Community Housing and Therapy

Highams Lodge

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Overall summary

- The provider had clear systems to keep people safe and safeguarded from abuse which included a range of policies accessible to all staff, induction and appropriate training, working with other agencies and multidisciplinary forums where resident safety could be assessed, monitored and managed.

- There were reliable systems for the appropriate and safe handling of medicines. Staff administered medicines in line with legal requirements and national guidance. Regular medicines audits were carried out.

- There was a good safety track record. Incidents and complaints were investigated with resident involvement, thoroughly and transparently with lessons and themes identified and used to improve safety in the service.

- There was a range of staff who had the skills, knowledge and experience to carry out their roles. Resident care was coordinated, and person centred. This included coordinating care with other services where needed to support residents to move onto independent living when they were ready.

- Staff treated residents with kindness, respect and compassion. The service actively sought feedback on the quality of care provided and all carers we spoke to were positive about how they had been treated. Most residents we spoke to described staff as caring and comforting, that they were made to feel safe and treated with respect.

- Carers we spoke to were impressed with the care and support their relative received and described it as accessible, approachable and always took time to listen.

- The provider organised and delivered services to meet residents' needs, taking account of their needs and preferences. For example, the service operated a therapeutic model which aimed to understand a resident's behaviour and the treatment plan is formed around this.

- The provider took complaints and concerns seriously and responded to them quickly and appropriately to improve the quality of care.

- Managers had the capacity and skills to deliver high-quality, sustainable care. They were visible and approachable, and demonstrated compassionate and inclusive leadership.

- The provider had a clear vision and strategy to deliver high quality care and good outcomes for residents. Staff were aware of and understood the vision and their role in achieving it.

However:

- Although conversations around capacity and consent were held with residents, we found that these were not always clearly documented within the care records.
- Fridge temperature recordings for both the medicines fridge were not being completed correctly. Staff were only checking and recording the maximum and minimum temperatures and not the current temperature.

Summary of findings

- The service did not have naloxone in their medicines stock even though some residents experienced substance misuse problems.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community-based mental health services for adults of working age	Good 	

Summary of findings

Contents

Summary of this inspection

Background to Highams Lodge

Highams Lodge is run by Community Housing and Therapy, an independent health provider of housing and therapy to support people who experience severe mental health difficulties. The provider has 7 therapeutic communities across London, Surrey, and East Sussex. They also operate a crisis service in Surrey which offers an alternative to hospital admission for those experiencing crisis as well as planned respite and emergency admissions.

Highams Lodge is a therapeutic community. They provide trauma informed support based on a relational treatment model in a therapeutic community. They can accommodate up to 15 adults in one adapted building. The service provides support to people with complex mental health needs and substance misuse issues within a therapeutic environment.

This is a step-down service to prepare people with the necessary life skills before moving on to more independent living. A range of staff including support workers, therapeutic practitioners, community psychotherapists, support workers and social work support residents through a range of different interventions including group based activities, therapeutic keywork and individual therapy. The service also has access to a consultant psychiatrist who visits every six weeks.

At the time of the inspection visit there were 15 people using the service.

Highams Lodge was previously registered as a care home. The last inspection was conducted using that methodology in February 2021 and was rated as good overall at this time.

The service is registered to provide the following regulated activities:

treatment for disease, disorder, or injury

There was a registered manager in place at the time of the inspection visit.

How we carried out this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

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

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

Before the inspection visit, we reviewed information that we held about the location. This was an unannounced inspection.

Summary of this inspection

As part of the inspection, the inspection team:

- Visited the service premises
- Spoke with 5 residents who were using the service
- Spoke to 2 carers of current residents
- Spoke with 7 members of staff including the registered manager, the psychotherapist, 2 therapeutic practitioners and a member of regular agency staff
- Looked at 3 care and treatment records
- Looked at medicines' management in the service
- Looked at a range of policies, procedures and other documents relating to the running of the service

Areas for improvement

SHOULDS

Core service

- The provider should ensure that conversations around capacity and consent are clearly documented in records.
- The provider should consider stocking naloxone given there have been residents who have overdosed in the recent past.
- The provider should ensure that fridge temperature recordings for medicines fridges are completed correctly.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based mental health services for adults of working age	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Community-based mental health services for adults of working age

Good

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

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good.

