Family Mosaic Housing

148 Hornsey Lane

Inspection report

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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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 6 February 2018 and was unannounced. At our last comprehensive inspection in December 2014, the service was rated Good overall with a Requires Improvement rating in the safe section. Following the inspection in December 2014, we carried out further two focused inspections to check if improvements planned by the provider had been made to meet the legal requirements. Following the final focused inspection 12 May 2016 the service overall rating remained Good and the safe domain was changed to Good as the service had met all legal requirements.

At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

148 Hornsey Lane provides accommodation and personal care to a maximum of 12 people with long-term mental health needs. At the time of our inspection there were 11 people using the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had been registered with the CQC since 14 May 2014. They knew the service well and they had appropriate skills and experience to provide the regulated activity.

There were systems in place to ensure people received their medicines in a safe way and as intended by a prescriber. Medicines were stored and managed well, and staff had received medicines administration training to ensure they knew how to administer medicines safely.

People felt safe at the service and staff took appropriate action to ensure people were safe from avoidable harm and abuse. Various systems were in place, which ensured that people were living in a safe environment and risks to their health and wellbeing had been regularly assessed. These related to regular health and safety and fire checks, infection control and management of incidents and accidents. Appropriate recruitment process helped to protect people from unsuitable staff.

People's care needs and preferences had been assessed before they moved into the service. A thoughtful and planned transition process supported people in settling in the new environment after they came to live at the service.

Staff received appropriate training to ensure they had the right knowledge and skills to support people in a safe and effective way. The registered manager supported staff by providing them with regular supervision, yearly appraisal of their performance and regular practice reflection sessions.

People were supported to live a healthy life. Staff supported people to have a healthy and nutritious diet that was in line with their individual dietary needs and preferences. People had access to health professionals when needed.

The service's design allowed people to spend their time on their own or in the company of others. There were communal areas to socialise with other people using the service and individual rooms to spend time on their own if preferred. The décor was homely and we saw people were comfortable in their environment.

The service worked within the principles of the Mental Capacity Act 2005. Staff had appropriate training and they had good understanding of the principles of the Act. Staff sought people's consent before any care and support was provided.

People told us they were supported by kind and compassionate staff who respected their privacy and showed an interest in people's health and wellbeing. Staff told us they empowered people to be independent and to continuously develop their life skills. Staff respected people privacy and dignity and we saw that people using the service were comfortable in staff presence.

People received care that was in line with their care needs and individual preferences, which were described in comprehensive care plans. Care plans included guidelines for staff on how to support people effectively. Staff knew people's needs and preferences well and were able to give us numerous examples of how people liked to receive their support.

The service had a formal complaint procedure in place which was available to people. People told us they had not had any complaints and they felt listened to by staff who offered their advice when required.

Staff thought the service was well led. They felt supported by the registered manager who they described as approachable and willing to participate in support worker's tasks to help when needed.

There was good communication between staff members at the service. Effective systems were in place to ensure formal discussion were recorded and agreed actions were followed. Staff were encouraged to participate in the running of the service. This gave them the opportunity to lead on allocated areas of responsibility and to develop their professional skills and knowledge.

There were regular residents' meetings taking place at the service. In these meetings, people were encouraged to voice their opinion about the support they received and participate in decision making about day-to-day matters related to living at the service.

The registered manager had effective systems in place to monitor staff performance and various elements of the service provision. Regular audits helped to identify any gaps in the service delivery. When gaps in the service delivery were identified, action was taken to ensure required quality of the service at all times.

External health and social care professionals spoke positively about the quality of care and support provided by the registered manager and the staff team at 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 remains Good.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The registered manager did not notify the CQC about one notifiable event. They assured us all notifications would be submitted as required by the Regulations in the future.

Staff were supported by the registered manager, they were given the opportunity to lead on specific areas of the service delivery and they knew what was expected from them.

People were asked about their feedback about the service and people's opinion was taken into consideration.

There were systems in place to monitor the service provision.

148 Hornsey Lane

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 6 February 2018 and was unannounced.

