Imagine Independence

Fielder Lodge

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	**Outstanding** ☆
Is the service effective?	**Outstanding** ☆
Is the service caring?	**Outstanding** ☆
Is the service responsive?	**Outstanding** ☆
Is the service well-led?	**Outstanding** ☆

Summary of findings

Overall summary

This was an unannounced inspection carried out on 20 September 2016.

The service was last inspected on 26 August 2014 and was meeting all the regulations assessed at that time.

Fielder Lodge, is a not for profit, women only, high support accommodation. Fielder Lodge provides a therapeutic environment, psychological safety and containment to enable people to progress at their own pace, towards sustained recovery and independent living. Fielder Lodge had eight self-contained one bedroomed flats, along with communal areas including a lounge, dining room and large communal garden. The building had adaptations including a ramp and wide door frames to accommodate wheelchairs. There was a fully adapted bathroom and one fully accessible flat to accommodate a person with restricted mobility.

A respite facility was located on-site, a complimentary therapy room, offices and a meeting room. There was one entrance and exit route and an intercom system to the flats and to manage access to the building. People residing at the service had fob access to their individual flats and there was CCTV security on the perimeters of the service. At the time of the inspection there were seven people living at Fielder Lodge.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The professional feedback we received regarding Fielder Lodge was extremely positive. We were told that Fielder Lodge was 'a breath of fresh air' and provided people with a sense of hope for their future.

Staff developed meaningful relationships with people which empowered them to proactively manage their own risks. This approach enabled people to feel in control and we saw it had resulted in positive outcomes for people.

Staff were creative and adapted their support in response to people's changing needs to mitigate risks. People spoke highly of the support received and attributed their progress, enhanced sense of wellbeing and quality of life to the staff and support recieved.

We saw staff received comprehensive training which provided them with exceptopnal knowledge and skills. People received multidisciplinary input from a range of staff which included forensic community psychiatric nurses, social workers, occupational therapist and psychologist.

Staff told us they felt extremely well supported by management and received very good support through training, regular supervision and team meetings. Staff received psychology input to undertake formulation

work, to equip them with the knowledge and skills to effectively support people. The psychologist also facilitated debriefing with the staff following incidents to ensure they were adequately supported.

People were at the heart of the service. The staff had achieved outstanding results based on people's goals. People themselves told us that they had not believed their achievements had been attainable and attributed their success to the relationships and trust that had developed between themselves and staff. People were empowered to achieve their goals and live a fulfilled and independent life. People and staff worked in true partnership as equal partners with a focus on recovery principles and shared decision making. Recovery principles were embedded throughout the service design. A recovery coordinator was employed at the service to ensure recovery remained at the heart of care planning.

People and staff were encouraged to influence service change. Staff spoke of being given opportunities to explore and implement their ideas. People were at the heart of the service design, recruitment and quality monitoring.

Without exception, people receiving support praised the staff for their caring and professional approach. One person told us; "The staff are very supportive. I couldn't have asked for more support. They've never given up on me. I can't thank them enough.They've constantly been there for me.

The management and staff were clearly motivated to make the transition for people to the service as cohesive as possible. Staff provided six week non-funded support prior to people's move to the service. Staff spent time with people on the ward, getting to know them, building therapeutic relationships, attending ward rounds and supporting people to visit the service and pick furnishings to make their flat their home.

People told us they had been involved in the planning of their care through the assessment and care planning process and at on-going reviews. Involvement of people who used the service was clearly embedded into everyday practice. There was a clear emphasis on people achieving their aspirations and staff were positive, motivated and focused on people's successes to support their continued progression.

Health care professionals working with the service told us that Fielder Lodge was a high quality provider that was at the forefront of services when they considered placements. We were told that staff were exceptional at responding to people that required additional support and the service had achieved excellent outcomes with people.

People's preferences and choices were fundamental in their care. Staff were innovative and suggested additional ways to embed these in their care, which people themselves might not have considered. People had developed in confidence because of how the staff cared for them.

When people were ready for stepping down, staff supported them through their transition. People were given practical support and people with lived in experience (peer support workers) would utilise their experiences to provide emotional support, advice and guidance throughout the person's transition to new accommodation.

Management had recognised people's sense of abandonment when progressing from the service and had developed the non-funded outreach service to provide continued relational security throughout this time.

The staffing structure in place made sure there were clear lines of accountability and responsibility. The vision and values were imaginative and person-centred and made sure people were at the heart of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Outstanding ☆

The service was extremely safe.

Staff had exceptional skills and the ability to recognise when people felt unsafe. Staff developed positive and meaningful relationships with people to keep them safe and meet their needs.

Staff showed empathy and enabled people to challenge themselves and empowered people to contribute to the management of their own risks.

People's medicines were managed safely by staff who had received appropriate training.

Is the service effective?

Outstanding ☆

The service was extremely effective.

The staff received a comprehensive training programme which was effective in meeting people's needs. The service worked in partnership with other organisations to make sure staff training followed best practice.

People received input from a multidisciplinary team which included CPN's, nurses, social workers, occupational therapist and holistic therapists to support their recovery.

The environment was designed by people using services and people choose their own furniture for their individual flats prior to their move to support their transition.

Is the service caring?

Outstanding ☆

The service was extremely caring.

The management and staff were committed to a strong person centred culture. Kindness, respect, compassion and dignity were key principles on which the service was built and values that were reflected in the day-to-day practice of the service.

Staff built meaningful relationships with people who used the

service and the relational model was applied to meet people's needs and assist them in regaining their independence.

Staff had a good understanding of people's care needs. People who used the service valued the relationships they had with staff and expressed great satisfaction with the care they received.

Is the service responsive?

Outstanding ☆

The service was extremely responsive.