Safe and clean environment

All clinical premises where residents received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. This included weekly bedroom fire and general health and safety checks.

The home had regular checks for Legionella and an up-to-date asbestos assessment.

All electronic items in the home were portable appliance tested.

The service had a fire safety policy in place with assembly points clearly stated in procedures and clearly visible around the home. The most recent fire risk assessment was completed in September 2022 and a fire action plan had addressed all areas for improvement identified.

Staff received infection control training and knew how to ensure this was maintained throughout the home.

Residents were encouraged to clean their rooms as part of their support with cleaning tasks assigned to each resident. Residents confirmed that they were encouraged to clean their rooms and to keep the communal areas clean and tidy. The manager told us that this formed part of residents' recovery and encouraged their independence. Notice boards had up-to-date cleaning logs and we observed the environment to be extremely clean. Furniture was well maintained in good working order.

At the time of the inspection the fire panel had not been working for 1 month. The service had implemented a plan to mitigate any risks related to this including battery powered smoke alarms and hourly 'fire watch patrols.' The manager had reported the faulty panel and the external company confirmed specific repairs were required. This panel was fixed on 2 May 2022.

Community-based mental health services for adults of working age

Good

Staff followed infection control guidelines, including handwashing. We observed handwashing signs around the home.

Safe staffing

The service had enough staff, who knew the residents and received basic training to keep them safe from avoidable harm. The number of residents on the caseload of individual members of staff, was not too high to prevent staff from giving each resident the time they needed.

Staff

Managers and staff told us there was enough staff to keep residents safe. Managers regularly reviewed staffing levels and sought support from senior managers if they were concerned about staffing levels.

The service used staffing model which typically had 5 or 6 staff on during the day, Monday to Friday and 4 staff on at weekends. The service employed a mix of staff including team leaders, senior therapeutic practitioners, therapeutic practitioners, and support workers. The latter were provided through an agency.

The service had a vacancy rate of 9.3%. At the time of the inspection visit there was 1 vacancy for a therapeutic practitioner however this post had been recruited to. The successful candidate was due to start at the end of May 2023.

Managers limited their use of bank staff and requested agency staff familiar with the service. Night staff were all employed through an agency and cover remained the same each night. This included 2 staff, 1 waking night and 1 sleep in (a waking night means the staff member is awake throughout the shift and the sleep in worker is woken only when needed).

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. This was comprehensive and had to be signed off by a manager. Agency and bank staff were expected to have this completed within 2 to 4 weeks. The induction included areas such as policies and procedures, medicines, safeguarding and mental capacity.

The service had low turnover rates. In the year prior to our inspection visit, 2 members of staff had left citing a change in career.

Sickness levels were low, and managers supported staff who needed time off for ill health. For example, making referrals to occupation health where necessary to provide staff with additional advice and support.

The service could get support from a psychiatrist quickly when they needed to. All residents were registered with the local mental health service in addition to care coordinators from their home borough (where applicable). In addition to this, the service employed a consultant psychiatrist who visited the service monthly and could provide assessment, information, and advice when necessary.

Recruitment records showed that staff were subjected to the necessary checks before starting to work with residents using the service. These included employment references, criminal records check, proof of identification and a record of the staff's previous employment. This meant the service had taken steps to ensure suitable staff were employed.

Community-based mental health services for adults of working age

Good

Mandatory training

Staff confirmed that they had undertaken mandatory training and that they were up-to-date with this. Mandatory training was comprehensive and met the needs of the residents and staff. The range of subjects included safeguarding adults (level 3) and children (level 2), mental capacity and deprivation of liberty, consent, infection prevention and control and medicines management.

The provider had a training system as part of their online human resources (HR) platform. This notified staff and managers when mandatory training modules were required to be updated with continual reminders sent until the module was completed. Staff training records we viewed confirmed that staff were up-to-date with all mandatory training.

