in Manchester. The following mandatory face to face training had compliance rates of less than 70%: suicide and self-harm , first aid at work, safeguarding, managing violence and aggression, the Mental Capacity Act and the Mental Health Act. The provider had addressed this by training the service development lead to roll out the training locally. This was due to commence in January 2016 and included a Mental Health Act training programme.

Assessing and managing risk to patients and staff

The clinical team had introduced robust risk assessments for every patient. We checked four patient records and in each case found the comprehensive risk assessments were of good quality and reviewed every three months or as patients' risks changed. Patients had risk management plans in place and staff regularly reviewed and updated these as appropriate. Patients were risk assessed at referral stage, followed by a more detailed assessment after the first week. Staff used the referral information to manage risk during their first week. Staff used structured professional risk assessment schemes such as Historical Clinical Risk Management-20, which assesses risk factors for violent behaviour. Risk assessments took into account patient's previous history as well as their current mental state. For example, a patient with a history of aggression towards others had their level of observations increased as their mental health declined.

The provider had a policy for the rapid tranquilisation of patients. Staff had not carried out any prone restraints or

rapid tranquilisation of patients in the last 12 months. On 24 occasions during this period, staff had carried out physical interventions. The service counted any form of placing hands on a patient as a physical intervention. All patients had an individual plan, which allowed staff to disengage with them in a safe area and support and debrief them after the event. The service did not have a seclusion room although they had a seclusion policy.

Staff understood how to protect their patients from abuse. They knew when and how to raise a safeguarding concern and followed the organisations policies and procedures. The service had raised 13 safeguarding concerns with the local authority in the last three months. Staff shared any safeguarding incidents during the shift handover meeting. Permanent staff were up to date with their safeguarding training, which was a basic level online programme.

Nurses were responsible for carrying out a weekly medication audit to ensure that patients had sufficient medication for their needs. We found that on three occasions staff had not given a patient his anti-psychotic medication, as it was not available. The nurse on duty had taken action and ordered the medication from the pharmacy but no one had reported this as an incident. We brought this to the attention of the operations manager.

Track record on safety

The service reported three incidents of serious assaults on staff in the last 12 months that had required investigation. Permanent staff were trained to use a specific approach to manage physical interventions. However, agency staff did not assist with physical interventions, as they did not have training in this type of approach. This meant there where shifts when permanent staff were placed in a vulnerable position, particularly when their colleagues on shift were agency staff.

Reporting incidents and learning from when things go wrong

Permanent staff had an understanding of what constituted an incident and what needed reporting. They had reported 450 incidents in the last 12 months covering a range of topics. For example, staff had reported five medication errors. Three of these related to missed signatures on prescription cards, one to concealment of medication and one to staff accidentally throwing medication away. The induction checklist for agency staff also included incident reporting.

Staff logged incidents using an online system and the service manager investigated them. The aim of reviewing incidents was to learn lessons, support staff and encourage the therapeutic relationship between staff and patients. Staff received feedback from investigations at team meetings. Clinical and operational staff provided a debrief and support following a serious incident.

However, lessons learned and changes to practice were not always timely. We saw the psychologist report and debrief following the serious incident in April 2015. The report clearly highlighted that the current techniques for managing violence and aggression were not adequate and recommended the use of a different type of intervention. No refresher or training in managing violence and aggression took place in the intervening months. Following a similar incident in October 2015 when a staff member was injured, the service had put plans in place for all permanent staff to undergo training in a technique more suitable to the environment and compatible with the training undertaken by agency staff.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Staff assessed patients' needs using the Manchester Care Assessment Schedule and developed individual care plans based on the 10 key areas of the 'recovery star' model. We reviewed four patient care plans and saw they were comprehensive and personalised. Each key area formed an individual plan that was detailed and lengthy but not written in a way that a patient with a learning disability would easily understand. The staff recorded the daily progress notes for each patient in the electronic clinical records, which we saw contained some accounts of the patients' views and of their involvement. While patients confirmed that they were encouraged to participate in the planning of their care, they were not able to say what their plan contained. Staff had updated two patients' care plans with 'no change', so it was unclear how the patient was moving through the pathway.

