The Corner House

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?	Good
Are services effective?	Good
Are services caring?	Good
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 The Corner House as good because:

- Each patient record contained a comprehensive personal behaviour support plan, which enabled staff to provide care tailored to their specific needs. A multidisciplinary team reviewed behaviour support plans regularly and there was evidence of patient input into them.
- The service had robust risk assessment and monitoring arrangements in place for all patients. When risks changed, staff reviewed and updated these.
- Patients had access to a range of activities and therapies aimed at promoting their independence and recovery
- Patients had access to on-site psychiatric treatment and psychological therapies through a contract the provider held with a local trust.
- Staff provided patients with on-going monitoring of their physical health needs and screened patients for conditions such as obesity and diabetes.
- Staff interacted with patients in a caring compassionate manner. They used verbal de-escalation appropriately to deal with patient anxiety.
- Patients had access to information about their care and treatment in an easy read format. Information about the service including a guide to meetings, events, and activities was displayed clearly in the reception area where patients tended to congregate.
- Managers and staff worked together to reduce restrictive practices and provided patients with access to the internet via their own mobile phones.
- Staff reported a supportive and open culture with colleagues and line managers. Managers were visible and available when staff needed guidance and support.
- The provider had made changes to the management and meeting structures leading to improved learning from incidents. Managers encouraged staff at all levels to report incidents.
- The service had recruited a large number of permanent staff including staff with a variety of part-time hours. This meant they had less reliance on agency staff so patients were familiar with the staff supporting them.
- The service was clean and well maintained. Staff had access to handwashing facilities and to anti-bacterial hand gel. They supported patients to keep their rooms clean and tidy.
- Patient rooms were well equipped and furnishings in communal areas were suitable, attractive and in good order.

However:

- When we asked the provider for information concerning whether patient leave had been cancelled or re-arranged due to staff shortages, they were unable to provide the specific dates on which two episodes of leave had been re-arranged.
- The provider gave us conflicting information about whether two courses were included in their staff mandatory training programme. These were positive behaviour support and moving and handling objects.
- When we looked at staff records, we found that some support staff had only recently started participating in regular line management supervision and some had not had an appraisal in line with Turning Point policy.
- When we visited the service, we observed two patients queueing at the door to the medication room so that one patient could see another patient accepting medication. This could have compromised the privacy and dignity of those patients.
- Not all staff had completed training in the Mental health Act,1983.
- The provider told us about two complaints they had received, one from a patient and one from a member of the public. However, when we visited, we could not find the records relating to those two complaints in the complaints log.

Summary of findings

Contents

Good

The Corner House

Services we looked at:
Long stay/rehabilitation mental health wards for working-age adults.

Summary of this inspection

Background to The Corner House

The Corner House is a purpose built 12-bedded locked rehabilitation unit in the Moorgate area Rotherham. The service is specifically designed to provide high intensity support and rehabilitation for men with complex needs, including mental health conditions and learning disabilities.The service can accommodate people who are detained under the Mental Health Act as well as those who stay there informally. The Corner House is run by Turning Point and 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.

At the time of our inspection, the service had no active registered manager, however, there was a clinical lead in post and a newly recruited interim operations manager. The service had a plan for the clinical lead to apply to become the registered manager. Input from clinical psychology and psychiatry were provided via a service level agreement with a local trust.

We have inspected The Corner House three times before. At the last comprehensive inspection in December 2015, we rated the service as requires improvement overall. We rated safe as requires improvement, effective as requires improvement, caring as good, responsive as requires improvement and well-led as requires improvement.

Following that inspection the provider was informed that it must take the following actions to improve long stay rehabilitation services;

- The service recruits to permanent staff vacancies in a timely manner
- The service introduces positive behavioural support in line with guidance from the Institute of Clinical Excellence.
- 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 a 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.

We also told the provider that it should take the following actions to improve long stay rehabilitation services;

- 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.

We issued the provider with requirement notices. These related to:

- Regulations 9 HSCA (RA) Regulations 2014 Person centred care
- Regulations 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulations 17 HSCA (RA) Regulations 2014 Good governance
- Regulations 18 HSCA (RA) Regulations 2014 Staffing

The Corner House has been subject to three Mental Health Act review-monitoring visits most recently in December 2015. There were no issues raised at this review.

The current inspection was announced.

Summary of this inspection

Our inspection team

Team leader: Liz Mather, Inspector, Care Quality Commission

The team that inspected the service comprised three CQC inspectors

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.

Throughout the inspection, the inspection team:

- visited the service, looked at the quality of the environment and observed how staff were caring for patients
- spoke with six patients who were using the service
- spoke with the clinical lead and the regional manager
- spoke with 17 other staff members; including doctors, nurses, support workers, a service user involvement worker, an occupational therapist, an assistant psychologist, a consultant clinical psychologist and a social worker
- attended a community meeting and a therapy group
- attended two hand-over meetings and a clinical governance meeting
- collected feedback from two patients using comment cards
- Spoke with two carers
- looked at five care and treatment records
- carried out a specific check of the medication management on the service
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

During our inspection we spoke to six patients and obtained feedback from two patients using comment cards. Patients told us they felt safe and the staff showed a caring attitude towards them. They told us the facilities were good and they liked being able to personalise their rooms, for example, with pictures and equipment like smart televisions. They felt involved in decisions about their treatment and knew how to make a complaint. One patient told us that patients were all friends and they liked most staff.

As part of our inspection, we spoke with two carers. They told us they were very pleased with the treatment at the service and the staff were very friendly and approachable. They also told us the environment was very clean and they knew what was going on with the care of their relative. The only negative comment was in relation to a carer having to tidy a patient's bedroom and wash the dishes.

We saw a copy of a recent family and carer survey from December 2016. The survey, which summarised views from five carers/family members, indicated that patients' families had opportunities to be involved in care plans and in general, they were happy with staff politeness and

Summary of this inspection

approachability. The majority of carers felt involved in the treatment of their relative, however, there were two comments that communication following care reviews could be improved.

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?

Good

We rated safe as good because:

- The service was clean and well maintained. Domestic staff supported patients to keep their rooms tidy and managers maintained a positive health and safety culture with regular audits.
- There were enough suitably trained nurses and support workers to ensure patients had access to one-to-one support from staff. Patients also had access to medical cover when needed.
- Both regular and agency staff received an induction to the service and had access to training appropriate to their role. Staff also had access to structured meetings to reflect on their practice.
- Staff had robust risk assessment and monitoring arrangements in place for all patients. When risks changed, staff reviewed and updated these.
- Managers had implemented a new incident reporting system, which had resulted in a reduction of the frequency and severity of incidents in the service.