People were at the heart of the service. The staff had achieved outstanding results based on people's goals which the people themselves had not believed attainable.

People felt the service was very flexible and based on their personal wishes and preferences. Care and support plans were developed from a recognised recovery based assessment tool (the mental health recovery star and horizon tool).

People were visited by staff whilst they were an inpatient to build relationships. The move to the service was facilitated gradually through a number of visits, overnight stays and extended leave before people were transferred fully.

Is the service well-led?

Outstanding ☆

The service was extremely well led

There was a strong person-centred culture. People using services had designed the home and people continued to be at the heart of the fundamental decisions involving the service.

The director, management and staff were passionate about providing excellent quality of care and making a positive difference to people's lives. The service provided an outreach service to ensure people's recovery was not jeapordised following move-on.

There was a strong emphasis on continual improvement and best practice which benefited people and staff.

Fielder Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was carried out on 20 September 2016 and was unannounced. The inspection team consisted of one adult social care inspector from CQC (Care Quality Commission) who is a registered mental health nurse.

We asked people for their views about the services and facilities provided. During our inspection we spoke with four people that lived at Fielder Lodge, six members of staff, which included; the director, two team leaders, recovery coordinator and care staff. We also spoke with three health care professionals.

We looked at documentation including: two care files and associated documentation,five staff records including recruitment, training and supervision. Three Medication Administration Records (MAR), audits and quality assurance documentation, a variety of policies and procedures and safety and maintenance completion of works and certificates

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding and incidents, which the provider had informed us about. A notification is information about important events, which the service is required to send us
by law. We did not receive a Provider Information Return (PIR), which is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was due to an administrative error and the wrong PIR form being sent to the provider.

We liaised with the local authority and local commissioning teams and we reviewed previous inspection reports and other information we held about the service.

Outstanding ☆

Is the service safe?

Our findings

We spoke with four people who lived at Fielder Lodge. Without exception, the feedback we received from people receiving support was complimentary and positive regarding the level of safety they felt whilst living at the service. People told us; "I feel safe. When you ask staff for a chat, they make time for you there and then and that's when you need it." "I feel safe here. I know the door is locked at night and staff will check on you through the night if you request it. I just ring staff when I need them and they come." "I feel safe. I have achieved things I never dreamed possible. Even at night if you have a worry, the staff stay with you and have a brew. They are there 24 hours for you."

The three health care professionals we spoke with consistently told us they had been impressed by the staff's willingness to persevere even in the most difficult circumstances. They said staff sought timely advice and crisis admission when the risk was unmanageable. We were told that staff had a good balance between understanding people's risk and seeking appropriate assistance whilst they worked with people, and provided intense support to empower people to regain control.

The approach to risk management was recovery focused, exploring every opportunity to support people to exert as much choice and control over their lives as possible whilst maintaining their safety. The service adhered to the principles of the 'relational model', which is deemed to be an effective model for working with people who have suffered from chronic emotional, psychological, and/or relational distress. It promotes satisfying mutual relationship with others. We saw that this had been particularly effective in supporting people to gain independence that had not previously been attained following long term secure placements. For example, we saw from one person's file that during their last placement they had spent long periods of time isolated due to their chronic violence and aggression. The staff had taken a therapeutic risk and as a result the person was now looking to step down from the service to more independent living. Staff response to risk was to convene a team meeting, reflect and consider the emotion behind the behaviour, to better understand what was driving the outbursts in order to manage the risks. The service ethos was to empower people to own their own recovery and staff relied on the therapeutic alliance with the person to achieve this.

The service used the Galatean Risk and Safety Tool (GRIST). The tool combines mental health risk assessment and clinicians judgement of risk based on their training and statistical analysis of the population. The tool enables a breakdown of risk and indicates the magnitude of risk and probability of it occurring. The GRIST was completed periodically and when there was a change in the person's risk, such as when a person had a change in their circumstances. The GRIST is a complex assessment tool but alongside this, the service also used a brief risk identification and management tool. This identified and rated behaviours of concern as major, moderate and minor. It also detailed factors that increased, decreased and contained the risk along with past triggers, early warning signs and events to pre plan. This meant staff were proactively assessing risk and had the required information to pre-empt challenging times for people living at the service, enabling them to increase support accordingly to maintain people's safety.

The staff empowered people to manage their own risks. The people living at the service had developed a

one page profile, in conjunction with staff, detailing what staff support they required to achieve this. The profile identified; what people admired about the person, what was important to them and how best staff could support them. People had also developed their own 'stay well' plan, which explained what contributed to their mental health deteriorating and what helped them to stay well. This approach enabled people to feel in control of their experience and rather than use self harm or violence in response to their trigger, encouraged people to take proactive measures to manage the risk.

The staff were creative and adapted in response to people's changing needs to mitigate risks. The service had a low stimulus room that people could use when their mental health deteriorated. The room contained a bed, chair and had an ensuite bathroom. The management had recognised that people personalised their flats but during times of emotional distress, they required a low stimulus environment which did not over crowd their senses. The flat provided people with a safe environment to retreat from their world for however long was required. One person told us they had only recently been discharged following a crisis admission but explained the lengths the staff had gone to in order to avoid the admission. The person told us their only means of distraction was painting and the staff had gone out and spent a large amount of money on paints and canvasses to keep them occupied. They told us management had agreed they could paint anything but the building and they proudly showed us a multi coloured bird table they had painted during their relapse.

People were provided with self-harm packs where necessary which contained clean implements and first aid equipment which was in line with harm reduction principles. The service also stocked red ice which people used to hold on to their wrists as the cold and red colour brought safe relief and feeling to the emotion experienced at that time.

