Care Quality Commission

Community Integrated Care
Finchley House
Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on the 7 April 2015 and was unannounced. This meant the provider did not know we would be visiting. A second day of inspection took place on 8 April 2015 and was announced. We last inspected the service on 6 August 2013 and found the provider was meeting all legal requirements we inspected against.

Finchley House is a care home run by Community Integrated Care. It is a detached bungalow set in a mainly residential area with good access to shops and local amenities. Six people can live there and it has good access both into and outside of the property. It is registered to provide accommodation for people and their nursing needs are met by the local community nursing services.

There was an established registered manager in post at the time of the inspection. 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.

Summary of findings

At the time of the inspection the registered manager was on annual leave so the senior staff member present supported us with the inspection and was responsible for the day to day running of the home.

Staff were not up to date with all their mandatory training, including safeguarding training and medicines training. However, some training had been booked and the provider had sourced a new trainer as they recognised the need to update staff training. Staff had not routinely received an annual appraisal but supervisions were up to date and staff said they felt well supported

People told us they felt safe living at Finchley House and the staff had a good understanding of their duty of care in relation to both safeguarding people and whistleblowing.

A variety of risk assessments had been completed which included a brief summary of the history associated with the risk and how the risk was currently being managed. Risk assessments included both environmental risks and risks associated with people and staff.

Staff were aware of how to respond in the event of an emergency and an easy to access emergency file was in place which contained all the relevant information that staff might need should they have to evacuate the building.

Computerised systems were used to record and monitor accidents and incidents. Senior managers had ready access to the logs and were able to review entries for completion and trends. Any action required to be completed was noted.

The local authority assessed each person's needs and informed the service of the level of staffing that was needed to meet their individual needs. This was managed well and monitored by the registered manager.

Recruitment processes were underway due to having two vacancies and procedures used were robust and included the completion of Disclosure and Barring Service checks.

Medicines were managed safely and all staff were competent in the administration of medicines. The ordering of people's medicines was completed by the senior staff member but they were training other members of the team so they would also be able to complete this. People had care plans and risk assessments in place for their medicine and protocols had been completed for people who had been prescribed 'as and when required' medicines.

Staff received regular supervision and told us they were well supported and well trained. The training received included moving and handling, food safety, person centred support, record keeping as well as diabetes and epilepsy. Staff said they could source their own training and make a proposal for it to be funded if the organisation felt it would be of benefit.

People were asked for their consent before being offered support and staff were aware of mental capacity and deprivation of liberty safeguards.

People received the support they needed in relation to health and nutrition and were included in decision making along with their family members if appropriate. Staff explained that they had moved away from offering people a set menu and moved towards offering people choice at mealtimes. We observed that people decided what to have for lunch and it didn't present a problem to the staff when everyone wanted something different to eat. People were involved in preparing meals if they chose to do so and we saw one person making cheese scones with the senior staff member.

Staff knew the people they were supporting well and had very warm and respectful relationships with people. Finchley House was full of laughter and fun during the inspection and everyone was included in a compassionate and caring way.

Care records were individual to the person and contained their preferences, likes and dislikes and their history as well as how people needed and wanted to be supported.

People were supported to engage in activities they enjoyed and to be active members of the local community.

We saw that people and visitors were encouraged to comment about the service and the complaints procedure was available in pictorial format for people.

The staff team had a shared vision of providing quality support for people and empowering people to be as independent as possible.

Summary of findings

Quality was high on the agenda and there were audits in place to monitor and assess service provision. Action plans were in place and as actions were achieved they were signed off.

Summary of findings

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. People told us they felt safe and staff had a good understanding of safeguarding and whistleblowing procedures.

Relevant risk assessments had been completed and there was an emergency response file in place which staff were aware of.

Staff told us there were enough staff to meet people's needs and the provider had appropriate recruitment practices in place.

Medicines were managed safely.

Is the service effective?

Requires improvement

The service was mainly effective. Some staff had not had an annual appraisal but they had regular supervision and said they were well supported.

Staff attended various training courses. The provider had sourced new trainers due to needing to catch up with the delivery of training. Some out of date training had been booked.

The registered manager had a good understanding of mental capacity and deprivation of liberty safeguards and was working with the local authority to meet people's needs.

People received appropriate support in relation to eating and drinking and there was regular contact with health care professionals.

Is the service caring?

Good

The service was caring. People benefitted from warm and caring relationships with their staff. There was a lot of fun and laughter in the house together with mutual respect and compassion.