However,

- The service did not always monitor the specific dates on which patients' leave had to be re-arranged. This could have made it difficult for managers to put measures in place to prevent this happening.
- When managers provided us with their training matrix, they gave us conflicting information about whether positive behavioural support training and moving and handling objects training were mandatory for all staff.

Are services effective?

Good

We rated effective as good because:

- Patients had an assessment as well as on-going monitoring of their physical health needs. This included an annual audit to screen patients for conditions such as obesity diabetes and cardiovascular disease.
- The service employed a user involvement worker to facilitate patient involvement in treatment plans and help staff work in a recovery focussed way with patients.

Summary of this inspection

- A newly appointed occupational therapist assessed patients' daily functioning skills and had put together a timetable of activities.
- The service provided on-site specialist psychiatric and psychological therapy to patients under a contract with a local trust.
- All patients had in place positive behavioural support plans. This enabled staff to work with patients to reduce the use of restraint and restrictive practices.
- The service had employed a social worker who supported staff with advice concerning safeguarding and assessing patients' capacity to make decisions.

However,

- Not all staff had completed training in the mental health Act, 1983. This meant there was a risk that staff might not have treated patients in accordance with their rights.
- Some support staff had only recently started participating in regular line management supervision and some had not had an appraisal in line with the provider's policy.

Are services caring?

Good

We rated caring as good because:

- We observed staff interacting with patients during the course of our visit. They treated patients in a respectful, caring way and clearly had good relationships with them.
- The service encouraged patients and their carers to be involved in their treatment using information in a format they could easily understand.
- Staff held regular care review meetings with patients where staff encouraged them to participate fully and provide feedback on the outcome of their review.

Are services responsive?

Good

We rated responsive as good because:

- Patients had recovery focussed care plans and could measure their own progress through treatment.
- Patients had access to hot drinks and food at times that suited them. They had individually programmed fobs which allowed them access to communal areas including the garden without having to ask staff
- Patients had access to a range of activities aimed at promoting recovery
- Staff provided patients with enough information about their rights and how to complain.

Summary of this inspection

However,

- Managers did not always keep accurate records of the complaints they received. This meant managers may not have known how staff had responded to individual complaints.
- We observed two patients queueing at the door to the medication room so that one patient could see another patient accepting medication. This could have compromised the privacy and dignity of those patients.

Are services well-led?

Good

We rated well-led as good because:

- Staff attitude and behaviour reflected the provider's values
- The service had a local risk register, which identified areas of concern and actions to manage and reduce risk.
- The service had enough staff to provide direct care for patients when needed.
- Managers encouraged staff at all levels to report incidents and cascaded learning through multidisciplinary meetings.
- Managers carried out internal quality assurance checks and produced action plans to address identified concerns.

However,

- Managers were not clear about whether positive behaviour support training and moving and handling objects training was mandatory for staff.
- Managers did not provide training for staff in the Mental Health Act as a mandatory requirement and not all staff had received this training.

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 provider carried out regular documentation audits, which we reviewed as part of our inspection. The service was compliant with regard to procedures for admission, renewal of detention, patient's rights, and consent to treatment. Staff checked records weekly and reported any errors through the incident report system.

Staff informed patients of their rights and had produced an easy read booklet for patients and carers. The service had information displayed about advocacy and how to make complaints in patient areas and on a television screen in the reception where patients liked to sit and talk to staff. All the patients we spoke to on our visit told us they were given information about their rights and had access to advocacy. The patients we spoke to told us they used advocacy services and knew who to complain to about their rights under the Mental Health Act. We observed information in communal areas on how to complain to CQC.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training was mandatory with evidence of staff being up to date with this. Staff had access to an on-site social worker who provided advice and support to them regarding capacity assessments and best interest decisions. The staff we spoke with had received training and knew to refer to the social worker where they had concerns about a patient's capacity to consent or make specific decisions.

Staff were able to discuss capacity as decision specific and understood that patients had the right to make unwise decisions. They also understood the fundamental principles of the legislation such as presuming capacity and using the least restrictive options when making best interest decisions. Staff used different methods of communication with each patient depending on their levels of cognition and understanding.

Long stay/rehabilitation mental health wards for working age adults

Good

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Good

Safe and clean environment

The Corner House was a locked mental health rehabilitation unit. The main entrance to the ward was through an air lock controlled by staff. An airlock strengthens security by providing an additional locked area that all staff, visitors and patients have to pass through to gain entrance or exit. On the day of our visit, the door to the air lock was not working properly meaning that it was more difficult to control access and exit. Staff had reported this to the provider as an incident requiring urgent attention and during our inspection, we saw it being repaired. During the time the door was broken, the manager had put extra staff on shift to lessen the potential for security breaches. Due to the layout of the unit, staff did not have a clear line of sight to all areas. However, all communal areas had staff presence and close circuit television which, meant staff could observe patients where there was no direct line of sight.

Each patient had their own room with self-contained kitchen and dining facilities and access to appropriate alarms and nurse call points. Patients had access to their rooms and other communal areas including the enclosed garden by use of a fob. This allowed them a certain amount of independence in moving around the unit, however, staff could restrict access to certain areas as needed by re-programming individual fobs. Staff carried personal alarms linked to an infrared system covering all points of the building. This meant staff could summon immediate assistance in the event of an emergency. The staff and patients we spoke with told us they felt safe in the service.

Managers carried out an annual environmental and ligature risk audit using a specific assessment tool. All patient rooms were fitted with anti-ligature fittings such as taps, coat hooks, doors and handles, which minimised risks to patients. Managers used the tool to identify and mitigate risks arising from ligature points in communal areas. Examples of mitigating actions included increased observation in line with the provider's policy for safe and supportive observation. Potentially dangerous kitchen appliances such as the cooker could be isolated and switched off from outside patients' bedrooms where necessary to minimise harm from accidental or deliberate misuse.

The service provided care and treatment to male patients. This meant the provider complied with guidance on same-sex accommodation. The service did not have seclusion facilities.