This inspection was carried out by one adult social care inspector and one Expert by Experience. An Expert by Experience (ExE) is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information we held about the service. These included statutory notifications that the provider submitted to the CQC as part of their legal responsibility.

During our visit, we spoke with eight people who used the service. We also spoke the registered manager and five staff members.

We looked at records, which included care records for three people using the service, recruitment, supervision and training records for four staff members. We also looked at other documents relating to the management of the service.

Following the inspection, we received feedback from three external health and social care professionals.

Good

Is the service safe?

Our findings

People using the service told us they felt safe with the staff that supported them Their comments included, "From day one I have felt safe in the way staff help to look after me and how friendly other people are" and "I have always felt safe with them."

Staff received safeguarding training and they had good understanding about protecting people form harm. Staff knew what action to take if they were concerned about a person's safety. A staff member told us, "We need to protect people from an unsafe environment and ill treatment." Since our last inspection, there were two safeguarding concerns at the service. We saw that the registered manager had dealt with both concerns promptly and safety measures were put in place to protect people from further harm.

Risk to people's health and wellbeing had been assessed and recorded in people's files. Risk assessment documents we saw included a description of identified risks for each individual and early warning signs indicating people may be at risk. There were guidelines for staff on how to support people in minimising these risks. Examples of risk assessments included those relating to people's enduring mental health, such us hearing voices or inappropriate behaviour towards others, management of finances, risk of choking and mismanagement of medicines.

The service's premises were free of clutter and environmental hazards. Records showed that a range of regular health and safety checks had been carried out to ensure people lived in a safe environment. These included monthly room checks, manager's monthly health and safety checks, periodic electric equipment and water hygiene checks. We saw that fire checks were up to date and each person had a personal emergency evacuation plan (PEEP) to ensure people were supported appropriately in case of fire. People using the service were permitted to smoke in their rooms. We were told that people were provided with fire resistant curtains, bedding and self-extinguishing ashtrays. This meant that further measures had been put in place to ensure the risk of fire was minimised.

There was a process in place for the reporting of incidents and accidents. The registered manager had logged all completed accidents and incidents forms electronically for further analysis and monitoring. Records showed that appropriate actions were taken to prevent accidents and incidents from reoccurring. In people's care files, we saw a summary of their individual accidents and incidents. This meant it was easy to monitor and analyse possible risk factors and behavioural patterns for each person. The service had submitted quarterly reports on accidents and incidents as requested the local authority as part of the contractual agreement. This meant there was an additional, external level of monitoring of accidents and incidents at the service.

Records showed there were suitable numbers of staff to cater for people's needs during each day. There was one staff member supporting people at night. We were told that nights were usually quiet and in case of an emergency an on call manager could be contacted to ask for support and guidelines. During this inspection we did not come across any information about disturbances at night indicating there should be more staff supporting people during night shifts. During our visit we saw there were enough staff to meet people's

needs and people did not need to wait for staff support. We observed staff having time to support people when required, chat or relax together with people in the communal of the service.

Staff were recruited in a safe way and records showed that the necessary background checks had been carried out. These included Disclosure and Barring service (DBS) criminal checks as well as verification of staff employment history.

People's medicines were stored securely and there were records of medicines received, administered and disposed of. The majority of medicines administered to people were pre-packed in blister packs. The service had daily and weekly medicines counts to ensure the medicines in stock matched with the medicine administered. We checked a sample of the stock levels of medicines that were not dispensed in blister packs. We found that the amount corresponded to the administration records for the majority medicines we looked at. We noted that topical creams, which were prescribed to be administered "as required" (PRN), were not taken into consideration when regular medicines counts were conducted. A staff member confirmed that these were not included in the count. This meant we could not balance if the amount of "as required" topical creams in stock was correct. We discussed this with the registered manager who assured us this matter would be addressed instantly.

We also saw good examples of the management of PRN medicines. When people were prescribed PRN medicines, there were corresponding PRN protocols in place telling staff how to administer these medicines correctly. PRN administration had been recorded on MARs. Staff administering it had made a note at the back of the respective MAR stating the reason and the quantity of the medicine administered. These meant there was a record of why the medicine was given.

