PRIMARY INSPECTION

Name of Agency:	**Positive Futures (The Gatelodge)**
Agency ID No:	**11017**
Date of Inspection:	**22 April 2013**
Inspector's Name:	**Audrey Murphy**
Inspection No:	**13503**

The Regulation And Quality Improvement Authority
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General Information

Name of agency:	Positive Futures (The Gatelodge)
Address:	The Gatelodge 326 Crumlin Road Belfast BT14 7EE
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Registered Organisation / Registered Provider:	Positive Futures Ms Agnes Philomena Lunny
Registered Manager:	Mrs Bernice Kelly
Person in Charge of the agency at the time of inspection:	Mrs Bernice Kelly
Number of service users:	11
Date and type of previous inspection:	9 August 2012 Primary Announced Inspection
Date and time of inspection:	22 April 2013 09:20 – 17:00
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 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	2
Staff	7
Relatives	1
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	25	18

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

The agency's progress towards full compliance with the one requirement and five recommendations made during the previous inspection (9 August 2012) was assessed. The agency has fully met the minimum standards in relation to the five recommendations made at the previous inspection. However, discussion with the service manager regarding the costs of fuel indicated that there wasn't a charge per mile per service user arrangement in place and that all three service users were paying an equal amount for the fuel consumed, regardless of usage. A requirement has been made with regard to this.

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 individuals who reside in the North and West Belfast area of the Belfast Health and Social Care Trust. The service is currently provided to 11 individuals with a learning disability and they are supported by 43 staff. 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;
- promote the rights of the people they support and support them to exercise these rights as citizens, and enable them to understand the balance between rights and responsibilities;
- provide a secure environment which recognises and responds to individual need; and
- 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.

Summary of Inspection

The announced inspection was undertaken on 22 April 2013, 09:20 – 17:00. The inspector met with the registered manager, the service manager and several support staff during the inspection. The inspector also availed of an opportunity to visit some service users in their homes on the afternoon of the inspection and met with the relative of one service user. Prior to the inspection, 18 agency staff forwarded to RQIA a completed questionnaire in relation to the quality of service provision. Feedback in relation to the inspection findings and comments made by agency staff in the questionnaires was provided to the registered manager and registered manager during the inspection.

Detail of inspection process:

Theme 1: Service Users receive care in their own home

There were satisfactory arrangements in place to ensure that the service users supported by Positive Futures are receiving a service which promotes their independence, autonomy and control. Service users have tenancy agreements and separate care / support agreements which set out the individuals' rights and expectations in relation to their specific needs. The agency has developed a range of its policies and procedures to reflect the principles of 'The Real Tenancy Test' and agency staff were able to describe their understanding of providing care and support to individuals in their own home.

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

Theme 2: Assessments, care plans, reviews and care practices reflect consideration of the service users' 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. It was noted that some restrictive interventions had been reviewed and removed from service users' care plans.

There were a number of restrictive interventions being implemented in the homes of service users including access to personal property, use of a "listening monitor" and restrictions in liberty. Not all of these care practices could be linked to a HSC Trust needs assessment and it was not possible to ascertain if they were in accordance with a HSC Trust care plan. There were some care practices being implemented which did not adequately reflect any consideration of the individual's human rights or other less restrictive interventions.
The service users' capacity to consent to interventions which are restrictive had not been assessed or documented and it was therefore not possible to ascertain which interventions the service users had consented to. There was no evidence of "best interests" decision making on behalf of service users.

There were three requirements made with regard to this theme.

The agency was assessed as "Not 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. However, the views of service users relatives / representatives were absent from the reports and the time of the visit and whether it was announced or unannounced was also absent.

A requirement has been made with regard to these areas for quality improvement.

The agency was assessed as "Not 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 this as either good or excellent. There were some suggestions made by staff in relation to the improvement of the quality of the training and these were discussed with agency management during the inspection.

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 service users 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:

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.