Each patient had "Daily Living Support Plans". These plans described the level of support required by the patient for each element of their care using a four-point scale. For example, one patient's support plan for self-catering had a rating of one on the scale. This meant he required minimal assistance. Staff told us this helped ensure patients received a consistent level of support given the frequent use of agency staff.

Four patients were using illustrated goal recovery timelines in an easy read format. "My Timeline to Recovery" was displayed on their bedroom wall. The one we saw set out the patient's objectives of unescorted leave, budget planning, volunteering and engagement in their Care Programme Approach meeting along a six month timeline using pictures and symbols. This meant the patient could understand what goals he needed to achieve.

The service used an electronic system for recording daily notes. Assessment and care plans were in paper format. Staff stored these securely in a filing cabinet in their office.

Staff ensured that patients had good access to physical healthcare. On admission, patients were encouraged to join a local GP practice, with which the service had good links. This was to encourage engagement in the community. All new patients underwent a physical health check on admission to the service. Staff carried out weekly checks on weight and blood pressure. Two clients had additional care plans to meet their physical health needs such as diabetes.

Best practice in treatment and care

We checked all the patients' medication charts and found these followed best practice. Staff monitored patients prescribed lithium or anti psychotics and kept their blood results attached to their prescription charts for easy reference. However, we found that on three occasions nurses had not given a patient his medication, as it was not available.

Patients currently had limited choice of psychological therapies. This was because the psychologist was part time and the psychology assistant had recently left the service.

Permanent support staff had received positive behaviour management training between 2012 and 2015, but only one qualified nurse had received this training. The Corner House had a policy for positive behaviour management procedure, which supported the Turning Point core policy on positive behaviour management. The psychologist wanted to introduce positive behavioural support (PBS) plans for patients in line with the latest guidance. They felt currently unable to implement PBS because of the lack of stability within the staff group and not all staff providing care had received appropriate training.

The service used several recognised rating scales depending on patients' needs and presentation. Staff assessed all patients using the health of the nation outcome scales. This covered 12 key health and social areas and helped clinicians to see how their patients' responded to interventions over time.

Clinical staff carried out a variety of clinical audits to monitor the effectiveness of the service. These included clinical records, and a monthly medication card audit.

Skilled staff to deliver care

Corner House did not have a full range of mental health disciplines and workers providing input to the ward due to existing vacancies. The service had not had any input from a qualified occupational therapist to since April 2015. However, the activities co-ordinator provided a group activities timetable for patients. The service had an arrangement in place with a local pharmacy for pharmacological input. They could make referrals to speech and language therapists provided by Rotherham general hospital if the need arose. The service did not employ a social worker to assist patients with employment, benefits or housing. Staff dealt with these issues.

All permanent staff underwent an induction to the service receiving support over a six-month period. The provider had an induction policy for any workers on a zero hour's contract and an induction checklist for agency nurses.

Nursing staff told us they used to have supervision monthly but this had become less frequent since the clinical lead left. Compliance with supervision was 72%. Five members of staff recently attended training to provide clinical supervision to their peers. The service expected to introduce this in 2016. All staff had yearly appraisals.

All staff had regular team meetings. We saw from the meeting minutes that topics included clinical effectiveness, risk management, safety alerts, training, clinical audits and health and safety.

Staff had access to specialist training. Three support workers were currently accessing NVQ training at level 2 in health and social care. Nursing staff had received training in diabetes and injection techniques updates

Multi-disciplinary and inter-agency team work

The clinical team from the nearby NHS trust had implemented changes to the way the weekly multi-disciplinary meeting functioned. Patients attended every two weeks and staff invited their carer to attend with them. Before the meeting, patients met with the service user involvement worker to discuss how they felt about their care and any issues arising. The worker supported the patient to make a personal involvement statement to the multi-disciplinary team. The service had recently introduced a form on which the patient recorded how much participation they had enjoyed in the meeting and how much consideration the team had given their request.