Apart of the issue with counting of topical creams we found that, on the whole, the service managed medicines well. There were systems in place to ensure medicines were administered safely and as prescribed. Each medicine administration was recorded on Medicines Administration Records (MAR). We saw that these were completed fully with no gaps. Changes in people's medicines were reflected on MARs and two staff members signed it to ensure the information had been transferred correctly. We observed the shift leader on the day of our inspection giving a person their medicines. We saw they took time to administer medicines, did it in a caring manner and without rushing. People told us they were happy with how staff supported them with their medicines. They told us they received their medicines regularly and on time. One person said, "Most mornings I get the knock on the door in time for my medicines. I like that so I can go to reception for my medicines and have a chat."

The service had policies and procedures in place to ensure appropriate infection control. Staff had received infection control training and were provided with appropriate personal protection equipment (PPE). We observed that the service was clean and there was information about infection control displayed in the communal area of the service. Cleaning products were stored safely in a lockable cupboard.

Good

Is the service effective?

Our findings

The registered manager allocated staff members who visited each person and assessed their care needs and preference before people moved in to the service. Records showed that matters discussed during the initial assessment included people's life history, cultural background, physical and mental health, daily leaving skills and their support needs. This information was used by the team to determine if a person met the service's admission criteria and if the service was able to support them effectively. The service had also taken into consideration people's gender to ensure balanced ratio of a male and female individuals living at the service.

Staff assisted new people to make the transition period to the service as easy as possible. Staff and people had formulated a move in action plan in which they specified each step of the settling in process. Plans we saw covered the first three weeks after a person moved in. Actions included the introduction to the key-worker, the staff team, other people living at the service and to the building. It also stated what immediate care needs had to be met to ensure people were comfortable and safe in their new home.

Newly employed staff had received an induction to ensure they knew and understood their role and responsibilities. The induction incorporated the training that the provider considered mandatory and shadowing of more experienced colleagues. The mandatory training included manual handling, safeguarding and the lone working procedure. New staff were also asked to complete Care Certificates. The Care Certificate is a set of standards that new health and social care staff follow when at the start of their professional duties. Towards the end of the induction process, the provider's training officer had checked and signed off new staff competencies confirming that new staff could work with people unsupervised. Staff we spoke with confirmed they received an induction and they said it was useful.

Other staff had refresher training at three yearly intervals to ensure they were up to date with their skills and knowledge required to work with people. We noted that not all staff had received a refresher in manual handling training. The registered manager had informed us that this training had been scheduled for the whole team at the beginning of April 2018. Staff could participate in additional training if needed. These included a range of courses helping staff to understand aspects of people's mental health as well as food hygiene, end of life and managing challenging behaviour training. Records showed, and staff confirmed, they received their training as required.

Staff had formal supervision and they told us they felt supported by the registered manager and the provider. Records confirmed that staff had regular supervision and a yearly appraisal of their performance. We saw that topics discussed in supervision meetings included staff training needs, supporting people who use the service and other matters related to staff professional role and duties. Staff had also received support in the form of reflective practice meetings chaired by an independent, external psychotherapist. The aim of the meetings was to help staff to better understand people's behaviour that at times challenged the service and to encourage staff to reflect on their practice.

People were supported to have a healthy diet that was nutritious and reflected their personal needs and

preferences. One person told us, "I go to the kitchen to make tea and breakfast. There is a set main meal time and menu but you are free to have what you wish and buy your own food." We saw there were weekly menus available at the service that had been created by the people in their weekly resident's meetings. When any issues around eating and drinking had been identified, staff helped people to receive support from relevant health professionals. For example, records showed that a speech and language therapist (SALT) had seen a person after the person had developed swallowing difficulties. We saw that when required staff had monitored people's weight. People's care plans contained clear guidelines for staff about how to support people to ensure they received enough food and drink. Staff were aware of people's individual dietary requirements and they knew how to support people accordingly. They told us, "One person is diabetic and we encourage them to eat less sugar" and "One person is vegetarian. We always make sure we get food that suits their needs."