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.	The agency maintains records of service users' assessments of capacity to manage their finances. The financial support arrangements in place were detailed and outlined the specific supports required by the individual service users. The finance agreements detailed the individuals' contributions, the arrangements for recording all transactions and the arrangements for safe storage of service users' finances. The agency's records contained evidence of service users being invoiced individually for fuel.	**Once**	**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.	**Once**	**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.	**Once**	**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. There was evidence of matching of staff and service users and of the individual needs of service users being used to coordinate the input of staff.	**Once**	**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.	**Once**	**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.	There was evidence of service users who share their accommodation being consulted with and there were records of the outcome of this. It was noted that the needs of one service user were impacting significantly on the needs and rights of their co-tenants. There was evidence of HSC Trust multi-disciplinary involvement in the review of the service users' circumstances.	**Once**	**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	
Every person supported within the Service 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 of the people we support. Most landlords provide an Easy Read Tenancy Handbook, which details rights and responsibilities in relation to being a tenant. 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).	Compliant

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 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:	
Service users rent their accommodation from a number of housing providers including Triangle Housing Association, Habinteg and from a private landlord. A number of tenancy agreements were examined and 'easy read' versions of these had been provided to service users. The tenancy agreements outlined the weekly rent and service charges. As stated in the self assessment, the tenancy agreements separate the provision of accommodation from care and support. There were separate support agreements which outlined the payments received by individual service users from the relevant HSC Trust, supporting people, housing benefit etc. The amounts received by individuals for housing support and care were noted to be different for each individual and reflected the assessed needs of service users. The inspector examined agency records which outlined the allocation of agency staff and hours worked in relation to individual service users. These records reflected a range of needs and dependency and it was evident that some service users required more intensive care / support than others. Staff work in the homes of service users over the 24 hour period. The inspector spoke with the relative of one service user and visited some service users in their own homes. It was evident from this engagement that service users' homes were being treated respectfully by agency staff and that service users' privacy and dignity were upheld. Staff advised the inspector that while there is a staff presence in the homes of some service users on a 24 hour basis, staff provide a discreet service and respect the service users' home at all times.	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 are currently reviewing 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 are being completed for each of the people supported by the Service, which include associated action plans.	Compliant

Where the people we support are not able to communicate verbally, we gather this understanding through the use of Learning Logs and Communication Charts.	
Inspection Findings:	
The support agreements issued to individual service users outlined the rights of the service user in relation to their access to any part of their home which they have a right to, as outlined in their tenancy agreement. The support agreement also outlines rights in relation to private space and to excluding staff and others visiting. Service users have also been issued with an Information Handbook which this outlines the tenants' right to exclude anyone, including staff from private space and to exclude visitors – but not the right to exclude staff supporting others in the household. The right to be consulted about who enters the individual's home is also outlined in addition to the expectation that when staff visit, they must always knock and wait to be let in. A service user's relative who contributed to the inspection provided further confirmation that service users can exercise control over who enters their home; the relative commented on the agency's commitment to ensuring that familiar, static staff provide support in a manner that promotes the individual's control over who they live with and who enters their home. It was noted that one group of service users had been experiencing on-going compatibility issues. There was evidence of the assessment of the compatibility of these service users and this had been completed by the relevant HSC Trust and focussed on culture and diversity, environmental factors, health factors, lifestyle and preferences, relationships, risks and challenges. There were also records of 'what's working well' and 'what's not working well'. These included issues arising in relation to the service users' access to their own property / belongings, and property damaged by co-tenants. Discussion with agency staff in relation to the management of these matters highlighted a range of interventions undertaken to address the compatibility issues. The agency's monthly quality monitoring reports reflected on-going monitoring of this situation and the actions taken to alleviate the stress experienced by service users in their home. The inspector visited service users at two addresses and spoke with agency staff during these visits. The arrangements in place to ensure that service users have unrestricted access to all areas of their home were	Compliant

discussed and service users were observed moving around their home in an unrestricted manner. Service users were observed receiving individual support to access areas within their home including items within the kitchen areas.	