We observed a shift handover, which was multi-disciplinary by nature. The handover was thorough; with clear direction from the doctor and included an in depth discussion about how each patient was presenting, updates about pending discharges, any disagreements between patients and reminder of individual risks. This not only reminded permanent staff about their patients' needs but also informed agency staff.

The service encouraged inter-agency work, with care-coordinators attending care programme approach meetings. Patients had greater contact with care coordinators and an increased number of meetings once identified for discharge.

Adherence to the MHA and the MHA Code of Practice

The service introduced a revised mandatory training programme on the Mental Health Act 1983 in September 2015. The programme was underway and 25% of staff had received basic Mental Health Act training since its introduction. The service expected all staff to be compliant within three months. Staff had access to a Mental Health Act advisor, who supplied administrative support and legal advice on the implementation of the MHA and its Code of Practice.

We carried out a Mental Health Act review of the service. We reviewed patients' current leave forms and saw that the patient's responsible clinician had clearly specified the conditions of the patient's leave. The patient had also signed each form. The patients we spoke with were aware of the amount of leave they could take and used it. Patients were encouraged to discuss any leave requests they might have at their fortnightly multidisciplinary team meeting.

All of the patients whose records we reviewed were receiving treatment authorised by the appropriate certificate. We saw that copies of the certificates were stored with the patients' prescription cards. In each case, an assessment of the patient's capacity to consent to the treatment was recorded. However, we found that on three occasions the patients' former responsible clinician had assessed the patients' capacity to consent to their treatment without a record of what information they provided to the patients.

We saw that the staff regularly attempted to inform the patients of their rights and had recorded their assessment of the patient's understanding of the information. Most patients we spoke with had a generally good understanding of their rights.

In three case records, we found that the copies of the patients' detention papers and the reports by the approved mental health professionals (AMHPs) were all in order. However, staff could not locate the document authorising one patient's restricted detention.

Cloverleaf provided advocacy services and we saw from a list that each patient received support from an advocate. Information on the advocacy service was displayed on a notice board together

with information on how patients could make a complaint. The service also displayed information about the CQC although the telephone number for the CQC was not included. We saw an easy read version of an information booklet on the rights of an informal patient but staff told us they did not use the easy read version of the rights of a detained patient.

Good practice in applying the MCA

Training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards was mandatory. The service had a 70% compliance rate for the online training and a 60% compliance rate with the face-to-face training. Overall, 84% of staff had undertaken some form of MCA training. Staff knew where to find the local and provider MCA policy. The service audited their staff's knowledge of

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Wards for people with learning disabilities or autism

the MCA using their internal quality assessment tool. Staff told us if they had any concerns about a patient's capacity, they would refer to them to the service doctor for assessment.

At the time of our visit, one patient had a Deprivation of Liberty Safeguard (DoLS) application made in August and the service was awaiting the outcome. A DoLS application becomes necessary when a patient, who lacks capacity to consent to their care and treatment, has to be deprived of their liberty in order to care for them safely.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

We saw that staff were responsive to their patients' needs and provided them with practical and emotional support appropriate to their individual needs. Staff were respectful towards their patients and interacted with them appropriately.

All the patients we spoke with were positive about how staff cared for them. One patient commented that he would miss them when he left.

The carer we spoke with praised the staff for their warmth and compassion and taking time to engage with patients. They also spoke highly of the psychologist input into the care and treatment of their relative.

Throughout our visit, we noted that staff had a good understanding of each patient's individual needs. For example, one patient engaged more with staff than with other patients so staff ensured they took the time to engage with this patient on a subject he particularly enjoyed.