Staff supported people to live a healthy life and have access to external health professionals. Records showed that people's health needs had been regularly discussed in people's individual key-work sessions. Staff supported people to attend various healthcare appointments when required. In people's care files we saw evidence of regular clinical care reviews with external health and social care professionals. These included a psychiatrist and care coordinators. People were invited to take part in these meeting. Topics discussed included matters related to people's mental and physical health and how people should be supported when their needs had changed.

The service was designed to enable people to socialise with others and spend the time on their own if they chose to. The accommodation was laid out over four floors with stairs and a lift access to each floor. Each person had their own room. People had access to shared facilities that included a bathroom on each floor and the kitchen, lounge, dining area and the garden on the ground floor. People could decorate their room as they wished to. Staff offered support with maintaining people's rooms when requested by people or when it was determined by the health and safety of the environment. The decoration in the communal area was homely. There were sofas for people to relax and pictures on the walls across the building showing people who used the service and various events they participated in. We observed that people could move freely between different parts of the building and they were comfortable and relaxed in their environment.

The mental capacity Act (MCA) provides a legal framework for making particular decisions on behalf for 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 lacked 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. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the time of our inspection, all of the people using the service had the capacity to make decisions about their care and treatment. We saw that people living at the service were free to leave the premises at any time. People said, "If I wish to go out, staff ask if I'd like to take a phone or ask if I'd like to go with someone" and "I can come and go as I please, if I wish someone to come with me, staff will make arrangements for a member of staff to come." Records showed that staff sought people's consent before providing any care. In people's files, we saw evidence of signed consents to care and treatment and sharing information with others. Staff had received the MCA training and all of the staff we spoke with had good understanding of the principles of the Act.

Good

Is the service caring?

Our findings

People were supported by staff that treated them with kindness and compassion. All of the people we spoke with expressed positive views about staff in how caring, friendly and helpful the staff at the service were. Some people's comments included, "This feels like home, best place I have been to and I've been to a few. Staff are lovely caring and helpful" and "There are some things I don't wish to talk to staff about but they are very nice and always ask if I want help or is there anything they can do." During our visit, we saw many interactions between staff and residents. This included everyday conversations, preparing food together, tiding up or simply sitting and relaxing together. We observed that staff and people using the service felt comfortable with each other. One external professional told us, "I am constantly impressed by the kindness, sense of humour and devotion that I see every time I visit."

The service supported people during difficult times when they experienced discomfort and emotional distress. People participated in regular reminiscence and feelings groups. The groups gave people a safe space to talk about their feelings and emotions they had been experiencing and not always knew how to manage. External health professionals ran both groups. One person told us, "The meetings are helpful. They help us to express ourselves, give tips we want and to deal with issues between us or any other issues." Staff at the service offered emotional support to people when appropriate and to show that people mattered. Records showed that staff visited people during hospital admissions and assisted them during various meetings and activities. During our visit, we observed how the service was preparing for a funeral of a person who used to live at the service and passed away shortly before our inspection. We saw arrangements were made for people to attend the funeral and they were given space to grieve for the loss of the person. We saw that the registered manager had organised a funeral wreath from the service. We were told this was to mark the person's time spent at the service and show respect following their passing.

Staff empowered people to be independent but at the same time respecting people's personal space and avoided unnecessary intrusion. People told us, "Sometimes I fancy lying in bed all day, staff come and check if I am missing too long but they don't intrude. They will always help if needed" and "I experience some pain today and they said would I like to see a doctor. I said no. It's nice they asked as I don't feel alone and they make me feel safe". Staff we spoke with told us how they empowered people to be independent as much as possible. They said they aimed at supporting people so they could live a life lead by healthy personal choices and decisions. Staff comments included, "We are trying to encourage people to make as many choices for themselves as possible" and "We encourage people's independence. We invite them to take part in cooking or deal with various formal matters. We would always support people if needed." In people's care plans, we saw information on people's life skills. There were guidelines for staff on how to support people in improving their skills, such us, cooking, keeping their rooms in good order or how to feel comfortable and relaxed in their own environment.