Managers also checked compliance with mandatory training during staff supervision and appraisal. Training records were kept for all staff and included mandatory training and additional professional development training as well as confirmation they had completed their induction. Locum or bank staff were required to provide evidence of mandatory training compliance.

Assessing and managing risk to residents and staff

Staff assessed and managed risks to residents and themselves well. They responded promptly to sudden deterioration in a resident's health. When necessary, staff worked with residents and their families and carers to develop crisis plans. Staff monitored residents on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.

Assessment of resident risk

Staff completed risk assessments for each resident on arrival, and reviewed this regularly, including after any incident. We reviewed 3 resident records, and all had comprehensive risk assessment and risk management plans in place. These were updated regularly including after any incidents. We saw risk management plans in place for residents with eating disorders, self-harm, relationships, and self-neglect.

Staff could recognise when to develop and use crisis plans and advanced decisions according to resident need. All residents had access to the community psychotherapist who was based at the service, and they would see residents usually on a weekly basis. She worked alongside the therapeutic practitioners and residents to co-produce crisis plans.

Residents had their own folder in which to keep their care plans, risks assessments and crisis plans if they wished to do so.

Management of resident risk

Staff responded promptly to any sudden deterioration in a resident's health. All new residents are registered with the local GP practice and staff described having good relations with their local GP practice which streamlined support available for resident's physical health needs.

Staff ensured that all residents were linked in with the local mental health team, and they described good working relationships with local care coordinators.

We were told of situations where staff had responded promptly to resident's sudden deterioration. For example, one incident involved a resident tying a ligature. Staff responded quickly, arranged for an ambulance and kept the person safe until they could be assessed and taken to hospital. Staff kept the person safe by removing any items that could be used to make a ligature and staying with the resident until the ambulance arrived.

Community-based mental health services for adults of working age

Good

Staff followed clear personal safety protocols, including for lone working. All staff completed mandatory training in lone working and the service had a lone working policy which was easily accessible for all staff.

Safeguarding

Staff understood how to protect residents from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

There was a robust safeguarding system in place, which was supported by a policy framework. Staff had been trained to recognise safeguarding concerns and knew how to respond to keep residents safe.

Staff said if they had any concerns, they would discuss with senior staff on duty in line with the provider's policy.

All staff had safeguarding adult training to level 3 and safeguarding children training to level 2. The manager had undertaken additional training from the Social Care Institute for Excellence and was the onsite safeguarding lead.

The manager met with the organisational safeguarding lead every 2 months to review any cases, provide updates and monitor progress. She also had strong links with the local authority.

Staff access to essential information

Staff kept detailed records of residents' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Resident notes were comprehensive, and all staff could access them easily.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each resident's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely.

The service provided staff with guidance and information on the safe management of medicines within their policies and procedures which were available on the organisation's intranet. All staff completed medicines competency assessments with a manager before they were allowed to dispense any medicines.

Medicines were stored safely and securely.

Controlled drugs (CD) were managed and recorded correctly. At the time of the inspection there were no CDs on site.

Community-based mental health services for adults of working age

Good

Records showed that appropriate arrangements were in place for obtaining medicines. Staff told us how medicines were obtained, and we saw that supplies were available to enable residents to have their medicines when they needed them. Residents who administered their own medicines were given blister packs on a weekly basis which they could keep in a locker in their room. Compliance was checked on a weekly basis and would be reviewed if there were any concerns.

We observed that appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed there were no gaps on the administration records and any reasons for not giving residents their medicines were recorded.

All the residents who used the service were registered with the same local general practitioner who reviewed and prescribed all non-mental health medicines. Staff ensured that each resident's medicines were reviewed regularly and that they could access advice about their medicines either through their own psychiatrist or the psychiatrist that visited the service monthly.

There were residents who used the service who took medicine which required regular blood tests and specialist monitoring. Both these residents attended a local clinic where this was managed.

There were clear guidelines in place if either person refused to take their medicine for more than two days.

The service carried out regular medicines' audits of stock and expiry dates. They had also had a recent medicines audit completed by their local pharmacy in August 2022 with no concerns noted.

