Richmond Fellowship (The)

Lowther Street

Inspection report

81 Lowther Street
Whitehaven
Cumbria
CA28 7RB

Tel: 01946691234

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 4 January 2018 and was unannounced. This was the first inspection of the service since the service was registered to the Richmond Fellowship in February 2017.

Lowther Street is both a 'care home' and the location for the delivery of community based services. The service has three distinct functions. 81 Lowther Street is a care home which provides short term, crisis intervention for people who need support due to mental health issues. The provider also delivers personal care to people in supported living services and to people living in their homes in the community who may be living with mental ill health.

The home can accommodate up to six people for short term care. Two people were in residence when the inspection started. A further five people were identified as receiving personal care in the supported living services and in the wider community. Other people did not need this level of care. We only looked at the care and support of people in receipt of personal care.

The service had a suitably qualified and experienced registered manager. 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.

Staff had received training on ensuring people were kept free from harm and abuse. The Richmond Fellowship had suitable arrangements for staff to report any concerns.

Good risk assessments and emergency planning were in place. Accidents and incidents were monitored and analysed and action taken to reduce risks. People had contingency plans to support them in a mental health crisis.

We saw that staffing levels were suitable to meet the assessed needs of people in the service. Staff recruitment was thorough with all checks completed before new staff had access to vulnerable people. The organisation had suitable disciplinary procedures in place.

Medicines were appropriately managed. Some people were supported to take their own medicines. People had their medicines reviewed by their GP and specialist health care providers.

Staff were trained in infection control and supported people in their own environment. The care home was clean and orderly as was the environment for two people we met in supported living.

The staff team had been supported to develop appropriately. Staff were keen to learn and we saw that induction, training and supervision had helped them to give good levels of care and support. All staff had received updates to their training in line with the policies of the new provider.

Staff received good levels of training around principles of care in relation to people living with mental ill health. They were trained in specific techniques to support people with varied disorders. Restraint was not used in this service.

Consent was always sought from individuals. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were supported to get good health care support from their own GP, specialist nurses and consultants. Staff worked with people to support and encourage them to visit health care providers.

Staff supported people to shop, budget and cook. People were helped to take good nutrition and were encouraged to eat healthily.

The care home was an older property that people felt met their needs. An upgrade to the building was being planned to reconfigure shared spaces and to provide ensuite facilities to bedrooms.

Staff we spoke to displayed a caring attitude. Staff understood how to support people to maintain their dignity and privacy. Staff showed both empathy and respect for people living with mental health issues. People in the service had access to advocacy.

Everyone supported by the service had been appropriately assessed. Person centred assessments and plans were in place. These were created in an electronic format and staff changed them when needs and wishes changed. Reviews of care were in place. In the crisis intervention house reviews were conducted by staff and the care co-ordinator during and after the stay. People living in the community or in supported living were reviewed internally and from time to time by social workers and other mental health professionals.

People were encouraged to go out and to engage, where possible with varied activities. The staff 'sign posted' people to community opportunities but were aware that people in crisis might find this difficult. We saw some good outcomes for people who were able to engage more with activities in the community.

Complaint procedures were in place. There had been no complaints received about the service.

The service had a suitably trained, qualified and experienced registered manager. Staff told us he was very visible in the service and easy to approach.

We judged that the registered manager had created a culture of openness and that staff worked in a non-discriminatory way. The atmosphere was one of enthusiasm and eagerness to continue to develop the service.

The Richmond Fellowship had a suitable quality monitoring system. We saw internal audits and records of visits by senior officers of the provider. Good monitoring and analysis of the service was in place.

Staff and other people involved with the service were satisfied that the management arrangements were appropriate and that matters of governance were being followed to give good levels of care and support.

The local mental health teams were satisfied with the joint work they did with 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?

Good

The service was safe.

Staff understood their responsibilities in keeping vulnerable people free from harm and abuse.

Staffing levels met people's needs.

Recruitment was suitably managed.

Is the service effective?

Good

The service was effective

The staff team were suitably inducted, trained and supervised.

People were supported to have a healthy diet.

Staff understood their responsibilities under the Mental Capacity Act and the Mental health Act.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect.

