What we expect to see[1]

NDTi *Excellence in Rehabilitation* Project for the East Midlands

This is a work in progress, and should not be regarded as a definitive statement, as further discussions are planned and other partners need to be consulted. We anticipate that this document will be helpful in the following three ways:

- Creating it, editing it and sharing it will trigger useful discussions about what excellent residential services look like and this will promote positive change. Some of this will come through the spread and adoption of excellent practice across teams and organisations, and other work on excellence will be co-produced, using a range of perspectives to construct ideas and solutions that did not exist before.
- It will be used as a structure for Peer Audits that challenge poor and merely satisfactory services, whilst emphasising the things that inspire excellence. In other words, we expect peer auditors to spend as much time as possible in column three of the table below.
- The focus on excellence will help to support a learning culture that recognises strengths and inspires positive behaviours in both individuals and organisations, staff and people using services, managers and relatives.

Poor services	Satisfactory services	Excellent services
Characterised by unsafe systems, illegal and unprofessional practices, and inadequate levels of service. People are at risk and relatives have justifiable and 'common-sense' reasons for complaint. External inspection and regulatory agencies spend most of their time here	Characterised by compliance with minimum standards and contract obligations. People are treated with dignity and respect. The ordinary things that should be done in any care environment are done properly. Satisfactory rehabilitation services are similar to services that focus on other goals. Contracting processes tend to insist on these standards	Characterised by clear goals and practices underpinned by strong values, well articulated theory and evidence that maximises rehabilitation outcomes. These approaches are what makes excellent rehabilitation settings distinctive, so will not be found in other services. After a brief summary of what constitutes satisfactory service levels, our project will focus here

[1] NDTi provided the column headings, the 'Excellence in Rehabilitation' group created the content on 30/09/2013, and NDTi sorted it as shown here. The group made further revisions on 21/11/13 and 27/02/14. For more information, contact peter.bates@ndti.org.uk

0. Before the person comes to us, we share with them what they can expect, especially as they arrive, on the first day and in the first week

- Information is inaccurate, incomplete, out of date, and difficult to understand.
- No face to face contact between staff and the person until they arrive in the unit.

- An information pack is provided to the person before they move in.
- The person and relevant staff from the new unit are invited to and attend discharge and transfer meetings in the person's previous residence. The person has an opportunity to visit the unit before they move in. By the time they move in, the service knows something about their preferences and interests.
- Clear information is provided to the person about how legal responsibilities will be met, such as S117 aftercare or CPA duties.
- The admission process includes introductions to people, the daily routines and access to staff and the care planning process.
- A therapy programme is devised in good time so that the newcomer is constructively occupied from the first day. The discharge pathway is explained very early on in the person's stay.
- During the first week, the person has a daily one-to-one session with a staff member.

- The information pack is available in different formats and the information can be personalised with staff photos and other information that will help the person understand and feel at home.
- Plans are discussed and managers seek views and suggestions, so that the person's living space is personalised in time for their admission.
- Contact is made with the family before the person moves in.
- The person has a chance to visit the unit on a trial basis before they formally move in and this trial visit is supported by the right staff (including key worker and responsible clinician), introductions and care plan. Their name is on the bedroom door and the room is personalised.
- The admission process is well paced and includes appropriate repetition and access to help so that the newcomer has the best chance of settling in.
- There is an early opportunity for both the new resident and the staff team to explain what they hope will be achieved during the person's stay.

1. We begin by getting to know the person. Can we hear their voice and understand their wishes and preferences, even before we plan their care?

- **Confidentiality** is compromised.
- **Communication supports** and interpreters are not available
- **Meeting with residents -** resident meetings do not occur or their comments are ignored and there is no resident voice in other meetings. Patient experience is neglected.
- **Advocacy** is not available.

- **Confidentiality**
- **Communication supports** – Care Programme Approach reports and other documents are provided and reviewed with particular attention to the wishes and views of the person.
- **Meeting with residents.**
- **Advocacy** service is available

- **Confidentiality** arrangements are in place, including effective information governance
- **Communication supports** and access to interpreters available. Documentation, such as My Shared Pathway is person-centred and clearly expresses the person's views.
- **Meeting with residents -** Full engagement of service users including in service development. Someone is identified from the existing resident group to act as a buddy to the newcomer and they have contact prior to the admission, and the buddy is on hand when the newcomer arrives.
- **Advocacy** - people's preferences affect discharge and transfer planning in the person's previous residence. Advance directives are in place.

2. Having met the person, can we build a good relationship and with them support them to plan their life within and beyond our service?