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 within the Service. 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 the use of 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 on a regular basis. If a person wishes to no longer 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. In addition, the Service is	Compliant

currently in the process of introducing a Distance Travelled Model. 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:	
A number of the ‘person centred portfolios’ referred to in the self assessment were examined and contained detailed individualised needs and risk assessments. There was evidence of positive risk taking within the records and staff reported they were using ‘active support’ to promote the independence of individuals. The individual arrangements for the provision of staff to care and support for service users was outlined in the care and support plans and there was evidence of the agency reviewing this regularly. It was noted however that not all of the service users’ needs assessments and care and support plans had been reviewed by the relevant HSC Trust on a regular basis. There was however evidence of agency staff engaging with the relevant HSC Trust in relation to the review of needs assessments and care plans. This is further outlined further in the inspection findings for Theme 2. As stated in the self assessment, there was evidence of staff being matched to the individual service users and a tool has been developed to support the matching of the individuals’ needs, wishes and preferences to staff with appropriate attributes. The inspector noted a “Matching staff “template in place for some service users which made reference to: supports wanted and needed, skill needed, personality and characteristics needed, shared common interests. Characteristics of people I like to be with / don’t like to be with. It was also evident from speaking with a service user’s relative and with agency staff that the individual needs and preferences of service users are taken into account when allocating staff to work in the homes of service users. A service user’s relative advised the inspector that their relative receives appropriate levels of care and support and that the staff presence in their home is not intrusive.	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 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:	
As stated in the self assessment, each service user has a 'Person Centred Portfolio' and these included the views of the service users and their relatives / representatives. Service users' portfolios also contained information on the communication needs of individual service users and methods of communicating effectively with them. Staff who returned a questionnaire indicated that they had received training on the supported living model of care / support and some staff provided comments on the main principles of supported living such as "To provide an ordinary life in their own homes", "Providing support where needed and choices and options and to help fulfil any dreams they may have to do things they may feel had been out of their reach". Staff who contributed to the inspection confirmed that service users can opt in or out of additional services within their home such as contributions to household groceries and meals. The inspector visited two of the homes of service users and discussed with agency staff the arrangements in place for household contributions. There was evidence of service users having their individual wishes and preferences promoted and of the service users' ability to opt in or out of shared expenses such as groceries or meal provision.	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. The Service is currently using iPad technology to aid the communication of supported individuals. 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. Communication Charts and Learning Logs are particularly useful tools for people with specific communication needs. Person centred tools are the foundation of an individual's Person Centred Portfolio and in turn their care / support planning. The information contained within an individual's Person Centred Portfolio informs the person centred review process and every effort is made to engage the person supported in this. To enable this process to be effective, staff are trained on how best to gather the perceptions of the people they support (eg PECS,	Compliant

person centred tools). In addition, staff are provided with training on human rights. The people we support and/or their representative are given information on human rights in an accessible format. We are currently developing a Human Rights and Restrictive Practice Policy as well as focusing on how to make Person Centred Review Meeting minutes more accessible.	
Inspection Findings:	
There was evidence in individuals' care records of communication needs assessments and detailed analyses of non-verbal communications including what this might mean for the individual. The individuals' preferences in relation to how they like to receive information is also recorded in addition to 'how to help the person understand', 'how to present a choice', 'the best times to make a decision', 'what is not a good time to make a decision'. A service user's relative who contributed to the inspection reported that they felt that agency staff communicate very effectively with their relative and that agency staff can anticipate their relative's needs and preferences. Fifteen of the staff who returned a questionnaire to RQIA confirmed that they had received training in human rights specific to the service users supported by the agency. Agency staff also confirmed that easy read information 'Understanding your human rights' had been supplied to service users in relation to their human rights.	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	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:	
As stated in the self-assessment, agency staff have received training in human rights and restrictive practices. Eleven staff who returned a questionnaire confirmed they had attended this training. The content of the training was examined and included references to the support needs of individuals who share their home with individuals who require significant restrictions. The training also covers the consideration of mental capacity and consent. Agency staff have received training in Person Centred Thinking, Positive Behaviour Management and in Restrictive Practice. The agency maintains a Person Centred Review Policy and Guidance and this outlines what is working for the individual and what is not working and a number of tools including learning logs, “the perfect week”, “good days and bad days”. There were several examples of person centred reviews examined and reflected a range of actions to be taken in relation to “what’s not working”. There were “Stress and coping” plans noted in service users’ records and these included clear descriptions of when a service user is experiencing distress and actions to be taken to alleviate this. There were a number of care practices being undertaken by agency staff which were not outlined in a human	Not Compliant