People were involved and included in decision making, team meetings and supervisions.

Information was provided for people in a way they would understand and staff were skilled at developing and enhancing people's rights and independence.

Is the service responsive?

Good

The service was responsive. Care was person centred and people were involved in the planning and review of the care they received.

People were supported to be active participants in the local community and to engage in activities that they enjoyed.

An appropriate complaints procedure was in place and visitors to the service were encouraged to leave comments in the signing in book.

Summary of findings

Is the service well-led?

Good

The service was well led. Staff told us, “The manager is brilliant.”

Quality and service improvement was high on the agenda for the whole staff team and they worked in a collaborative manner to provide the best service they could for people.

There were a variety of audits in place and action plans were completed to ensure a named person was responsible for completing the work.

Consultation meetings were being held to de-register the service which included the commissioners of the service, family members, staff and the people affected by the proposed move to a supported living service.

Finchley House

Detailed findings

Background to this inspection

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

The inspection took place on 7 and 8 April 2015. Day one of the inspection was unannounced.

The inspection team included one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

During the inspection we met with all six people who lived at the service. We spoke with four members of staff including care staff and senior care staff. The registered manager was not at the service on the days of our inspection. We spoke with them later on the telephone. We contacted the local authority safeguarding team and commissioners of the service to gain their views. They had no concerns about the service.

We looked at two peoples care records and four staff files including recruitment information. We reviewed medicine records and supervision and training logs as well as records relating to the management of the service.

We looked around the building and spent time with people in communal areas.

Good

Is the service safe?

Our findings

We asked people if they enjoyed living at Finchley House and one person nodded and said, "Yes." They added they felt, "Happy and safe."

Staff had a good understanding of safeguarding. One staff member said, "Safeguarding's about how we report untoward concerns and how they are managed." They added, "It could be financial or physical. We have a duty of care to report things." When asked about whistleblowing one member of staff said, "Whistleblowing is if we are suspicious of colleagues we need to report it, either abuse or a breach of trust. Again it's about duty of care. It's about protecting people's dignity, privacy and a right to life free from harm."

The senior staff member explained that the safeguarding log was completed electronically and we saw that alert forms had been printed off and included actions taken, including alerting the local authority safeguarding team and notifying The Care Quality Commission. Staff had access to the providers own policy as well as the local authority policy and information from the Sunderland Safeguarding Board. The people living at Finchley House had pictorial information on safeguarding and how to protect themselves from harm.

Relevant risk assessments had been completed for people and included a brief summary of the history of the risk as well as how it was currently managed. Moving and handling risk assessments were completed and reviewed on or before a scheduled date. Information included the person's ability to weight bear, whether they had a history of falls and if they understood instructions. The equipment the person used was listed as was a summary of any handling constraints such as sensory needs, restricted movement, skin problems and localised pain. There was information of the number of staff needed to support someone with moving and handling and a detailed plan of how to support the person.

Risk assessments included review information such as the people who were involved, the reason for the review and whether a change to the support plan or risk assessment was needed. If a change was needed there was space to include a description of the change and the date of the changed plan. This document was signed by staff and the person it related to.

Environmental risk assessments had been completed to identify any specific hazards and manage any risk within the home environment. This included how to respond in emergency situations such as falls or incidents of choking.

An emergency response file was in use which included a fire plan of the building, a copy of the fire procedure, a staff signature sheet and a list of contact numbers including the on call manager, the housing association number and a list of their responsibilities. There was also a copy of the night time evacuation plan.

Personal emergency evacuation plans were in place and included a designated place for people should they need somewhere else to stay. This included information on the specific equipment people needed and where this was available. The number of staff needed to evacuate each person was detailed and a list of their medical needs. There was specific instruction for staff to use the 'mattress floor drag' technique if the hoist could not be used or wasn't available to use to evacuate people.

There were procedures in place for staff to follow in the event of gas leaks, loss of electricity, burglary and so on.

Accident and incident logs were completed on an electronic system with all the relevant information recorded. Incidents were signed off as completed once necessary action had been taken. Senior managers were able to review the information and request any additional information or action as required. Senior care staff said, "If it was noted that someone was having several falls, a falls risk assessment would be put in place and a referral to the falls team made."

We were told that each person had been assessed by the local authority who decided on the number of support hours each person needed. The senior staff member explained that these hours were managed via the rota system and we saw there was a system in place for monitoring the provision of hours. The senior staff member said they were moving towards individualised rota's and registered managers were being trained on how to develop this further.

