PRIMARY INSPECTION

Name of Agency:	**Positive Futures (Lisnaskea)**
Agency ID No:	**11020**
Date of Inspection:	**18 September 2013**
Inspector's Name:	**Jim McBride**
Inspection No:	**14676**

The Regulation And Quality Improvement Authority
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General Information

Name of agency:	Positive Futures (Lisnaskea)
Address:	Unit 16, Manderwood Park Drumhaw Lisnaskea BT92 0FS
Telephone Number:	028 67724700
E mail Address:	joanna.clarke@positive-futures.net
Registered Organisation / Registered Provider:	Positive Futures Ms Agnes Philomena Lunny
Registered Manager:	Ms Joanna Clarke (Registration pending)
Person in Charge of the agency at the time of inspection:	Ms Joanna Clarke (Registration pending)
Number of service users:	8
Date and type of previous inspection:	2 August 2012, Primary Announced Inspection Announced Finance Inspection 16 May 2013
Date and time of inspection:	18 September 2013 primary announced inspection 9.30 am – 2.30 pm
Name of inspector:	Jim McBride

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 service users 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:

Service users	5
Staff	5
Relatives	0
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. The inspector has added individual comments to the body of this report.

Issued To	Number issued	Number returned
Staff	25	10

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: Service Users receive care in their own home**
- **Theme 2: Assessments, care plans, reviews and care practices reflect consideration of the service users' human rights**
- **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

All requirements /recommendations issued during the last primary inspection have been completed by the agency and have been fully met.

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 domiciliary care services in a supported living environment; the service currently operates within the Lisnaskea and Enniskillen area of the Western Health and Social Care Trust. The service is currently provided to 10 individuals with a learning disability and they are supported by 27 staff. The aims of the service are clear and stated on their statement of purpose: to enable adults with a learning disability to lead fuller, more valued lives, and participate meaningfully as part of the wider community; to 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 they support; to 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; 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 and housing support assessment; this assessment looks at specific areas such as:

- Assessment of need.
- Personal support tasks.
- Housing support tasks.

Statement Of purpose

The agency's statement of purpose was examined and reflected the nature and range of services provided by Positive Futures at the time of the inspection. The document was reviewed 16 June 2013.

Summary of Inspection

The announced inspection took place on the 18 September 2013. The inspector reviewed actions completed by the agency in line with the requirements/ recommendations issued during the last primary inspection. The actions completed by the agency in relation to these were assessed as fully met by the inspector. The inspector had the opportunity to meet with five staff who provide service to people supported in their own home.

The inspector discussed with the manager and staff, the principles of supported living, quality monitoring and human rights.

The manager verified to the inspector that she had informed the people supported during their house meetings of the inspection visit and the inspector had the opportunity to speak with five people supported.

All comments received from the people supported and staff have been added to this report. The manager, staff and people supported interviewed during the inspection described the scheme as having effective communication that is integral to the provision of good quality care and this enables and supports:

- Independence
- Informed choice

Staff training and the ethos of the agency show clear ways in which staff can deliver active support to the people individually.

Care and support is delivered in a person centred way, this was verified by the manager and staff on duty who were able to discuss the comprehensive referral system and positive actions in place to encourage individual wishes and choices.

The inspector would like to take the opportunity to thank the staff, and the people supported for the help and cooperation afforded to him during this inspection.

People supported comments

"This is better than living in hospital"
"I'm free to do what I want"
"Staff support me and listen to me"
"I can choose what I want to do and staff help"
"Supported living is good for me"
"Staff are great and help me with what I want"
"I have no restrictions I can come and go as I please"
"Positive futures understand me and what I want"

Staff comments

"Induction was comprehensive and informative"
"Supervision is one to one and you are free to discuss anything"
"Management have an open door policy"
"We have a great team and communicate well with each other"
"This is not like work it's a pleasure"
"The people supported come first, their human rights and life is important to us"
"We encourage empower and support individuals"
"Training is excellent and a great learning experience"
"We believe in the person centred approach to support"

Staff questionnaires returned to RQIA.

10 questionnaires were received prior to inspection.