The involvement of people in the care they receive

Prior to admission, the patient was encouraged to visit the service with their carer or care coordinator, gradually building up to an overnight stay. A dedicated member of staff was responsible for introducing new patients to the ward. Staff gave the patient an easy read welcome pack to help inform them.

We saw evidence that staff carried out risk management plans and recovery star care plans in corroboration with patient. The service user involvement lead encouraged patients to participate in their multi-disciplinary reviews and liaised with them before meetings to support them. All patients received support from an advocate.

The service invited carers to meetings and reviews appropriately. A carer told us the service contacted them with updated information about their relatives. The service actively encouraged and supported family visits with no restrictions on the regularity of the visits. Visitors to the ward were over 18 years and had been risk assessed.

The service user involvement worker was developing a carer's forum.

Staff held patient community meetings twice a month. Patients were able to discuss what they thought was good and what they thought was not so good about the service. We saw evidence of patient feedback in the community meeting minutes.

Patients could be as involved in the decisions about the service as they wanted to be. For example, patients had selected the design for the wall mural in the dining room. One patient had been involved in the recruitment of staff to the service.

Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

The Corner House had referral criteria and did not accept patients with high level of risk, poor levels of engagement, or those who required high observation levels. The clinical team had introduced a referral pathway to meet these criteria. The service did not have a target to achieve in respect of referral to assessment times. Their referral process gave timeframes for assessment and decision making process. The bed occupancy rate over the last six months was 83%.

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Wards for people with learning disabilities or autism

The service distinguished between discharge plans and a discharge pathway. Patients with an agreed discharge date had a structured discharge plan in place. However, discharge planning for those without a planned discharge date was variable. Out of the four care plans we looked at, three did not have any plans detailing how a patient would progress through to discharge. This included two patients who had been in the unit for over 12 months. All long-stay patients should have a plan for discharge in line with the Winterbourne View commitment to support patients to return to their communities.

The service was also awaiting the transfer of a patient whose mental health had declined since admission. Staff were managing the risk through increased observation levels.

The facilities promote recovery, comfort, dignity and confidentiality

The Corner House was a purpose built spacious unit. All patient rooms included a single bed with en suite shower and toilet facilities. The rooms contained a sofa, table and chairs, wardrobe and a safe for patients to store any valuables. Patients personalised their rooms with pictures and personal belongings and chose the colour of the feature wall. Each room had a food preparation area and cooking facilities, which patients could access independently or under supervision. Staff could control the power and water supply to each room, managing any assessed risks on an individual basis. This helped to promote patient independence. Staff supported patients with self-catering and keeping their rooms clean depending on individual need.

The unit had a full range of rooms and equipment to support treatment and care. The dining room was bright and cheerful and had a super hero's mural decorating one wall, which the patients had chosen. One wall clearly displayed the day's menu choices and the weekly takeaway evening. The patients we spoke with made positive comments about the food and choices available to them. The dining room doubled as an activities room and included a tabletop football game.

The lounge had well-maintained soft furnishings although it lacked a homely feel. It had a television and games console. The clinical room had a stable door. Patients had individual allocated time to collect their medications to avoid queuing and to respect their dignity.

Patients could attend a community meeting, which took place every two weeks. We saw records included a note of the patients who attended and the issues they raised. Staff followed up and discussed these issues at their weekly meetings. The activities coordinator held daily planning meetings, which patients were encouraged to attend. This informed patients what the planned activities were for the next day and gave them the opportunity to request activities for any future section 17 leave.

The activities coordinator arranged group activities for the patients. Patients told us activities included tidying their rooms, support with cooking, watching movies and playing on the games console. Patients with section 17 leave had access to community-based activities such as going into town or to the nearby hospital shop, cycling sessions and 'base to beat' sessions (singing and recording). The service did not offer a set activity programme on a Saturday. On Sundays, patients and staff participated in board games as a social event and arranged an evening buffet.

