PRIMARY INSPECTION

Name of Agency:	**Positive Futures (Cookstown)**
Agency ID No:	**11019**
Date of Inspection:	**26 September 2013**
Inspector's Name:	**Audrey Murphy**
Inspection No:	**14677**

The Regulation And Quality Improvement Authority
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General Information

Name of agency:	Positive Futures (Cookstown)
Address:	5 Oldtown Arcade Oldtown Street Cookstown BT80 8EF
Telephone Number:	028 86766246
E mail Address:	j.diamond@positive-futures.net
Registered Organisation/ Registered Provider:	Positive Futures Ms Agnes Philomena Lunny
Registered Manager:	Mr John James Diamond
Person in Charge of the agency at the time of inspection:	Mrs Jo Corcoran (acting manager in the absence of the registered manager)
Number of service users:	6
Date and type of previous inspection:	16 August 2012 : Primary Announced Inspection
Date and time of inspection:	26 September 2013 : 9:40 am – 6:30 pm
Name of inspector:	Audrey Murphy

Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect supported living type domiciliary care agencies. A minimum of one inspection per year is required.

This is a report of a primary inspection to assess the quality of services being provided. The report details the extent to which the standards measured during the inspection were met.

Purpose of the Inspection

The purpose of this inspection was to ensure that the service is compliant with relevant regulations, minimum standards and other good practice indicators and to consider whether the service provided to people supported was in accordance with their assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, procedures, practices and monitoring arrangements for the provision of domiciliary care, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Domiciliary Care Agencies Regulations (Northern Ireland) 2007
- The Department of Health, Social Services and Public Safety's (DHSSPS) Domiciliary Care Agencies Minimum Standards (2011)

Other published standards which guide best practice may also be referenced during the inspection process.

Methods/Process

Committed to a culture of learning, RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the Minimum Standards.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.

Specific methods/processes used in this inspection include the following:

- Analysis of pre-inspection information
- Discussion with the registered manager
- Examination of records
- Consultation with stakeholders
- File audit
- Evaluation and feedback

Any other information received by RQIA about this registered provider and its service delivery has also been considered by the inspector in preparing for this inspection.

Consultation Process

During the course of the inspection, the inspector spoke to the following:

People supported	6
Staff	6
Relatives	2
Other Professionals	0

Questionnaires were provided, prior to the inspection, to staff to find out their views regarding the service. Matters raised from the questionnaires were addressed by the inspector in the course of this inspection.

Issued To	Number issued	Number returned
Staff	13	11

Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to establish the level of compliance achieved with respect to the following quality themes:

The following four quality themes were assessed at this inspection:

- **Theme 1: People supported receive care in their own home**
- **Theme 2: Assessments, care plans, reviews and care practices reflect consideration of the human rights of the people supported**
- **Theme 3: Assessment and monitoring of quality of services**
- **Theme 4: Adult protection concerns are identified by the agency and followed through**

Review of action plans/progress to address outcomes from the previous inspection

The agency's progress towards full compliance with the one requirement and five recommendations made during the previous inspection (16 August 2012) was assessed. The agency has fully met the minimum standards in relation to the five recommendations made at the previous inspection. The agency has also been assessed as fully compliant with Regulation 15 (6) (d) in respect of the areas for quality improvement identified during the previous inspection of 16 August 2012.

The registered provider and the inspector have rated the service's compliance level against each good practice indicator and also against each quality theme.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

Profile of Service

The agency provides supported living type domiciliary care services to six individuals with a learning disability in the Cookstown area. The staff team is comprised of the registered manger, one deputy service manager, a senior support worker, eleven support staff and four relief staff. Services are provided to the people supported on a 24 hour basis.

The aims of the service are to:

- enable adults with a learning disability to lead fuller, more valued lives, and participate meaningfully as part of the wider community;
- enable individuals with a learning disability to establish and maintain a home they have chosen within the community;
- to promote the rights of the people supporedt and support them to exercise these rights as citizens, and enable them to understand the balance between rights and responsibilities;
- to provide a secure environment which recognises and responds to individual need; and
- to promote a culture of risk enablement by assessing risk and facilitating positive risk taking.

Each individual person supported is provided with a comprehensive person centred plan unique to their needs and aspirations. Each person supported also has in place a personal housing support assessment.

At the request of the people who use Positive Futures supported living services, Positive Futures has requested that RQIA refer to these individuals as 'the people supported'.

Summary of Inspection

The announced inspection was undertaken at the agency's registered office on 26 September 2013, 9:40 am – 6:30 pm. In the absence of the registered manager, the inspection was facilitated by Mrs Jo Corcoran, acting manager.

The inspector had the opportunity to meet with four of the people supported at the registered office and with a further two people supported who invited the inspector to meet with them in their home.

The inspector also met with the relatives of a person supported and with a number of agency staff, administration and management staff.

Prior to the inspection, agency staff were invited to return to RQIA a completed questionnaire in relation to their views on the quality of service provision. Eleven agency staff returned a questionnaire and feedback from the inspection visit and from the questionnaires was provided to the acting manager, Jo Corcoran, Positive Futures at the end of the inspection visit. Inspection outcomes were also discussed with Mr Paul Roberts, Managing Director, Positive Futures on 21 October 2013.

Feedback received from the people supported was very positive and several spoke of their independence being promoted by agency staff and of having a wide range of opportunities to experience activities both within their home and in the community. People supported and the relatives of a person supported also reported high levels of satisfaction with the quality of care provided and the agency staff's friendly and sensitive approach.

Agency staff who met with the inspector spoke with enthusiasm about their role in supporting the people supported and demonstrated their understanding of the ethos of supported living and in maximising independence and choices.

The inspector would like to thank the people supported, their relatives, and agency staff for their warm welcome and full cooperation throughout the inspection process.

Detail of inspection process:

Theme 1: People supported receive care in their own home

The people supported and relatives expressed high levels of satisfaction with the quality of care provided by Positive Futures staff in their homes.

All of the people supported have been issued with a tenancy agreement and an individual support agreement which outlines a range of rights and charges associated with the individual's care and support.

It was not clear from the agreements or from the service user guide (Information Handbook) however what the people supported were receiving in relation to the charges made to each of them for care and support. A requirement has been made in relation to this.

The people supported described a range of inputs from agency staff and highlighted skills they had developed in the areas of meal preparation, cooking, budgeting and maintenance of their home.

The arrangements in place to ensure that people supported experience exclusive possession of their home and have control over who enters their home were discussed with staff and the people supported. The homes of four people supported were noted to have an interconnecting door and it was evident that the use of this door by the people supported and agency staff had significantly compromised the privacy and security of the homes of the people supported.

A requirement was made in relation to this and it was recommended that the arrangements are reviewed, in light of the concerns raised with the inspector by the people supported.