One staff member said, "Yes, I think there's enough staff to meet people needs. It depends on the skills of the people supporting really. We rely on each other and our knowledge of people." They added, "It's good to spend time one to one with people, you can give quality of life and really benefit people." A senior staff member said, "We usually have four

Good

Is the service safe?

staff during the day and one sleep in and a waking night overnight. We can operate on three staff if we need to. They added "We are recruiting care staff as two have left and one is on maternity leave."

We saw that appropriate recruitment practices were in place and employee checklists were used to ensure all necessary checks such as references and disclosure and barring service checks were completed before people were offered employment.

People's medicines were managed safely. Each person had an individual medicine file which contained their photograph and a list of all staff who were competent to administer medicine along with their signature and initials. A copy of the medicine policy was included in the file which stated that people's medicines were kept in their rooms in locked medicine cabinets. The procedure included instruction that staff were to observe people taking their medicine before signing the medicine administration record (MAR) to say it had been administered. There was a reminder that the medicine support plan should be followed and that any staff administering medicine should have completed training and a competency workbook.

There was an explanation of why people had been prescribed the medicine in their file, for example, for hay fever or skin irritation. The MAR highlighted the times that medicine should be administered and the coding system for any missed medicine was used appropriately, for example for recording that 'as and when required' medicine wasn't needed. 'As and when required' medicines are those given only when needed; such as for pain relief or anxiety.

Medicine care plans were current and specified the level of support that was needed and stated that staff should be trained and should have completed a competency to administer eye drops. For 'as and when required' medicines staff were instructed to observe people's behaviour to see if medicine was needed, for example observe to see if someone was scratching as an indicator that their skin was irritated. Topical body charts were used to show where creams had been administered.

One care plan gave specific instruction to 'tell the person what they are taking and tilt the pot on their behalf into their mouth as they will stand with the medicine pot for a long time, and provide support with a small glass of water to aid swallowing.' The risk assessment gave a scale of risk before control measures were put in place and then a scale after control measures were introduced to ensure the risk was being managed proactively. Control measures included training, staff competency, following the MAR and administering prescribed medicines as directed. Risk assessments assessed the risk as low, medium or high and this set the time frame for review. Where risks remained high it was stated that support should not be delivered until hazards and potential risks could be reduced to medium.

'As and when required' medicine protocols included information on the medicine, the strength, route, dose and intervals between doses as well as the maximum dose allowed in a 24 hour period. Special instructions were recorded such as, 'don't take if have kidney problems.' The reason for administration was recorded such as, 'itchy skin, observe and administer. If not detected skin may become sore or infected.' Reasons included the condition, the symptoms, any triggers for needing the medicine and the type of pain someone may be experiencing.

Staff were trained and said, "The key is to be thorough." Medicine audits were completed weekly as were health and safety checks.

Requires improvement

Is the service effective?

Our findings

We reviewed the staff training matrix provided to us on 8 April 2015 and noted that out of 13 staff six needed to attend safeguarding training and a further two staff had safeguarding training that did not meet the providers requirement for refresher periods. Eight staff had medicine training that was out of date and four staff had not received training in medicines. On discussion with the senior care staff we saw that places had been booked for four staff to attend safeguarding training. The senior care staff said, "Head office have sourced new trainers due to being behind on delivery of training."

We did not see any evidence of people having received an annual appraisal since 2013. When asked the senior care staff member said, "No, the newer staff won't have had one yet." It was explained that of the staff files we looked at no one had evidence of an appraisal since 2013. One person said, "Oh, it doesn't seem like that long ago."

When asked about training staff said, "It's nice to have training reinforced. It instils what you need to be aware of." Staff said, "I've had training in moving and handling, food safety, person centred planning, record keeping." They added, "Sometimes we have in-house training or discuss things in the team meetings. I've done diabetes care and epilepsy care. It's nice to have the information to access when you're supporting someone. We can get our own training and CIC might pay for it if they think the training is necessary. I've done food training – dysphasia and food preparation."

We saw that staff received training in health and safety, first aid, moving and handling, challenging behaviour, food and hygiene, medicines, mental capacity act and epilepsy. For senior staff who supervised others they are trained in supervision skills.