Staff worked with people at a pace they found comfortable.

People in the service responded positively to the staff who supported them.

Is the service responsive?

Good

The service was responsive.

Staff ensured that people had suitable care and support through good care planning.

People were encouraged to participate in meaningful activities.

The service had an appropriate complaints procedure in place.

Is the service well-led?

Good

The service was well-led.

The service had an experienced and suitably qualified registered manager

The provider had suitable arrangements in place to monitor quality

Good partnership working was in place.

Lowther Street

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.

This inspection took place on 3 January 2018 and was unannounced. This was the first inspection of the service since a change of provider from the Croftlands Trust to the Richmond Fellowship in February 2017.

Lowther Street is both a 'care home' and the location for the delivery of community based services. The service has three distinct functions. 81 Lowther Street is a care home which provides short term, crisis intervention for people who need support due to mental health issues. The provider also delivers personal care to people living with mental health problems in supported living services and to people living in their homes in the community.

People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home can accommodates up to six people in one adapted building. People only stay in the home for short periods of time. No one lives permanently in the building.

This service also provides care and support to people living in three 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

There were also other people being supported in their own homes across the Allerdale and Copeland areas. Only one of these people were in receipt of personal care. Not everyone using Lowther Street receives the regulated activity, personal care; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

We were informed that across all these services personal care was being delivered to seven people at the time of the inspection.

The inspection was conducted by an adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Both members of the team had experience of supporting people with mental health needs.

We reviewed the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We also spoke with social workers, health care practitioners and commissioners of care. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We planned the inspection using this information.

We visited the care home and one of the supported living services. We spoke with four of the seven people in receipt of personal care. We also spoke with two relatives of one person living in the community in their own home. We read their care files and those of the other three people in receipt of care. We looked at two care files for people who had been in receipt of care in the care home in the two months before our inspection. We read comments people had made after their stays and we saw 'exit' surveys for the care home. We looked at medicines being stored or administered on behalf of people.

We met the Cumbria locality manager, the registered manager, two team leaders and five support staff. We looked at three staff recruitment files and we also looked at three other supervision records making a total of six personnel files. These files also contained appraisal notes. We received a copy of the training matrix for staff and had sight of the training plan the Richmond Fellowship devised for staff in all their services.

We looked at maintenance records, menus and fire logs for the care home. We also looked at records related to the way staff supported people with their personal finances.

We checked the information we held about statutory notifications sent to us about incidents and accidents affecting the service. A statutory notification is information about important events that the provider is required to send to us by law. We used a planning tool to collate all this evidence prior to visiting the home.

Good

Is the service safe?

Our findings

People were very positive about the service. We learned this from talking with people, looking at surveys done by the provider and looking at comments left by previous service users.

One person said, "I feel really safe here, I don't feel safe in hospital... I know there are staff around here and I can get to them." Another person using the service told us, "I do feel safe here. They are good to me, I can always knock on the office door if I need owt [anything]." A third person said, "I feel safe, there are people about and I can ask them if I need help."

One person who had recently come in and had found hospital admissions difficult told us, "I am frightened [specific issues] but I don't mind here because the staff are about." People felt that the services were suitably staffed.

People also spoke about the support they received in taking medicines. People felt that this was important because sometimes they had problems being compliant with medicines or had taken too many when they were mentally unwell. One person said, "They remind me to take my medicines because I forget." A person in the supported living service told us, " "I go down and get my medicines from [staff] because I can't manage them myself."

We met with support staff in the service who could talk about their responsibilities in relation to safeguarding. They told us that they had received training in safeguarding and that this was also discussed in supervision and in team meetings. The Richmond Fellowship had suitable policies and procedures in place and the registered manager had local contact details. These were available in the services and we saw leaflets and posters in the services we visited. The staff understood how to make safeguarding referrals to appropriate agencies. Staff told us they felt comfortable talking to management and that they were aware of the organisations 'whistleblowing' arrangements and would use this confidential service if necessary.

The registered provider also had appropriate policies in place related to discrimination and human rights. These subjects were part of induction and on-going training. We looked at equal opportunities policies in relation to personnel matters. We spoke with staff who displayed appropriate views in relation to these issues. We did not see, hear or read anything that was discriminatory in content.