- **Key worker** not identified for all patients.
- **Care plans** are missing, incomplete, out of date and lack evidence of person-centred care and goalsetting. Care is fragmented. Lack of continuity of care.
- **Transition** planning is missing. Discharge documents are missing or meagre. Absence of discharge planning meetings. Discharge discussions are used as a threat. A group of residents may be moved in a block to a new service for non-emergency reasons (perhaps for business reasons rather than due to a fire!). The choice of places to move on to is restricted to a small cadre of organisations that we routinely work with, rather than all available facilities.

- **Keyworker** - identified for each person. There is evidence of meaningful engagement with the person in general and in planning, and the keyworker can explain how people are making progress. They complete reports and care plans.
- **Care plans** discussed with MDT and patients are aware of it. Care plans are periodically reviewed and updated. Continuity of care.
- **Transition** - planning discharge from the point of admission. Block movement of people happens rarely.

- **Keyworker** - Service user and staff share common view of needs and the goals of rehabilitation. Person-centred and recovery focused care is embedded. Effective use of keyworker system which includes regular one to ones with the person, during which they formulate the care plan. There are regular opportunities for the person and their keyworker to have both formal 1:1 meetings and informal time together. People are involved in the selection of their key worker, and help to decide if this key worker has suitable training and competencies for their role.
- **Care Plans** – are person-centred, meaningful and individualised and include a high level of patient involvement in formulation, implementation, review and evaluation processes. Quality is checked via peer review and plans look different from one another. Care plans clearly present the person's own preferences and views (often through direct quotes), are held by the patient, signed by them and amended as care progresses to demonstrate continual evaluation through good audit trail.
- **Transition** –Discharge planning starts at the earliest possible moment and is used therapeutically. People move as individuals and not as a group. There is a shared understanding between all stakeholders, including the person, about why the person is here, how long they might stay, and what needs to change before they can move on. The balance of choice and safety is actively negotiated and the person is as involved in this as possible. Seamless service from and into community based support, including long stay, rehab, step down and community support. External partners recognise that the service is delivering agreed outcomes, including discharge plans. The person is followed up post discharge with support and help with care planning. The commissioner values the insights of the care team and helps to resolve unwarranted delays in rehabilitation and move-on.

3. The person-centred plan should then drive the programme of activities and therapy on offer to the person.

- **Activity** –people are bored and just sit around while activities get cancelled. Lack of meaningful activities or therapy on offer. People are harmed by unfair, punitive or restrictive controls, living arrangements and relationships. People are processed in groups within and beyond the service so that everyone gets the same plan, activity programme and destination on discharge.
- **Medication** - poor information on medication and side effects. There are frequent drug errors.
- **Monitoring** - evaluation tools to judge progress and the impact of interventions are not used
- **Outcomes** – there is no tracking of clinical effectiveness. People experience the 'revolving door'.

- **Activity** and Therapy programme in place with a personalised timetables of activities that are most autonomous, least restrictive, maximise choice and control, and involves people in decision-making. Lifestyle issues include a focus on physical healthcare and wellbeing. In exceptional circumstances, people are treated as a group rather than as individuals, and everyone gets the same thing, but this is rare.
- **Medication** is periodically reviewed within prescribing guidelines, and as part of care plan targets and goals. People manage their own medication to the greatest extent possible.
- **Monitoring -** Recovery tools (such as the Recovery Star, CPA reports and interests checklists) are used to identify people's needs and it is clear how they drive the activity programme.
- **Outcomes -** Length of stay is efficient and effective. Clinical governance and audit are in place and well recorded. Interventions are informed by research evidence.

- **Activity** – a full range of therapeutic activities is available so that activity is meaningful and purposeful, based on what the patient wants to do and needs to do to progress rehab. Peer support opportunities are available for service users. There is equality of access to service and treatment across all areas and a proactive approach is taken to reduce any inequalities of access, such as provision of interpreters. Physical healthcare is addressed to meet the low secure CQUIN target.
- **Medication** – is used as sparingly as possible within prescribing guidelines to give people the greatest potential and a stepped care process is used to promote self-management. There is evidence of informed choice and consent in the use of medication. The person has frequent opportunities to discuss medication with key nurse, advocate and pharmacist in terms that they understand. People have access to e-learning opportunities on medication. Help is available in how to talk about medication with people who may have difficulties in comprehension. Medication is part of a governance framework that may include peer review or visits from external pharmacists.
- **Monitoring** – The evidence base for interventions is clear and utilised both in prescribing and improving services. Significant progress is measured and can be clearly demonstrated by using assessment tools.
- **Outcomes** – auditing is used to aid organisational improvement. Evidence of the efficacy of interventions is made available to patients, so they can make informed choices about participation.