All new staff were completing a relevant induction and a probation period review had been held with them. Staff received regular supervision which was recorded appropriately and included discussions around the people supported, quality systems, personal development and overall feedback on performance. Staff said they felt well supported. One staff member said, "If you need anything just ask, I'm always asked if I need support and you get it." They went on to say, "Team working is good, if you see someone struggling you support them. It's about a shared skill set."

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. People had mental capacity act assessments in relation to a consultation exercise about changing the registration of the service from a residential home to domiciliary care. These had been completed appropriately and assessed people's capacity in relation to managing their own tenancy. We spoke with the registered manager about mental capacity assessments and Deprivation of Liberty Safeguards. They said, "The social worker is aware and we have been advised to wait to complete applications due to the de-registration process as community orders would be needed once we are de-registered." We contacted the local authority commissioning team who stated, "We have had no issues raised regarding Finchley House. For information Finchley is going through the deregistration process." This show's relevant stakeholders had been informed and involved in the consultation process.

Staff were asked about behaviour that might challenge the service. One staff member said, "It's quite minimal really. We know what triggers to look for and can manage it well." When asked staff said, "We would never restrain anyone; we have had challenging behaviour training." Care plans on behaviour which might challenge were in place and identified triggers and actions that staff should take to manage any behaviour. Staff were observed recognising these triggers and responding appropriately. They were able to explain what the indicative behaviour meant. For example, one person was seen pulling at their clothes which meant they were becoming anxious and the staff response was to distract them by offering a cup of tea and supporting the person away from the situation. In this way staff managed the situation before there was any escalation in anxiety or behaviour that may be described as challenging.

We observed lunch time and saw that people were asked what they would like for lunch rather than choosing from a set menu. People chose to have different things and this was well catered for by staff who sat with people in the dining room and enjoyed lunch as a very sociable

Requires improvement

Is the service effective?

occasion. Conversation was relaxed and people chatted about what they had been doing that morning and what their plans were for the afternoon. People spent quite a while at the table enjoying each other's company and were not rushed at all. We saw that people had been referred to dietitians and the speech and language therapist due to needing additional support with diet or diabetes and staff were aware of people's individual needs.

People had hospital passports in place which are a recognised tool to help people communicate their needs to doctors, nurses and other health professionals. They included a section on 'things you must know about the person' such as allergies, current medicines, medical history and communication needs. A section on 'things that are important to the person' and 'things I'd like to happen.' We observed staff engaging in a discussion with a health professional in regard to the management of a person's epilepsy. The staff member was knowledgeable about the person and knew how to respond in the event of the person becoming unwell. We also noted that there were visits from a chiropodist and a district nurse on the day of the inspection.

The service was in a good of repair and decorators were redecorating communal areas during the inspection. People had been involved in decorating their own rooms which were very personal to them in choice of colour, decoration and furniture and fittings. Staff were very conscious of the potential disruption the decoration of the home may be having on people and were actively managing any risks and supporting people to continue with their day to day routines and activities.

Good

Is the service caring?

Our findings

We observed positive relationships between people and staff. People were treated with kindness and respect and staff were clearly in tune with people and the way they communicated their needs.

There was a great deal of fun and laughter during the inspection and people were very relaxed and at home in each other's company.

Staff spoke about being peoples, "extended family." One staff member said, "People settle in really well, they are doing really well here."

Staff members understood how important contact with family members was. Staff supported people to maintain contact with family and friends and they supported people to visit their relatives regularly and welcomed family members to the home. Where appropriate family members were kept up to date with information about people's care and health needs and often attended appointments with their relative. Staff were conscious of family member's emotional needs and their need to be involved in people's lives and decision making.

The senior staff member told us, "People often come and sit in the hub with us while we work. People will join in with staff supervisions and come to the team meeting if they want to." The hub is a space used by staff to complete paperwork as the service no longer has a traditional office space as they felt it was more of a home environment if they did not have a formal office. One staff member said, "It's taking time to get used to not having an office but people come and sit with us in there which is good." One of the people supported at Finchley House spent time with us in the hub during the inspection and was involved in conversations and general discussion.

Some of the people living at Finchley House did not express themselves using traditional methods of communication and used limited verbal communication. Staff were very aware of people's communication needs and knew how to involve people in decision making and planning. We heard staff offer choice to people in a very respectful manner and when people did not respond staff knew when to accept their decision.

Communication passports were in place. Communication passports are a person centred thinking tool used to document vital information about how to communicate with and understand someone; how to offer choice and how to involve people in decision making. There was a section containing summary information about the use of gestures, the sensory needs of the person and any communication aids that were used.