The clinic room had emergency equipment, which nursing staff checked weekly. There was no examination couch, however, staff told us that where required, interventions such as changing wound dressings would be carried out in patients' own bedrooms.

The décor was well maintained and communal areas were visibly clean and tidy. The furniture was comfortable and in good order with enough space for staff and patients to interact. We observed staff practicing good infection control procedures including hand hygiene and instructions for effective hand washing were visible above sinks. Safety equipment, such as firefighting equipment

was in date and there was evidence that portable electrical appliances had been checked and labelled with a re-check date. The provider had completed a health and safety audit in January 2017, which identified some minimal actions. During our inspection, we saw managers had purchased some new equipment for the kitchen in line with the audit.

Safe staffing

The establishment levels for staff were as follows:

- Qualified nurses 7.2 whole time equivalent
- Support workers 14.5 whole time equivalent

Each day, the nurse in charge completed a safe staff assessment for each shift. The provider told us the minimum number of staff required on each shift was one nurse and two support workers. However, managers confirmed the service would always try to exceed minimum staffing numbers to allow for patient leave and activities. When we examined copies of staffing rotas, we saw that support worker staffing levels were higher than the minimum levels specified in the staffing tool. When we spoke to managers, they confirmed they had the authority to increase staffing levels on each shift in line with service requirements. None of the patients or staff we spoke with had any concerns regarding staffing levels. When we visited, we regularly observed several staff at once interacting with patients in the reception and other communal areas.

Prior to our visit, the service had recruited to a number of key posts including a new operations manager, nursing staff, a senior nurse, and a social worker. There were four support worker vacancies, for which managers were actively recruiting. Agency nurses were still being used but only to cover unexpected absence. Nursing staff staggered their leave and covered for each other during planned absences.

Managers had a contract in place with a recruitment agency allowing them to block book agency staff to cover for sickness or other absence and whilst permanent support workers were recruited. The contract allowed agency staff to be placed for three months, which meant staff undertook regular shifts allowing patients to build up therapeutic relationships with them. The contract also stipulated mandatory training requirements for agency staff, which meant they could undertake the same duties as regular staff.

Staff and patients told us that escorted leave was rarely cancelled and activities usually took place as scheduled. We examined staffing assessments for the previous three months and confirmed two episodes where patient leave had been re-arranged due to a shortage of staff. However, the records we looked at did not specify an exact date on which this took place. Managers told us they intended to review their staffing tool to enable them to systematically audit where leave had been cancelled.

All staff were required to attend mandatory training which was mainly, though not exclusively delivered via an e-learning package. Staff compliance with mandatory training was up to date with the exception of infection control awareness, which was 67% and moving and handling objects, which was at 71%. However, when managers sent us the mandatory training matrix, there was confusion concerning whether moving and handling objects training was mandatory for all staff. When we visited, we observed good standards of infection control with enough appropriate hand washing facilities for both staff and patients. When we spoke with support workers and nursing staff, they all confirmed they had access to mandatory and other training appropriate to their job role. Four support workers told us they had recently completed face-to-face training in assessing mental capacity and best interest decision-making. Mandatory training did not include Mental Health Act,1983, or mental health awareness training.

The service had an agreement with a local trust who seconded specialst psychiatric staff. A specialist doctor was based there five days per week and a consultant psychiatrist was based at the service two and a half days per week. Staff and patients had access to an on-call consultant psychiatrist out-of-hours through a service level agreement with a local trust. If required, they would attend the service. Staff told us they sometimes had to call on the out-of-hours service when patients required urgent psychiatric care. The service used the local accident and emergency department about half a mile away to deal with out of hours physical healthcare emergencies.

Assessing and managing risk to patients and staff

From the 1 June, 2016 to 30 November 2016, the service reported no episodes of seclusion or long-term segregation. In the same period, the were no incidents of restraint in the prone position.

Long stay/rehabilitation mental health wards for working age adults

Good

The service did not have seclusion room but had policies concerning seclusion and rapid tranquilisation. However, staff told us these methods were rarely used but instead, they worked with patients to implement positive behaviour support programmes to reduce incidents of restraint. The service had a contract with an external provider for clinical psychology input on two days per week but also employed a full-time psychology assistant. There was a positive behaviour support policy in place, which meant that each patient had an individualised plan, which was reviewed regularly with them. Staff worked together with patients to identify alternative methods they could use to manage potential aggression. When we visited, we observed staff using verbal de-escalation and distraction techniques to calm a patient who was becoming agitated. In the six months prior to our visit, the service had only used physical restraint on three occasions with three separate patients. When we spoke with staff, they confirmed they had appropriate training in managing aggression, which included verbal de-escalation techniques. Staff reported they had access to good support from the psychology and occupational therapy team on implementing positive behaviour support plans.

The service had a mixture of patient electronic and paper records and, as part of our visit, we reviewed five patient records. The records we reviewed confirmed that risk assessments were in place and regularly reviewed by staff. The risk assessments took into account patients' previous history as well as their current mental state and included the risks of self-harm and absconding. Restrictions were put in place only as necessary after an individual risk assessment had taken place. Staff assessed patients' propensity for violence using a recognised clinical risk tool, which appropriately trained staff used every six months or less to review on-going risks.

At the time of our visit, the service was reviewing its policy on restrictive practices and contraband items. We attended a clinical governance meeting where managers and members of the multidisciplinary team attempted to increase the number of items patients had access to unless contraindicated by an individual risk assessment. This meant that patients, for example, could have access to mobile phones with internet access if they wanted. They also had access to mouthwash, razors and lighters, which previously had been restricted items for all patients. Staff told us searching patients occurred only in response to identified risks and that they had been trained in non-invasive searching techniques.

Staff were up to date with their mandatory safeguarding training and could seek advice and support from the newly appointed social worker who also took the lead in safeguarding matters. We looked at minutes from reflective practice meetings where we could see staff had discussed safeguarding issues. Staff understood how to protect patients from abuse and had support from a newly appointed full time qualified social worker. Safeguarding incidents and concerns were recorded on the incident report system but then monitored separately on a safeguarding tracker document. We looked at two recent safeguarding cases, which had been notified to CQC. In both cases, staff had taken appropriate action including referrals to the local safeguarding adults' team. Staff confirmed that safeguarding issues were discussed at weekly safeguarding supervision meetings attended by operational managers, medical staff and nurses. In addition, all staff attended monthly reflective practice sessions facilitated by the consultant psychologist. The psychologist had access to the minutes of the safeguarding meeting and cascaded relevant information through the reflective practice sessions. When we spoke with staff, they confirmed they had access to a lot of specialist support and that they could access this in a timely way when needed.