The inspector was advised by the people supported of their wish to have agency staff join them in their evening meal. Agency staff confirmed that only evening meals are eaten in the homes of the people supported and there were records of reimbursements made to the people supported in respect of these costs and other costs associated with staff working in the homes of people supported on a consistent basis.

It was recommended that the agency's service user guide is reviewed and should include information for the people supported in relation to their right to opt out of these arrangements and if opting in, should be advised of the amounts paid to them in respect of staff costs.

The agency was assessed as "Not Compliant" for this theme.

Theme 2: Assessments, care plans, reviews and care practices reflect consideration of the people supported' human rights

The agency has developed policies and procedures in relation to restrictive practices and staff have received training in this area and in human rights.

Restrictive practice assessments had been undertaken for all of the people supported and it was noted that some restrictive interventions had been reviewed and removed from the care plans of people supported.

There were a number of restrictive interventions being implemented in the homes of the people supported including access to medication, money and levels of staffing within home of the person supported.

The inspector was advised of the arrangements in place to liaise with the Trust in scheduled review meetings in relation to the capacity of the people supported to consent to or decline care practices which are restrictive.

The agency was assessed as "Substantially Compliant" for this theme.

Theme 3: Assessment and monitoring of quality of services

The agency has in place a range of methods for the assessment and monitoring of the quality of services provided. The inspector discussed these with agency staff and examined a range of agency records.

The agency's monthly quality monitoring reports were examined and contained comprehensive information in relation to the quality of the services provided. The agency has developed a report format which is in accordance with RQIA's guidance on monthly quality monitoring. The monthly monitoring reports contained information obtained during consultations with people supported, their relatives and with professionals involved in the lives of the people supported.

The agency was assessed as "Compliant" for this theme.

Theme 4: Adult protection concerns are identified by the agency and followed through

The agency has in place a range of robust systems to contribute to the safeguarding of the vulnerable adults in receipt of a service.

Agency staff who contributed to the inspection reported they had all received training in safeguarding vulnerable adults and rated their knowledge of the reporting arrangements 'good', 'very good' or 'excellent'.

The agency maintains an updated Safeguarding Vulnerable Adults policy and procedure and this reflects the regional guidance and the expectations outlined within this theme.

There have been no safeguarding vulnerable adults referrals made by the agency in respect of any of the people supported however there was satisfactory evidence to provide an assurance that any such referral would be made in a timely manner and followed through appropriately.

The agency was assessed as “Compliant” for this theme.

Additional matters examined

Complaints

The agency’s complaints records were examined and there had been no complaints made in 2012 or in 2013.

Statement of Purpose

The agency’s statement of purpose was examined and continues to reflect the range and nature of service provided.

Service User Guide

The agency has produced an ‘Information Handbook for people using Positive Futures Supported Living Services’. An easy read version of this was examined and a plain English version was referenced within it.

The Information Handbook had been reissued in July 2012 and contains the organisation’s mission statement and summarises the nature and range of services provided. The handbook also outlines the organisational structure and details of the staffing arrangements, RQIA contact details, complaints information, and registration and inspection information are also included in the handbook.

The charging arrangements for care and support were discussed with agency staff as it was apparent that all of the people supported were making a contribution from their benefits to the care or support received. The Information Handbook states: ‘we may also ask you to pay for some of the help you get from staff from your DLA.’

It was not clear from the information in the handbook what additional services were received in light of these charges and a requirement has been made in this regard.

Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Number of Times Stated	Inspector's Validation of Compliance
1.	Regulation 15 (6) (d), 4.1, 4.2, 5.1, 5.2, 5.3, 8.3 and 8.6.	It is required that agency continue with the review and update their personal finance policy and procedures to ensure: • All people supported have individual assessments of their capacity to manage finances. • Financial support arrangements reflect the outcome of this and any support required. • Travel expenses collected are invoiced individually to ensure agreement has been sought.	People supported have undertaken financial capability assessments with agency staff; these have been signed by the people supported, agency staff and HSC Trust representatives. The outcome of financial capability assessments outlined the nature of support required. The arrangements for travel expenses to be invoiced were discussed with agency staff and with the people supported. The agency provides a car for the use of the people supported. The people supported were not aware of any costs associated with the routine use of the car and agency staff confirmed that people supported do not pay for the costs of the car, unless it is used to facilitate holidays for the people supported. Agency staff described the arrangements for people supported who use the car on holiday meeting some of the transport costs of other people supported in the absence of the agency's car.	One	Fully Met

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Number of Times Stated	Inspector's Validation of Compliance
			Arrangements of this nature were not included within Positive Futures' finance policies and it was recommended that the registered manager ensures all staff are familiar with, and work in line with the agency's policies and procedures and any revision thereof. The arrangements for people supported to avail of transport provided by agency staff using their own cars was discussed with agency staff. There was evidence of individual invoicing for miles travelled in accordance with the agency's procedures. Agency staff described a range of monitoring and oversight arrangements in relation to the people supported making payments to staff for transport costs.		

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Number of Times Stated	Inspector's Validation Of Compliance
1.	Standard 1.1, 2.1, 2.2, 4.1, 4.2, 8.6, 8.7, 8.8, 8.9, 9 (1-5) and Appendix 1.	It is recommended that the agency's organisational policies, procedures, processes and documents should show how they underpin the principles of the service users choosing where they live.	The agency's Referral and Assessment Policy and Procedure was examined and reflected the principles of the individuals choosing where they live. The agency's Guidance Document entitled "Supporting people to access our adult services or enter accommodation" was examined and had been re-issued in November 2012; the document clearly outlined the ability of individuals referred to the service to choose where they live and who they live with. The people supported who met with the inspector indicated that they had chosen where they live and that they remain happy with this choice.	One	Fully Met

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Number of Times Stated	Inspector's Validation Of Compliance
2.	Standard 4 (1-5).	It is recommended that the agency should show clearly how organisational policies, procedures, processes and documents support the separate provision of care and accommodation.	The people supported who contributed to the inspection outlined their understanding of their rights as tenants The agency's support agreements have been developed to clearly outline the separation of care and accommodation. The agency's Guidance Document entitled "Supporting People to access our adult services or enter accommodation" was examined. The document clearly outlined the separation of the care and support from the tenancy.	One	Fully Met
3.	Standard 6 (1-4), 8.6 8.7, 8.8, 8.9, 9 (1-5) and Appendix 1.	It is recommended that the agency's organisational policies, procedures, processes and documents clearly show how they underpin the principles of the service users choosing who supports them and how they are supported.	The agency's support agreements include the right of the people supported to choose who supports them. The agency involves people supported in staff matching; the agency also includes people supported in the recruitment and selection of care staff.	One	Fully Met