Staff individually assessed patients for mobile phones. Patients had individually programmed key fobs that gave them access to the courtyard and smoking area when they liked, up until midnight.

Patients were encouraged to get involved in the running of the service by becoming a fire warden or assisting with laundry or housekeeping duties. Patient engagement in this was low, with only one patient actively participating.

Meeting the needs of all people who use the service

Group activities were available and clearly displayed on an activity chart. Activities play an important part in the rehabilitation process. However, we observed a lack of meaningful and structured daily activities taking place within the service and patients told us they were bored. Patient attendance for activities varied particularly in a morning. Staff told us this was because patients were sometimes not motivated. The lack of occupational therapist meant that the service was not meeting patients' individual needs.

The service was able to accommodate patients with mobility problems. Two rooms had been adapted for use by people with disabilities. An assisted bathroom was available and there was a lift to first floor bedrooms.

Requires improvement

Wards for people with learning disabilities or autism

The information board near the entrance to the service contained lots of pictorial information about patient treatment and care in an easy read format. Patients told us that staff had given them explanations about their medications.

The service was able to meet the patient's individual dietary requirements for health and culture, preparing specialist diets for patients who needed them.

Staff were respectful of people's cultural and spiritual needs. Patients could visit the chapel at nearby hospital and other local places of worship. Staff gave us examples of how they provided support to meet the diverse needs of their patients including those related to disability, ethnicity, faith and sexual orientation. We saw evidence of this in patient records. The service challenged any negative behaviour displayed by patients and had invited the police to attend the service to talk to patients about racism and its impact. Although one patient said he did not like the police coming in.

Listening to and learning from concerns and complaints

The service reported five formal complaints in last 12 months. The service had upheld two complaints made by a carer and a service user. They had carried out an independent investigation into the remaining three complaints, which fellow professionals had made.

Patients we spoke with told us they knew how to make a complaint. Information about making a complaint was available to patients in an easy read format. Patients could also raise concerns at the fortnightly community meeting.

Staff resolved informal complaints and liaised with the service user involvement worker if necessary. The provider had a clear process for handling formal complaints within set time scales. The service manager who made initial contact with the complainant dealt with these initially. The risk management team would investigate any complaints that could not be resolved in service.

Are wards for people with learning disabilities or autism well-led?

Requires improvement

Vision and values

The service manager told us that the Corner House vision is 'to engage and empower people through choice, to support and strengthen people through involvement and to coach people to achieve their best'. Staff and patients developed the vision statement together. The provider had a set of values but these were not specific to The Corner House.

Staff knew who the senior managers in the organisation were. Senior managers visited the site and attended regional meetings, which regularly changed venues.

Good governance

The service had good access to governance systems to manage the service and provide information to the organisation. They had clearly documented key performance indicators and commissioning for quality and innovation (CQUINs) payments framework, which monitored performance and showed what the service had actually achieved. The provider held monthly-integrated governance meetings across the organisation. This meant the operational manager could compare the services performance with that of other services within the organisation.

Face to face mandatory training compliance was under 70%.The provider had put plans in place to address this and had trained the local development lead to provide local training from January 2016. All staff were expected to complete mandatory training.

Staff appraisals were up to date, which meant that the manager could monitor professional development and the quality of care and treatment provided to patients. Monthly supervision for nursing staff had taken place on a monthly basis prior to the clinical lead leaving. Staff had recently undertaken training in providing clinical supervision, with a view to introducing this in January 2016.

The service had a high turnover of staff and retention of nursing staff was poor. Two qualified nurses (33%) and four support workers (29%) had left in the last 12 months.

The provider had been slow to recruit to vacancies. Regional meeting minutes showed that the service had stopped recruiting staff in August. The service had a high usage of agency staff, which affected the quality of the service delivered and staff morale.

Requires improvement

Wards for people with learning disabilities or autism

Due to the instability and lack of permanent staff, the psychologist had not been able to introduce positive behavioural support plans.