rights context and there were inconsistencies in the documentation of the HSC Trusts' authorisation of restrictive interventions. While there was evidence of the agency's Managing Director 'approving' the implementation of these interventions, the agency is required to ensure that the care practices are in accordance with the HSC Trust care plan. Discussion with agency staff during the inspection provided evidence of the agency's attempts to engage the HSC Trust in the authorisation, on-going review and monitoring of care practices which are restrictive in nature. The inspector was advised of the development of an organisation wide Positive Futures Human Rights Committee which is due to meet in May 2013 and will include representatives from a range of professional backgrounds and agency staff.	

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:	
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 range of restrictive interventions being implemented in the homes of service users and the inspector examined the care records of four such service users. The restrictive practice assessments included the following categories: access to personal possessions, your home, wider environment, money and medication, privacy, safety, health and wellbeing, freedom of speech and any other restrictive practice. The restrictive practice assessments examined had been signed by agency staff and in some instances, by the service users' relative and the Managing Director of Positive Futures. However, the relevant HSC Trust did not appear to have been involved in the review of the restrictive practices and the inspector was advised by agency staff that one service users' needs had not been reviewed by the HSC Trust for 14 months. There was evidence of agency staff making efforts to engage with the HSC Trust in relation to this service user's review. RQIA will raise this matter with the relevant HSC Trust. There was also some evidence of service users' needs being reassessed and restrictive practices being reviewed and removed. As outlined above in Statement 2, there were a number of restrictive interventions being implemented which did not correspond to any HSC Trust needs / risk assessment or care plan. A requirement has been made with regard to this. One service user was noted to be using a "monitor" to enable agency staff to hear night time seizure activity. The service users' needs assessment and care plan did not include any consideration of their right to privacy or any alternative, least restrictive measures considered.	Not Compliant

The specific circumstances of one service user in relation to their ability to leave their home in an unrestricted manner were discussed. The service user who shares with a peer who requires an external door to be locked was also experiencing this restriction. Agency staff provided assurances that an arrangement was in place for this service user to have a key and as such there was no the restriction in the service users' liberty. Some service users were noted to be experiencing restrictions due to the needs of the service users they share their home with. Examples of these included access to personal belongings, ability to freely leave their home. The impact of these on service users was discussed with agency staff and the inspector was advised of a range of measures in place to minimise the impact of these practices.	

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 meetings where there are issues about any individual's capacity to consent to any support or interventions.	Compliant
Inspection Findings:	
The Restrictive Practice Assessments examined included consideration of: How has the restriction been agreed? Who was involved in the decision making? What action has been agreed to reduce / remove each restriction (including timescale), Does the person supported understand the restrictions listed? While the service users' care records contained evidence that some restrictive practices had been "approved" by the agency's Managing Director or "signed off" by agency staff or the HSC Trust and service	Not Compliant

users' relatives, there were no records pertaining to the service users' capacity to consent to interventions or of any best interest's discussions or meetings. A requirement has been made with regard to this.	