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Number of Times Stated	Inspector's Validation Of Compliance
			The agency's Guidance Document entitled "Supporting People to access our adult services or enter accommodation" was examined and reflected the agency's commitment to ensuring that individuals are consulted with regard to who supports them and how they are supported.		
4.	Standard 6 (1-4), 8.6, 8.7, 8.8, 8.9, 9 (1-5) and Appendix 1.	It is recommended that the agency clearly show that service users are aware that they can remain in their accommodation even if the provision of care is no longer required or no longer meets their needs.	The agency's revised support agreements were examined and outline the individual's rights in relation to changing their landlord and in changing their care / support provider.	One	Fully Met
5.	Standard 1.1, 2.1, 2.2, 4.1, 4.2, 8.6, 8.7, 8.8, 8.9, 9 (1-5) and Appendix 1.	It is recommended that the agency's organisational policies, procedures, processes and documents should underpin the principles of service users being able to choose who they share their accommodation with. The agency should further clearly demonstrate how they discuss and consult with the service users about who they share their accommodation with.	The agency's Referral policy and procedure had been re-issued to incorporate the agency's commitment to ensuring that people supported choose who they share their accommodation with. People supported have been issued with an Information Handbook which has been produced in an easy read version. The handbook outlines the ethos of Positive Futures Supported Living services.	One	Fully Met

THEME 1 – PEOPLE SUPPORTED RECEIVE CARE IN THEIR OWN HOME	
Statement 1 Service users receive care in their own home • The service user has a valid occupancy agreement (tenancy, licence etc.) that offers security of tenure; • The service user has an agreement specifying the number of support hours available to them individually; • The service user is enabled to understand rights and responsibilities of tenancy in a format suitable to their individual needs; • The landlord has no control over the care/support staff, the care/support staff have no control over housing; • The service user's home looks like his/her home and does not look like a workplace for care/support staff. •	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Each individual has their own Tenancy Agreement with their landlord. This is separate from their Support Agreement with Positive Futures which specifies the support each individual receives. The landlord has no control over support staff and there is no link between care / support and provision of accommodation. An Information Handbook regarding care and support is given to each individual. Most landlords provide an Easy Read Tenancy Handbook, which details tenant rights and responsibilities. We ensure that people understand their Tenancy Agreement by using appropriate methods of communication, as identified for the individual. This ensures that the individuals supported and/or their representative have an understanding of their rights and responsibilities associated with their tenancy. Within the homes of the people we support, there may be a room where staff sleep and/or a filing cabinet is kept to store necessary documentation (eg Care / Support Plans). Staff meetings take place in dedicated office space and therefore do not take place in the homes of the people supported by the Service. Staff do not bring other people supported by Positive Futures to the homes	Compliant

of the individuals we support uninvited. Any designated car parking space is only used by the person supported and there is no allocated staff parking. Staff can describe the rights and responsibilities associated with the tenancies of the people they support as well as give real life examples.	
Inspection Findings:	
As stated in the self-assessment, people supported have been issued with a tenancy agreement from Triangle Housing Association. Easy read tenancy agreements have also been made available to the people supported. The tenancy agreements do not make reference to care provision and outline the security of tenure of the people supported. The tenancy agreements set out the weekly rental and service charges and had been signed by the people supported. The agency's House Meeting Minutes contained evidence of discussions held between agency staff and people supported in relation to their tenancies. People supported, staff and relatives who contributed to the inspection advised that people supported are encouraged to personalise their homes. The inspector visited the home of two people supported and noted it to be comfortable and personalised by both people supported. A number of support agreements were examined and a revised version of the agreement had been developed for implementation on 1 October 2013. Revised support agreements reflected new transport arrangements. It was noted that all of the people supported were contributing towards the cost of some of their care or support and the support agreements outlined the amounts to be paid by people supported for their care or support. The support agreements of the people supported also outlined in detail the total care and support hours the individual is entitled to. It was unclear from the support agreements what the charges for care or support related to or if these charges were in respect of care needs assessed by the HSC Trust. A requirement has been made with regard to this.	Substantially Compliant

THEME 1 - PEOPLE SUPPORTED RECEIVE CARE IN THEIR OWN HOME	
Statement 2 Services users exercise control over who they live with and who enters their home: • The service user is in control of who enters their home and no-one else has keys to the accommodation without the permission of the service user; • The service user is consulted about who the accommodation is shared with; • The service user is not denied or restricted access to any part of their home that they have a right to as stated in their tenancy agreement; • The service user has exclusive possession of their own private accommodation. •	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
The people supported, and/or where necessary their representative, have keys to their own home. In addition, people supported can choose to have a lock for their bedroom door or a lockable cupboard / tin for the storage of personal items. Furthermore, we have reviewed our Keys and Alarms Policy to ensure the independence of the people supported is maximised. Where it is necessary for Positive Futures' staff to have a copy of keys, this is recorded and the agreement with the person supported and/or their representative is also documented. Support Agreements detail the fact that the people we support can ask staff to leave their home if they wish. In addition, when entering the homes of the people supported, staff must always knock and wait until they are let in. The people we support and/or their representative can describe how they are consulted with about shared accommodation. The people we support have unrestricted access within their home, including bedrooms, bathrooms and outdoor spaces. Staff presence does not intrude on the right to privacy. Real Tenancy Tests	Compliant

are being completed for each of the people supported by the Service, which include associated action plans.	
Inspection Findings:	
People supported have keys for their homes and reported they have free access to all areas of their home. All of the people supported indicated they were consulted about who they live with and are happy to continue sharing with their current co-tenants. Agency staff provide a 'sleepover' service in the homes of several people supported. The staff sleepover room is not accessible to people supported and this is outlined within their support agreements. Some people supported who met with the inspector described an interconnecting door between their home and the home of two other Positive Futures people supported. People supported and staff advised the inspector that the door was not secured as it is a fire door and a potential means of escape. The inspector was also advised that the housing association had installed the door prior to the tenants moving in to both houses. The use of the interconnecting door was discussed with people supported and agency staff. It was apparent from these discussions that there had been occasions when people supported had used the door to gain entry to the home of other people supported uninvited and unexpected. It was also apparent that agency staff would use the door to access people supported in both houses and in particular at night as agency staff would use the bathroom in one house and the 'sleepover' room in the other house. The right to privacy of the people supported was discussed and the inspector was concerned that the use of this door by agency staff and other people supported had compromised the privacy of the people supported and could potentially increase their vulnerability. The inspector was concerned that the use of the interconnecting door, rather than the front or back door of either house could result in people supported not experiencing full control of who enters their home. The inspector was also concerned that people supported may not experience exclusive possession of their home if they are not assured of who has access to their home.	Not Compliant

A requirement has been made with regard to the arrangements in place to ensure the safety and security of property of the people supported, including their homes; services provided to people supported must be in a manner which respects the privacy, dignity and wishes of people supported, and the confidentiality of information relating to them. The agency has undertaken work with individuals with regard to the Real Tenancy Test. However, the potential issues associated with the use of an interconnecting door were not identified in this work; people supported reported to the inspector that when the door is open there are potential and actual risks of other people supported entering their home uninvited. It was recommended that the agency review these arrangements within the homes of the people supported in light of the feedback provided to the inspector.	