Records showed there had been 2 medicines incidents in the last 12 months. However, these had been investigated appropriately.

Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use.

However, fridge temperatures recordings for both the medicines fridge were not being completed correctly. Staff were only checking and recording the maximum and minimum temperatures and not the current temperature. We raised this with the manager on the day of our visit who updated staff guidance to ensure they understood how to check and record fridge temperatures properly.

The service did not stock naloxone (a medicine used to reverse or reduce the effects of opioids), even though previous residents had substance misuse problems including opioids. This meant the service would not be prepared should a resident overdose on opioids in the future. Following the inspection visit the manager told us that they would be ordering naloxone to store onsite.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong.

The service managed resident safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave residents honest information and suitable support.

Community-based mental health services for adults of working age

Good

Staff knew what incidents to report and how to report them. Staff told us that they were encouraged to report all incidents in line with the provider policy.

The service had no never events in the 12 months prior to the inspection visit.

Staff understood the duty of candour. They were open and transparent and gave residents and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff we spoke to told us that they had opportunities to debrief and felt supported by management when things went wrong. The staff team and residents were able to reflect and consider any learning together. Incidents were also shared with the senior management team and the residents' care coordinator (the professional who has responsibility for coordinating the residents care and support).

Managers investigated incidents thoroughly. Residents and their families were involved in these investigations. When an incident involved a resident, this would trigger a joint meeting to update the residents' keeping safe plan and, if appropriate, it would be discussed and reflected upon in the community reflective meetings.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to resident care.

There was evidence that changes had been made because of feedback. We reviewed in key performance indicator (KPI) audit reports from December 2022 and February 2023 which showed improvements across all KPIs. For example, completion of risk management plans had increased from 90% in December 2022 to 97% in February 2023. The completion rate of treatment plans had also risen from 90% to 95% across the same time period.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the mental health needs of all residents. They worked with residents and families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-orientated.

We looked at 4 resident records and all had a comprehensive mental health assessment of each resident. The service used a trauma informed model to support residents in their recovery journey by developing their skills and confidence needed to eventually live independently. This meant that people's needs were assessed at the point of referral to the service.

Assessments were detailed and included personal psychiatric history, relapse risk factors, substance misuse, compliance with medicines and self-care.

Community-based mental health services for adults of working age

Good

Staff made sure that residents had a full physical health assessment through the local GP and knew about any physical health problems. For example, one resident had been referred to specialist eating disorder and substance misuse services.

Staff developed a comprehensive care plan for each resident that met their mental and physical health needs. All records we looked at had evidence that staff were aware of residents' physical healthcare needs. For example, one record gave details about a resident's restrictive eating habits and how these could be safely managed.

Although we did not find evidence of care plans specific to physical health care, we did see examples of residents being supported with exercise plans and weight monitoring as well as referrals to specialist services such as opticians and dermatology.

All records we looked at showed that staff regularly reviewed and updated care plans when residents' needs changed including after any incidents occurred. Formulations were done on a 3 month cycle basis to ensure that they were up to date and reflected the resident's needs and goals.

Care plans were personalised, holistic and recovery-orientated. They included short and long terms goals and strategies. Care plans we looked at had a strong therapeutic focus, were highly personalised and viewed through the resident's individual life experiences. The care plans had clear evidence of the resident's expressed wishes included.

Best practice in treatment and care

Staff provided a range of treatment and care for residents based on national guidance and best practice. They ensured that residents had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the residents in the service. This included 1 to 1 and group psychotherapy sessions, reflective discussions and group activities.

The service model worked to understand reasons behind a resident's behaviour, how to support them to engage and what their goals were. The intervention and treatment plan was formulated around this.

The service provided a programme of group-based therapeutic activities such as community meetings which supported residents to form good relationships with their peers and staff as well as develop their skills though social and recreational activities. Residents engaged in therapeutic key work sessions to enable them to plan their day-today activities and encouraged the development of risk management strategies.