We walked around the care home and we saw suitable risk management plans in place. We also noted that there were risk management and suitable action taken in the supported living services. Equipment in use had been maintained appropriately. We noted that this equipment and equipment for fire safety were routinely checked.

There were appropriate contingence plans for any emergencies and the care home and the supported living properties were owned by a housing association who would work with the registered provider to overcome any problems.

We saw records relating to accidents and incidents management and we had been informed of any problems arising that required a notification to be submitted. Accidents and incidents were recorded, analysed and discussed with the registered manager in supervision and in team meetings. There had not been anything of concern reported in the service that had not been dealt with appropriately.

We looked at rosters for the four weeks prior to our visit to the care home and in supported living services. The home had suitable levels of staffing with a minimum of two staff available to people in the home. A staff member said "There are always two of us on and often the [registered] manager as well, the nights are waking nights so we always have help if we need it." We saw that the hours allocated to each person were suitably covered in supported living services and there were no concerns raised by the commissioners of care. We noted that the team would talk to the commissioners of care if they felt the hours provided were not appropriate.

We looked at recruitment in the service by checking on personnel records. We also spoke with members of staff who confirmed that background checks were made prior to them having any contact with vulnerable people. We had evidence to show that the registered provider's recruitment was done appropriately to protect people and promoted equal opportunities. The provider encouraged people who used their services to participate in the recruitment process, where possible. The Richmond Fellowship had suitable disciplinary procedures in place and we had evidence that the registered manager followed these when necessary.

Each person had individual procedures in place for their support in taking medicines. Staff understood these and we saw good records of medicines. We checked records and medication in the residential home and in the supported living service we visited. These were in order. Some people had their medicines stored for them and they came to staff when they needed to take these. Some admissions to the home were directly related to people finding medicines difficult to manage, other people managed their own medicines. Some medicines were prescribed by GPs but some of the stronger medicines were prescribed by psychiatrists and monitored by the staff and by the specialist community mental health teams. We had evidence to show that the team asked for medicine reviews for people to ensure they were being given the right medicines for their needs. We saw the evidence for a good review and amendments to medicines in the supported living service we visited. Staff received suitable training on the management of medicines and some staff had recently attended a Richmond Fellowship good practice day on medicines.

We observed suitable measures in place to promote good infection control in the services we visited. There was personal protection equipment readily available in the properties. Staff told us they had received training. We saw this in the training plan and we had evidence to show that there were suitable policies and procedures in place and guidance in the business continuity plan.

We had evidence to show that this service had analysed and reflected on the way the service was being run. The registered manager adopted a 'lessons learned' approach and we saw that he had reflected on how the staff worked with people who were living with paranoia as this had been highlighted in surveys as an issue. We also noted that deployment of staff and care planning systems were analysed and reflected on and discussed with the team to ensure that any matters arising would be used to ensure that improvements were made to ensure people received the best care and services possible in the service.

Good

Is the service effective?

Our findings

We spoke with people about how effective they judged the care home to be. The care home dealt with crisis intervention to prevent admission to psychiatric care. It was also be used as a 'step down' service when people are ready to leave hospital. We had evidence of very effective interventions and people said the service "Kept them out of hospital ". In some cases people said this was "For longer" or that they had not been readmitted to psychiatric care because they used Lowther Street when they felt unwell. One person said, "They are really good they know how to help me...and prompt me to eat because I forget that too." This person also said, "I went out by myself the other day for the first time in 12 years...and I will be here a little while, I've been before and it was really helpful."

People in supported living who were in receipt of personal care told us, "It's fine here, I like it, the girls are good if you need help." People told us that they were satisfied with the arrangements in place and that they got "the right" levels of support to let them be independent but to have the help they needed, when they needed it. People thought the staff understood mental health needs. One person said, "They know what it's all about ...and they listen to my mental health worker."

There was only one person in the community based services who was in receipt of personal care. We spoke with two relatives of this person who judged that the support they received was effective, the staff pleasant and punctual and there had been no missed calls. We saw audits that showed that people who had non-personal care support were also happy with the efficacy of the service.