THEME 1 –PEOPLE SUPPORTED RECEIVE CARE IN THEIR OWN HOME	
Statement 3 Service users receive a service designed around their individually assessed needs that enables autonomy and independence: • Care and support needs have been individually assessed by a multidisciplinary team, agreed with the service user and/or their representative; • Risks and risk taking have been formally considered and balanced with positive risk taking that enables autonomy and independence; • The level of staff presence for care/support in a service user's home has been assessed by a multi-disciplinary team, agreed with the service user and/or their representative, reflected in person-centred care plans and regularly reviewed at pre-determined intervals; • The service user has been consulted about who provides care and support.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Each individual supported has a Person Centred Portfolio (which contains their care / support plan) which reflects multidisciplinary assessment of their needs and how they wish their service to be provided. Support Agreements also evidence the support provided to each individual. Positive Futures has processes to support positive risk taking which is agreed with the individual and/or their representative as well as other appropriate professionals. There are adequate numbers of skilled staff available to ensure that the identified risks are appropriately managed. We ensure that staffing levels are adequate through staff establishments and rotas, which are agreed with the person supported and/or their representative as part of the initial multidisciplinary assessment of need. These are reviewed regularly. If a person no longer wishes to be supported by the Service or if they wish to change tenancy, they are supported to do so. This is detailed in our Move on and Termination of Tenancy Guidance. Bromford Assessment Plans enable greater levels of autonomy and independence.	Compliant

A “matching staff” person centred tool is carried out with every person supported to identify the characteristics of the people they wish to support them. The people we support are aware that they can decline some or all of the care / support they receive from staff	
Inspection Findings:	
The inspector examined a number of care and support plans which outline risks and arrangements in place to promote independence and safeguard people supported. There was evidence of risk assessments being read and signed by staff and people supported. There was also evidence within the risk assessments of the alignment of risks with potential human rights considerations. The risk assessments were noted to be up to date and reflected current needs and had been reviewed regularly, evidencing full involvement of people supported. Person centred risk assessments had been completed for those people supported who were being encouraged and supported to access the swimming pool, independent travel, time alone at home and to increase independence in the area of medication administration. People supported, staff and the relatives of a person supported described the arrangements in place to support people supported to choose who support them. There was evidence of staff matching with people supported and the use of rotas for people supported to advise them of who will be supporting them in their home.	Compliant

THEME 1 –PEOPLE SUPPORTED RECEIVE CARE IN THEIR OWN HOME	
Statement 4 The model of service provision is consistent with the ethos of a supported living service: • There is evidence available to demonstrate that the service user and/or their representative is at the centre of service provision and all decision making processes; • If living in shared accommodation, the service user can "opt in or out of" additional services, such as household contribution to groceries, meals provision; • Any routine has been individually devised by the service user to facilitate his/her preferred service provision.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
The people we support are at the centre of decision making processes and this is evidenced through their direct involvement in the creation of their Person Centred Portfolio, associated risk assessments, reviews and through the use of various person centred tools. Bromford Assessment Plans are in place for each of the people supported to facilitate personalised support. Staff have a clear understanding of the supported living model and how this works in practice. This understanding is gained through training and through use of our person centred processes. All the people we support and/or their representative opt-in or opt-out of any collective contribution arrangement for utility bills and groceries. The people supported, in conjunction with their representative (where relevant), get to choose where they live, who they live with, who supports them, what they do and ultimately how they live their lives. Individuals and/or their representatives have full control over what happens in their life and can make friendships and relationships with people on their terms. They are supported to live a healthy and safe life, whilst being able to take positive risks.	Compliant

Inspection Findings:	
The people supported and relatives who contributed to the inspection provided very positive feedback in relation to the care and support provided by agency staff. In particular, people supported described high levels of independence, autonomy and control in their lives and highly commended agency staff for their caring and sensitive input. It was also evident from these discussions that people supported are at the centre of service provision and that they have the ability to receive their care and support in a flexible manner, in accordance with their preferences and needs. It was apparent that people supported enjoy sharing a range of domestic and daily living tasks including shopping, meal preparation and cleaning. People supported described their preferences in these areas and how they had negotiated with fellow people supported with staff support, who would complete tasks on a daily and weekly basis. People supported described the arrangements for meals provision and groceries. People supported advised the inspector they are supported to meal plan and to shop independently of other tenants and encouraged to make their own individual choices. There were a number of arrangements in place to ensure that people supported have access to items of their choice. People supported and agency staff advised the inspector that agency staff are invited by people supported to share the evening meal with the people supported and that this provides the people supported with both practical and social support. The agency maintains a policy entitled 'Contributions from the people we support towards staff expenses when being supported in social activities – supported living and short break services'. The policy states: 'Where staff are required to support people to prepare and eat their meals, they may be entitled to eat their meals alongside people supported.'	Substantially Compliant

The arrangements in place to ensure that people supported are not financially disadvantaged by this agreement were discussed with agency staff and it was apparent that Positive Futures make a contribution to the joint bank accounts of the people supported in respect of staff meals and other costs associated with staff being at the home of people supported including utility costs. Staff confirmed they only eat meals with people supported at main meal times. The payments made to the accounts of the people supported were examined and appeared reasonable having been calculated on the basis of the numbers of staff providing support to people supported in their home and sharing the evening meal. However, it was not apparent during the inspection if people supported had been made aware that they could opt out of these arrangements and from discussions with people supported, it was evident that people supported were not aware of any reimbursements made to them by the agency in respect of costs incurred by agency staff. It is recommended that the agency's service user guide is reviewed and that people supported are made aware of their right to opt out of these arrangements and if opting in, should be advised of the amounts paid to them in respect of staff costs. The agency maintains a policy on eating out with people supported which outlines the amount people supported contribute towards the cost of a meal eaten by agency staff when supporting the person supported to eat out. The agency's service user guide does not include these charges and a requirement has been with in this regard.	