Staff delivered care in line with best practice and national guidance (from relevant bodies such as NICE). For example, the community fostered a psychologically informed environment (PIE) which aimed to take resident's past experiences alongside the holistic community space to support them to develop connections, build confidence and gain independence.

Staff made sure residents had support for their physical health needs, either from their GP or community services. All residents were supported to register with the local GP and dental surgeries as soon as possible and an optician visited the service on an annual basis.

Community-based mental health services for adults of working age

Good

Staff supported residents to live healthier lives by supporting them to take part in programmes or giving advice. For example, we saw examples of residents being supported with exercise plans as well as smoking cessation.

There was also a health and wellbeing notice board which displayed information on a balanced diet, dental hygiene, details of the local GP, dentist and opticians as well as a poster on grounding techniques residents could use when experiencing symptoms of anxiety.

The service used a range of rating scales to assess and record resident's conditions and care and treatment outcomes. This included validated self-reporting tools to measure a person's history of trauma and aspects of their recover such as social functioning and skill development. For example, CORE-OM (clinical outcomes in routine evaluation – outcome measures) which has 34 statements about how the person has been over the previous week which they can rate, and dialog-plus (which measures resident satisfaction with life domains and aspects of their treatment).

Staff used technology to support residents. For example, residents could access an online portal which had 19 training modules. The programme supported residents develop practical and emotional skills to support their recovery.

Staff took part in clinical audits and quality improvement initiatives. The provider monitored their impact and published results in annual impact reports. The strategic plan for 2023 to 2026 included commitments to further develop their research and outcomes processes to improve services in the wider mental health sector. The provider joined forces with other stakeholders to lobby NICE (the National Institute for Health and Care Excellence) to address flaws in draft depression guidelines.

Managers used results from audits to make improvements. We reviewed audit data which looked at resident's records and which showed an improvement on the completion of documentation such as risk management plans, treatment plans and outcome measures.

Skilled staff to deliver care.

Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had (access to) a full range of specialists to meet the needs of each resident. In addition to the psychotherapist and therapeutic practitioners, there was also access to social work and psychiatry support.

The service had an on-site community psychotherapist who led the clinical model and supervised the therapeutic practitioners who had all completed, or were committed to completing, a 2-year, foundation in psychotherapy at national vocational qualification (NVQ) level 3.

The service employed a psychiatrist who visited the service every 2 months to meet with staff and residents as a group or individually. He would discuss treatment, medicines and their side effects as well as liaise with their GP and mental health community teams, as needed.

The provider had a lead social worker who attended the service twice a month, attended progress reviews and provided support to carers.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the residents in their care, including bank and agency staff.

Community-based mental health services for adults of working age

Good

All staff had access to an online training portal which tracked their compliance with mandatory training. This included a range of relevant subjects for example, risk management, equality and diversity, privacy and dignity, food hygiene, the Mental Capacity Act and whistleblowing.

The training matrix showed all staff were up to date with their mandatory training.

All staff, including agency staff, completed an induction before working in the service. This covered orientation to the service, crisis management, the keywork relationship, recording & reporting systems, policy and procedures, medicines and fire safety.

Therapeutic practitioners completed a 2 week induction programme which involved visiting the provider head office as well as other services. Staff told us their induction had been very helpful, with one person saying they felt 'comfortable and empowered' to do the job once they had completed it.

Staff received regular supervision every 6 weeks, a yearly appraisal and opportunities for reflective practice on a weekly basis as a staff group (in addition to reflective practice as a community which included residents). Residents were also offered the opportunity to provide feedback for staff appraisals.

Staff told us that supervision was helpful and told us they felt supported to their job effectively because of it.

Managers made sure staff attended weekly team meetings and gave information to those who could not attend. We reviewed minutes of meetings which were circulated to staff by email and included a range of standing agenda items for example, the therapeutic programme, incidents and safeguarding and health and safety issues.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. One staff member told us they had been supported to develop their skills and knowledge and had been given opportunities for professional development.