We had evidence to show that, for people living in supported living, assessment of individual need had been completed prior to admission and that this was done on an on-going basis. We also noted that, when appropriate, health and social care professionals would assess and reassess people's needs and goals. We were in the care home when a new referral came through by telephone. We were impressed with the way the staff member gleaned information from the referrer. The team on duty then made a decision about how appropriate an admission would be. Staff told us that they did this all the time because they had to make decisions quickly because their focus was on crisis intervention. On-going joint risk assessment and assessment of need was done by the staff and by the mental health team.

We checked on the training records for the service and we saw that all the staff had completed the training that the provider deemed to be necessary for support workers. Staff who had worked for the previous registered provider had received refresher training. New staff received suitable induction and training. Staff had received training on person centred thinking, care planning and the support needed by people with mental health needs. Staff said they attended some face to face training but that they also completed e-learning that covered all aspects of their role.

We saw that staff had been given regular supervision after the initial change of provider. The records of planned supervision covered the work people did with individuals, working in a team and their own personal development needs. The registered manager had appraised all the staff and was planning the next stage in the provider's appraisal process. Staff confirmed that they had been given suitable induction and

good support to develop in their role. We saw records which were detailed, related to the work people did and helped them to widen their knowledge.

People in supported living were encouraged to participate in shopping, cooking and managing their own dietary needs as much as possible. Staff told us that if people were not eating well they would take advice from dieticians and other professionals. Food preferences and nutritional needs were recorded in care plans. We saw that staff cooked with some people and tried to provide healthy choices where possible. Staff recorded nutritional intake where there were issues.

We checked the kitchen and the menus in the care home. There was plenty of food available for people to prepare their own breakfast and lunch and to have snacks. People were encouraged to eat together at dinner and staff helped people to prepare a meal for everyone. People were encouraged to participate as part of skills building and to encourage confidence and socialising. Again where there were issues around nutritional intake the staff would work with dieticians. For some people who had used the service this might be part of a complex package to support a person with an eating disorder. We judged that the staff team supported people to eat as well as possible.

We had evidence from files and from discussions with people and with staff to show that people had good support from health care professionals. People in supported and community living had local GPs and were supported to visit chiropody, dentists and opticians when necessary. The people the provider supported also had contact with mental health professionals because their on-going problems were the reason that they needed support.

People living temporarily in the care home lived in either Copeland or Allerdale and were encouraged to visit their own GP for any physical health problems. People had a named mental health professional who was their case worker and who would support them to access mental health support. People saw psychiatrists, psychologists and mental health nurses as appropriate. They were also supported to visit other health professionals if necessary.

81 Lowther Street is a large Georgian property in the middle of Whitehaven. It was adapted for its current use some 17 years ago and provides accommodation in single rooms. There are suitable shared facilities including bathrooms and kitchen areas. Only one room is ensuite. The Cumbria locality manager and the registered manager told us of the provider's plan to modernise and improve the property. This would include a reconfiguration of shared areas and ensuite facilities in rooms where possible.

We spoke to staff who told us how important it was to communicate with each other because of the planned approach they had to give to people in the service who were living with mental health needs. We noted that the service held meetings and that senior staff visited on a regular basis. Staff told us that they discussed issues together and gave detailed handovers to each shift. We observed some of these detailed exchanges when we visited. The service had recently transferred all care files to computer and this meant that staff with a specific need to check delivery could monitor people's care needs from any computer terminal. We also noted that the IT system allowed senior staff to check on things like personnel matters and incidents and accidents management.

People consented (and often asked) to come into the crisis intervention house and we saw that staff supported people in a subtle way and searched for full consent. With some people living with long term mental health problems the approach was one of persuasion and negotiation. One person had agreed to a change of tenancy suggested by their care manager. This allowed access to the person's flat if they were unwell and would prevent more serious interventions.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. This had not been used in this service. No one in the service was being deprived of their liberty. Staff and mental health professionals would use the Mental Health Act rather than the Mental Capacity Act if someone was so unwell they could not be given appropriate support.

Good

Is the service caring?