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 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 services. There was a calendar in place outlining the person taking responsibility for the monthly quality monitoring	Compliant

visits to the service and these were noted to have been completed by a senior manager, on behalf of the registered person. The inspector discussed quality monitoring with the service manager and the registered manager and examined a range of records including team meeting minutes, complaints records, tenants' meetings and the reports of the monthly quality monitoring visits to the service on behalf of the responsible person. In addition to the monthly quality monitoring undertaken by senior management, the agency's manager also undertakes quality monitoring and there were records of these visits. There were a number of reports of unannounced visits undertaken by the manager to the address of several service users. The agency also undertakes annual consultations with HSC Trust professionals, service users, family members. A report titled 'Your Voice Counts Survey, April 2013' was examined and contained a range of views from professional staff, relatives / carers, service users from across Positive Futures services and a range of 'what's working' and 'what's not working' comments from each group. A questionnaire and focus group is used to obtain the views of key stakeholders	

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:	
There was evidence of quality monitoring of the service being undertaken on a monthly basis and the inspector noted a calendar outlining the nominated person responsible for the monthly monitoring visits of the service throughout 2013. The monthly monitoring reports for January 2013, February 2013 and March 2013 were examined during the inspection and the reports contained action plans and actions taken following RQIA inspection visits. Fourteen staff who returned a questionnaire indicated that their views are sought during the monthly quality monitoring visits; 11 staff indicated that service users' views are sought and 13 indicated that the views of service users' representatives are sought during the visits. However, the views of service users' relatives or professionals involved in the lives of service users were absent from all three reports. It was noted that the time of the quality monitoring visit was not recorded and it wasn't clear if the visit had been announced or unannounced.	Not Compliant

A requirement has been made with regard to these areas for quality improvement.	
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 has developed a 'checklist' and report format which includes the views of service users, their representatives, staff and any professionals involved. The report format also includes information about accidents / incidents, complaints, use of restrictive practices. The report format also includes a review of risk issues, suggestions from people supported, and comments on review of quality improvement plan from RQIA or internal audit. The condition of the office premises, condition of the houses of the people supported, and review of previous monthly action plan were also included. The report format also contained an action plan, the person responsible for the action, the planned completion date and actual completion date of action taken. The inspector examined three monthly quality monitoring reports and as stated previously in Statement 2, there were a number of areas for quality improvement noted.	Substantially 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
	Not 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	
There is both a Safeguarding Vulnerable Adults Policy and a Safeguarding Children Policy. These policies aim to ensure that staff and volunteers understand and recognise abuse, neglect and exploitation of children and vulnerable adults and how to respond, including recording and reporting requirements. We consult with people we support when we review our Safeguarding Policies. Staff receive periodic training on safeguarding in line with RQIA requirements. We assess the compatibility of people living together before and during the support provided by the Service. If we are aware that a person we support may pose a risk to another individual supported by the Service, a Risk Assessment and associated actions are completed with the individual at risk and/or their representative and relevant Trust personnel. If any person we support is subjected to behaviour from a person they live with which results in distress,	Compliant

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 Review of Winterbourne View Hospital). Our safeguarding processes are systematic and ensure that, should any safeguarding issues arise, there is clear documentary evidence.	
Inspection Findings:	
The agency's training records were examined and provided evidence that all staff had received training safeguarding vulnerable adults. Update training was noted to be scheduled for May 2013 for some staff. 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. The agency's "Safeguarding Adults at Risk in Group Care – Awareness Raising Workbook" was examined and was noted to have been completed by agency staff in preparation for the training. The inspector was advised that on occasions, Positive Futures supplies staff members from other domiciliary care agencies to work in the homes of service users. The service manager advised the inspector that the Positive Futures maintains a profile of each member of external agency staff and the inspector was advised that this provides an assurance that these staff have up to date training safeguarding vulnerable adults. Agency staff members who returned a questionnaire all confirmed they had received the training. All of the staff indicated that they felt that incidents of suspected, alleged or actual abuse are reported and investigated in accordance with the agency's procedures. All of the staff who returned a questionnaire indicated they felt their knowledge of the reporting procedures was good or excellent and all staff indicated they felt the effectiveness of the training was good or excellent. Seven staff reported they felt the training could be improved with suggestions for improvement including more time spent on types of abuse and recognising signs of abuse.	Compliant

There was evidence from care records, quality monitoring reports and from discussion with staff that a small number of service users were particularly vulnerable in their home due to compatibility issues. The actions taken by the agency and HSC Trust to address these matters was discussed and remains under review by the agency. As outlined in Themes 1 and 2, there was evidence of a range of actions being taken to alleviate the issues arising from the compatibility assessments of the service users involved. The inspector was advised that there had been no safeguarding concerns reported within the service.	