The ten questionnaires returned indicated the following:

- Protection from abuse training was rated as excellent
- Care/support plans meet tenants needs
- Tenants views and experiences are taken into account
- Monthly monitoring takes place
- Staff are aware of the main principles of supported living and stated :-

"Live as independent as possible"
"Support to the level they want"
"Non-restrictive practice"
"People supported have ownership of their homes"
"Individual support on a personal basis"
"Person centred support"
"Choice and empowerment"

The staff members also stated that systems are in place to ensure the people supported individual opinions are heard they include:-

- Face to face discussion with staff
- Compliments and complaints procedure
- House meetings
- Open door policy
- Hi Life Group
- Rapport with keyworkers
- ACE consultation
- Monitoring visits

The areas indicated previously were verified by:

- Staff meetings records
- House meeting records
- Discussion with the manager
- Monthly monitoring visit records
- Staff training records.
- Discussions with tenants
- Minutes of Hi Life group meetings

Detail of inspection process:

Theme 1: Service Users receive care in their own home: The agency has achieved a compliance level of "Compliant" for this theme.

The agency has demonstrated a commitment to this theme; the agency has in place documentation showing the following:

- Individual tenancy agreements (landlord specific)
- Individual care agreements showing care needs agreed with and by the people supported.
- Documentation stating the move on process
- Person centred plans
- REACH assessments for all the people supported

The agency has provided supporting evidence of this theme in its statement of purpose and the person supported assessments which describe supported living as people being able to:

- Live where they want to live
- With people they want to live with
- Being supported by who they want to support them
- Doing the thing they want to do, with the people they want to be with.

The above was discussed with staff and managers during the inspection and the staff were able to put supported living into context, whilst discussing choice, individuality and person centred planning. Staff stated:
"Live as independent as possible"
"Support to the level they want"
"Non-restrictive practice"
"People supported have ownership of their homes"
"Individual support on a personal basis"
"Person centred support"

"Choice and empowerment"

Theme 2: Assessments, care plans, reviews and care practices reflect consideration of the service users' human rights: The agency has achieved a compliance level of "Compliant" for this theme.

The agency has in place comprehensive risk assessments describing capacity as well as measuring the ability of individuals to achieve greater independence and choice in daily living. The agency manager and staff have received individual training on human rights and this was evident in records examined, as well as during discussion with the manager. Staff interviewed were able to demonstrate their understanding and commitment to human rights for individuals supported citing choice, and person centred planning, risk management and assessment of need as the important areas of their model of care. The people supported have in place risk assessments that have been developed with the individual and the trust. The agency also has in place individual risk assessment documentation that clearly shows the human rights article pertaining to the risk. The agency has demonstrated a commitment to human rights endeavouring to incorporate them into policy and procedure and daily use.

Theme 3: Assessment and monitoring of quality of services: The agency has achieved a compliance level of "Compliant" for this theme.

The agency has demonstrated a commitment to quality monitoring. The monthly reports reflect action plans being taken forward and include contact with people supported and staff gaining views and feedback from them. The reports also show outcomes for tenants in relation to care/support and tenancy. During discussions with staff it was clear they are aware of the monitoring visits and were able to discuss outcomes for the people supported.

Theme 4: Adult protection concerns are identified by the agency and followed through: The agency has achieved a compliance level of "Compliant" for this theme.

The agency provided supporting evidence of training and development in relation to protection and the last training completed was 13 May 2012. The manager and staff described the use of their documentation and policy. The manager and the adult protection team discuss referrals to the team as well as the decisions made. The manager stated that she and the safeguarding team have both to be assured that any referral or individual risk is fully assessed to ensure further actions if any to be completed in accordance with the Protection Of Vulnerable Adults policy.

Additional matters examined

Monthly Quality Monitoring Visits by the Registered Provider

The inspector read the last three months monitoring reports in place. Action plans have been completed by the manager. Evidence of discussion with the people supported and relatives is in place.

Staff training:

The following staff training has been completed by staff:

Positive behaviour management 14 January 2012
Human rights awareness 3 April 2013
Safeguarding 13 May 2012
Medication training 6 June 2013
Active support 15 May 2012
Restrictive Practice 20 June 2012
Finance training 8 May 2012

The agency has completed their annual “your voice counts survey” and the inspector has added some of the comments received by the people supported on the quality of the service citing what’s working and what’s important to them. The manager informed the inspector that this information was gathered at a focus group for the people supported in this service.

Individual Comments made by some of the people supported

“Staff are honest”
“They try more than their best”
“I like taking part in the “Hi Life Group”
“Good support always someone to talk to”
“Staff help me with worries and the other things to help and they support me to sort things out”
“I feel happy and safe”

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.	**Completed :** The agency had a finance inspection on 16 May 2013 in which a number of requirements were made and a further quality improvement plan was issued, this was returned to the RQIA and approved 2 August 2013. The inspector was advised of the arrangements for the provision of transport to service users including the occasional use of staff cars. Individual invoicing is in place.	**One**	**Fully Met**