When we carried out the last inspection in December 2015, we found that on three occasions, staff had not given a patient his anti-psychotic medication and this had not been reported as an incident. However, when we inspected the service this time, we found the provider had contracted with a local pharmacy to supply medications and carry out audits including stock checks. Each week a pharmacy technician visited to check medications were in date and had been labelled appropriately. The technician also provided advice and support to clinicians on a 7 day week basis including some late evening cover. In addition, on a monthly basis, a pharmacist employed by the provider completed an audit of medication cards checking any contra-indications and that prescribed dosages were within recommended ranges. Any issues were highlighted to the nurse in charge or operations manager and documented on an action plan. We saw that medication errors were reported as incidents and investigated appropriately.

Long stay/rehabilitation mental health wards for working age adults

Good

Track record on safety

Since our last inspection in December 2015, the provider had implemented a new electronic incident management system, which had resulted in a reduction in both the frequency and severity of incidents in the service. In the six months prior to our inspection, the service reported two medication errors and no serious incidents. We saw records detailing that appropriate action had had taken place in relation the medication errors and that no harm had been caused to patients because of the errors.

Reporting incidents and learning from when things go wrong

All staff including agency staff had access to and training in using the electronic incident reporting system. Staff told us they knew how to report incidents and were encouraged to do so by managers. We saw evidence that incidents had been reported by staff when we attended the weekly clinical governance meeting where managers discussed all incidents. The clinical governance meeting was attended by doctors, psychologists, the social worker and chaired by a regional manager from Turning Point . We saw how managers were managing incidents including implementing actions and cascading lessons learned to the wider staff team. We saw examples where staff had taken specific action in response to incidents in order to minimise the risk of them occurring in the future.

We saw staff had documented incidents appropriately in patient's files and information concerning lessons learned from individual incidents had been cascaded by managers to team meetings. Support workers did not always have time to read full team meeting minutes but we saw managers had put summaries on the walls in the staff kitchen to communicate important messages from team meetings. We also observed staff discussing and reviewing incidents during daily handover meetings. We saw an example where staff had amended a patient's behaviour support plan in response to an incident.

Managers allocated incidents to the most appropriate professional to investigate and make recommendations for action. For example, we saw that safeguarding incidents were assigned to the social worker to investigate and medication errors to the speciality doctor. Staff discussed feedback from individual incident investigations in weekly clinical catch up meetings and team meetings.

Staff confirmed managers appropriately supported them following serious incidents and encouraged them to be open and honest with patients when things went wrong. We saw the provider had a duty of candour policy and monitored these types of incidents separately in their incident system.

Managers told us there were plans to develop incident analysis so they could share with staff data concerning overall themes trends and patterns.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

As part of our visit, we examined the care and treatment records of five patients which were securely stored in locked cabinets and in password protected electronic files All five records contained comprehensive assessment information covering a variety of domains including mental health, physical health, self-care and living skills, social relationships, addictive behaviour, work and responsibilities.

On admission to the unit, the speciality doctor completed an initial assessment and discussed this with the responsible clinician prior to initiating treatment. The speciality doctor was based at the service full time whilst the responsible clinician was based there for 2.5 days per week.

On admission, patients had an assessment as well as on-going monitoring of their physical health needs. The speciality doctor had developed an emergency 'grab sheet' and a health action plan for each patient. The grab sheet contained patients' medical information, for example, allergies and current medication to enable staff to provide or obtain effective treatment in a medical emergency. Each week nursing staff monitored the weight, blood pressure and body mass index of each patient. The results were discussed in weekly multidisciplinary meetings where specific actions were agreed to support patients in their treatment.

The provider had introduced a specific toolkit, which supported patients to develop their own recovery goals in

their care plan. The records we looked at contained holistic care plans, which were person, centred and individually tailored to each patient's needs. When we spoke to patients, they confirmed they were encouraged to be involved in developing their care plan and to keep a copy for their own reference. When we spoke with support staff, they told us that the information contained in care plans was clear and accessible. Support workers attended fortnightly multidisciplinary reviews to provide input into care and daily support plans.

Best practice in treatment and care

Since our last visit in December 2015, the service had appointed an occupational therapist who was in the process of conducting assessments with all the patients. The therapist used a specific screening tool every three months to assess patients' occupational functioning. Patients themselves had input into this and were encouraged to complete a self-assessment of their daily living skills. The assessments were used to document progress towards occupational therapy intervention goals and the therapist had put together a timetable to provide on and off-site activities for patients. Staff assigned patients a risk rating to identify whether patients posed a risk of violence. Staff reviewed these risk ratings regularly to determine what steps were necessary to protect public safety.

We observed a multidisciplinary meeting taking place where support staff and the nursing team on duty discussed the physical health needs of several patients and supported them to access appropriate community health facilities.

Medical staff carried out physical health checks in line with the Maudsley prescribing guidelines for all patients taking anti-psychotic medication. This meant staff could monitor potential side effects throughout treatment. Prior to our visit in December 2016, staff had been involved in auditing physical healthcare checks to ensure patients were adequately screened and treated for conditions such as obesity, diabetes and cardiovascular disease. Staff told us they carried out these audits annually. They used a risk rating for each patient so they could take preventative measures, for example, by advising patients about healthy eating where they were identified as being at risk from obesity.

During our visit, we observed a behaviour therapy skills group facilitated by the psychology team and attended by patients with their support workers. Staff developed the group specifically for patients with learning disabilities. The group contained elements of self-talk, mindfulness, and other activities designed to encourage patients to think and behave differently. Staff tailored activities to each individual's capability and concentration levels. They encouraged patients to participate only as much as they felt comfortable. The team completed pre and post intervention assessments using, for example, anxiety and depression scales. Each patient had a functional behaviour assessment, which staff repeated every 3 months to monitor their progress.

Staff told us they tried to avoid prescribing unnecessary medicines and gave us an example of how they had reduced a patient's medication because it seemed to be making them too lethargic. Staff monitored the patient carefully for adverse reactions but found they responded positively so were looking to move the patient on to live in a community setting. Staff used the "Recovery Star" to measure patients' progress with their recovery goals. The star contained ten areas covering the main aspects of patients' lives including living skills, relationships, work, identity and self-esteem. Patients set their own goals and measured over time how far they had progressed towards these goals.