4. In addition to activities inside the unit, are there opportunities for people to build a life in the community beyond the service?

- **Frequency** – people never go out. There is no contact with the local community, or the person's original home area.
- **Range** – few or no community venues are utilised.
- **Purpose** – a preoccupation with security and in-house activities result in community opportunities being ignored. when people do go out, the therapeutic purpose is not understood and it is seen as merely keeping people busy or giving them an outing.

- **Frequency** – there are opportunities for engagement in community activities and evidence that they are taken up. People spend time each week using community amenities such as shops, GP surgery and leisure services. Opportunities for people to engage in education opportunities outside the unit.
- **Range** – People have access to community amenities and services. Universal services are promoted so that over time, use of specialist services reduces wherever possible.
- **Purpose** – the focus is on appropriate behaviour in these community locations and the development of practical skills to enable the person to use these facilities, such as how to use a self-swipe checkout in the supermarket.

- **Frequency** - visitors come to the unit and people go out and meet the wider public because of the interests or activities they share with patients. Open days and other events at the unit welcome members of the public regularly and showcase people's talents. It is recognised that people can take positive 'time off'.
- **Range** – A wide range of community opportunities are available, ranging from employment, education and volunteering to leisure activities and membership of both formal groups and informal social networks. Faith and cultural communities are in contact with individuals where appropriate, and people are encouraged to maintain or repair old connections as well as build new ones. Both face-to-face and online connections are encouraged. Staff in the unit see their role as including the job of seeking out community opportunities and helping them to offer a respectful welcome to people.
- **Purpose** - social inclusion is timely and meaningful to the individual, with a deliberate goal that people will build natural and informal friendships with members of the community, in addition to their relationships with other people using the service. Time in the community is seen as a chance to enhance skills rather than merely something to do or a risk. Staff use these opportunities to check out whether people are utilising the skills they have learnt. Evidence of support for cultural diversity. The direction and pace of progression and transition is led by the person. A range of training opportunities are available, including topics that might traditionally be seen as only of interest to staff.

5. A life beyond the service presses us to maintain good links with family, external agencies and other stakeholders.

- **Family** members are excluded
- **External agencies** – absence of contact, poor relationships
- **Inspections** – poor report from CQC and others. No external peer review.

- **Family** contact is promoted and people get unescorted time with their relatives whenever possible and go out together when they can. Facilities are available for family and friends to visit and the least restrictive support is provided to keep everyone safe, driven by an individualised risk assessment and support plan. Carers assessments are available.
- **External agencies** – links exist to smooth the discharge process and contacts with community teams are actively maintained. .
- **Inspections** - the service makes constructive use of the inspection process and ensuing reports in order to improve services.

- **Family** – support for families is available, including advocacy to support people to get a carer's assessment. Educational programmes and systemic family therapy help relatives to offer good support to the person. Manage sensitivities regarding confidentiality and different expectations between the person and their relatives Offer a 'meet the team' opportunity every 6-8 weeks - an informal opportunity for staff and families to get to know each other and offer peer support. Online contacts are encouraged to maintain relationships between visits. Wherever appropriate, staff provide weekly feedback to relatives.
- **External agencies** – good relationship with stakeholders. Evidence of multi-agency working as external partners work together. Clear understanding of funding streams. Commissioners are engaged in conflict resolution when needed, to enable specialist and local services to work together successfully. People have some choices about where to go for healthcare.
- **Inspections** - Evidence of external quality assurance e.g. Star Ward accreditation. Up to date with legal issues and regulations. Peer review from other agencies. In-house staff take a special interest in the inspection process and become skilled in supporting the agency to act on inspection priorities.

6. A clear understanding of what we need to do to support the person helps us be clear about what the requirements for building, furnishings and equipment

- **Building and furnishings** – unsafe, un-stimulating, neglected decor and furnishings. Large institutional wards without differentiation.
- **Security** – people may be placed in an environment that doesn't suit them. Security is highly visible and intimidating.
- **Private space** is non-existent, as staff assume the right to enter their rooms without invitation.
- **Outside** – people get little or no access to the outdoors and long views.