Managers recognised poor performance, could identify the reasons and dealt with these. The manager said performance issues would be picked up through audits or resident feedback and dealt with through a mix of supervision and reflective practice.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit residents. They supported each other to make sure residents had no gaps in their care. Staff had effective working relationships with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss residents and improve their care. The therapeutic community model meant that residents were routinely invited to attend these meetings to discuss their care and treatment plan. This included reflective practice following incidents and residents were invited to be part of these meetings.

Progress review meetings were held every 3 months with residents and their families as well as their local care coordinators invited to attend. This meant there was always a focus on how residents were progressing and if any additional support was needed.

Community-based mental health services for adults of working age

Good

Staff made sure they shared clear information about residents and any changes in their care, including during transfer of care. Records we looked at reflected this and we saw examples of information being shared effectively with GPs and community mental health teams.

Staff had effective working relationships with external teams and organisations. Records showed evidence of interagency working. For example, one resident was referred for a social care assessment. We spoke to a care coordinator visiting the service who described staff as 'very responsive' and good at communicating with him about the resident's wellbeing and progress.

Good practice in applying the Mental Capacity Act

Staff supported residents to make decisions on their care for themselves. They understood the provider policy on the Mental Capacity Act 2005. However, capacity was not always clearly recorded for residents who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and the service had a clear policy on the Mental Capacity Act which was easily accessible for staff and which they were expected to read as part of their induction.

Staff gave residents all possible support to make specific decisions for themselves before deciding a resident did not have the capacity to do so. Although conversations around capacity and consent were held with residents, we found that these were not always clearly documented within the care records. For example, a resident with COVID-19 was asked to self-isolate in their room and although a discussion around their capacity to consent to do this had been held with them and they had capacity to decide to do so, this had not been clearly documented within their record. This meant there was potential for residents to be deprived of their liberty.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated residents with compassion and kindness. They understood the individual needs of residents and supported residents to understand and manage their care, treatment or condition.

Staff introduced residents to the community when they were initially referred, and they spent time getting to know them when they first visited the service. Although we received mixed feedback about the staff, most residents we spoke to told us that staff were good, with one resident describing staff as caring, comforting and there when they needed them.

Residents said staff treated them with dignity and respect, and that they approached them in a friendly manner. Most residents we spoke to said they felt safe at the service although 1 resident felt that there was not enough staff to take care of everyone's needs.

Residents were allowed to keep their own pets which were a source of comfort for some, providing structure and routine. One resident told us their pet was their reason for getting up in the morning.

Community-based mental health services for adults of working age

Good

Residents worked with the manager to put together and sign a contract which gave clear instructions about what should happen if they require hospital admission.

Involvement in care

Staff involved residents in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that residents had easy access to independent advocates.

Involvement of residents

Staff involved residents and gave them access to their care plans. All residents were given folders containing their care plans which they could keep in their rooms. All records we looked at had clear evidence of residents being involved in their care and treatment plans. Although residents did not always sign their care plans, language used clearly reflected their views and wishes.

Staff made sure residents understood their care and treatment (and found ways to communicate with residents who had communication difficulties). Staff said residents were given time and space to be able to engage with the community and be part of the decision making process, to make sure their voice was heard.

Staff involved residents in decisions about the service, when appropriate. The service operated as a therapeutic community where most aspects of service delivery were discussed and agreed with residents at the weekly community meetings. For example, residents decided how domestic tasks were divided up, the weekly menu and who cooked each day as well as what activities would be on offer.

Residents could give feedback on the service and their treatment and staff supported them to do this. For example, they could also provide feedback for staff appraisals.

Involvement of families and carers

Staff informed and involved families and carers appropriately. We spoke to 2 carers and they both said staff were supportive, responsive and approachable. Staff were described as taking time to listen properly and responded appropriately to any concerns.

Staff helped families to give feedback on the service. Carers told us that staff always took time to listen to their concerns and respond.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and waiting times.

The service was easy to access. Its referral criteria did not exclude residents who would have benefitted from care.

The service had clear criteria to describe which residents they would offer services to and offered residents a place on waiting lists. For example, there was clear exclusion criteria for someone not being accepted into the service. This included people with a history of sexual offending or setting fires.