Staff used every opportunity to assess and manage risks. Staff let people in to the building, which enabled them to greet people on their return. Staff indicated that it was polite and respectful to greet people but that it was also an opportunity for staff to risk assess the situation. The assessment on people's return would consider if the person had consumed alcohol, drugs and if the person had returned with somebody. Although the management encouraged people to have visitors and friendships to promote social inclusion, 24 hours' notice was required along with identification of the person, due to the nature of the service. People visiting were required to be accompanied when accessing and leaving the person's flat so that other people at the service were protected.

During our inspection, we checked to see how the service protected vulnerable people against abuse and found suitable safeguarding procedures in place. The provider had a named safeguarding lead to offer specialist advice and support to the service if they had a safeguarding concern. All of the staff we spoke with confirmed they had attended safeguarding training and identified whistleblowing processes that could be pursued if they were not satisfied with the management's response to their concern. Staff demonstrated a comprehensive knowledge of what could constitute abuse and the procedure to follow. Comments from staff included; "Abuse could be talking to a person in a poor manner, inappropriate or disproportionate contact with people. The potential harm to people here would be significant." "People living here are at particular risk of being exploited. I'd be concerned if some family members came back on the scene. We have a framework and procedure to follow."

We looked at how the service ensured there were sufficient numbers of staff to meet people's needs and keep them safe. We found the service had sufficient skilled staff to meet people's needs and people and staff confirmed this. A person said; "There is enough staff, they have always been able to provide the support at the times that I have needed it." Staff told us, "There is enough staff. There is a minimum three at night but sometimes four and we always have four during the day and team leaders."

All staff employed had been through a thorough recruitment process before they started work for the service. We looked at six staff personnel files and saw they contained an application form detailing work history, interview questions and two references. Disclosure and Barring checks were in place to establish if there had been any cautions or convictions, which would exclude them from working with vulnerable people.

Clear systems were in place to assist people with the management of their medication. The clinic room was clean and tidy. The clinic room and refrigerators were checked daily by staff to ensure that medicines were stored at the correct temperature and were safe to use. In order to administer medicines, staff completed training, written assessment and had an experienced staff complete three observations of their practice before being deemed competent to do so.

Staff completed a medication sheet which detailed the incoming medication received. There was a description detailing when required medication (PRN) could be offered and two staff signed to confirm medicines had been administered. Each person's medicines were stored in individual lockers within the clinic room, which was kept locked at all times. Controlled drugs (CDs)were appropriately stored and signed off within the CD register when dispensed. We checked stock levels for two people, which were correct. Medication stock was checked weekly and only the shift leader held the key for the clinic room.

People's capacity to understand their responsibilities to keep medicines safe was assessed prior to engaging with a self-medication programme. Staff completed a risk assessment and a contract was devised with the person prior to agreeing a staged process for self-medication. Staff monitored people and if the person missed their medication, staff prompted them. Creams were signed out to people and managed independently. One person told us; "I have my own medication in a locked cupboard. At the first stage, I go and tell staff that it's time for my medication. If I'm late, staff prompt me."

The service was clean and well maintained. People and health professionals commented favourably on the cleanliness and maintenance at the service. We were told that if anything was broken it was fixed straight away. If it was dirty, it was cleaned. The management took pride in the environment which encouraged the people living there to do the same.

The service was homely and comfortable. Regular checks were conducted on the environment which included health, safety and fire arrangements and cleanliness of the communal areas.
Regular checks were conducted on the environment which included fire drills, call point checks, health and safety checks, gas safety checks, PAT testing and internal audits. Legionella prevention procedures were also completed, with the taps in vacant flats turned on for the required time period each week.

People had Personal Emmergency Evacuation Plans (PEEPs) in place, but in recognition that some people may not hear the fire alarm due to the sedative effect of medication, vibrating pillows had been installed to alert people to a fire. The service also had a quick grab fire evacuation pack to ensure staff had everything they required in the event of a fire.

We saw accidents and incidents were closely monitored within the service and monthly audits of accidents were undertaken to capture re-occurring themes. Staff completed a standard incident form when an incident occurred which was initially reviewed by the team leader. We saw risk assessments and care plans had been updated and incidents were handed over to staff to monitor. Lessons learnt and outcomes were also disseminated throughout the team to promote best practice. The team leader also informed the senior management team so that trends could be considered in relation to other services.

Outstanding ☆

Is the service effective?

Our findings

People we spoke with reported being happy with the care they received and felt staff had the appropriate skills and knowledge to support them. Comments from people included; "The staff are really skilled. I would not be here now, if it wasn't for them." "The staff know what they are doing, they are very professional." "The staff are well trained. They have supported me to achieve so much."

We consistently received positive feedback from professionals regarding the staff's knowledge and skills. Professionals told us the staff were reflective in their practice and didn't focus on the negatives of getting something wrong but focused on learning from things to improve outcomes for people.

A number of the people living at Fielder Lodge had a diagnosis of personality disorder and whilst the staff recognised that people's experiences were different, there are common themes associated with the disorder, which were reflected in the service design. We saw there was a thorough handover and these occurred every 12 hours, at the change of each shift. In addition to this, there was a further comprehensive handover every four days which looked back at the last four days to ensure consistency, coordination and effective communication. There was comprehensive information on each person to ensure that all members of the team were kept up to date on current issues and to inform decisions about future holistic care needs. This promoted a consistent response from staff and reduced the opportunity for splitting staff, which is a key feature of personality disorder.

Links with health and social care services were excellent. People living at Fielder Lodge had complex and continued health needs and were supported by staff who sought every opportunity to adhere to best practice. The service achieved this through comprehensive training and multi-agency working. The service had close links with the local psychiatric services and a forensic community psychiatric nurse (CPN) from Greater Manchester West (GMW) was based at Fielder Lodge. The provider covered the full time equivalent wage to enable this resource to be available.