- **Buildings and furnishings** are of a good standard but rather plain and standardised. Wherever possible, people live in apartments of six or fewer, with an integral lounge, kitchenette and en-suite individual bedrooms. There are a variety of arrangements offered from single rooms to shared apartments, and people have a choice of whether to live in the town or countryside and which room to take.
- **Security** is proportionate and unobtrusive with a comfortable and homely environment..
- **Private space** is differentiated to create variety, homelike environments and opportunities for personal expression by residents. Adjustments are made in good time so that when their support needs become apparent, the provision is already adapted to minimise the disruption caused by this.
- **Outside** – people have frequent opportunities to spend time outside.

- **Buildings and furnishings** – are attuned to the needs of residents (such as the late stage dementia ward that had selected furnishings from the 1950s), including appropriate levels of sensory arousal for each individual. The impression is homely rather than institutional. Residents are consulted on design and changes to the environment. Residents are involved in chores and DIY and have free access to activities that reflect those enjoyed by other citizens. Noticeboards present useful and timely information to residents. Where needed, there are specialised environments, such as a wet room, aids for disabled persons or a space to assist in the safe management of aggression. People make appropriate use of different rooms for different functions and can access suitable equipment for each space, so computers or cookery equipment is not locked away.
- **Security** – Staff use security in ways that are discreet and almost invisible (such as a fob system that can be used subtly and does not delay progress). Staff appear 'conversation-ready' rather than 'combat-ready'. Residents have access to many parts of the building.
- **Private space** reveals the activities and interests of the resident. Some spaces are uniquely adapted to retain the dignity of the individual.
- **Outside** spaces are diverse and varied**.**

7. A good relationship with the person, a plan that supports their priorities and a environments that are fit for purpose should all improve safety. Is risk well managed?

- **Risk management** poor risk management practices and staff have not been trained in this.
- **Safeguarding** – deficits in all areas. Physical and verbal abuse. No whistleblowing or safeguarding systems or actions.
- **Complaints** – no procedure and complaints are ignored.
- **Challenging Behaviour** - poor management of challenging behaviour, including use of aversive strategies and poor training

- **Risk management** – Good incident analysis and learning from experience. Evidence that audits are carried out and lead to improvements in standards and patient outcomes.
- **Safeguarding** - evidence of procedures being implemented. People are safe. People are aware of the whistleblowing policy and procedure
- **Complaints** - clear idea about how to complain and complaints recorded. The complaints procedure is robust and complaints lead to changes. Feedback is given to the person who brought the complaint.
- **Challenging Behaviour.** Clearly defined principles and guidance for managing difficult behaviour are in place, including clear management plans for individuals, in-house training and supervision of all staff to ensure they implement a consistent and unified approach.

- **Risk management** – easy and fluent dialogue about incidents that leads to changes in practice and guidance. Positive management of risk and opportunity. All stakeholders (especially people themselves) feel able to speak out, both directly and via surveys. Views feed through into action plans and are published on websites.
- **Safeguarding** – meet regularly with local safeguarding team every 4 months. They review both actual events, npotential hazards and seek patterns to find areas for improvement.
- **Complaints** In addition to the robust complaints systems, there are many informal opportunities for residents and relatives to have a quiet word and draw attention to a problem. Complaints lead to an action plan, change and evaluation with the impact fed back to people using the service.
- **Challenging Behaviour** – Everybody has an individual support plan, rather than being “managed”. Each person’s history is understood, so that they are supported to avoid escalating events in the future. Advanced directives are in use.

8. Now we move on to the staff side of these arrangements. We begin by asking whether the organisation as a whole is clear about its purpose.

- **Mission statement –** there is no clear direction, inconsistency in approach and no clear statement is in the public domain.
- **Mission statement** is clear, based on sound values and the organisation is aligned to deliver it. This is reflected all the way through policies and procedures, including. recruitment, induction and continuing professional development.
- Mission statement provides a framework within which the service adapts to reflect the needs of residents and other stakeholders. People are engaged with the mission statement and help to determine whether it is being delivered. There is external accreditation through national standards, perhaps via the Institute of Psychiatry.