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

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, alleged 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 Article1, 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 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. The agency has undertaken an exercise in learning from Winterbourne View – Serious Case Review. The outcome of this has been a range of 'Key things we need to keep to doing' and 'Other things we could do'. Organisational actions from the exercise have been identified including: staff training, visible management in services, review of current induction programme, NISCC registration, buddy scheme for new staff, The provider organisation's operations department risk register was examined and included a risk in relation to the risk assessment of people we support to include identification of potential risk from staff and volunteers. There was evidence of training in in RQIA's inspection themes 2013 / 2014 being undertaken by a significant number of agency staff. There was also evidence of consideration of individuals living in their own homes and the application of inspection themes to the individuals who use the service.	

THEME 4 - ADULT PROTECTION CONCERNS ARE IDENTIFIED BY THE AGENCY AND FOLLOWED THROUGH	
Statement 3 **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 close 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

Any other areas examined

Complaints

The agency forwarded to RQIA a summary of complaints received during the period from 1 January 2012 – 31 December 2012. The agency had received one complaint during this period. The complaint was categorised as an 'environmental' issue. The records in relation to this complaint were examined discussed with the service manager and the registered manager. It was noted that the complaint had been resolved.

The agency had records pertaining to two complaints received in March 2013, one of which had been resolved locally. The second complaint was from a staff member and did not refer to direct care issues.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Bernice Kelly, Registered Manager and Mrs Anne Magee, Service 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 (The Gatelodge)

22 April 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 Bernice Kelly, Registered Manager and Mrs Anne Magee, Service 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.	15 (6) (d)	The registered person shall specify the procedure to be followed where a domiciliary care worker acts as agent for, or receives money from, a service user. This requirement refers to the arrangements in place to ensure that individual service users are only charged for fuel used by them.	One	Written agreements are in place for the allocation of fuel costs equally between the people we support who share a mobility car. These have been agreed and signed by the individual's family representative. We will review these agreements with family representatives to ensure this arrangement remains in the best interests of the people we support.	One month from date of inspection – 20 May 2013
2.	15 (2) (a)	The registered person shall ensure that a written plan ("the service user plan") is prepared which shall be consistent with any plan for the care of the service user prepared by any Health and Social Services Trust. This requirement refers to the implementation of restrictive interventions in accordance with the HSC Trust care plan.	One	Restrictive interventions will be in accordance with HSC Trust Care Plans.	One month from date of inspection – 20 May 2013
3.	15 (2) (b) (c)	The registered person shall ensure that a written plan ("the service user plan") is prepared which shall	One	Restrictive Practice Assessments will be revised to ensure they detail all restrictions.	One month from date of inspection – 20 May 2013

		(b) specify the service users' needs in respect of which prescribed services are to be provided; (c) specify how those needs are to be met by the provision of prescribed services. This requirement refers to the implementation of interventions which are restrictive and impact on the service user's human rights.			
4.	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, and 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.	One	Capacity to consent to Restrictive Practices will be discussed and recorded with the individual's representatives, including any best interest discussion or meeting.	Three months from inspection – 15 July 2013
5.	23 (1)	(1) The registered person shall establish and maintain a system for evaluating the quality of the services which the agency arranges to be provided.	One	Managers completing monitoring will record: - all efforts made to speak to family representatives / professionals - whether their visit was	Immediate and ongoing

				announced or unannounced - the time of the visit as per existing guidance.	

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	Bernice Kelly
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	30 July 2013
Further information requested from provider			