PRIMARY INSPECTION

Name of Agency:	**Positive Futures (Rainey Street)**
Agency ID No:	**11018**
Date of Inspection:	**16 May 2013**
Inspector's Name:	**Audrey Murphy**
Inspection No:	**13505**

The Regulation And Quality Improvement Authority
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General Information

Name of agency:	Positive Futures (Rainey Street)
Address:	46a Rainey Street Magherafelt BT45 5AH
Telephone Number:	028 79395260
E mail Address:	j.diamond@positive-futures.net
Registered Organisation / Registered Provider:	Positive Futures Ms Agnes Philomena Lunny
Registered Manager:	Mr John James Diamond
Person in Charge of the agency at the time of inspection:	Mr John James Diamond
Number of service users:	6
Date and type of previous inspection:	16 August 2012 Primary Announced Inspection
Date and time of inspection:	16 May 2013 9:00 am – 5:00 pm
Name of inspector:	Audrey Murphy

Introduction

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

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

Purpose of the Inspection

The purpose of this inspection was to ensure that the service is compliant with relevant regulations, minimum standards and other good practice indicators and to consider whether the service provided to 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	4
Staff	4
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.

Issued To	Number issued	Number returned
Staff	7	7

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 (16 August 2012) was assessed. The agency has fully met the minimum standards in relation to the five recommendations made at the previous inspection. The agency has also demonstrated full compliance with one requirement that had been made during the previous inspection.

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

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

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

Profile of Service

The agency provides supported living type domiciliary care services to six individuals with a learning disability in the Magherafelt area. The staff team is comprised of a manager and seven support 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;
- to promote the rights of the people we support and support them to exercise these rights as citizens, and enable them to understand the balance between rights and responsibilities;
- to provide a secure environment which recognises and responds to individual need; and
- to promote a culture of risk enablement by assessing risk and facilitating positive risk taking.

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

Summary of Inspection

The announced inspection was undertaken at the agency's registered office on 16 May 2013, 9:00 am – 5:00 pm.
The inspector was provided with an opportunity to meet with four service users and four staff during the inspection visit.
Prior to the inspection, agency staff were invited to return to RQIA a completed questionnaire in relation to their views on the quality of service provision. All agency staff returned a questionnaire and feedback from the inspection visit and from the questionnaires was provided to the registered manager and Jo Corcoran, Positive Futures at the end of the inspection visit.

The inspector would like to thank the service users and agency staff for their warm welcome and full cooperation throughout the inspection process.

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.

Service users who participated in the inspection provided very positive feedback to the inspector in relation to their experience of receiving care in their own home. Service users also referred to a range of rights they enjoy as tenants including being able to choose who they live with and how they are supported.

One requirement was made with regard to this theme and that was in relation to the agency's arrangements for receiving money from service users for services. It was unclear during the inspection what service users were being charged for and the agency is required to specify this.

The agency was assessed as "Substantially 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.
Restrictive practice assessments had been undertaken for all service users and 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 medication, money and levels of staffing within the service users' home.

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.

One requirement was made with regard to this theme and that was in relation to the agency's arrangements for ensuring care practices are undertaken with the consent of service users.

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, it was noted that the same service users were consulted on a consistent basis during the monitoring visits and there was little evidence of the views of all service users being sought or represented.

A recommendation has been made with regard to these areas for quality improvement and the registered manager provided an assurance that this matter would be raised with the appropriate individuals within the organisation.

The agency was assessed as "Substantially 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. All staff indicated they felt their knowledge of the agency's reporting procedures was excellent.

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

There have been no safeguarding vulnerable adults referrals made by the agency in respect of any of the 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 had been revised on 1 May 2013. The Statement of Purpose continues to accurately reflect the range and nature of services provided to users of the domiciliary care service.