People were supported to express their views and be actively involved in making decisions about their care and the environment they lived in. Each person had an allocated keyworker who was responsible for coordination of a respective person's care at the service. A staff member told us, "Key work help us to build positive relationship with people. It is essential in getting to know people, building trustful relationships and

finding out what people want." We saw that people and their keyworkers met regularly do discuss various elements of the support provided by the service. Records showed key work discussions covered topics like personal wellbeing, formal appointments and living skills. We also saw evidence of conversation on how staff could support people in ensuring care provided was complete and beneficial to people.

People's privacy and dignity was respected at all times. Personal care was provided to people when they requested it and staff respected if people chose to receive it less frequently. One person using the service told us, "On some days staff help, if I wish, to have a bath." The registered manager told us, "Some people using the service had historically refused personal care. We respect that. Staff had built positive relationship with people and people are now more likely to accept our support." People's choices had been respected. Records showed people could decide if a male of female worker provided them with personal care. People could also specify which staff member they felt more comfortable with and they would like to support them when receiving personal care. Staff told us, "I always ask when people would like help with their personal care. I always tell people what I am doing when providing personal care and I encourage people to do as much as possible for themselves." Another member of staff told us "I offer as much privacy as possible during personal care. I close the door and I don't do anything people do not want me to do. I may pass a sponge and encourage as much independence as possible."

Good

Is the service responsive?

Our findings

People were provided with care that was tailored to their individual needs. Each person had a care plan, which described who people were and their individual support preferences. Care plans were comprehensive and included information on people's care needs, their physical and mental health condition as well as their social and life skills. We saw that care plans consisted of clear guidelines for staff on how people liked to be supported and what was important to them. For example, one person liked to smoke in their room and we saw the information about this was included in their care plan. Another person preferred to do arts and crafts in their room rather than socialise with others. This was also recorded in this person's care plan. People were encouraged to participate in review of their plans of their care. All of the people we spoke with were aware of their care plans and they felt the document incorporated their needs sufficiently.

Staff had been respectful toward people's personal histories and their individual backgrounds. We saw that the information about these had been recorded in people's care plans. Staff we spoke with knew how to assist people to follow their religious, cultural and other personal customs. Staff told us how they supported people to attend a place of worship or to eat food that was in line with people's personal cultural requirements. We were also told, and we saw photographic evidence, about a recent black history week, which incorporated celebration of various cultures, backgrounds and food from around the world.

People were supported to follow their interests and do things they liked. One person using the service told us, "I like all the people here and most days a few of us meet in the main room to watch Countdown on TV together." In people's care files, we saw information about people's hobbies and preferred ways of spending leisure time. In the communal area we saw a range of age appropriate games, a display of various arts and crafts created by people and photographs of various events that took place at the service or during trips out. At the time of our inspection we did not witness any activities at the service. The registered manager explained that this was due to the sudden passing of a person who used the service and people grieving for their loss. This showed that the service supported people in a sensitive way with respect to how various life events could influence people's emotional wellbeing.

People were encouraged and supported to maintain relationships with the people that mattered to them. One person told us, "If I feel a bit down and want to talk to family for a change, we have a phone kiosk for privacy on the top floor, sometimes it's nice to talk to family if I have any concerns and let them know that I feel safe and happy here". In another example, staff told us about a person who was supported to meet other people from their country of origin at community setting. Care records for this person described their relationship with members of their community and how these relationships impacted the person's health and wellbeing.

The service had a formal complaint procedure in place. We saw that this was displayed in the communal area and people had access to it. Records showed that the complaints procedure had been explained to people as part of their care planning process. There were no current formal complaints during the time of our inspection. The registered manager explained that the majority of complaints had been raised and dealt

with in weekly residents' meeting. The registered manager said, "People are encouraged to raise concerns as they are vulnerable and they may have difficulties in making their voice heard." Other ways people could raise their complaints were through an anonymous complaints and suggestions box in the communal area of the service. They could also do so through discussions with their external care coordinators or other chosen preferred representatives. People told us they did not have any complaints about the care they received or about the staff who supported them. They said that staff listened to them and offered their advice when required.