Skilled staff to deliver care

The service had a wide range of qualified and experienced mental health and social work disciplines including a consultant psychiatrist, a speciality doctor, a consultant clinical psychologist, a psychology assistant a social worker, and an occupational therapist. Staff had access to support from a pharmacy technician contracted from a local service. The provider had also employed their own pharmacist who visited the location regularly to audit medications.

As part of the visit, we reviewed three personnel files. There was evidence in the files that managers had assessed job applicants' suitability for the roles they had applied for and had carried out appropriate pre-employment checks. For example, we saw employment references, disclosure and baring service checks and evidence that staff had appropriate professional registration certificates where required. Managers confirmed they had dedicated human resource support from the provider and that they had received management training including managing staff performance.

Long stay/rehabilitation mental health wards for working age adults

Good

We interviewed five support workers three nurses and the service user involvement worker about their experiences of induction and training. They all confirmed they had received an appropriate induction and had access to a range of training which equipped them for their role. Staff were encouraged to pursue vocational qualifications such as the diploma in health and social care and one member of staff told us they had been encouraged to apply for a mentorship qualification to allow the service to take nursing students in the future. When we looked at the range of training on offer to staff, we saw that managers encouraged support workers to participate in further training such as autism awareness.

In addition to reflective practice meetings, managers told us, staff had regular line management supervision every four-to-six weeks and an annual appraisal. We interviewed seven staff who told us access to one-to-one line management supervision and appraisal had been sporadic up to the last few months when new staffing and management arrangements were put in place. However, they were now starting to participate in more regular supervision and had access to supervision as needed from the nurse in charge. Information from the provider suggested that in the previous 12 months, 73% of non-medical staff had received supervision and 65% had received an appraisal. Managers told us the supervision policy and procedures were under review to provide increased levels of supervision and compliance.

Specialist medical and psychology input was provided to The Corner House via a service level agreement with a local trust. When we visited the service, we spoke with all the consultant and speciality medical staff seconded under this agreement. They all confirmed they received supervision, appraisal and revalidation through their employing organisation. Managers of the service told us they held regular contract monitoring meetings with the trust and any issues regarding supervision and appraisal were raised.

The provider had appropriate human resource policies in place and managers confirmed they received dedicated support and training from the provider to deal with staff performance issues.

Multi-disciplinary and inter-agency team work

The staff we spoke with told us the mixture of different disciplines working together had greatly improved the scope and quality of treatment available to patients. Staff had the opportunity to attend a range of meetings where they discussed patient issues. This meant they were informed and up-to-date with patients' treatment and could share information and ideas with different members of the team. Staff told us they could influence the care provided and their views were taken into account by medical staff including qualified therapists. As part of our visit, we observed a multidisciplinary team handover meeting and shift handover meeting. We observed staff from different disciplines working together effectively to discuss the events of the day and issues affecting patients. Handover meetings were thorough and included in-depth discussion about how each patient presented including any incidents, which staff on the next shift needed to be informed of.

We saw three sets of summary notes from weekly team meetings posted in the staff area. When we spoke with staff, they confirmed if they could not attend a team meeting, they had access both to the full minutes and to bullet point summaries. Meetings were chaired by the operations manager and staff could add items to the agenda and make suggestions for improvements to the service. For example, one staff member suggested putting comfortable seating in the reception area where patients tended to congregate. This idea was later discussed in a community meeting where staff asked patients their views. When we visited, we saw that furniture had been purchased and patients were using it a lot.

Staff told us that all patients were registered with a GP and a dentist and those patients we spoke to confirmed this. Staff encouraged patients to involve external professionals in their treatment reviews, for example, advocates could be present at care plan review meetings.

Patients had access to specialist assessment and treatment via a service level agreement with a local trust. When we spoke with members of the multidisciplinary team , they gave us an example where staff had sourced forensic psychology assessment services where this was indicated by patient need.

Doctors, psychologists, and occupational therapists worked well together to provide patients with access to individual and group therapy. We saw that staff met together following a therapy group to review it and plan changes for future meetings. One staff member we spoke with gave us an example of how they encouraged a reluctant patient to become involved with occupational therapy.

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Good

The service employed a service user involvement worker whose job it was to support staff and patients to work together in implementing recovery focussed support plans. Staff from different disciplines had worked together effectively to provide a diversity awareness course for patients and this had improved relationships between patients.

Support workers were guided by the on-site therapy team to implement positive behaviour support plans with all nine patients. We saw evidence of this when we attended a therapy group where support workers and therapists worked together with patients to improve their thinking and coping skills.

Adherence to the MHA and the MHA code of Practice

Managers provided staff with access to mental health awareness and Mental Health Act,1983, training though neither of these courses were mandatory. When we spoke with support staff, they told us they had recently attended basic mental health awareness and were familiar with the provisions of the Mental Health Act,1983. They also had access to a Mental Health Act administrator who supplied administrative support and legal advice on the implementation of the Act and the Code of Practice. Managers told us that 58% of staff had received training in the Mental Health Act.

As part of our visit, we interviewed the responsible clinician at the service and looked at detention records for five patients. We also reviewed the latest Mental Health Act audit report carried out on the service by the provider in October 2016. Each patient had a separate file containing their Mental Health Act documentation. Copies of consent forms were attached to medication charts where appropriate and current leave forms were held in the nursing office. We found that documentation was well maintained and generally in order. The service was compliant with regard to procedures for admission, renewal of detention, patient's rights and consent to treatment. Staff checked records weekly and reported any errors through the incident report system. We attended a clinical governance meeting where managers discussed a minor incident involving a patient's leave form. We saw how staff changed procedure because of the error and communicated the changes to nursing staff through the weekly clinical catch up meeting.

We saw that staff informed patients of their rights and had produced an easy read booklet for patients and carers. The service had information displayed about advocacy and how to make complaints in patient areas and on a television screen in the reception where patients liked to sit and talk to staff. All the patients we spoke with on our visit told us they were given information about their rights and had access to advocacy. We observed information in communal areas on how to complain to CQC.