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 registered manager discussed the agency's revised Personal Finance Policies and Procedures. These have been updated to incorporate a financial capability assessment for each person supported. The arrangements in place to support individuals with their finances reflected the outcome of their financial capability assessment and the detail of the supports needed. The registered manager confirmed that service users do not make contributions to their travel expenses unless accessing public transport or private taxis. Service users have access to a car belonging to the service and service users do not pay for fuel or any other expenses in relation to the vehicle.	**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.	Service users who contributed to the inspection provided evidence that they continue to choose where they live and that they have opportunities to raise any issues in relation to this with agency or HSC Trust staff. 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	The agency's Guidance Document entitled "Supporting People to access our adult services or enter accommodation" was examined.	**One**	**Fully Met**

		accommodation.	The document clearly outlined the separation of the care and support from the tenancy. Service users who contributed to the inspection outlined their understanding of their rights as tenants.		
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.	Discussion with service users, agency staff and examination of records provided evidence of agency staff being 'matched' to work in the homes of service users. 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. Service users and staff and contributed to the inspection provided additional evidence of service users being consulted on an on-going basis in relation to who they share 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	
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:	
All of the service users are tenants of Triangle Housing Association and have been issued with Licence Agreements. The Licence Agreements of two service users were examined and had been issued to them in 2001. Each of the service users has also been issued with a Support Agreement which clearly highlights the separate roles of the care provider from the landlord (Triangle Housing Association). The Support Agreements also outline the service user' rights in relation to remaining in their own home if they choose an alternative care provider and their right to change their landlord and retain their care provider. The support agreements outline the costs of the individual's care and support and the contributions to be made by the HSC Trust, the Supporting People programme and the individual. The Support Agreements also outline the costs associated with living in a shared house. There was evidence within the agency's records of the service users receiving explanations of their support agreements. Service users had also signed to indicate they have received their support agreement. The support agreements also outlined in detail the support hours allocated to each individual supported and the times that staff would be available to provide support. The agreements also outlined the areas of the shared houses that are not accessible to the service users – i.e. the staff sleep over bedroom. Service users who participated in the inspection indicated that their home is comfortable and that staff do not treat their home as an office or workplace. Service users reported that there is a staff sleep over bedroom in their home and that this room is used by staff for storing files etc. The agency has developed 'The Real Tenancy Worksheets' for individual service users and these outline the agency's progress towards fulfilling the expectations of 'The Real Tenancy Test'. Outcomes of these exercises provided evidence that service users have chosen to live at their address independently of the care provider and that service users are consulted about who they share with. The	Compliant

exercise also reflected the changing needs of service users and the actions taken by agency staff to adjust the care and support arrangements in accordance with these changing needs.	

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

Inspection Findings:	
The service users who participated in the inspection expressed a high level of satisfaction in relation to their relationships with agency staff who provide their care and support. Service users stated that they welcome the staff into their home and enjoyed having staff visit them and providing a presence in their home. Service users also reported that they had been sharing their homes with the other service users for several years and were continuing to make the choice to live with their fellow tenants. Service users also indicated that agency staff provided them with regular opportunities to comment on how the support could be improved and support to resolve any difficulties or issues arising from sharing with others. The service users' support agreements clearly outline the inputs of agency staff into the service users' homes and the use of a bedroom within their home for the purposes of accommodating staff who provide a 'sleep over' service. The service users indicated that they had full and unrestricted access to all areas within their home with the exception of the staff sleep over room and that this arrangement was acceptable to them. The service users' restrictive practice risk assessments made reference to this. Service users also indicated that they were aware of their rights in relation to their own private areas within their home and their responsibilities in relation to respecting the privacy of other service users in their home. There were agency records to support the self assessment in relation to issuing staff with copies of keys of service users' homes. Service users who participated in the inspection also indicated that they had their own keys and had their permission sought by agency staff to allow agency staff to retain a copy of their key. Staff who participated in the inspection reported that they respect the privacy of service users in their homes at all times and provide care and support in a manner that is friendly and not intrusive. Staff also reported they promote the homeliness of the service users' homes.	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 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. Bromford Assessment Plans are in place which enable greater levels of autonomy and independence. Active	Compliant

Support Plans also enable greater levels of autonomy and independence. In addition, the Service is 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:	
The agency's Statement of Purpose was examined and states: "The individual is fully involved in the planning of his / her own support service. The support provided is intended to enable the individual to maintain and develop maximum levels of independence within his / her own home and local community. Comprehensive reviews of the services provided take place at regular intervals". The agency has undertaken risk assessments in relation to service users spending time alone in their home for periods of time. These assessments reflected the wishes of the service user in relation to their privacy and the service user's HSC Trust representative's involvement. There were also risk assessments in place in relation to service users self-administering their medications. It was evident from speaking with the service users and the staff that service users are happy with the levels of care and support they receive and that the correct balance has been struck between promoting independence and autonomy and providing support, security and a welcome presence in the homes of service users. Service users and staff who participated in the inspection confirmed their participation in the 'matching' of staff to support individuals and there was evidence of service users being able to express a preference of staff to provide support with specific activities. The staff matching assessments examined reflects common interests, skills needed, personality and characteristics needed to support the individual.	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. Bromford Assessment Plans are in place for each of the people supported in the Service. 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. A Joint Account Agreement is in place for each of the people supported by the Service. These are reviewed annually. The people we support can opt-out of paying a Joint House Account. 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	Compliant