PROVIDER'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	**COMPLIANCE LEVEL**
	Compliant

INSPECTOR'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	**COMPLIANCE LEVEL**
	Not Compliant

THEME 2 - ASSESSMENTS, CARE PLANS, REVIEWS AND CARE PRACTICES REFLECT CONSIDERATION OF THE HUMAN RIGHTS OF THE PEOPLE SUPPORTED	
Statement 1 Service users participate in their needs assessment, care planning and reviews • Service users with communication needs have their communication needs assessed and there is a plan in place to promote the service user's ability to meaningfully engage in the assessment of their needs and care planning, and in the review of their needs and services; • Where there are communication needs identified, there are appropriate arrangements in place to promote effective communication; • Service users with significant communication needs are supported by non-agency representatives in the assessment and review of their needs and in care planning; • Service users are provided with information in an accessible format in relation to their human rights.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Where people we support have specific communication needs, these are assessed with the relevant professionals (eg Speech and Language Therapist) and a plan put in place to promote meaningful engagement and communication with the individual. Where appropriate, an individual's representative may assist in the identification and review of their needs. People supported participate in their needs assessment through the use of a range of person centred tools, including Communication Charts, Learning Logs, Participation Groups and House Meetings. Person centred tools are the foundation of an individual's Person Centred Portfolio and in turn their care / support planning. Information contained in Person Centred Portfolios informs the person centred review process and every effort is made to engage the person supported in this. Staff are trained on how best to gather the perceptions of the people they support (eg PECS, person centred tools). In addition, staff are provided with training on human rights.	Compliant

The people we support and/or their representative receive accessible information on human rights. A Human Rights and Restrictive Practice Policy is being developed.	
Inspection Findings:	
The agency maintains a person centred review policy and guidance and there was evidence of HSC Trust reviews of care practices with people supported fully involved in needs assessment, care planning and in the reviews of their services. People supported have their own individual portfolios which were noted to be colourful, pictorial and included a range of person centred tools including a communication network map, communication chart, information about vital objects and comprehensive 'how best to support' information. The information in the portfolios was noted to be very detailed and person centred and reflected the individual needs and preferences of the people supported. The communication needs of individual people supported were apparent within the care records and agency staff were knowledgeable and confident in their ability to communicate effectively with people supported. There was evidence from the records of house meetings of human rights being discussed with people supported and people supported had signed to indicate their receipt of a 'Understanding your human rights' document.	Compliant

THEME 2 - ASSESSMENTS, CARE PLANS, REVIEWS AND CARE PRACTICES REFLECT CONSIDERATION OF THE HUMAN RIGHTS OF THE PEOPLE SUPPORTED	
Statement 2 Agency staff can identify care practices which may impact on the human rights of service users • Agency staff have received training and or guidance on the Human Rights Act and how this impacts on service users; • The human rights of all service users are explicitly outlined in care records; • Care practices which impact on the human rights of service users are only undertaken if in accordance with a HSC Trust care plan; • The agency can provide evidence that there are no practices undertaken which impact on the service user's right to freedom from torture, inhuman and degrading treatment (Article 3, Human Rights Act); • There are arrangements in place to detect and raise with the relevant HSC Trust any concerns about potential or actual breaches of people supported' Article 3 rights; • All service users have unrestricted access to fresh air, daylight, snacks, fresh water and toilets; • Service users can form and sustain personal relationships.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
All staff receive training and guidance in human rights relevant to the lives of the people we support. We ensure staffing levels are adequate through the use of establishments and rotas are agreed with the person supported and/or their representative as part of the initial multidisciplinary assessment of need. These are reviewed regularly. Individuals supported and/or their representative are provided with easy read information to promote awareness of their human rights. Restrictive practices are identified within specific Risk Assessments. All restrictive practices are approved by our Managing Director and will only be implemented where absolutely necessary and where these are in the best interest of the individual supported. Any restrictions are signed by the people we support and/or their	Compliant

representative and are agreed with the Trust. There is a clear Challenging Bad Practice (Whistleblowing) Policy in place for staff and a complaints procedure for the people we support. Detailed risk assessments are in place which inform how the person is supported. A range of person centred tools are used to support the individual to form and maintain personal relationships and friendships on their terms. A Relationship Policy is being developed to provide greater clarity for the people we support and staff in relation to human rights in this area. Positive Futures works directly with accredited external consultants, (Studio III led by Dr Andy McDonnell) who are recognised as a leading authority on Restrictive Practice, to ensure we are aware of and integrate best practice.	
Inspection Findings:	
All of the agency staff who returned a questionnaire to RQIA indicated that they had received training in human rights. The content of the human rights training was examined ('Human Rights and Restrictive Practice Training') and discussed with staff who provided examples of upholding the rights to liberty and privacy of the people supported. Staff also demonstrated their understanding of the principle of least restriction when supporting people. The training content also included references to the relevant policies and legislation. Feedback had been obtained by Positive Futures from staff in relation to this training and this was noted to be positive. Agency staff had also received training in RQIA inspection themes and had opportunities to reflect on the learning from the serious case review of Winterbourne View. Agency staff confirmed that people supported are fully involved in their care planning and that agency staff proactively complete learning logs in respect of the individuals' identified care and support needs. Agency staff also confirmed that people supported are not subject to any care practices that would impact on their right to freedom from torture, inhuman and degrading treatment. There was evidence from the care records of the HSC Trust endorsement of support plans and of the inclusion within the records of human rights considerations.	Compliant

THEME 2 - ASSESSMENTS, CARE PLANS, REVIEWS AND CARE PRACTICES REFLECT CONSIDERATION OF THE HUMAN RIGHTS OF THE PEOPLE SUPPORTED	
Statement 3 Care practices which are restrictive in nature are undertaken in accordance with the HSC Trust needs / risk assessment and care plan and are reviewed regularly • The agency has developed a working definition of 'restrictive practice' which includes the use of physical restraint • The agency undertakes audits of 'restrictive practices' and can demonstrate a commitment to reducing these, in particular the use of mechanical or other means to restrict the service user's ability to leave their home or areas within their home freely; • The agency can demonstrate compliance with DHSSPS guidance in relation to restrictive practices • The agency engages with the HSC Trust regularly to review any 'restrictive practices'; • The principles of necessity, proportionality and least restriction can be evidenced in practice; • Care practices which are restrictive in nature impact only those service users who have assessed needs; • Where there are a number of service users, there are arrangements in place to evaluate the impact of restrictive practices on those service users who do not require any such restrictions.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Any restrictive practices are initially identified within Risk Assessments before being explored further in a Restrictive Practice Risk Assessment. All restrictive practices have to be approved by our Managing Director and will only ever be in place if deemed absolutely necessary and in the best interest of the individual supported. The principles of necessity, proportionality and least restriction are addressed within this assessment. The Service communicates directly with the Health Trust regarding any restrictions in place. All restrictive practices are documented on the Restrictive Practice Risk Assessment which is regularly reviewed, with a view to reducing / removing these practices, where possible. Any restrictions are signed by the people we support and/or their representative and agreed with the Trust.	Compliant