Community-based mental health services for adults of working age

Good

The staff worked hard to ensure that people referred would settle in well by providing opportunities for them to visit the community and meet other residents before deciding whether they wished to move.

The service met provider target times for the resident's journey. For example, most residents were expected to stay for up to 2 years and during this period work towards more independent living. One resident had been at the service for longer than 2 years, the service was working alongside the resident and their care coordinator and social worker to identify a suitable placement for them to move to.

Staff tried to engage with residents who found it difficult, or were reluctant, to seek support from mental health services. Many of the residents had multiple hospital admissions or other placements that had not worked due to their complex needs.

Carers told us that the service had supported their relative where others had been unable to, by focusing on the resident's strengths. For example, one carer said staff had worked hard with their relative to engage them by making a meal and sitting with them to eat. This meant they built rapport and were able to support the resident take their medication and avoid readmissions to hospital.

Staff supported residents when they were referred, transferred between services, or needed physical health care. Residents were supported to register with the local GP and local mental health teams. Staff routinely invited residents care coordinators to review meetings and discharge planning was routinely discussed with agreed actions and goals at each review meeting.

The facilities promote comfort, dignity and privacy.

The design, layout, and furnishings of treatment rooms supported residents' treatment, privacy and dignity.

Each resident had their own room with ensuite facilities and shared facilities which included a large dining kitchen, dining room and living area as well as a well-maintained communal garden and a large garden room. We observed all these areas to be clean, tidy and well maintained. As a community, the residents were supported with cleaning by staff and there was a cleaning rota displayed in the living room detailing who was responsible for what.

Therapy was conducted in the therapist's office which offered residents privacy and we observed to be a comfortable, welcoming space.

There was no designated male or female areas however, residents were able to lock their rooms and were encouraged by staff to do so.

Meeting the needs of all residents who use the service.

The service met the needs of all residents – including those with a protected characteristic. Staff helped residents with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for residents with disabilities, communication needs or other specific needs. There were bedrooms available on the ground floor and ramps down to the kitchen and lounge areas. There was also a ramp from the garden patio down to the garden room.

Staff made sure residents could access information on treatment, local service, their rights and how to complain. There were several notice boards which displayed useful information. For example, the community notice board displayed information on the weekly timetable of activities, the latest community meeting minutes and information on the local crisis line. The complaints procedure was also available.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

All the residents, relatives and carers we spoke to knew how to complain or raise concerns. Complaints information was readily available on the notice board in the service.

Staff understood the policy on complaints, how to acknowledge them and knew how to handle them. Residents were given opportunities to provide feedback or suggestions anonymously as well as receiving support to make a formal complaint. Staff we spoke to told us resident complaints were discussed in the handover meetings including exploring ways of resolving these.

Staff knew how to acknowledge complaints and residents received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. The manager kept a complaints log which showed there had been 2 formal complaints in the year prior to the inspection visit. We reviewed both complaint investigations and found that they were comprehensively investigated with feedback provided to the resident involved.

Staff protected residents who raised concerns or complaints from discrimination and harassment.

Residents received feedback from managers after the investigation into their complaint. For example, one resident received detailed feedback following mediation with a staff member after a complaint they had made. Although the complaint had not been upheld, the feedback was sensitive to the needs of both the resident and staff member. This mean that there was a good outcome, and the therapeutic work was able to continue positively.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, two new templates had been created which introduced residents to their keyworker and what was involved in a key working session. This was in response to residents' concerns that there was not enough notice of these sessions. This meant that key work sessions would be coproduced with the residents.

The service used compliments to learn, celebrate success and improve the quality of care. For example, acknowledgements were a standing item on the team meeting agenda where individuals were thanked for their contribution and support on a regular basis.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Community-based mental health services for adults of working age

Good

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for residents and staff.

Staff said leaders and managers in the service were supportive and spoke highly of them. The manager was aware of the key challenges and risks and were open in sharing them. They were clear about how staff were working to provide high quality care that was safe, whilst striving for continued improvement.