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.	
Inspection Findings:	
It was evident from discussions with service users that they were choosing to undertake a number of their support tasks in the company of other tenants, for example, completing shopping. Service users also described the arrangements in place to ensure that they could choose to opt out of aspects of the routines of the household. A number of the person centred portfolios referred to in the self-assessment were examined during the inspection and provided evidence of individualised needs assessment and support planning. The agency uses a number of person centred tools to assist service users to be fully involved in their support planning. The service user agreements of three service users were examined and provided an outline of the weekly and monthly expenditure incurred by the service users. It was unclear however what the amounts deducted from service users' accounts were for and staff could not clarify this during the inspection. It was also noted that each of the service users makes a personal contribution towards their care and support and the amount contributed was the same for each service user. The inspector was advised that individual expenditure had been calculated with the service users however it was unclear what the specific amounts were for and whether this had been outlined to the service users and their representatives. A requirement has been made with regard to the agency's arrangements for receiving money from service users. The registered manager and Positive Futures senior manager provided the inspector with an assurance that the financial agreements for all service users would be reviewed in light of the inspection findings; the inspector was further advised that all charges payable by service users would be fully itemised and documented within the individual service users' financial agreements. The registered manager provided an assurance that this area for quality improvement would be fully addressed within the current inspection year.	Moving Towards Compliance

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

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

THEME 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. 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, person centred tools). In addition, staff are provided with training on human rights.	Compliant

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:	
Staff who participated in the inspection indicated that all service users have regular input from their HSC Trust representatives who are invited to three monthly and six monthly reviews of the service provided. Within the service users' person centred portfolios there were a number of person centred tools including communication charts, learning logs, 'what's working / what's not working', 'good day / bad day', 'perfect week / month'. The person centred portfolios also contained decision making profiles which outline – 'how I like my information', 'how to present choice to me', 'how can you help me to understand', 'what are the best times to ask me to make a decision', 'when is not a good time for me to make decisions'. The person centred portfolios had been prepared in a format suitable to the communication needs of service user and those service users who participated in the inspection referred to their portfolios. The agency maintains copies of the 'Understanding Your Human Rights – Disability Action' document and there was evidence that this had been discussed during staff meetings and circulated to staff members. There was also evidence that this had been discussed with service users and their comments sought. Copies of the document had been provided to service users.	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 Challenging Bad Practice (Whistleblowing) Policy in	Compliant

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, it was evident from speaking with staff that they had undertaken training in relation to the RQIA themes for the 2013/ 2014 inspection year. Human rights training had been undertaken by agency staff in March 2013 and a 'learning from Winterbourne View' event had been attended by staff in April 2013. Evaluations of staff understanding of supported living, restrictive practices and tenancy rights had been completed and reflected consideration of the service users' human rights and their independence. The restrictive practice assessments undertaken by the agency reflected consideration of human rights and had been signed by the relevant HSC Trust representative. Restrictions being experienced by service users included provision of one to one support to access the community, supports to manage money and medication. The restrictive practice risk assessments had been completed and reviewed regularly and reflected the assessed needs of the service users, as verified during discussions with agency staff. 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". Discussion with service users and agency staff provided evidence that effective working relationships had	Compliant

been established with service users and that staff were skilled and experienced in responding to the needs of the service users. All of the staff indicated in their returned questionnaire that service users have their views taken into account in the way the service is provided and that care plans meet the individual needs of service users. The agency's monthly quality monitoring 'checklist' prompts the monitoring to comment on issues regarding restrictive practices and the human Rights dilemmas or concerns that may arise. The service users' Article 3, 5 and 8 Rights are specifically highlighted within this section.	