Staff have a clear understanding of what constitutes a restrictive practice, the rationale for these and the impact on the people they support. This working knowledge is enabled through a range of Organisational processes and training. We are currently developing a Human Rights and Restrictive Practice Policy. Where there is a restriction on a person supported due to someone else they live with, the impact is evaluated and actioned accordingly.	
Inspection Findings:	
The agency's staff training records were examined and provided evidence of training undertaken in Positive Behaviour Management, human rights, and restrictive practice training. The agency has developed a Restrictive Practices Policy which contains a definition of "restrictive practice" which includes a range of restrictions and descriptors. The policy also references the principles of necessity, lawfulness, proportionality and least restriction. There were a number of restrictive practices noted in the care records of people supported including one to one supervision and restricted access to medication and money. It was evident that these practices had been reviewed and staff provided examples of previous restrictions being reviewed and ceased in light of needs assessments. The agency's restrictive practice assessments had been reviewed in May 2013 and were scheduled for further review in November 2013. The assessments made appropriate references to the human rights of the people supported.	Compliant

THEME 2 - ASSESSMENTS, CARE PLANS, REVIEWS AND CARE PRACTICES REFLECT CONSIDERATION OF THE HUMAN RIGHTS OF THE PEOPLE SUPPORTED	
Statement 4 The capacity of service users to consent to or decline care practices is assessed, reviewed and documented • Service users who experience care practices which impact on their human rights have been given the opportunity to consent to or decline the proposed intervention; • Where there are concerns about the individual's capacity to meaningfully consent to care practices decision specific capacity assessment is undertaken in conjunction with the HSC Trust; • The agency participates in and informs 'best interests' decision meetings.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Restrictive Practice Risk Assessments detail any restrictions placed on the people supported by the Service. Any restrictions have to be approved by our Managing Director and consented to / signed off by the relevant individuals and/or their representative (depending on an individual's capacity) and the Trust. Human rights training for staff covers the rights of the people we support, particularly focusing on consent to care and treatment and the duty of care which staff have to the people they support. All the people currently supported by the Service have the capacity to meaningfully consent to care practices.	Compliant
Inspection Findings:	
The capacity of people supported to consent to restrictive practices was not documented within the care records of the people supported. The inspector was advised of the agency's plan in place to address this at forthcoming review meetings. A requirement was made with regard to this.	Moving Towards Compliance

PROVIDER'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Compliant

INSPECTOR'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Substantially Compliant

THEME 3 - ASSESSMENT AND MONITORING OF QUALITY OF SERVICES	
Statement 1 The registered person shall establish and maintain a system for evaluating the quality of the services which the agency arranges to be provided	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Positive Futures has an overarching Quality Management Framework in place. As a part of this, each month a monitoring report is completed on behalf of the Registered Person. There is a monitoring calendar in place which details the person responsible for completion of the monitoring. To maximise independence, provide fresh perspectives and share best practice, a range of different individuals undertake monitoring on behalf of the Registered Person (ie Senior Manager: Operations, Managing Director, Business Excellence Manager and other Service Managers). There is detailed guidance on how to complete this report to ensure consistency of approach. This process includes review of key documentation and discussion with key stakeholders. There is a documented record of the completed monitoring which includes associated actions with timeframes. In addition, an Annual Consultation Exercise is carried out with key stakeholders including Trust personnel and families / carers. This adopts a questionnaire and focus group methodology. Central to this process is the collation of perception data from the people supported by the Service and action planning in response to this. Furthermore, there is an internal auditing process of quality and compliance carried out by the Business Excellence Department. This process identifies a range of recommendations for the Service. The Service Manager also regularly monitors the quality of the Service, which includes a range of unannounced visits.	Compliant

Inspection Findings:	
The agency's arrangements for quality monitoring are set out in the Statement of Purpose which makes reference to annual quality audits and monthly quality monitoring of the supported living service. The Statement also outlines the quality monitoring undertaken the relevant HSC Trust. As outlined in the self assessment, the registered person has a range of measures in place to evaluate the quality of the services provided including monthly quality monitoring visits undertaken on behalf of the registered person by a member of Positive Futures management. The agency has undertaken a 'Your Voice Counts' survey and has produced and shared with people supported the outcomes of the survey. People supported, agency staff and relatives who contributed to the inspection all confirmed that their views are sought on a regular basis in relation to the quality of service provision and that their views are used to shape improvements within the service.	Compliant

THEME 3 - ASSESSMENT AND MONITORING OF QUALITY OF SERVICES	
Statement 2 Assessment of the quality of services provided is undertaken on a monthly basis and a report is prepared which reflects the registered person's assessment of the: a) Quality of services provided b) the views of service users and their representatives c) the agency's response to areas of quality improvement identified by RQIA	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
A detailed quality monitoring report is completed on a monthly basis. This process includes review of key documentation (including actions as identified by RQIA) and discussion with key stakeholders, which include the views of the people we support and their representatives. Each monitoring form has associated actions. Completion of these actions are owned by the Service Manager and followed up at the next monitoring visit.	Compliant
Inspection Findings:	
The agency has developed their monthly quality monitoring recording template to include the previous action plan on the front page alongside progress towards completion of actions identified from previous visits. The agency maintains a list of contact details for the people supported and these include comments in relation to preferences of the relatives of the people supported regarding contact for the purposes of monthly quality monitoring. Quality monitoring was discussed with agency staff and people supported during the inspection. From these discussions it was apparent that the individual undertaking the quality monitoring visit speaks with staff and people supported, visits them in their homes, examines portfolios, speaks to staff about safeguarding, supervision, support. Recommendations made during the visits are discussed and shared with staff during visits.	Compliant

The reports of the monthly quality monitoring visits of May, June, July and August 2013 were examined and had been completed on behalf of the registered person by a number of Positive Futures managers. The reports were comprehensive and included the views of people supported, staff, relatives and professionals. The reports also outlined in detail actions to be taken, by whom, the timescale and progress towards completion.	