There was detailed information about how to communicate with the person, such as being relaxed, friendly, start by saying the person's name so they know who you were speaking to. The physical space that should be kept between people was documented so the person wasn't overcrowded. There was also information on how to promote understanding. This included the need to keep sentences short, any topics of conversation that should be avoided and that prompts and gestures should be used.

There were also cues to end the conversation or activity, for one person it was to say it was the end and ask if they would like a cup of tea. This acted as an indicator for the person that the activity was finished. When asked about involving people staff said, "We ask people for their opinion and judge the answer by their body language or facial expression. It can be difficult but we know people well."

The staff team were trained 'Hearing Champions' and had made a pledge to communicate effectively with people and to be more aware of the signs of hearing loss.

The staff team were very aware that their role was support people to live independent lives, to respect their choices and to involve people in all aspects of the community. Staff were often heard saying to people, "You're the boss," or "You're in charge what do you want."

People's family members advocated on their behalf if there was a need to do so and staff were aware of general advocacy services where they could refer people if appropriate to do so.

Good

Is the service responsive?

Our findings

People's care records included an 'All About Me' file. This included information about the person that was specific to them. There was a photograph of the person and information about their morning and evening routines. This included how to wake the person, their preference in terms of bathing or showering, what they would do independently of support, what areas they needed verbal prompts with and where physical support was needed. Information included the need for staff to communicate with people and explain what they were doing. What personal, protective equipment was needed to be worn such as gloves and aprons was detailed. There were instructions around using a bath chair stating that it should be at a safe working height for the staff member. One person's routine also gave a reminder about the need to use prescribed bath oils.

Morning routines included what people liked to do after they had got up. For one person this was to go into the kitchen for breakfast and while the person enjoyed their breakfast staff were to clean the bathroom and ensure all personal items had been returned to the person's room.

Evening routines were described in similar, individual ways. One person would go to their room and get their nightclothes and a towel to communicate that they would like to have a bath. This acted as an indicator to staff to prepare the bathroom for the person. After having a bath the person would have a cup of tea in the lounge and then at around 10pm would go to their room with a small glass of milk with the TV on.

People had one page profiles which included information on what others liked about the person, what their favourite food was, their favourite people and things, what things annoyed the person, who were important to them and what makes their best day. One page profiles are an example of a type of person centred thinking tool which helps staff to think about and focus on the individual and how best to support the person.

Pictorial information was included in people's files, such as 'My Memories.' This included photographs of holidays with housemates and photographs of friends and family from favourite parties. This was completed on a monthly basis and included a written review of the month on the reverse of the pictorial information.

Information passports had been completed which included information that should be shared with professionals if the person was admitted to hospital. It included a list of other professionals involved in their care, whether lasting power of attorneys were in place and how decisions would be made. These documents included information on the person's support needs and how many staff were required to support the person. There was a summary of the person's communication needs, such as limited verbal communication but understands short instructions and whether the person was mobile. There was also a medical history, a description of behaviour and what it means and how the person presents when they are experiencing pain.

People had documents called 'My Goal Plans' which showed what they wanted to achieve; what they would be able to do once they were successful; when they will have achieved it by and a description of how they needed to be supported to achieve their goals.

Support plans were individual and reflected people's preferences and individual needs for support and how they wanted this to be delivered. Areas of support included cooking, mobility, personal hygiene, accessing the community and maintaining contact with family and friends. Care plans had risk assessments attached to them. We noted during the inspection that two people's care plans were a month late for being reviewed. This was mentioned to the senior care staff on day one of the inspection and they said, "I'll deal with it straight away." We saw that on the second day of inspection one person's care plans had been reviewed and there were plans in place for everyone else's to be completed.

Care plans included a description of the level and type of support that was needed as well as a description of how to provide the support and the outcome people would achieve if the support was followed.

Each person had a community map. This is a person centred thinking tool which is used to identify the places and activities a person enjoys attending in the community. The aim is that people are supported to move from having a presence at the event, i.e. by a passive participant, to making a contribution, i.e. being an active member of the group.

When asked about activities staff said, "People go to the day centre, or do cooking, out for walks, we are lucky to be so close to the beach. We do a lot of singing and dancing

Good

Is the service responsive?

and we have transport." The senior staff member explained that the people who lived at Finchley House owned the minibus so it was used regularly. They said, "We get people out as much as possible."