Good practice in applying the MCA

According to the most recent information sent by the provider, training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was mandatory with evidence of staff being up to date with their training. The service had recently commissioned an external provider to deliver workshops to staff in assessing mental capacity and best interest decisions. Managers had also recruited a social worker who provided advice and support to staff in assessing capacity and making best interest decsions. Staff told us these measures had greatly improved staff understanding in relation to mental capacity. Staff were discussing patients' capacity more and had worked hard to ensure communication was tailored to individual patient needs. Just prior to our visit, the staff had been involved in a multidisciplinary discussion concerning a patient decision. Staff were able to discuss capacity as decision specific and understood that patients had the right to make unwise decisions.

The staff we spoke with had received training and knew to refer to the social worker where they had concerns about a patient's capacity to consent or make specific decisions. When we examined patient care records, we saw evidence of capacity assessments using a standard assessment form developed by Turning Point. The form was accompanied by clear guidance for staff in how to apply the principles of the legislation and how to make best interest decisions. The guidance was dated February 2017 so not all staff had had the opportunity to familiarise themselves fully with it. One of the staff commented they felt more training in the area of mental capacity and deprivation of liberty would be beneficial for the service as case law was complex and changed frequently.

At the time of our visit, all the patients at The Corner House were detained under the Mental Health Act 1983 and therefore no Deprivation of Liberty Safeguards, (DoLS) applications had been made as they were being treated

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Good

using this legislation instead .The service had some experience of requesting applications using the Deprivation of Liberty Safeguards but not in the six months prior to our inspection.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Good

Kindness, dignity, respect and support

Staff interacted with patients frequently in the communal areas especially in the reception area where they tended to congregate. We observed how staff spoke with patients in a respectful and caring way. On one occasion, we saw a patient become verbally agitated but staff were able to de-escalate the situation in a calm manner and with considerable skill. Staff knew the patients well and this was evident in the quality of their interactions. Staff had taken the time to read care and support plans and understood patients' individual needs. The service user involvement worker had facilitated better communication between staff and patients using pictures and easy read materials.

In the patient survey conducted in October 2016, nine out of ten patients said they felt listened to and treated with respect by staff. Nine out of ten patients said they were happy with the support and treatment they were receiving. All the patients we spoke with told us staff were very caring and supportive. One patient told us they felt comfortable talking to staff and that they did their best to help. In December 2016, a family and carer survey showed that five out five carers felt the staff were approachable and polite.

The involvement of people in the care they receive

Staff were committed to involving patients in their care and in the running of the service. The service had employed a dedicated worker to encourage patients to be as involved as possible in their care and help staff to work in a patient focussed way. Staff encouraged patients to take on responsibilities within the service and provided additional support where this was identified by the patient. Roles and duties were assigned depending on patients' interests and included assisting staff with health and safety checks, laundry duties, cleaning and assisting with staff recruitment.

Most patients attended a weekly community meeting which we observed as part of our visit. Patients' chaired the meeting and minutes were put up on the notice board in the dining room by staff. Turning Point had produced an easy read welcome booklet with information about the service including a guide to activities, meetings, meal times and therapy sessions. We saw examples of staff asking patients their opinions about furniture for the service and about the new food menu.

We were shown examples by staff of how each patient completed an evaluation sheet prior to and after they attended their care review meetings which were every two weeks. Prior to reviews, staff asked patients things like what had gone well since the last review, which activities had they participated in and whether they would like their advocate to attend the review. Following the review patients completed an evaluation of whether they had felt involved in the process and whether they were happy with the outcome. We saw evidence the service user involvement worker reviewed patient evaluation sheets and provided feedback to the multidisciplinary team.

Each patient had a "daily living support plan" which described the level of support required by the patient for each element of their care using a four-point scale. Patients were encouraged to rate their own needs and plans were in an easy to read format with colourful pictures so they could more easily describe their needs. Staff encouraged patients to be involved in daily tasks, for example, cooking, cleaning, and laundry. They gave us an example of how they involved a patient in assisting staff with health and safety checks in the building. This had increased patient's self-esteem and confidence to interact more with staff and other patients in the service.

Following our visit, we reviewed the latest patient feedback survey from October 2016 and the latest family, and carers' survey from December 2016. Five carers participated in the December survey and all ten patients gave their feedback in the October survey. Eight out of ten patients said they were always asked or sometimes asked about how the service was run. Nine out of ten patients agreed they were involved in the planning of their care and treatment. There were no negative comments from patients about the service. When we spoke with patients during our visit, they were all happy with the services they received. The only negative comment we received was in relation to the Wi-Fi

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Good

that, according to one patient was not available. When we spoke to managers about this, they assured us that the problem with the Wi-Fi was temporary and it would be fixed imminently.

Five carers gave their feedback through a carers' survey. Three carers said they felt involved or sometimes felt involved in their relative's care. In general, carers felt supported and able to communicate with the staff in relation to their relative's treatment. However, there were two comments that communication following care reviews could be improved. Following the survey, two staff agreed to meet to identify improvements in promoting carer involvement. At the time of our visit, both patients and staff were involved in planning a family social day involving cooking and eating a meal at the service with patients and their families.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

At the time of our visit, the service had three unoccupied beds and the bed occupancy rate had been 83% from the period 1 December 2015 to 30 November 2016. The clinical team had introduced a referral pathway but the service did not have a target to achieve in respect of waiting time from referral to assessment. Staff had implemented a new referral and discharge pathway because of previous inappropriate referrals, which had been difficult to manage.

When we spoke to staff, they told us the recruitment of the occupational therapist and assistant psychologist posts had been crucial in ensuring the service retained a focus on getting patients ready to be discharged into community settings. Some staff, however, expressed anxiety that the service was not being marketed effectively as they had no current new referrals. When we looked at the local risk register for the service, we noticed that low bed occupancy was highlighted as a risk which required urgent action. The risk register contained an action plan to address the concerns about low numbers of referrals and this was dated 13 February 2017.

During the period December 2015 to November 2016 the average length of stay for patients at The Corner House was 808 days. During our visit, we examined five patient care records. Staff and patients produced recovery goals which were contained in all five of the patients' care and support plans we looked at. Recovery plans contained a "Recovery Star", a recognised tool that enabled patients to measure their own recovery progress. Staff told us the Recovery Star focussed on developing patients' skills and confidence to access community services including employment and education. The aim was to achieve a successful transition over an 18-month period back into the community. When we spoke with staff, they told us one patient was preparing to be discharged and one patient was being transferred to a facility more appropriate to their needs.