The CPNs undertook individual work with people and provided enrichment, coaching and mentoring. The CPNs had an in-depth understanding of self-harm behaviours and provided additional debrief support to enable staff to understand and recognise transference emotional response and behaviours. This meant that people at the service had access to a specialised support team that was complimented by a CPN whose competencies remained current as they continued to work within the wider forensic community.

The forensic CPNs also provided training for staff regarding routine, culture and the practices in operation within an inpatient environment, so that staff could provide informed input that demonstrated an empathic understanding of the institutionalisation people would have been exposed to.

All newly recruited staff had completed an induction training programme before they started working at the service. Staff attended a five day induction and then completed the care certificate. The care certificate assesses the fundamental skills, knowledge and behaviours that are required to provide safe, effective and compassionate care. It is awarded to care staff when they demonstrate that they meet the 15 care certificate

standards which include; caring with privacy and dignity, awareness of mental health, safeguarding, communication and infection control. The care certificate was introduced to improve consistency in the training health care assistants and support workers received in social care settings.

We saw from the training matrix staff attended training consisting of; first aid, surviving abuse, mental capacity act, safeguarding, equality and diversity, mental health, medication, de-escalation and self-harm. In addition to this, staff received tailored comprehensive training that reflected people's experiences and how an individual wanted and needed to receive their care. This ensured staff had the required knowledge to understand the person's needs and the skills to consistently respond effectively to manage people's behaviours. The service offered training and staff development to the staff that enabled them to put their learning into practice and deliver outstanding care that met people's individual needs.

Staff told us; "Whatever is specific to the person, the management get trainers in." "We have good team work. I feel very well supported. We receive regular training, supervision, team meetings and we are always debriefed following incidents so that we can off load and learn. If we need more training, it's available. If things are particularly challenging, we are even given the opportunity to work at another Imagine site." "The training broadens our awareness. When we did the ligature training it focused our attention on low points that people could use."

The staff also attended a two day introduction course to using cognitive analytic perspective, drawing on the principles of cognitive analytic therapy (CAT). The introductory course covered the key cognitive analytic concepts and their application to non-therapy work. It increased staff awareness in; cognitive analytic concepts to aid recognition of damaging relational patterns, which repeat in restrictive, unhelpful and at times extreme and damaging ways. For example; aggression, rejection of others and forms of self-harm and neglect. CAT provides an understanding to people's repetition, assists in the understanding and management of risks and builds awareness through shared recognition of these patterns that with improved management can facilitate change. This equipped staff with a framework for managing people diagnosed with a personality disorder and an understanding of the behaviours that can manifest themselves. Staff's consistent approach, reflection and formulation of people's behaviours provided people the relational security to consider and adopt new coping strategies.

Fielder Lodge had a fully qualified holistic therapist visit the service weekly which did not incur a charge to people living at the service. The holistic therapist would spend 1:1 time with people and would commence with reiki before introducing massage. People living at Fielder Lodge had previously felt dehumanised by their experiences of services; mental health placements having at times used restraint and seclusion to manage their attendant risks and assault behaviours. The staff recognised people's vulnerability and tentatively introduced 'touch' in to people's lives. For example, painting a person's nails, combing their hair, holding their hand and progressing people gradually to being able to engage in holistic therapy and attend for a back massage. Holistic therapy had provided people a positive experience and one person that had previously been unable to tolerate physical contact, had progressed and was able to tolerate appropriate touch without it triggering an aggressive response. People were supported to use massage and relaxation as a mechanism to manage life stressors in contrast to the behavioural response that had previously developed. One person had left the service and was living independently but they continued to return to Fielder Lodge weekly to engage in holistic therapy. Management had enabled the person to do this as it was recognised as a support mechanism in maintaining their mental health and enabling them to stay well.

People living at Fielder Lodge received further input from CPNs in addition to the CPN in the staffing compliment. There were registered nurses and social work staff that were part of the staffing compliment alongside unregistered staff. The provider also had other professionals supporting the service including an

occupational therapist that had time specific input across the providers services, which included Fielder Lodge. People had regular contact with their psychiatrists and the CPN service maintained effective, consistent and regular communication with people's responsible clinician.

People were registered with a local GP within the first week of moving to the service for physical health assessment and ongoing checks. Staff could access other professionals for people via referral through the GP, for example dietician or speech and language therapy. People received support to ensure they received appropriate physical and dental health care including attending primary and secondary medical care appointments. People were encouraged to attend their GP for annual physical health checks. People had a comprehensive 'physical health check' plan, which was a recognised tool formulated by the charity Rethink Mental Illness to improve physical health outcomes for people affected by mental illness in line with national CQUIN (Commissioning for Quality and Innovation) targets. People had a health passport which was a one page profile covering, brief risk identification, copy of medication, times, bio-dose etc. People told us; "If you want staff to attend appointments with you they will." "They support you to get the appointment you need straight away. I'm currently seeing the dentist because I broke my tooth."

People received assistance with meals, usually in a 'reablement' form and staff assisted them to be independent. People told us they chose what they wanted to purchase and cook. People were complimentary about the support provided and indicated that their cooking abilities had progressed since living at Fielder Lodge enabling them to prepare a repertoire of dishes.

People confirmed their consent was always sought and we saw people had consented to their medication, signed a consent form to enable staff to share relevant and required information with other professionals and had signed a pre-agreed plan detailing the circumstances in which staff could fob in to their home. Staff told us people's consent was also ascertained before undertaking any task.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Management and staff spoken with demonstrated a good awareness of the Mental Capacity Act (MCA). The management told us of an occasion when a person had transferred to the service and ceased taking their cardiac medication. The staff had attributed their decision to a degree of transitional anxiety but also that the person did not have capacity as they lacked understanding of the implications. The service implemented extra observations and sought medical advice whilst the person was refusing their cardiac medication. In conjunction with building a therapeutic relationship and providing relational security, staff arranged a best interest meeting with the consultant cardiologist in attendance. The staff also applied for an independent advocate to be allocated to support the person. The outcome was positive as the person did recommence taking their treatment following the meeting, but staff identified that ultimately if the person had been deemed to have capacity following the meeting, then they would have been powerless to do anything further and would have had to accept the person's decision despite the consequences.