Staff participated in a range of clinical audits to monitor the effectiveness of the service. Audits included clinical records, and a monthly medication card audit

The service had a local risk register, which identified areas of concern and actions to manage and reduce the risks identified. Service performance reports and audits were used to review the effectiveness of controls and actions.

We requested information from the service during the inspection. When the service sent this to us electronically, they breached data protection. The service has since introduced processes to ensure this does not happen again.

Leadership, morale and staff engagement

There was a lack of local leadership within the service and a lack of cohesive working. The operational manager was frequently off site engaged in provider business. The clinical lead had recently left and the service had temporarily filled the position internally. The lack of leadership and the high use of agency staff had led to poor morale among nurses and support workers. Staff told us they did not feel valued by the organisation. Minutes for a contract meeting in November recorded the issue of low morale in isolation and provided no explanation or solution.

The service had recently recruited to three of the four support worker vacancies and had recently changed the way they recruited agency staff. This was so they could establish a core group of regular agency staff familiar with the patients and the service. However, the occupational therapist role remains vacant. The recruitment process for the psychology assistant was poorly coordinated, resulting in the position not being filled in a timely manner. This limited the choice of recovery focused therapies and meaningful activities available to patients as part of their rehabilitation.

The clinical team were concerned about the lack of clinical governance in place and the lack of support from the operational manager in implementing changes to strengthen clinical processes.

The clinical team developed and improved the referral process, risk assessments and management plans and restructured multi- disciplinary team meetings.

The service had low sickness and absence rates.

At the time of our inspection, staff were not pursuing any grievance procedures. Previously, the service had investigated bullying and harassment allegations and implemented personal improvement plans as a result.

Staff we spoke with were aware of their organisations whistleblowing policy and said they would use it if they felt the need.

Commitment to quality improvement and innovation

The service was developing the service user involvement worker role to provide a carers forum.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that:

- The service recruits to permanent staff vacancies in a timely manner.
- The service introduces positive behavioural support in line with NICE guidance.
- Nurses manage medication in line with medications management procedures and incident reporting procedures.
- Staff are trained in appropriate physical intervention and de-escalation techniques for working with people with challenging behaviours. Agency staff must also have undergone the same training.
- There is strong and clear leadership that leads to cohesive team working.
- The service adheres to the data protection act and provides secure storage and transfer of records in relation to both staff and patients.

Action the provider SHOULD take to improve

- The provider should consider simplifying patients' care plans so that patients are able to understand them.
- Discharge planning should be in place for all patients and should clearly identify what goals the patient needs to achieve to progress towards independence and discharge from the service.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that the registered person had not provided patients with appropriate care and treatment to meet their needs. How the regulation was not being met: • The service provided a limited choice of therapeutic interventions. • The service provided a lack of meaningful activities individually tailored to the needs of the patient. • The service had not implemented effective Positive Behaviour Support plans. This was a breach of regulation 9 (1) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not supplied or managed medicines in a way that met the needs of patients and ensured their safety. How the regulation was not being met: • A patient missed three doses of his psychoactive medication as it was not available. This was not reported as an incident. This was a breach of regulation 12 (f) and (g)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not operated systems and processes effectively to ensure compliance with good governance. How the regulation was not being met: • There was a lack of local leadership, which affected staff morale and the delivery of care and treatment. • The service breached staff and patient confidentiality when they sent the CQC confidential information electronically. This was a breach of regulation 17 (2) (d)
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered person had not deployed sufficient numbers of suitably qualified, competent, skilled and experienced staff. How the regulation was not being met: • The service had a high turnover of staff and had key staff vacancies. • Not all staff that provided care had been trained in positive behavioural support. • Staff were not up to date with mandatory training. This meant they had insufficient well-trained permanent staff. • Staff had not received training in techniques for physical interventions that met the needs of the service. This was a breach of regulation 18 (1) and (2)