The facilities promote recovery, comfort, dignity and confidentiality

The Corner House was a purpose built spacious building. All patient rooms included en-suite shower and toilet facilities. The rooms contained a sofa, table with dining chairs, wardrobe and a safe to store valuables. Patients were able to personalise their rooms with pictures and personal belongings. Each room had a fully equipped kitchen allowing patients to prepare their own food. Each patient had a daily living support plan which was a self-assessment of how much support they needed with certain tasks, for example, personal hygiene, food preparation and cleaning. We looked at the last patient survey carried out by the service in October 2016, which told us that nine out of ten patients were happy with their room, the facilities, and the general cleanliness of the unit.

Patients attended a community meeting which took place every two weeks. As part of our visit, we attended a community meeting and looked at notes from six previous meetings. We saw the notes contained a list of staff and patients who attended and a record of what was discussed. Staff followed up and discussed these issues at their weekly meetings. The service user involvement worker held a daily planning meeting, which informed patients of what activities were on offer for the next day and gave them the opportunity to request new activities. Examples of activities on offer included life skills groups, baking, photography, movie night, breakfast club, games, arts and crafts. Those with section 17 leave could access a gardening group with an allotment, sporting activities including basketball and inclusive football, walking and cycling. There was access to some activities at weekends.

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Good

Facilities in the service generally had been designed to promote patient independence. Patients had individually programmed key fobs that gave them access to a small courtyard and garden area. They were encouraged by staff to personalise their rooms as much as possible. Menu choices were clearly displayed with a range of healthy options. We observed managers and staff discussing minimising restrictions on patients and all patients were allowed mobile phones with internet access. This seemed particularly important for some patients who told us it promoted their sense of independence. Patient engagement in activities was generally high and the service set a target to provide patients with a minimum of 25 hours activity each week. We saw an activity report for all nine patients, which showed actual activity levels compared with planned levels. The report showed that although planned activity levels were above 25 hours per week, patient engagement declined when the activity coordinator left the organisation in November 2016. In response to this, managers recruited an occupational therapy assistant to maintain and develop the activity timetable. When we spoke to patients, they told us there was enough things to do and activities they could get involved in. One patient, however, commented that there was not as much to do at weekends. When we asked managers about this, they told us they had plans to recruit an additional occupational therapy assistant to co-deliver more groups and activities in the evenings and at weekends.

We noted there was no examination couch in the clinic room but when we asked staff about this, they told us patients would be treated in their own bedrooms or taken to community health services as necessary to their particular health condition. Some patients were working towards administering their own medication and patients could choose whether to have medication dispensed in their rooms or go to the clinic room at set times. We saw the service had a medication administration policy to support staff practice in this area. When we visited, we observed two patients queuing at the stable door to the medication room. This meant that one patient could see another patient accepting medication, which could have compromised their privacy and dignity.

We saw evidence in team meeting minutes that managers had reminded staff about confidentiality and the need to ensure patients had consented to share information with their relatives and carers before disclosing personally identifiable information.

Meeting the needs of all people who use the service

The service was able to accommodate patients with reduced mobility. An assisted bathroom was available with a mobile hoist. Staff told us training would be made available so they could use the hoist if a patient needed it. Some bedrooms were situated on the ground floor but there was a lift to other first floor bedrooms.

Staff had put a variety of information concerning patient rights including access to advocacy on display screens in the reception area and in leaflet racks in meeting rooms. When we spoke with patients and saw information in their recovery and behaviour support plans, it was evident that staff took a person centred approach to communication. Easy read leaflets with pictures and emoji's were available for patients and their carers. Turning Point had revised their welcome brochure to provide patients with information in short simple language about the care team, what they did and how they could help. The social worker offered a regular drop-in clinic where patients could get advice about a range of matters including safeguarding concerns and benefits advice.

Staff were respectful of patients' cultural and spiritual needs. Patients had access to the nearby chapel at the local hospital and one patient was supported to attend the local church. Staff had supported a patient to have a prayer and an imitation candle in their room. The cook attended community meetings to take feedback on the quality and choice of food on the menu including meals to meet dietary requirements. Patients were encouraged to try different foods and staff would prepare food outside set meal times if asked to by patients.

Managers and staff actively challenged discriminatory behaviour and developed a specific equality and diversity education session for all patients. Managers told us that patients had gained a lot from the sessions and the interaction between patients and staff had improved.

Listening to and learning from concerns and complaints

In the 12 months prior to November 2016, the service had four complaints, none of which were upheld. No complaints were referred to the Ombudsman. When we spoke to patients, they told us they were aware of how to make a complaint and that they could approach staff if they had a concern. Data from the last patient survey in October 2016 suggested that seven out of ten patients

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Good

knew how to make a complaint but only one patient had made a complaint prior to completing the survey. The patient reported they were happy with the outcome of their complaint.

When we asked to see records of complaints, we were told by staff that they did not often receive formal complaints and tended to resolve any patient concerns at the time in an informal a way as possible. Managers told us some complaints were dealt with through the incident reporting system, for example, complaints involving bullying or harassment. However, the provider had told us about two complaints they had received, one from a patient and one from a member of the public but when we visited, we could not find the records relating to those two complaints. Staff told us they knew how to deal with patient complaints and we saw evidence staff had taken action on one occasion and responded by letter to a complaint raised by a carer. The service had posters displayed encouraging patients to report concerns to staff which involved bullying or harassment.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Good

Vision and values

The provider had a set of values, which were very visible both in the patient welcome booklet, on posters and display screens in the reception area. Values were underpinned by appropriate behaviours so staff could clearly identify how to put the values into practice. The provider's values were;

- everyone having the potential to grow
- embracing change
- building a strong and viable organisation
- communicating in a supportive and challenging way
- encouraging new ideas and thinking
- supporting individuals however difficult and challenging

The service had recently been through a number of staffing changes including changes to operational and senior management. All the staff we spoke to thought the changes had improved the service. They were aware of the provider's values but they had yet to be fully embedded into the service. However, we did see evidence of the provider's values in staff interactions and in the way managers ran day-to-day operations. For example, staff behaved towards patients and each other with support, encouragement and the belief that everyone had the potential to change and grow. Managers encouraged staff to contribute new ideas and different ways of supporting patients to recover.