We saw there was nobody living at the service requiring a DoLS authorisation. Some people at the service had Mental Health Act conditions and we saw that when a person had been discharged from hospital with a community treatment order (CTO), staff had supported the person to seek legal advice and access advocacy services. Advocacy service information was also displayed throughout the service.

Fielder Lodge is a purpose built home that was designed by service users in 2009. As part of the de-institutionalisation approach, service users living at Fielder Lodge were supported to choose their own furniture as part of the process of creating their own home. The service has a communal garden, lounge and kitchen. There is one disabled access flat and a lift for people with impaired mobility. All flats were equipped with a pull cord to raise an alarm if the person was distressed and required staff support.

Outstanding ☆

Is the service caring?

Our findings

Without exception, people receiving support praised the staff for their caring and professional approach. People told us; "The staff are very supportive. I couldn't have asked for more support. They've never given up on me. I can't thank them enough. They've constantly been there for me. I wouldn't have got through things without them, they deserve all the credit, they really do." "The staff are lovely. I've gelled with the staff. It's the first time being out of hospital that I have liked." "The staff are all kind. I feel they really care about you." "The staff are really caring. One staff member that I had met during assessment changed their shift so that they would be here when I arrived so I saw a familiar face."

The management and staff team demonstrated that they truly cared for the people they supported and did everything they could to help ensure people reached their full potential and attained their independence. Everyone that we spoke with told us they were treated with kindness and compassion by the staff and that positive relationships had been developed. Staff told us; "We care about each other too. We have a good camaraderie. I feel privileged to be here. Every staff member is professional, patient and has the greatest compassion for people."

The management and staff were clearly motivated to make the transition for people to the service as cohesive as possible. Staff provided six weeks non-funded support prior to people moving to the service. Staff spent time with people on the ward, getting to know them, building therapeutic relationships, attending ward rounds and supporting people to visit the service and pick furnishings to make their flat their home.

The service had a strong, visible person-centred culture. People were at the heart of the service and their care and support was designed around their goals. People told us they had been involved in the planning of their care through the assessment and care planning process and at on-going reviews. Involvement of people who used the service was clearly embedded into everyday practice. There was a clear emphasis on people living a fulfilled life. People were supported to challenge themselves and staff provided relational security to empower people to achieve this. People valued the relationships that had developed with staff and expressed their gratitude for the care and support they had received. One person stated, "They are fantastic, very, very caring, they have really been there for me."

People had signed to say they agreed with their care and people confirmed staff always sought their consent before providing support and assistance. When people needed additional help to support them with decisions, the service had information about advocacy services and people had been supported to visit the citizen's advice bureau when needed (CAB). Advocacy services help support and enable people to express their views and concerns and provide independent advice and assistance where needed.

We looked to see how the service promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights through well-developed established, person-centred care planning. Support planning documentation used by the service enabled staff to capture information to ensure people from different groups received the help and support they

needed to lead fulfilling lives and meet their individual needs. Staff spoke openly with people about gender, sexuality and relationships. The staff team was all female due to people's background and histories to be responsive and sensitive to their needs. Staff were non-judgemental and recognised people's presentation and coping strategies to be a consequence of adverse life experiences.

Management told us they were always looking at ways to support people to be more independent and to reduce people's reliance on services. This was demonstrated to us in a variety of ways but included staff making time to spend structured, time specific one to one time with people. This was an approach that ensured staff set aside time in their day to spend with' people. It gave people the opportunity and space to express their feelings without interruption. Knowing that they had a staff member's undivided attention at a certain time provided some security and reduced their maladaptive behaviours to seek staff attention. We saw how this was utilised with effect when a person presented at the office to engage in one to one support. We saw from this person's records that the staff had reduced the frequency and duration of the support and were continuing to do this gradually to support the person to be able to occupy their time independently.

We spoke with people about how they were encouraged to be independent when receiving care and support. People told us; "The staff promote your independence but still help you. They won't leave you struggling. They get the balance so right. When we went shopping, I used to get anxious when packing the bags and I'd be shaking. Staff would assist and help me to pack. If I need to phone benefits or something, they'll sit with you. It gives me the confidence to do it and I feel the achievement after doing it." "They offered me help to unpack which I declined but then I found myself overwhelmed and upset. Next thing there was a knock at the door and we got it done together. The staff go out of their way to help at the right time."

People had developed in confidence because of how the staff cared for them. We met one person who due to their previous long term placement had developed social agoraphobia. The person would only access the hospital grounds unaccompanied and relied on taxis and staff accompanying them to visit family and leave the confines of the hospital grounds. The previous placement did not address this, so staff at Fielder Lodge supported the person with an active graded exposure plan. This had been successful and had enabled the person to reconnect with their family and go out for meals with them unaccompanied. The person told us they had travelled on a bus and tram independently and had met their relative to go shopping on their birthday. We were informed of the positive impact this achievement had had on the person's self-esteem and staff spoke with obvious pride and admiration of the person for their achievement. The person told us; "I have been on a bus for the first time in 20 years. The more I got to know the staff, the more I trusted them and they built my confidence. The staff motivate you and although I was frightened, I felt the benefit when I got back. I started out by just standing at the bus stop with them. Now I am doing journeys with my family on my own and I no longer need the staff to come with me." This had given the person an enhanced sense of wellbeing and an exceptional quality of life.