Each person had a designated keyworker who was the main staff member responsible for the updating of care records. They completed a checklist of care records on a monthly basis to ensure information was up to date. A monthly review of the persons care was completed and progress scores were given for specific areas such as health, staying safe, achieving and enjoying, positive contribution and economic well-being. This gave an indication of the progress the person had made against their goals. It was also indicated if the goal had been maintained once it had been achieved.

We asked the senior staff about annual reviews for people and they said, "We have completed reviews due to the forthcoming plans to de-register the service. We are waiting for information from Four Housing [the Housing Association] before moving things on."

There was a complaints and compliments policy which specified timeframes for action. Staff explained that the signing in book was used for people to add comments about the service but formal complaints would be addressed by the manager and logged onto the computer system for monitoring.

When asked about surveys we were told, "Annual surveys for relatives had been identified on our monitoring tool and so have been sent out today." They added, "Staff surveys had been completed by staff however these were completed confidentially through an external organisation. We will as an organisation receive the results but they will not be service specific." Staff explained that, "Annual surveys were sent randomly throughout the organisation with the results for 2012-2014 posted on the organisation website."

Good

Is the service well-led?

Our findings

There was a well-established registered manager in post and in their absence the senior staff member held responsibility for the day to day management of the service. It was the senior staff member who supported us with the inspection.

One staff member said, "We have brilliant managers."

Staff handovers were completed in writing and verbally and included information on people including any activities they had been involved in and any appointments they needed to attend. It also included a medicine check and a summary of any tasks that needed to be completed. These were signed off once completed.

Team meetings included the people who lived at Finchley House and everyone was encouraged and supported to participate in the meeting. Positive feedback was given to people and staff during the meetings and it was used as a means to encourage independence. Items discussed included spot checks and housework, whistleblowing, a reminder that it may be a place of work but it was also people's home. People were reminded about their responsibility in relation to activities with people and that they needed to work together as 'one team'. Staff's work was appreciated and it was recorded that 'together we can achieve our goals.'

Staff had a good understanding of the values of the organisation and explained these to be individuality, person centred care and growth. Staff were aware that the service was looking to de-register as a care home and move to a supported living arrangement. Stakeholders, commissioners and the people living at Finchley House were involved in this process and one step had been to remove the office space from the building and create a 'hub'. This meant people were free to spend time in the 'hub' with staff and get involved in the work that was being completed.

One staff member explained that they felt able to share their knowledge and skills from previous posts with the staff team to encourage development and learning.

Another staff member said, "[The manager and senior] are really good at supporting us and increasing people's confidence. They've personally been very supportive of me, as have my colleagues."

When asked about challenges staff said, "There are lots of good challenges, it makes it interesting. It makes you a better person to be challenged to make life better for people." They added, "It's about being challenged in a good way. The decorators being here are a challenge. We need to maintain people's quality of life and assess risk but we are doing it, it's good."

A de-registration meeting was held in January 2015 and was attended by the housing association, the social work team, family members and people supported at Finchley House. This meeting had been planned in coordination with the commissioning team. We saw that an action plan was in place for the proposal to de-register the service and consultation processes were underway. Pictorial information for what supported living would mean for people had been shared.

A service quality assessment tool was in use and being completed to assess the quality of the service. Areas covered included support planning, risk assessment, nutrition, health care and caring; communication and decision making; health and safety; environment; medicine management; safeguarding; leadership, staffing and training; quality management and complaints.

We saw that this quality tool had been mapped to The Care Quality Commission key lines of enquiry and included a rating system which indicated where action plans were needed.

Actions included reminders for staff to sign specific documentation as well as additions that needed to be made to support plans so the staff team responded in consistent ways if people were distressed.

Regional managers completed service visit checklists and recorded actions that needed to be taken along with a record of who was responsible for completing the action and the target date. The completion date was recorded once the action had been met. In October 2014 it had been noted that flooring was to be replaced due to health and safety concerns, one staff member's probation was still outstanding; supervisions were to be held bi-monthly, some training was outstanding and one page profiles were to be completed. The senior care staff advised that actions had been completed although some work was still ongoing in relation to training and one page profiles.

A policy and procedure file was available for staff to use and the senior staff member showed us the online system

Good

Is the service well-led?

for accessing current policy and procedure. There was a reference file held in the service which included procedures for missing people, unexpected deaths, infection control, safeguarding, and actions to take in the event of emergencies.