Staff knew who senior managers in Turning Point were and we saw evidence of governance meetings taking place at the service where senior managers had been present.

Good governance

Overall, the service had good access to governance systems through the provider's quality and governance procedures, which were updated in 2016. At The Corner House, we saw evidence that managers used internal quality assessment tools to audit systems such as health and safety and medicines management. We saw evidence that recommendations from audits were acted on by operational managers.

Staff compliance in mandatory training was generally up to date but only 67% of staff had completed infection control training. When we spoke with managers, they told us action was being taken to address this with staff expected to complete all their mandatory training by the end of February 2017. When we spoke with staff, we found them to be knowledgeable in relation to the duties they were expected to undertake. However, we received conflicting information regarding the mandatory training matrix. Managers were not clear whether positive behaviour support training and moving and handling objects training were mandatory for support workers. When we spoke with staff, they told us they were supported on a day-to-day basis to implement positive behaviour support by members of the on-site psychology team. We confirmed this when we attended a therapy group and a multi disciplinary team handover meeting.

Not all staff appraisals were up to date and some support workers had only begun to receive regular supervision since December 2016. This was because previously the service had a large number of vacancies in key supervisory roles. Since then, however, the service had recruited a regional manager to oversee the running of the service and recruited staff into key posts. During the five months prior to our visit, the service had recruited two senior nurses, a social worker, a clinical lead and a new operations

manager. These new roles had taken a lead in ensuring that staff were receiving regular supervision and management support. When we spoke with staff, they told us they had received line-management supervision and felt supported by managers in their day-to-day work and on-going development.

At the time of our visit, managers told us they only had four vacant support worker posts and recruitment was underway for them all. When we visited the service, we saw that there was enough suitably qualified and experienced staff to cover each shift and they spent a lot of their time involved in direct care with patients.

Staff participated in a range of clinical audit, for example, medication audits and patient annual health checks. Managers encouraged staff at all levels to report incidents. We saw evidence of incidents reported by agency staff, administrators and support workers. All incidents were overseen by higher managers and discussed at a local level by medical staff and operational managers at weekly governance meetings. Learning was cascaded via team meetings and handover meetings. Managers told us there were plans to provide staff with incident trend data so staff could identify themes from incidents. Staff followed safeguarding and mental capacity procedures and were supported by specialist social work staff to carry out these duties. Higher managers audited Mental Health Act procedures and ensured appropriate actions were implemented where necessary.

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.

Leadership, morale and staff engagement

When the service was last inspected in December 2015, the service lacked local leadership and the high use of agency staff had led to low staff morale amongst nurses and support workers. However, during the latter half of 2016, the provider had recruited to a number of key posts including a new regional manager, clinical lead, operations manager, social worker, and occupational therapist. Support workers had also been recruited and there was less reliance on agency staff. The nominated individual was acting in the role of registered manager whilst their their newly appointed clinical lead progressed their application to become the registered manager. Staff morale had improved greatly and, in response to direct feedback from staff, managers had introduced the following changes;

- Clinical supervision training days were provided for all qualified nursing staff.
- A clinical staff development forum was established and protected time for team development.
- Free tea and coffee had been made available for all staff breaks.
- Managers allowed staff more choice and flexibility in choosing shift patterns, which suited them.
- Managers set shift rotas six weeks in advance so staff know when they were working and when they had time off.
- Support staff could work over time which meant part-time staff, for example, could work additional shifts as and when they were available.

A staff survey carried out in February 2017 indicated that 94% of staff thought staff morale was either good or very good. Managers had introduced a “thankyou” board where staff were encouraged to post positive comments to colleagues. Staff told us this had improved relationships between colleagues and made the service a better place to work. In general, according to the most recent survey, the majority of staff thought the service was well-led and had improved hugely over the previous 12 months.

When we spoke with staff, they told us there was an open culture in the service where concerns could be reported to managers without fear of victimisation. The provider had produced a specific poster encouraging staff to share ideas as well as concerns including anonymously where necessary. The poster contained information about where staff could locate the whistleblowing policy, grievance procedures and about where they could access further help and advice.

The service had introduced a new electronic incident reporting system where duty of candour incidents were identified and monitored separately to other incidents. In the team office, we saw an incident report flow chart and a duty of candour internal report investigation template. At the time of our visit, the service had not experienced any notifiable patient safety incidents in the previous 12 months so had not had cause to investigate under the duty

of candour. We saw evidence that higher managers provided oversight of the incident investigation process and would identify where serious incidents had not been dealt with appropriately.

In general, when we spoke with staff, they had a sense of empowerment and job satisfaction. They had development opportunities and some support staff had undertaken nationally recognised qualifications in health and social care.

Commitment to quality improvement and innovation

The service had developed a specific service user involvement role to encourage patient focussed treatment. As a result, staff had developed a carer forum where relatives and carers were offered the opportunity to meet, provide each other with support and input into service development. Managers and clinical staff were working on developing a positive risk taking culture including lessening restrictions on patients. The service allowed patients mobile phones with internet access and staff only searched patients in response to identified risk. We observed a clinical governance meeting where managers and staff reviewed the list of restricted and banned items to increase individual freedoms to patients.

Medical staff at the service carried out annual physical health checks in line with the Maudsley prescribing guidelines for all patients taking anti-psychotic medication. We saw evidence of medical staff identifying alternative treatment methods to medication in appropriate cases.

Both managers and staff were particularly proud of their positive behaviour support programmes which had been implemented with all nine patients in the service. This meant, for example, staff knew specifically how patients wanted to be treated if they became anxious or upset. It also meant the service was actively reducing restrictive practices with patients. The consultant clinical psychologist and the assistant psychologist were writing a research paper and were due to appear at a national conference to speak about using positive behaviour support to reduce restrictive practice in long-stay rehabilitation services.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure they identify which training courses they consider mandatory for staff.
- The provider should ensure all staff have completed training in the provisions of The Mental Health Act,1983 and the associated Code of Practice.
- The provider should ensure they monitor any specific dates where patient leave is cancelled due to staff shortages.
- The provider should continue to ensure all staff participate in regular line management supervision and appraisal.
- The provider should ensure they keep written records of all complaints and the action they have taken to resolve them
- The provider should ensure patients' privacy and dignity is maintained when accepting medication