We looked at how the service promoted people's privacy and dignity. Each person we spoke with confirmed staff always treated them with dignity and respect. Staff spoke about the people they supported with compassion and demonstrated they respected people's privacy and dignity. A staff member told us; "I treat people how I would want to be treated. For example, I went to wake somebody but I had a male visiting professional with me and I stopped them from going in to the person's bedroom because the person was exposed."

Outstanding ☆

Is the service responsive?

Our findings

Health care professionals working with the service told us that Fielder Lodge was a high quality provider that was at the forefront of services when considering placements. We were told that staff were exceptional at responding to people that required additional support and that Fielder Lodge was considered among professionals as the best place they visited.

People's care and support was planned proactively in partnership with them and people were extremely positive regarding the care they received. People told us; "If you need extra support, they put it in place. I change my flat around a lot because it's a good distraction. They'll help me rearrange the furniture because it helps." "I'm receiving excellent care." "I get a lot of support. I have set times but they do help at different times if it's really needed." "There is a healthcare professional here if needed." "They've supported me a lot with cooking, I make proper meals now; spaghetti bolognaise, pasta bake and sunday roast dinners." "The service were I lived had notice to close so the staff had only a short notice to me moving in. I can't say how much they've really impressed me. They've really listened to me. I was so against the move but they've given me a completely different outlook."

Everyone we spoke with told us that when their care was being planned prior to moving to the service, the staff had spent a lot of time with them finding out about their preferences, what care they wanted/needed and how they wanted their care to be delivered. People were involved in their assessment and identified what getting it wrong and what getting it right looked like to guide staff on their individual requirements when meeting their care needs.

The service showed that both it and the staff were flexible and responsive to people's individual needs and preferences and empowered people to live as full a life as possible. People had identified things that they could not tolerate being said to them. One person had identified this was staff asking them; 'how are you feeling?' As a result, staff had agreed with the person to ask 'what are your thoughts today?' Staff indicated that they adhered to this initially while relations and trust developed, but that this would be later challenged within the security of the relational model because the person was likely to encounter the statement they couldn't currently tolerate frequently in their everyday life, and they needed to be equipped to respond to this natural enquiry appropriately.

Another person had encountered difficulty eating in the company of others whilst an inpatient and this had been the cause of frequent outbursts. However, having had to eat in the company of others in a hospital environment for so long, upon moving to Fielder Lodge the person disclosed to staff that they missed having people around them at meal time. In response, staff cooked with the person and they sat and ate their meal together whilst the person settled in to the service. The frequency of staff eating with the person was gradually reduced so they did not become dependent and the person had progressed to being able to eat in the company of others and on their own without it having a detrimental effect on their mood and behaviour.

People's preferences and choices were fundamental in their care, however staff were innovative and

suggested additional ways to embed these ,which people themselves might not have considered. A person moved in to the service that was vegetarian, which coincided with staff looking at ways to introduce healthier eating into people's lives. The occupational therapist (OT) employed by the provider visited the service and the 'Incredible edible initiative' was introduced. This entailed the OT and people living at the service planting two vegetable plots in the communal garden to enable the people to grow their own produce. The vegetables were then eaten in communal meals. This engagement in an outside activity promoted social well-being and the physical aspect of the project provided some people with physical exercise and social stimulation in a safe environment at a time when they had difficulty leaving their flat.

Staff members had continued the healthy eating initiative and provided other health advice. People told us that one member of staff continued with the healthy eating weekly and was preparing healthy fish and chips with them that week. Another staff member had received smoking cessation training and took a lead role in providing people with smoking cessation advice.

Professional feedback was extremely positive regarding staff support during people's transition to the service. Professionals told us that staff went 'above and beyond' to support people's move from acute or long term secure services. We were informed that the staff provided an inreach/outreach service that was recovery focused and preventative to relapse. We were told that Fielder Lodge was 'a breath of fresh air' and that the service was very person-centre focused. It was explained that the physical effort of supporting somebody to move to Fielder Lodge was immense as people had spent a long time in secure placements. Professionals said the environment was well maintained, breakages were instantly repaired and the management took pride in creating a homely, well maintained and clean home which made people feel hopeful. We were told people came to Fielder Lodge and their whole world was opened up.

We saw in collaboration with the care team and through negotiation with the commissioners, how staff had supported the transition in to the service of one person that had been debilitated by their psychosis and a deep psychotic need to protect their relatives. The standard time for commissioned leave is ten overnight stays. However, an eight month transfer was negotiated as the person would have been unlikely to ever achieve the transition and would have remained in an inpatient setting as a consequence of not structuring the move appropriately. The person had successfully moved and settled at the service and spoke with pride of their achievements whilst being at the service. The person told us; "I feel confident with the staff here that each set of goals are always my goals."

People told us they were involved in their care and needs and support was continually reviewed in conjunction with them. People told us; "We complete the STAR and plan the next six months. I'm very much a part of that. They put things in place to support me achieving the goals I set." "I'm involved in my care. I don't like some of the things that my consultant has put in place but that's not the staff's fault." "The goals I set are my goals and not staff goals. I like that about here. They just help me achieve them."

The service ethos was built around the recovery model. However, the recovery model has its limitations as it is not an empowering model when people have experienced a period of challenge and have potentially not progressed as they would have liked in their recovery journey. In these circumstances, staff looked to the future and supported people to complete a horizon plan. Completing a horizon plan helped people to look at the present situation, decide where they wanted to be in their recovery journey and make positive decisions about how to get there.