Our findings

We measured this outcome by talking with people and by talking to the staff themselves. We also observed the interactions between staff and people in the service. One person who was leaving the crisis intervention service was keen to tell us that although the service did not meet their needs they had found the staff to be "Marvellous really kind and nice. They are all wonderful, the staff...it's a great place just not for me at the moment." Another person said, "The staff are dead nice and really helpful, I can speak to them really easily." People found the staff to be empathic and considerate. One person said, "They do understand and they don't judge."

The relatives of a person living in the community told us that "[The support workers] who come are really nice, very polite and kind. No issues at all...happy with them."

The two people we met in the supported living house told us, "I'm happy here it's a grand place" and "It's fine here, I like it, the girls are good if you need help."

We look at some of the audits and exit surveys that people had returned and we saw that people were happy with the, ' kind', 'caring' and 'supportive' staff. We also noted that there had been no comments or complaints about staff attitude and approach. Audits and surveys highlighted that staff were non judgemental and there were no complaints around issues of diversity or equality.

We heard staff talking to people and we saw genuine and compassionate interactions. Staff showed an understanding of need and ability and were able to pace the level of support appropriate to people's needs. People were encouraged to do things independently but were also offered support when the task was proving difficult. One person was supported by a staff member who said, "I can easily come with you, if you need and we can do it together." We saw daily records that showed how staff gave support appropriately and that the interaction was driven by the person's own goals.

We also heard people having things explained to them in a way that was appropriate and did not patronise people. People we met were relaxed with staff and we observed interactions between equals. Humour and compassion were part of these supportive relationships. We read comments from previous service users that showed that people were comfortable with this equitable and open approach. The 'My journey' book in the crisis house was very positive about the way staff supported and encouraged them.

People understood that, at times, staff needed to negotiate and encourage in a positive way. One person said, "It must be difficult for the staff to give [my relative] the support but they don't seem to mind the way they speak ...or the illness they have. They just encourage them...very cheerful girls." Staff told us that sometimes they had to follow a very specific approach to help people with the behaviour created by the person's ill health but this would be done as part of a care package developed by the mental health team.

People had the right to advocacy and other support. People using the service had a social worker or a specialist nurse and were under the care of psychiatry.

Good

Is the service responsive?

Our findings

People told us that they had been supported to set their own goals and devise their own care plans. Each admission to the crisis house meant a new assessment of needs and an update to the care and support plan. We read a number of these during the inspection and we learned that people very much steered their own recovery. One person said, "I do my own care plan and we talk about it." A person in supported living told us, "I please myself what I do and I go out and see my friends." Another person said "I talk to my care coordinator, I have my say."

We saw that each person in receipt of care had initial and on-going assessments in place. These were completed by mental health professionals and by the staff team. We noted that the care planning processes were adapted and developed to respond to needs and preferences. We read care plans and we could see by the content that these reflected what people needed. We also noted that there were contingency plans so that staff could support people if their mental health was to break down. Care planning in the crisis house was done after each person had the opportunity to analyse and assess their needs for admission. Where there were risks these were dealt with right at the start of the stay but after this people could set their own goals. Sometimes goal planning was very simple and people saw the purpose as being to help prevent a crisis or to give them a place of safety and respite from their daily lives.

All care files were now in an electronic format but some people wanted their care plans and assessment work printed out and we saw that this was done. The Cumbria locality manager said that the registered provider was planning to give people access to their own electronic file and that pilot schemes were underway with people across the country to make sure they were giving people what they wanted and needed.

Staff were fully aware of the diverse needs of people and treated them individually and at a pace they preferred. A member of staff said, "Some people need space from their families or friends, some have partners, families and friends who come and give a lot of support. Some service users need the space for a while, it's just whatever people want and need."

We also saw that the staff in the supported housing services encouraged and supported people to be as independent as possible and to engage in local activities. We learned of meals out and people being supported to go out and about and to engage in their preferred activities. We noted that the staff teams gave people 'signposts' to what was available and that notice boards had details of entertainments, self-help and advice groups and local activities. Lowther Street also had a resource area where people could borrow books and pamphlets about recovery.