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Number of Times Stated	Inspector's Validation Of Compliance
1.	Regulation 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 people supported 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.	**One**	**Fully Met**
2.	Regulation 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 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.	Regulation 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 people supported choosing who supports them and how they are supported.	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.	**One**	**Fully Met**

4.	Regulation 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 people supported 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.	Regulation 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 people supported being able to choose who they share their accommodation with. The agency should further clearly demonstrate how they discuss and consult with the people supported 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.	**One**	**Fully Met**

THEME 1 - SERVICE USERS 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 of the individuals we support uninvited. Any designated car parking space is only used by the person	Compliant

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:	
The inspector examined both tenancy and care/support agreements in place for individual people supported. These documents verify the separation of, the service users' accommodation from their care provider. Each tenant has in place an agreement specifying the number of support hours available to them individually.	Compliant

THEME 1 - SERVICE USERS 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 or key pad 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. All the people supported in this Service have their own keys to their homes. Staff do not have keys to any homes of the people we support. 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,	Compliant

bathrooms and outdoor spaces. Staff presence does not intrude on the right to privacy. Real Tenancy Tests are being completed for each of the people supported by the Service, which include associated action plans	
Inspection Findings:	
People supported have in place individual care/support agreements as well as risk assessments pertaining to individual need. The agency adheres to person centred planning and this was verified in records available as well as staff and persons supported discussion during the inspection. The people supported are aware of staff involved in care/support and each one has an individual keyworker. Evidence of individual reviews was in place on all records read by the inspector. The manager verified that the people supported are in control of who enters their home and no-one else has keys to the accommodation without the permission of the individual tenancy holders. There is no restricted access to the individual accommodation. During inspection it was clear to the inspector that individuals choose who enters their home with permission. The manager and staff were able to describe the discussions held recently with a person supported about sharing their house.	Compliant

THEME 1 - SERVICE USERS 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. Active Support Plans enable greater levels of autonomy and independence. 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.	Compliant

Inspection Findings:	
Individual care/support plans are comprehensive and person centred, risk assessments are individual and reviewed regularly. The agency has stated in their agreements that individuals can opt out of services currently provided. There is evidence of people supported involvement in all aspects of care/support including review and risk assessment. The agency has in place records of regular reviews of the people supported and action plans to ensure needs are met. The agency has in place a matching process that shows evidence of the people supported being consulted about who provides their individual support.	Compliant

THEME 1 - SERVICE USERS 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. Active Support Plans are also being rolled out 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 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:	
Individual care/support plans are comprehensive and person centred, risk assessments are individual and reviewed regularly. The agency has stated in their agreements that individuals can opt out of service. There is evidence of people supported involvement in all aspects of care/support including review and risk assessment. The agency has in place records of regular reviews of the people supported and action plans to ensure needs are met. The agency has in place a matching process that shows evidence of the people supported being consulted about who provides their individual support. Person centred planning is individually devised by the service user to facilitate his/her preferred service provision. The current service users have agreements in place about food bills and share some costs, bills etc. are divided equally between the tenants for those sharing.	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 2 - ASSESSMENTS, CARE PLANS, REVIEWS AND CARE PRACTICES REFLECT CONSIDERATION OF THE SERVICE USERS' HUMAN RIGHTS	
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 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:	
Evidence was in place of human rights information being provided to individual people supported. Any current person supported with communication difficulties has in place a current and up to date risk assessment to help with their understanding of their rights. Reviews and monthly meetings gives people supported the opportunity for any clarification needed of any areas of concern. The inspector read a number of meeting records in place. The people supported are provided with information in a useable format for them individually.	Compliant

THEME 2 - ASSESSMENTS, CARE PLANS, REVIEWS AND CARE PRACTICES REFLECT CONSIDERATION OF THE SERVICE USERS' HUMAN RIGHTS	
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 service users' 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 representative and are agreed with the Trust. There is a clear Challenging Bad Practice (Whistleblowing)	Compliant

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:	
Staff have attended human rights training records in place show this was completed. Staff interviewed stated their understanding of individual rights. Care/support plans are comprehensive and individual the human rights of all service users are explicitly outlined in care records/risk assessments.	Compliant

THEME 2 - ASSESSMENTS, CARE PLANS, REVIEWS AND CARE PRACTICES REFLECT CONSIDERATION OF THE SERVICE USERS' HUMAN RIGHTS	
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:	
Restrictive practice assessments in place is approved by the seniors managers and the local trust multi-disciplinary team and procedures agreed by them the agency and the person supported. The inspector read a number of the risk assessments in place for the people supported. The agency's policy and procedures outline the definitions of restrictive and restraint.	Compliant