The service had not provided end of life care to people who lived there. However, when appropriate staff supported people in voicing their preferences and choices on what people would like to happen in case of their death. Records showed that this subject had been approached with sensitivity. People could express their wishes and staff would support them in making appropriate arrangements. We also saw that when people decided not to discuss the matter, this had been respected and a note had been made to reflect people's decision.

Requires Improvement

Is the service well-led?

Our findings

As part of the process, we looked at statutory notifications submitted by the service to the Commission. We found that the service had notified the CQC about a range of matters that affected people who used the service. However, we found one incident that took place in July 2016 that the service had not notified the Commission about. We clarified with the registered manager their responsibility to notify the commission about all notifiable events under the Health and Social Care Act. The registered manager accepted that the notification should have been made when the accident occurred. They assured us all notifications would be submitted in the future as required by the Regulations. We are looking at this further.

Staff thought the service was well led and they felt supported by the registered manager. They told us, "We have a very good manager. They are very approachable and you can always speak to them" and "The service is well managed. We have enough staff now, people are comfortable and if there are any issues the manager works alongside of us to resolve them." We observed that the service was well organised and staff were provided with information on what was expected from them. In the staff office, we saw an information board reminding staff about regular and other activities planned for each day. Staff were allocated tasks and duties they needed to complete during each shift. We saw that these were recorded and signed off by staff following the completion of the task. This meant there was a clear distribution of responsibilities and accountability amongst the staff team.

There were systems in place to ensure good communication amongst the staff at the service. There were monthly team meetings, weekly catch up meetings and daily shift handovers. The meetings were recorded which meant there was a written evidence of topics discussed and actions agreed by the staff team. During our visit, we observed staff continuously communicating about tasks they completed and care provided to people who used the service.

Staff were encouraged to participate in the running of the service as much as possible and to contribute to its development. In the recent staff team meeting minutes we saw that all staff members were asked to be a shift leader during different shifts. The shift leader is a person who ensures that everything that needed to happen during the shift had happened. Staff we spoke with told us about their individual areas of responsibility, such as management of medicines or ensuring health and safety at the service. This meant staff were enabled to develop detailed knowledge around specific areas of the service provision, to lead on it and to educate and share knowledge and skills with other staff.

People who used the service were encouraged to voice their opinion about the service and their voice mattered. There were weekly residents meetings. From the minutes we saw meetings were well attended. In the meeting minutes, we saw that topics discussed included everyday living, emotional support, participating in household duties, planning of social activates and general discussions about matters related to living at the service. Additionally people could provide their feedback about the service they received in their individual key-work sessions and through a suggestion box placed in the communal area. Records showed that people's voice had been listened to and actions were taken to respond to people's comments. For example, people said that they would like to take their hot drinks to their rooms upstairs.

This was not permitted due to the possible spillage causing a health and safety risk. In the quarterly monitoring report submitted to the local authority, we saw that the service had provided people with special caps with lids and trays that they could use to carry their drinks upstairs.

The registered manager had numerous systems in place to screen and monitor the service provision and take action if required standards were not met. These included a variety of audits such as medicines management, staff competency assessment and accidents and incidents logs. The registered manager told us they had not carried out a separate audit of people's care files. Instead, these had been regularly discussed and actions needed recorded in staff individual supervisions. Care files we saw were in good order and consisted of up to date information about people. Therefore, we were confident that the system used by the registered manager was effective. Additionally the registered manager had submitted quarterly quality monitoring reports to the local authority. We saw that the reports were comprehensive and included information on service developments, people's care and feedback and other elements of the service provision. This meant there was another level of regular quality assurance and monitoring in place to ensure the service had worker within their contractual agreements with the local authority and according to the Regulations.

The service had built effective relationship with external health and social care professionals. Records indicated regular contacts about care and support provided to people GP, psychologist and representatives of the local authority. The service received very positive feedback from external care professionals. One professional told us, "I have the utmost respect for the way that Hornsey Lane is run" and "There is an exceptional culture of staff co-operation and communication there."