Leaders and managers were visible at the service, interacting with residents and staff. They attended staff and community meetings and handovers regularly. The leadership teams had worked hard to support and develop good relationships and promote and inclusive culture.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Managers embodied the provider's values in their approach to their work, working openly and collaboratively with the staff team to support a positive culture and improve resident experience in the service.

Staff were enthusiastic about the service and enthusiastic about the benefits of the therapeutic community. They displayed the provider's values, and most patients told us staff treated them kindly and with respect.

Culture

Staff felt respected, supported and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

All staff we spoke to felt positive and were proud to work for the service. The service continually asked for feedback on a range of different areas. For example, staff were recently surveyed about the clinical tool they used. This feedback was collated and analysed, and a report shared with the senior leadership team and an action plan developed including timescales for delivery as a result.

Career development was supported. Staff supervision included conversations about development goals. Staff said managers supported them to identify professional development opportunities. For example, staff said they were supported to access additional training opportunities, if they were interested. The service had recently recruited to 2 trainee therapeutic practitioner roles who would be trained in role.

Staff were involved in decisions about the service and their jobs. For example, staff were recently given the opportunity to have a say on what their job titles would be.

Staff said they could raise concerns with their colleagues and managers without fear of reprisals. They said their views would be listened to and acted upon. Staff were aware of and knew how to use the whistleblowing process.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Community-based mental health services for adults of working age

Good

Leaders had developed and operated effective governance processes. Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Managers and staff were clear on the risks they faced and worked working hard to make improvements and mitigate any risks. Performance and risks were routinely discussed in staff and community meetings.

There were effective governance processes in place to improve and discuss care which covered areas including risk, audit results and care planning.

However, governance arrangements had not identified the issue of recording mental capacity and staff needed to be clearer when recording conversations with residents about their capacity to consent to decisions involving their care.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The service worked with residents with complex needs some of whom had also experienced multiple hospital admissions and placement breakdowns. We found that clear systems of recording and handover of risk supported staff at all levels to work with residents and keep them safe from harm.

Managers and staff were aware of key risks faced by the service, and this was reflected in risk management plans. The main risk identified during the inspection visit was the broken fire panel which had been reported to the contractor. This was fixed the week of the inspection visit however, prior to this, the service had put a management plan in place to keep residents and staff safe.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The electronic recording system was effective for documenting residents' needs, care planning, monitoring mental and physical health as well as recording and updating risk assessments. Resident records were kept confidential.

We reviewed minutes management meetings and safeguarding assurance action group meetings from the 3 months prior to the inspection visit and found there was clear recording of information, updates and actions.

Notifications were made to external bodies as appropriate including statutory notifications to CQC and local authorities.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Managers worked closely with mental health teams locally and from each resident's home borough to ensure that their pathway in and out of the service was clearly defined. This helped to ensure each resident was supported to move on to more independent living when ready.

Community-based mental health services for adults of working age

Good

Residents had multiple opportunities to give feedback. They attended regular community meetings each week which they took turns in chairing. Residents had the opportunity to raise issues at these meetings and minutes showed that resident feedback was listened to and acted upon.

The provider worked in partnership with several local authorities and health trusts to deliver services that met the resident's needs. They also worked with housing trusts to provide supported living services and create a pathway through their therapeutic communities toward independence.

The provider also delivered a range of training to other agencies. For example, on psychologically informed environments, personality disorder and working with people with complex needs.

Learning, continuous improvement and innovation

There was a clear commitment to development and improvement. Managers and staff had worked together to ensure that the resident group worked well in the community together.

Residents' recovery and engagement was strongly supported by staff. For example, residents were involved in decision-making around budgets including the food budget or buying something for the community. They would meet and decide together how they wanted to spend the budget to best meet their needs.

Staff were encouraged to consider possibilities for improvement and development of the service. They were encouraged to develop their skills through training and career development opportunities.

The provider was hosting an awards conference named after Elly Jansen, one of the first pioneers of therapeutic communities. The Provider had invited submissions for articles and research proposals which came with cash prizes and grants with the winners being given the opportunity to present their article or research proposal at the conference.