THEME 3 - ASSESSMENT AND MONITORING OF QUALITY OF SERVICES	
Statement 3 Assessment and monitoring of quality of services is undertaken in accordance with RQIA published guidance 'Monthly Quality Monitoring by Registered Persons' (March 2012)	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
The monthly monitoring process was designed on the basis of the RQIA published guidance ('Monthly Quality Monitoring by Registered Persons' (March 2012)). Additional areas were added to further meet the needs of the Organisation and the people we support. We continue to review and refine this process and have a Monitoring Working Group who aim to improve this process.	Compliant
Inspection Findings:	
The monthly quality monitoring checklist developed by the agency is in accordance with RQIA published guidance and includes a range of additional areas being kept under review by the provider.	Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Compliant

INSPECTOR'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Compliant

THEME 4 - ADULT PROTECTION CONCERNS ARE IDENTIFIED BY THE AGENCY AND FOLLOWED THROUGH	
Statement 1 Agency staff can identify safeguarding concerns, record and report these in a timely manner to the agency manager • Staff have received training in types of abuse, symptoms of abuse and reporting procedures; • Records confirm that safeguarding concerns have been communicated to the agency manager; • Service users are free from risks posed by other service users and do not experience assaults from other service users or have their property damaged; • Staff can identify when service users are experiencing distress, mental / physical suffering and take appropriate action; • Staff intervene appropriately in the event of service users experiencing threats or assaults from other service users or damage to their property.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
We have both Safeguarding Vulnerable Adults and Children Policies which aim to ensure that staff & volunteers understand & recognise abuse, neglect & exploitation of children & vulnerable adults & how to respond, including recording & reporting requirements. We consult with people we support when we review these. Staff receive periodic training on safeguarding in line with RQIA requirements. Vulnerable Adults issues are also discussed at Participation Group meetings. We assess the compatibility of people living together before support is provided and on an ongoing basis. If any individual is subjected to behaviour from a person they live with which results in distress, property damage, threats, assaults etc we support them and/or their representative to complain and bring this to the attention of relevant Trust personnel. All risks posed to the people supported are detailed in individual Risk Assessments and, where appropriate,	Compliant

identified within the Operations Risk Register. The Service has also considered the learning from external Vulnerable Adults issues (eg Serious Case Review of Winterbourne View Hospital). Our safeguarding processes are systematic & ensure that, should any safeguarding issues arise, there is clear documentary evidence.	
Inspection Findings:	
The agency maintains a Safeguarding Vulnerable Adults Policy which had been re-issued on 19/04/13. The policy clearly sets out the role of statutory agencies in the safeguarding of vulnerable adults and the role of the agency to respond to suspected or actual abuse. The types of abuse are outlined along with a procedure for staff to follow in the event of a disclosure or observation of an abusive situation. The signs of abuse are also outlined and reference is made to the Warwickshire County Council's Learning Disability Service 'Hate and Mate Crime Handbook, 2012. Reporting and recording requirements are outlined. Attached to the policy and procedure is a flow chart which summarises the procedure for safeguarding vulnerable adults and includes the agencies to be notified including PSNI, RQIA, HSC Trust, as appropriate. The Safeguarding Vulnerable Adults policy sets out the individual human rights and makes specific references to Article 1, Article 3 and Article 5. 'The people we support have the right to feel safe and secure in their own home and be protected from the impact of the behaviour of anyone they live with'. The agency's policy and procedure outlines the role of the HSC Trust and the agency's cooperation with the Trust investigation or assessment. The agency aims to report any concerns to the HSC Trust, to implement the protection plan, to consider capacity and consent issues, and to record the Trust's assessment of the referral including maintaining a record of any decision to 'screen out' referrals. There is also the expectation noted that staff are informed of when the case is closed. The agency also maintains a Safeguarding Children Policy – re-issued 19/04/13 which has a procedural flowchart which reflects ACPC guidance (2005). The contact numbers of the out of hours Positive Futures staff are listed alongside the numbers of the HSC Gateway teams. Agency staff confirmed they had received safeguarding training and were confident in their ability to implement the agency's procedures. Agency staff reported they have not made any safeguarding referrals to the HSC Trust.	Compliant

The agency's records of meetings with people supported provided evidence that the safeguarding vulnerable adults policy had been discussed with people supported during house meetings. The content of the 'Safeguarding Adults at risk in group care' training was examined and contained a definition of a vulnerable adult and a number of exercises and case studies. Safeguarding Adults at Risk in Group Care – Awareness Raising Workbook also examined and was reported to have been completed by agency staff prior to the training. The inspector examined 'Post Course De-Briefing' records and these reflected the individual's staff member evaluation of the training and how they would apply the learning to their practice. Agency staff confirmed they would respond appropriately to any indications or expressions of distress or physical/mental anguish from people supported. Agency staff also confirmed their understanding of the rights of people supported in relation to protection within their home from other people supported.	

THEME 4 - ADULT PROTECTION CONCERNS ARE IDENTIFIED BY THE AGENCY AND FOLLOWED THROUGH	
Statement 2 Systems are in place to ensure that safeguarding concerns are reported by the agency in accordance with policies and procedures • Safeguarding concerns are reported immediately to the HSC Trust designated person and other agencies as required (i.e. PSNI, Emergency Services, RQIA) and confirmed in writing within 2 working days. Service users' relatives / representatives should be informed when appropriate.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Within our Safeguarding Vulnerable Adults Policy and Safeguarding Children Policy, there are clear reporting procedures, flowcharts and forms. Any concerns identified through referrals, complaints, Risk Assessments, consultations, records or monitoring are communicated accordingly to the relevant internal manager and external agency / agencies. The contact details of the HSC Trust designated person are detailed within the relevant policies. Staff receive coaching on safeguarding at induction as well as formal training aimed at ensuring the safeguarding of adults and children. Staff have completed either Learning Disability Qualifications (LDQ), the Learning Disability Award Framework (LDAF) or the Positive Futures Foundation Programme (PFFP) which is signed off and confirms their knowledge and competency in handling safeguarding issues.	Compliant
Inspection Findings:	
As stated in the self-assessment, the agency's Safeguarding Vulnerable Adults policy and procedures set out the agency's responsibility to immediately report to the HSC Trust any safeguarding concerns and to follow these up in writing within two working days.	Compliant

All agency staff returned a questionnaire and indicated in these that they rated their knowledge of the agency's procedures for reporting safeguarding concerns as 'Good', 'Very Good' or 'Excellent'. Staff also indicated in their questionnaires that they felt that incidents of suspected, alleged or actual abuse are reported and investigated in accordance with the agency's procedures. The acting manager advised the inspector that there had been no incidents of alleged, suspected or actual abuse within the supported living service. The circumstances of a person supported were discussed in relation to the agency's management of risk when the person supported independently accesses the community. It was evident from these discussions that agency staff were appropriately responding to the risk posed by the person supported when exercising their right to leave their home independently. There was evidence of liaison with the HSC Trust, GP of the person supported, the PSNI and the regional emergency social work service in support of this individual. The registered manager had previously discussed these circumstances with the inspector during the inspection year.	