We saw a lot of small touches in the care home that people told us were very supportive. The main hall had a box with a 'self-help' card box with the advice to 'take one a day and commit to it'. There was also a 'journey' book which was available for anyone in the service to read. This included stories of how frightening it had been to come in but how people felt understood and did not feel patronised or made to feel 'crazy' or 'disgusting'. One entry said "I thought there was no helping me but I was wrong". There was an

'achievements' board where service users posted their days achievements and these, we were told by people, were heart-warming and encouraging.

There had been no complaints about the service but the provider had a suitable complaints procedure in place and lots of information about how and who to complain to. One person told us, "I have nothing to complain about ...but I can speak up...not worried about having my say."

Good

Is the service well-led?

Our findings

People said they were happy with the way the service operated. One person said, "I think it is great it has been a good help to me" and a member of staff told us, "It's great. I love working here, I really do...the manager is good... we can talk to him any time"

The service had been operated for many years by a local charity, The Croftlands Trust. This was then amalgamated with the Richmond Fellowship and the service is now registered as part of the Richmond Fellowship. The change-over was completed in a staged manner with the full transition happening in February 2017 when the service became registered under the new provider. The Richmond Fellowship met with the Care Quality Commission during the transition and kept us up to date with the progress and the plans for the services in Cumbria. They made appropriate changes to registration matters, reorganised the way the services were governed and produced a business plan to take the services forward.

Previously Lowther Street had been a stand alone registration of a crisis intervention home but the new registered provider felt that local community services, including supported living houses, could easily be managed from one location. This change was strengthened by the fact that all records of care delivery and all staff records were now stored electronically. This much more efficient way of recording allowed a centralised management of Copeland and Allerdale services. The registered manager was also developing a new outreach service which would give people even more support when they felt at risk of ill health. This was in response to feedback from people and commissioners.

The service had a suitably qualified and experienced manager who was registered with the Care Quality Commission. He had worked in the service since it opened and had been the registered manager for a number of years under the previous provider. He had extensive experience and training in care and management and was a qualified mental health nurse. Discussions with him showed us that he was aware of his responsibilities under the law. We had confirmation from his line manager that the provider was satisfied with the way he was managing and developing the service.

Staff told us the registered manager was very knowledgeable and that he guided and supported them in the work they did. They also told us that he displayed the values and vision of the provider and ensured that they also worked under these principles. Staff told us, "He works alongside us and we respect his knowledge...he is really one of us and we get good support." We spoke with staff about the values and behaviours that the provider expected of the staff. They could discuss these with us and we saw examples of adherence to these with staff talking positively about people and having a good understanding of mental ill health. The staff took a person centred approach. A staff member took time to explain to us how the team needed to understand the background and history of the person to understand current issues. We judged that the staff were mentored and encouraged to support people in an appropriate way.

When we discussed individual personal care with the registered manager and with the staff team we had evidence to show that he had kept up to date with good practice and had ensured that the staff team were also up to date with appropriate approaches. For example the team were aware of a number of therapeutic

approaches they might take with people who had been diagnosed as having a 'personality disorder'. The vision and values of the Richmond Fellowship ensured that good practice was the guiding principle of the service. We saw that things like empowerment and inclusivity were promoted in the service and in the wider organisation. The team worked closely with local mental health professionals and also took practice guidance from them.

The Richmond Fellowship had a quality assurance system that was used throughout the country in all their services. We saw that this system was being used in this service. We looked at some of the policies and procedures and at quality standards and monitoring records. We learned that improvements were made as a result of on-going quality monitoring in the service. There were regular internal and external audits of quality in place. Surveys were sent to people and families and other professionals involved in the care of the person. People in the crisis house completed an 'exit' survey when they were discharged. This was used to analyse the efficacy of the service. It had also led to the development of a proposed 'out of hours' appointment system so people could access support and a place of safety. We saw computer based audits of care planning, paper records of medicines management and good records of things like incident analysis, maintenance of equipment and personnel records' reviews.

Health and social care professionals were positive about the partnership working that went on with the service. They told us that the registered manager and his team worked well with them to ensure the best possible care for the people in the service. The commissioners of care had approached them to deliver new services because they were satisfied with the way the organisation operated in Cumbria.