THEME 2 - ASSESSMENTS, CARE PLANS, REVIEWS AND CARE PRACTICES REFLECT CONSIDERATION OF THE SERVICE USERS' HUMAN RIGHTS	
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. Positive Futures participates in any best interest discussions or meetings where there are issues about any individual's capacity to consent to any support or interventions.	Compliant
Inspection Findings:	
All restrictive practice is approved by the seniors managers and the local trust multi-disciplinary team and procedures agreed by them the agency and the person supported. The people supported are given the opportunity to discuss any restrictive practice. One person supported stated to the inspector that he was aware of his restrictions and does have the chance to discuss this with staff.	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 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 has a range of processes for monitoring the quality of the service including:- Staff supervision (all records of dates were read by the inspector. These were up to date and in line with policy)	Compliant

Staff meetings(Records examined) House meetings(Records examined) Complaints (Records examined) Monthly monitoring visits(Records examined) ACE quality survey and action plan (Records examined) RQIA inspections The inspector verified the records in place of all the above and discussed relevant areas with the manager and the staff. The monthly monitoring reports in place were comprehensive and up to date. Records show discussion with staff, people supported and include updated information on any action plans in place from RQIA, as well as follow up information following the annual quality review. The inspector was advised by the manager that the manager and the monitoring individual discuss the report following each visit.	

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 inspector read the monthly monitoring reports in place. These were up to date. Records show discussion with staff, people supported, and relatives and include updated information on any action plans in place from RQIA, as well as follow up information following the annual quality review. The manager stated that she and the monitoring individual discuss the report following each visit.	Compliant

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 agency's monitoring visits are recorded in line with the guidance documentation issued by the RQIA (March 2012). The documentation in place as well as the records shows current compliance.	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. Each person supported is also provided with an easy read Safeguarding Pack. 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 we are aware that a person we support may pose a risk to another individual supported by the Service, a Risk Assessment & associated actions are completed with the individual at risk and/or their representative & relevant Trust personnel. 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, identified within the Operations Risk Register. The Service has also considered the learning from external Vulnerable Adults issues (eg Serious Case	Compliant

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 has had four vulnerable adult issues to report to the Trust. The manager on duty verified this during discussions. Staff training has taken place for all staff. Staff are aware of the policies in place and gave examples of when the procedure is to be implemented. The agency has an identified safeguarding team within the local trust and has direct access to that team. Safeguarding is also discussed during staff meetings enabling staff to consolidate training and to discuss any concerns they may have. The records of house meeting shows clear evidence that the manager discussed with individuals supported the topic of vulnerability/safeguarding and what the agency's role and the people supported responsibility is, in relation to reporting and investigation. As part of their training staff are trained to identify the indicators of abuse and the reporting procedures. The inspector discussed scenarios with staff and their responses did show clear understanding of safeguarding issues.	Compliant

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:	
The agency adheres to the policies and procedures of Positive futures as well as the local trust policies for reporting safeguarding issues. This was verified by the manager and staff during discussions at the inspection. The inspector read the agency's policy and procedures which clearly direct staff to record outcomes of any safeguarding reports, clear evidence of procedures underpinning practice was in place.	Compliant

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 adheres to the policies and procedures of Positive futures as well as the local trust policies for reporting safeguarding issues. This was verified by the manager and staff during discussions at the inspection. The inspector read the agency's policy and procedures which clearly direct staff to record outcomes of any safeguarding reports, clear evidence of procedures underpinning practice and outcomes was in place. The agency had in place records of individual discussions with the trusts safeguarding team and the manager was able to inform the inspector what procedures she would follow if the screening process was of concern.	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:	
Records in place show clear evidence of the agency's involvement in any safeguarding discussions.	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:	
The manager advised the inspector that the review of the protection plans and risk assessments were in place and have been discussed with the local trust.	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

Any other areas examined

Complaints

The agency has had two complaints during the last year, this was verified by returns sent to RQIA and examination of records held on site. All complaints have been resolved to date.

QUALITY IMPROVEMENT PLAN

As no requirements or recommendations were made following the inspection a Quality Improvement Plan has not been appended on this occasion. The registered manager/provider is asked to please complete and return a copy of the signature page at the end of the report for our records by **12 November 2013**.

Enquiries relating to this report should be addressed to:

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

No requirements or recommendations resulted from the **primary announced** inspection of **Positive Futures (Lisnaskea)** which was undertaken on **18 September 2013** and I agree with the content of the report.

Please provide any additional comments or observations you may wish to make below:

NAME OF REGISTERED MANAGER COMPLETING	Joanna Clarke
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING	Agnes Lunny

Approved by:	**Date**
Jim Mc Bride	8/11/13