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 number of restrictive practices referenced within individual service users' care records and these included the provision of one to one support to access the community, supports to manage money and medication. The restrictive practices in place were reviewed regularly and the records of these reviews were examined and reflected the views of the service users. There was also evidence of regular input from the HSC Trust representative in relation to the reviews of restrictive practices. The impact of restrictive practices on other service users was discussed with agency staff during the inspection and it was evident from this and from discussion with service users that this was minimal. It was also evident that service users were not experiencing any interventions which would impact on their Article 3 rights.	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.	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 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.	Not 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 3 - ASSESSMENT AND MONITORING OF QUALITY OF SERVICES	
Statement 1 The registered person shall establish and maintain a system for evaluating the quality of the services which the agency arranges to be provided	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Positive Futures has an overarching Quality Management Framework in place. As a part of this, each month a monitoring report is completed on behalf of the Registered Person. There is a monitoring calendar in place which details the person responsible for completion of the monitoring. To maximise independence, provide fresh perspectives and share best practice, a range of different individuals undertake monitoring on behalf of the Registered Person (ie Senior Manager: Operations, Managing Director, Business Excellence Manager and other Service Managers). There is detailed guidance on how to complete this report to ensure consistency of approach. This process includes review of key documentation and discussion with key stakeholders. There is a documented record of the completed monitoring which includes associated actions with timeframes. In addition, an Annual Consultation Exercise is carried out with key stakeholders including Trust personnel and families / carers. This adopts a questionnaire and focus group methodology. Central to this process is the collation of perception data from the people supported by the Service and action planning in response to this. Furthermore, there is an internal auditing process of quality and compliance carried out by the Business Excellence Department. This process identifies a range of recommendations for the Service. The Service Manager also regularly monitors the quality of the Service, which includes a range of unannounced visits.	Compliant
Inspection Findings:	
The agency's arrangements for quality monitoring are set out in the Statement of Purpose which makes reference to annual quality audits and monthly quality monitoring of the supported living service. The Statement also outlines the quality monitoring undertaken the relevant HSC Trust. The arrangements in place for evaluating the quality of services provided by the agency were discussed with	Compliant

the registered manager. Methods of quality monitoring within the service included team meetings and house meetings. The registered manager also confirmed that agency staff receive regular supervision. The agency's training records were examined and reflected uptake in training in all of the mandatory areas. Staff were also noted to have received training in human rights, restrictive practices, NISCC Code of Practice, Record keeping, Active Support, and Positive Behaviour Management. There was a calendar in place outlining the person taking responsibility for the monthly quality monitoring visits to the service and these were noted to have been completed by a senior manager, on behalf of the registered person. The registered manager also undertakes unannounced visits to the homes of service users in order to undertake quality monitoring. The records of these were examined and reflected the engagement with the service users and staff who were providing care / support at the time of the visit. Service users who participated in the inspection provided further evidence that the registered manager seeks their views in relation to the services provided on a regular basis. The records of a service user Focus Group were examined and reflected comments made by service users in relation to 'what's working / what makes you happy, what do you like about Positive Futures'. Service users provided a range of positive statements and comments in relation to these areas. In relation to 'What Choices to you get to make each day?' service users reported they choose when to get up, what to wear, when to do shopping and where, to go to work, or not, what time to go to bed, what to watch on TV. Service users indicated they have a say in the decision making within their service. The records of an Internal Quality and Finance Audit undertaken in March and April 2013 were examined and reflected a number of key strengths within the service and some recommendations including the details within the agency's Restrictive Practice Risk assessments. The records of the 'Your Voice Counts' Survey were examined during the inspection and included a range of views from professional staff, relatives / carers, service users and a range of 'what's working' and 'what's not working' comments from each group.	

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 reports of the four most recently completed quality monitoring visits were examined during the inspection and had been completed in accordance with the agency's monthly quality monitoring checklist. The reports reflected engagement with service users, agency staff, service users' relatives and representatives. However, it was noted that the same service users were approached during the four most recently completed quality monitoring visits and that there was limited representation of the views of all service users. A recommendation has been made with regard to this and the registered manager provided an assurance that this matter would be brought to the attention of the responsible person and those individuals within the organisation scheduled to complete the quality monitoring visits. There was evidence of the monitoring of restrictive practices and of practices being reviewed and relaxed. There was also evidence within the reports of the action plans in place to address areas identified as needing quality improvement as identified from previous monitoring visits. The actions arising from outcomes of RQIA inspections were noted in the reports as being completed.	Moving towards compliance