9. Every organisation has its own enduring culture that affects everyone and everything

- **Transparency** absent so everyone is kept in the dark and communication is poor. Opaque governance structures.
- **Expectations** - demotivated staff. Sense of hopelessness and stagnation with low morale. Staff do not know patients very well.
- **Leadership** is missing or poor
- **Teamwork –** is dysfunctional

- **Transparency** – there is a clear declaration of the organisation's mission and the desired organisational culture and everyone knows what it is and is positively engaged with it.
- **Expectations**
- **Leadership**
- **Teamwork**

- **Transparency** – accountability, critical appraisal at all levels. Close links between 'Board and ward'. Information is shared and everyone is willing to openly discuss, review service and change as needed. Full involvement of all staff in directing change and organisational development. Plans are discussed and managers seek views and suggestions. Development of flexible and innovative learning culture.
- **Expectations** are high that people can achieve their aspirations. Unmitigated optimism, especially about people that others are pessimistic about. Believe people can recover old skills and develop new ones.
- **Leadership** – staff are supported to be innovative and flexible in care delivery. Staff can become champions and lead in best practice and innovations in care. Opportunities for people to be trained and supervised to deliver the positive culture. Residents are recognised as leaders and experts in their own care, and can also sit as Board members and sit on advisory groups locally and also further afield.
- **Teamwork** - Clear streamlined tools for communication within and beyond the care team. Open and honest culture. Sharing of good practice. Peer support available for staff.. Expectations are shaped by all stakeholders and not just one body or group of people.

10. Does the organisation have the right staff?

- **Staffing levels** – Low staff numbers make the service unsafe. High sickness absence and turnover.
- **Staff type** - high level of unskilled staff (poor skill mix), agency use. Wages at or below National Minimum Wage. Generic staff who have no specialist skills for this setting.
- **Staff recruitment** - poor recruitment and wider HR practices with no service user involvement. Inadequate HR
- **Multidisciplinary** approach is not available to people

- **Staffing levels** – adequate.
- **Staff type** – not much use of agency and inexperienced bank staff.
- **Staff recruitment** is effective and timely.
- **Mulitdisciplinary** - appropriate skill mix
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- **Staffing levels** – Retention is good, upheld by investing in staff, offering training and giving people a sense that they are valued.
- **Staff type** – Staff have the right skills and knowledge i.e. LD, PD etc. as well as lived experience where appropriate. Recognising that some people don't start with the right experience but do have right values and learn..
- **Staff recruitment –** hire the right people. Capable staff with specialist skills relevant to support in the needs of the service users. Patients are involved in the recruitment and selection process..
- **Multidisciplinary** – sufficient skills, knowledge and lived experience to assemble a full MDT. People can get extra specialist help.

11.Are the staff well trained and supervised?

- **Training** –even mandatory training is missing, as well as professional and CPD training. Training that happens is of poor quality or sends out harmful messages. Records of training not maintained.
- **Supervision** missing, irregular or poor quality.

- **Training** – staff have appropriate skills for the needs of the people currently using the service. Mandatory training is in place, but may not influence the usual custom and practice of staff. Processes are in place to assess the effectiveness of training and make adjustments as necessary.
- **Supervision** is in place and is robust, regular and includes reflective practice. Supervisors have their competency assessed and opportunities to upskill. Group supervision is available so staff learn from one another and develop through reflective practice. These group supervision sessions have access to an independent facilitator.

- **Training** – staff are skilled and knowledgeable through an active programme of service specific training with detailed induction training into the specific role that helps to embed principles of individualised care. Evidence that staff are engaged in CPD and are up to date with best practice and innovations in care. People are involved in the design and delivery of some training sessions – such as induction sessions where they act as experts by experience. Arrangements are in place to make it practical for people to attend any training session that is offered to staff. All staff have opportunities to learn by visiting other services, attend conferences and network with people in other services. Where team change is needed, the whole team have a chance to learn together, rather than sending one delegate to the training.
- **Supervision** - Culture of self improvement and lesson learning based on evidence, reflection and sharing of good practice. Peer review and 360 review of all staff. Performance is managed effectively using an evidence based format that specifies outcomes. Supervision is meaningful, purposeful, supportive and skills enhancing - and reviews the quality of care plans and paperwork, identifying specific challenges where appropriate. Supervision and development opportunities are specific to the work setting and skills required – perhaps via a peer in another unit.

12. Do care records and other documents demonstrate that the service is working well?

- **Records** – are poor and care records are not signed by the patient. Copies are not given to the patient.
- **Policies** and procedures missing or not accessible

- **Records** - Clear documentation with detail and rationale behind decision making. Diary entries reveal that the care plan is being delivered as agreed. Satisfaction surveys show that stakeholders approve of the service.
- **Policies** and procedures exist, are clear and are used. Records show that Governance structures are in place.

- **Records** are maintained, efficient and help with good communication and meet legal obligations whilst not distracting staff from patient care. People contribute to their care plans and the whole document is accessible to them. They carry their own care plans into assessment and review meetings.
- **Policies** are co-produced with people using the service and are written in an accessible format.