There was a transition and recovery coordinator at the service whose primary focus was to embed recovery and to ensure the principles remained at the heart of the service. When people were experiencing changes in behaviour and mood, the recovery coordinator refocused staff and the person's action plan. They also

supported people to focus on the next steps and ensured recovery was at the forefront of their support. Staff told us; "The person really is at the heart of the service."
"We have really good outcomes for people living independently that have spent many years in hospital."
"The people here are ladies, not referred to as service users. We have mutual respect."

People also received individualised practical support to aid their recovery. For example, access to appropriate welfare benefits, support with budgeting, assistance with activities of daily living, such as shopping, cooking and cleaning. Throughout our time at Fielder Lodge, we saw staff providing enthusiastic and individualised support to people with daily tasks such as planning and shopping for meals, cooking and tidying. People were supported to access social, cultural and leisure activities, education and vocational resources to support their recovery. One person liked animals so they had been supported to apply to the local dogs and cats home to undertake voluntary work. Another person had applied to work with the elderly.

When people were ready for moving on to more independent living, staff supported them through their transition. People were given practical support bidding for properties, support to attend assessments and the management offered support to future service providers by way of formulation, support and discussion about the person's care needs to promote a smooth transition. People with 'lived in experience' were involved with the service, this is people that have previously used the service and are now providing peer support to people going through similar experiences. The peer support worker would utilise their experiences to provide emotional support, advice and guidance throughout the person's transition to new accommodation. People were further supported during the move by the staff through a non-funded outreach service to support people's step down in to the community. The outreach service gradually reduced its visits and phone contact over a three month period but was more intense in the initial stages of the move to reduce the risk of people developing feelings of abandonment.

Fielder Lodge operated with the minimum of routine due to people's institutionalised experiences and provided a flexible service responsive to people's support requests and need. People were provided individual structure but were also supported to occupy their own time. Professionals told us that there was always something going on and that it was always different. We were told staff were proactive and persevered with people achieving their goals despite the challenge and response they sometimes incurred. Professionals told us that staff didn't pursue an easy option and that they would invest two hours to cook a meal rather than get somebody to do a ready meal in five minutes.

We saw engagement was on a one to one basis and individualised to meet people's personal aspirations. However, every Friday the service had a social evening were each week a different person chose the meal and cooked for the other people living at the service. Due to the intensity of relationships and co-dependency this was an opportunity to encourage positive social interactions. People spoke positively of the evening. Comments included; "We have social night on Friday. We have a rota and each week one of us cooks. Every last Friday of the month, we get a takeaway."
"I go out every day. I see my friends but I do stay in for the Friday tea."

The service had effective systems in place for people to use if they had a concern or were not happy with the service provided to them. This information was displayed around the service and the people we spoke with were able to identify the complaints process. We saw there were only a couple of minor complaints having been received and the management had kept a complaints record with the date received which was sent to the quality manager who tracked this through to completion. We saw an informal complaint had been raised regarding the use of unfamiliar agency staff which had been actioned and the management had spoken to the agency and two members of agency staff had been identified as the only workers to be offered shifts at the service. This meant that people would not be supported by unfamiliar staff.

People with lived in experience had identified that people may not complain about services due to fear of repercussions. As a result, the management had provided a direct phone number to head office so that people did not feel that they were required to raise a complaint with staff that provided their everyday support. People told us; "I've no complaint and I would be confident to speak to staff if I did."

The service had received a large number of compliments which showed people were happy with the care they had received and the messages conveyed the impact that staff had made to their lives. Their comments included, "A huge big thank you for supporting me and helping me get somewhere I can call home." "Thank you for always making me feel so welcome." "Thanks for everything that you have done for me." "Thanks so much, you have all gone out of your way to support me so thanks again." "Thanks for the support; I could not have made it without all the support you have given to me." There was also a couple of professional compliments that had been received expressing their gratitude and commending the staff for their excellent risk management and the successful transition of people with high risk profiles in to the community.

Outstanding ☆

Is the service well-led?

Our findings

The service was extremely well led by a management team that were committed to supporting people to be empowered to achieve their goals and live a fulfilled and independent life. People told us; "It's a very, very good service. I have absolutely no regrets that I came here. I have achieved things I didn't ever think were possible. I would definitely recommend Fielder Lodge to other people in a similar position." "It's a really good place; I'd definitely recommend it to others. They are a cool team." "It's a really good place to live. It is the only place that I have ever felt truly welcome. I'm comforted, warm and happy. I feel comfortable here."

The professional feedback obtained substantiated our findings during inspection that there was a strong leadership and emphasis on continually striving to improve. We were told the culture at Fielder Lodge was very positive. Professionals told us they admired the staff and recognised that the management supported people to reflect through debrief and formulation. Formulation is a process that looks back at people's experiences to support staff to understand people's behaviour and provide support. We were told that it wasn't easy. Professionals indicated that people can become fixated on staff; they can transfer their emotions but that people were not de-humanised at Fielder Lodge and were provided safety and reassurance. We were told that Fielder Lodge was absolutely great and a cut above other places.

Staff and the professionals we spoke with told us that the management provided effective support and training which created a really motivated team. Staff told us; The management is very good. The management will support and provide assistance when needed. We all muck in. It really is teamwork from the director to the team leaders." "It's a good culture. I have so many ideas; I am bursting at the seams. I am encouraged and told to go for it. We are told to ask people if they want to get involved or go ahead with our ideas and see if people join in when things are underway."

Professionals indicated management and staff were proactive and always up for trying new things despite people's high risk profiles. Professionals repeatedly told us that people were safe and as they had the upmost confidence in the management, they didn't have the same worries about people once they transferred to Fielder Lodge.