THEME 4 - ADULT PROTECTION CONCERNS ARE IDENTIFIED BY THE AGENCY AND FOLLOWED THROUGH	
Statement 3 The agency ensures it records the outcome of the HSC Trust screening of the VA referral and any immediate protection plan agreed with the Trust to ensure the service user/s safety.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
In the case of a Vulnerable Adult issue, the HSC Trust designated person will screen the issue. The Trust will then investigate the Vulnerable Adult issues in accordance with their procedures. Records, Risk Assessment, Person Centred Portfolios and meeting minutes confirm implementation of the immediate protection plan required. Records within the Service detail agreement / disagreement with the Trust's screening decision.	Compliant
Inspection Findings:	
The agency's Safeguarding Vulnerable Adults policy and procedure sets out the agency's responsibility to record the outcome of the HSC Trust's screening and to record the agency's agreement with this. The procedure also makes reference to the agency's implementation of any agreed immediate protection plan. The agency's Safeguarding Vulnerable Adults policy and procedure outlines the role of the HSC Trust and the agency's cooperation with the Trust investigation or assessment. The agency aims to report any concerns to the HSC Trust, to implement the protection plan, to consider capacity and consent issues, and to record the Trust's assessment of the referral including maintaining a record of any decision to 'screen out' referrals. There is also the expectation noted that staff are informed by the relevant HSC Trust representative when the case is closed.	Compliant

THEME 4 - ADULT PROTECTION CONCERNS ARE IDENTIFIED BY THE AGENCY AND FOLLOWED THROUGH	
Statement 4 The agency is included in the VA case discussion convened by the Trust designated person and contributes to the protection plan as directed by the Trust	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Positive Futures fully cooperates in any Vulnerable Adult case discussions and fully contributes to any protection plan. Relevant Risk Assessments are reviewed and support information is updated following any Vulnerable Adult issue. This is communicated to staff in Team Meetings	Compliant
Inspection Findings:	
As there had been no referrals made to a HSC Trust with regard to safeguarding issues, there were no records of case discussions to examine. However, discussion with agency management provided evidence to support the self-assessment. The agency's Safeguarding Vulnerable Adults policy and procedures set out the role of the HSC Trust in the investigation of safeguarding concerns and the agency's role in fully cooperating with all stages of the investigation and implementation of any protection plan.	Compliant

THEME 4 - ADULT PROTECTION CONCERNS ARE IDENTIFIED BY THE AGENCY AND FOLLOWED THROUGH	
Statement 5 The agency is included in the monitoring and review of the VA protection plan. The agency is informed when the VA concerns have been resolved and the VA case closed.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Positive Futures fully cooperates in the monitoring and review of any Vulnerable Adult protection plan. Managers and staff are aware of the process and how to resolve Vulnerable Adult issues. All meetings held with the HSC Trust designated person in relation to a Vulnerable Adult issues are minuted. Relevant Risk Assessments are reviewed and support information is updated as required following any Vulnerable Adults issue. This is communicated with staff in Team Meetings.	Compliant
Inspection Findings:	
As stated in the self-assessment and in Statement 3, the agency's Safeguarding Vulnerable Adults policy and procedures outline the agency's role in the on-going monitoring and review of the protection plan and cooperation with the HSC Trust. The procedures also prompt staff to note when the HSC Trust have closed the vulnerable adults' case.	Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Compliant

INSPECTOR'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Compliant

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Jo Corcoran, acting manager, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Enquiries relating to this report should be addressed to:

Audrey Murphy
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
BT1 3BT

Quality Improvement Plan

Announced Primary Inspection

Positive Futures (Cookstown)

26 September 2013

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Jo Corcoran, acting manager during the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Statutory Requirements

This section outlines the actions which must be taken so that the Registered Person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Domiciliary Care Agencies Regulations (NI) 2007

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	14 (d) (e)	Where the agency is acting otherwise than as an employment agency, the registered person shall make suitable arrangements to ensure that the agency is conducted, and the prescribed services arranged by the agency, are provided— (d) so as to ensure the safety and security of service users' property, including their homes; (e) in a manner which respects the privacy, dignity and wishes of service users, and the confidentiality of information relating to them; This requirement refers to the use of an interconnecting door between the homes of the people supported.	One	The interconnecting door between the two homes of the people we support is now locked.	Two months from date of inspection – 21 November 2013
2.	6 (1) (b)	The registered person shall produce a written service user's guide which shall include— (b) the terms and conditions in respect of the services to be provided to service users, including details as to the amount and method of payment of fees, if appropriate; This requirement refers to the payments charged to people supported for care or support received.	One	This requirement regarding care and support is already met in the revised version of the Information Handbook and Support Agreement.	Two months from date of inspection – 21 November 2013

3.	15 (5) (a) (b) (c)	The registered person shall, for the purpose of providing prescribed services to service users, so far as is practicable – (a) Ascertain and take into account the service user's and where appropriate their carer's, wishes and feelings; (b) Provide the service user, where appropriate their carer, with comprehensive information and suitable choices as to the prescribed services that may be provided to them; and (c) Encourage and enable the service user, and where appropriate their carer, to make informed decisions with respect to such prescribed services. This requirement refers to the capacity of the people supported to consent to or decline care practices which are restrictive in nature.	One	The Lakeland Supported Living Service was assessed as compliant for this theme based upon the same evidence. The Restrictive Practice Assessment form has been amended to reflect a determination of the person's capacity to consent or decline restrictive practices. There is, however, no regional guidance on how a determination of capacity can / should be undertaken within supported living services in situations such as this. Positive Futures will work with the Trust to ensure that this requirement is met.	Four months from date of inspection – 23 January 2014

Recommendations

These recommendations are based on The Domiciliary Care Agencies Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the Registered Person may enhance service, quality and delivery.

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	1.4	It is recommended that action is taken, where necessary, following receipt of feedback and comments to make improvements to the quality of the service. This recommendation refers to the feedback received from the people supported in relation to the use of an interconnecting door between two homes of the people supported .	One	We will ensure that any feedback or comments made by the people we support inform improvements to the quality of the Service. The interconnecting door is now locked.	Two months from date of inspection – 21 November 2013
2.	2.2	It is recommended that the agency's service user guide is revised in relation to the general terms and conditions for receipt of the agency's services. This recommendation refers to the arrangements for agency staff to avail of a meal in the home of the people supported and for reimbursements made to the people supported in respect of costs incurred by agency staff. The people supported should be made aware of their right to opt out of these arrangements and if opting in, should be advised of the amounts paid to them in respect of staff costs.	One	The Information Handbook has been amended as required.	Two months from date of inspection – 21 November 2013

3.	8.3	It is recommended that the registered manager ensures that all staff are familiar with, and work in line with the agency's policies and procedures and any revision thereof. This recommendation refers to the monitoring and oversight of any agreements between the people supported and staff in respect of transport; in particular, any arrangements for the provision of transport to the people supported should be in accordance with the agency's policies and procedures.	One	Positive Futures ensures that staff are familiar and work in line with all policies and procedures.	Two months from date of inspection – 21 November 2013

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

NAME OF REGISTERED MANAGER COMPLETING QIP	John Diamond
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Agnes Lunny

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	✓	Audrey Murphy	14/05/14
Further information requested from provider			