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. Review of risk issues, suggestions from people supported, 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, review of previous monthly action plan. Best practice observed. Action plan, by whom, planned completion date and actual completion date. The monthly quality monitoring checklist developed by the agency is in accordance with RQIA published guidance and includes a range of additional areas being kept under review by the provider.	Compliant

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

INSPECTOR'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Substantially 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 maintains a Safeguarding Vulnerable Adults Policy which had been re-issued on 19/04/13. The policy clearly sets out the role of statutory agencies in the safeguarding of vulnerable adults and the role of the agency to respond to suspected or actual abuse. The types of abuse are outlined along with a procedure for staff to follow in the event of a disclosure or observation of an abusive situation. The signs of abuse are also outlined and reference is made to the Warwickshire County Council's Learning Disability Service 'Hate and Mate Crime Handbook', 2012. Reporting and recording requirements are outlined. Attached to the policy and procedure is a flow chart which summarises the procedure for safeguarding vulnerable adults and includes the agencies to be notified including PSNI, RQIA, HSC Trust, as appropriate. The Safeguarding Vulnerable Adults policy sets out the individual' human rights and makes specific references to 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's policy and procedure outlines the role of the HSC Trust and the agency's cooperation with the Trust investigation or assessment. The agency aims to report any concerns to the HSC Trust, to implement the protection plan, to consider capacity and consent issues, and to record the Trust's assessment of the referral including maintaining a record of any decision to 'screen out' referrals. There is also the expectation noted that staff are informed of when the case is closed.	Compliant

The staff training records were examined reflected uptake by all agency staff in training in safeguarding vulnerable adults. The agency's safeguarding vulnerable adults policy was also noted to be discussed during staff team meetings. The content of the 'Safeguarding Adults at risk in group care' training was examined and contained a definition of a vulnerable adult and a number of exercises and case studies. Safeguarding Adults at Risk in Group Care – Awareness Raising Workbook also examined and was reported to have been completed by agency staff prior to the training. The inspector examined 'Post Course De-Briefing' records and these reflected the individual's staff member evaluation of the training and how they would apply the learning to their practice. Staff members who returned a questionnaire all confirmed they had received the training. The agency's team meeting records reflected regular discussion of safeguarding vulnerable adults and restrictive practices. The records of meetings held with service users contained references to the agency's 'Be Safe, Stay Safe' policy and to discussion of the Safeguarding Vulnerable Adults policy and procedure.	

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

All agency staff returned a questionnaire and indicated in these that they rated their knowledge of the agency's procedures for reporting safeguarding concerns as 'Excellent'. All seven staff also indicated in their questionnaires that they felt that incidents of suspected, alleged or actual abuse are reported and investigated in accordance with the agency's procedures. The registered manager advised the inspector that there had been no incidents of alleged, suspected or actual abuse within the supported living 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 closed the vulnerable adults' case.	Compliant

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

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

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 no complaints during this period or subsequent to this period.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr John Diamond, 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 (Rainey Street)

16 May 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 Mr John Diamond, Registered 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 is in relation to the agency's arrangements for documenting in detail the nature of all charges made to service users.	One	Budget plans will clearly detail all charges made to the people supported by the Service.	Three months from date of inspection - 8 August 2013
2.	15 (5) (a) (b) (c)	The registered person shall, for the purpose of providing prescribed services to service users, so far as is practicable – (a) Ascertain and take into account the service user's and where appropriate their carer's, wishes and feelings; (b) Provide the service user, where appropriate their carer, with comprehensive information and suitable choices as to the prescribed services that may be provided to them; and (c) Encourage and enable the service user, and where appropriate their carer, to make informed decisions with respect to such prescribed services.	One	Capacity to consent to Restrictive Practices will be established and recorded with the individual's representative, where appropriate, and any best interest discussions will also be recorded.	Four months from date of inspection – 5 September 2013

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	8.11	It is recommended that the registered person monitors the quality of services in accordance with the agency's written procedures and completes a monitoring report on a monthly basis. This report summarises any views of service users and / or their carers / representatives ascertained about the quality of services provided, and any actions taken by the registered person or the registered manager to ensure that the organisation is being managed in accordance with minimum standards. This recommendation refers specifically to the agency's engagement with service users during monthly quality monitoring visits.	One	Those completing monitoring forms will ensure that they seek the views of all of the people supported and their representatives.	Immediate and on-going.

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

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

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	✓	Audrey Murphy	4 July 2013
Further information requested from provider			