The management involved people in a range of ways and at all levels from the start of the service in 2009 to the present time. It just depended on the level of engagement people wanted to input. People were involved initially in the design of the building which was created and designed by people using services. The service consisted of independent flats positioned around a courtyard with all the front doors facing the courtyard. The office was on the opposite side of the courtyard next to the only exit in to the building. The design enabled people to feel a sense of security whilst providing freedom and promoting independence. Each flat had its own access but this was secure as the only entry in to the courtyard was governed by staff.

We saw there was a suggestion box in the foyer which was emptied weekly. There was a hotline to whistle blow which by passed staff so people didn't feel any anxiety at raising a concern. There were peer led initiatives and surveys, the questions for which had been devised with the input of people with lived experience.

The service had further inclusive methods to enable people the opportunity to voice their views. There were frequent peer social meetings which offered people the opportunity to input and direct the support offered at Fielder Lodge. The service had a newsletter and one page of the newsletter was dedicated to people to include something they wanted to share with other people; a short story, positive message, art work or poetry.

People were involved in their assessments, set their own goals and supported to develop plans to identify the level of staff support they required to achieve their outcomes. The management had supported people with lived experience to become peer support workers to empower them to share their experience to enable people experiencing similar challenges to feel positive and empowered about their own journey. A peer support worker had identified that they would like to pursue a support worker role and management were supporting this transition through training and mentoring to equip the person with the required knowledge, skills and information regarding the differing roles which would successfully support their transition.

The vision and values of the service were person-centred and made sure people were at the heart of the service. The service was developed and reviewed with people and staff which underpinned practice. The service was governed by the women's committee which had representation from people with lived in experience. The nominated individual was answerable to the women's committee quarterly. There was also involvement from people with experience of services on the trustee board.

People using services were instrumental in recruitment at the service. People were involved in the job advert, short listing and interviews. Management at Fielder Lodge invited people from different services with the provider group to sit on the panel when staff were being recruited to Fielder Lodge and vice versa at other services in the provider group. This was to ensure that there were no power dynamics in situ when a member of staff commenced with the service. People with lived experience or using services had equal weighting on the panel to staff and management.

When people entered the recruitment process prior to the invite to interview, they were given an introduction to the service by people using the service. There were group activities and an assessment day which involved table top group exercises which were facilitated by the Team leader, people using services, senior staff and a healthcare practitioner. People devised their own questions that they wanted using during recruitment and people were involved with sitting on the recruitment panel.

The provider recognised, promoted and implemented innovative systems to empower people to monitor services which resulted in a high quality service that met people's individual needs. There was a service user involvement officer employed by the provider and they provided six months preceptorship to people that wanted to be involved in auditing the providers services. This enabled people an opportunity to be confident in doing audits and quality monitoring whilst using their own personal understanding and knowledge of people's experience in order to improve services.

People with lived experience conducted audits at Fielder Lodge. The criteria were set by people using services and the results evaluated by people using the service. The results were actioned and 'you said' and 'we did' posters were displayed in communal areas at Fielder Lodge identifying the actions within the agreed timescales. This had resulted in the consideration that people may not be confident to raise a complaint through concern of repercussion and had instigated the management at Fielder Lodge to provide people with a direct contact to head office. This demonstrated a positive culture in the service encouraging people to raise issues of concern with them and implementing systems to provide people security to feel that they were able to raise their concerns.

Managers carried out audits in a number of areas including medication, people's involvement, risk management and infection control. The management conducted a weekly walk through with a person living at Fielder Lodge to identify issues within the physical environment that required addressing. The quality assurance process was underpinned by best practice and were aligned with the commission's key lines of enquiry. The management had introduced the key lines of enquiry to the service upon the change of our inspection method and had spent time with staff through away days and with people using the service at forums, discussing the key lines of enquiry. Staff and people had compiled a comprehensive and extensive list of what the key lines of enquiry meant to them and how they demonstrated the evidence. This was displayed on very large posters in the office area documenting the work that had underpinned their thinking.

The management and staff pursued opportunities to empower people to be active participants in their communities. Peer support workers were provided a platform to make the transition from peer support worker to a support worker through training, mentoring and support. The management recognised that the roles were significantly different and invested in people to seek employment.

There was a strong emphasis on people pursuing full, active lives in their own communities. Staff had undertook a community mapping exercise to ensure the staff team and people living at Fielder Lodge had a good awareness of other organisations and activities available in their community. This was frequently re-visited so that people had access to current information. Management had recognised they were an urban base and with alongside people using the service they had built a bug hotel to conserve ecology and consider bio diversity within their local community. People spoke with fondness and humour regarding the bug hotel.

The management had built links with the local police and the name of the community officer was displayed on the wall in reception. The management team also had quarterly meetings with the housing provider, Great Places to monitor anti-social behaviour in the local community and to monitor whether there was further safety measures required to maintain the people's safety at Fielder Lodge.

Management had recognised people's sense of abandonment when progressing from the service and had developed the non-funded outreach service to provide continued relational security throughout this time. People spoke of a service that went 'above and beyond'. A person told us; "When I moved here, I didn't have any money. The management paid for my gas, electric and food. The staff did a list with me and they made sure that I didn't go without." We observed this occurring during the inspection with a person that had just moved in to the service. The person told us; "The staff and the management have been so welcoming. They've completely changed my way of thinking regarding this move."

Staff told us they felt very well supported through training, regular supervision, team meetings and received psychology input to undertake formulation work to equip them with the knowledge and skills to effectively support people. The psychologist also facilitated debriefing with the staff following incidents to ensure they were adequately supported. One staff member told us that management also offered them an alternative place of work within the provider group if they required a change from their current service. The provider subscribed to an employment and legal advice service (ELAS) to ensure staffing issues were dealt with fairly based on impartial specialist advice. Senior staff were available via the on call, and bleep 24 hours a day. The provider invested in away days and staff told us they felt empowered to influence changes in the service.