PRIMARY INSPECTION

Name of Agency:	**Sperrin Supported Living & Peripatetic Housing Support Services**
Establishment ID No:	**11151**
Inspector's Name:	**Audrey Murphy**
Inspection No:	**13506**
Date of Inspection:	**28 May 2013**

The Regulation And Quality Improvement Authority
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General Information

Name of agency:	Sperrin Supported Living & Peripatetic Housing Support Services
Address:	Unit 29e Gortrush Industrial Estate Great Northern Road Omagh BT78 5EJ
Telephone Number:	028 8225 4430
E mail Address:	joanne.grimes@positive-futures.net
Registered Organisation / Registered Provider:	Positive Futures Ms A Lunny
Registered Manager:	Mrs Joanne Grimes
Person in Charge of the agency at the time of inspection:	Mrs Joanne Grimes
Number of service users:	15
Date and type of previous inspection:	13 August 2012, 9:30 am - 2:30 pm Primary Announced Inspection
Date and time of inspection:	28 May 2013 9:40 am – 6:30 pm
Name of inspector:	Audrey Murphy

Introduction

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

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

Purpose of the Inspection

The purpose of this inspection was to ensure that the service is compliant with relevant regulations, minimum standards and other good practice indicators and to consider whether the service provided to 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	5
Relatives	0
Other Professionals	0

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

Issued To	**Number issued**	**Number returned**
Staff	25	9

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 one requirement and five recommendations made during the previous inspection (13 August 2012) was assessed. The agency has fully met the minimum standards in relation to the five recommendations made at the previous inspection. The requirement made at the previous inspection related to the agency's financial procedures and to the support agreements in place for individual service users. Progress was noted in this area and service users have all participated in a financial capability assessment and have a detailed financial support plan in place. The arrangements for charging service users for transport require some development however and this requirement has been restated.

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 a supported living type domiciliary care service, as well as peripatetic domiciliary service in the Omagh area. A service is provided to 15 individuals with a learning disability and they are supported by 25 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 we 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.

The agency's staff team is comprised of the registered manager, deputy manager, senior support workers and support workers.

Summary of Inspection

The announced inspection was undertaken at the agency's registered office, 29e Gortrush Industrial Estate, Omagh, 28 May 2013, 9:40 am – 6:30 pm.

The registered manager was available throughout the day and had made arrangements for the inspector to meet with four service users. The inspector also met with five agency staff members.

Nine members of agency staff returned to RQIA a completed questionnaire in advance of the inspection. The outcome of the returned questionnaires is incorporated into the body of this report.

Feedback was provided to the registered manager and to 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

The agency has demonstrated a commitment to ensuring that service users receive a service in their home which affords them control, choice and autonomy. 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 expressed a high level of satisfaction with the services provided by agency staff and there was evidence of staff being matched to the individual needs and preferences of service users.

There were no requirements or recommendations made with regard to this theme and the agency was assessed as "Compliant".

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

The agency has provided all staff with training in human rights and in restrictive practices and agency staff could describe their understanding of this during the inspection and provide examples of how the rights of service users are upheld.
The agency has developed a range of methods for promoting the communication of service users and through the use of person centred tools, agency staff have captured the individual wishes, preferences and needs of service users.
Agency staff have undertaken regular reviews of the needs of service users and maintain documentation which is of a high standard in relation to needs assessments and person centred care / support plans.
Some service users experience restrictions within their home and these were noted to have arisen from the multi-disciplinary assessment of needs and risks. The impact of restrictive practices on other service users was noted to have been assessed and managed appropriately, involving all of the service users in the decision making process.

The agency has sought the involvement and cooperation of service users with regard to a range of care practices. 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.

Within two of the reports examined the inspector could not ascertain which service users had been consulted and in one report there was no record of consultation with service users' relatives.

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. Agency staff also reported they felt their knowledge of the reporting procedures to be good or excellent.

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

The inspector was advised of two safeguarding referrals made to the HSC Trust in respect of one service user and the records of these were examined and discussed with the manager. The agency had reported the concerns in a timely manner to the HSC Trust and PSNI and there was evidence of joint working arrangements between agency staff, the service user and the HSC Trust to safeguard the service user.
However the agency had not reported these incidents to RQIA in accordance with regulations and a requirement has been made with regard to this.

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

Additional matters examined

Statement of Purpose

The agency's Statement of Purpose was examined and had been revised in April 2013. The Statement of Purpose continues to reflect the range and nature of services provided by the agency.

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.	Service users have had assessments of their capacity to manage their finances – these have been signed by HSC Trust staff. Individual agreements for supporting service users to manage their finances had also been signed by HSC Trust staff. The inspector was advised of the arrangements for the provision of transport to service users including the use of staff cars. There were no transport agreements in place to evidence that the arrangements for charging service users for travelling in staff cars had been agreed by the service users, their representatives or the HSC Trust. This requirement has been restated.	**One**	**Partially 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. Service users who participated in the inspection advised the inspector they had chosen where they live and who they live with and that there are regular opportunities to discuss this with agency staff.	**One**	**Fully Met**
2.	Regulation 4 (1-5).	It is recommended that the agency should show clearly how organisational policies, procedures, processes and documents support the separate provision of care and accommodation.	The agency's Guidance Document entitled "Supporting People to access our adult services or enter accommodation" was examined. The document clearly outlined the separation of the care and support from the tenancy.	**One**	**Fully Met**

			Service users and staff also outlined their understanding of the separation of care provision from the service users' accommodation.		
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.	Service users and staff described the agency's matching processes and confirmed that the individual needs of service users are matched to appropriately experienced and skilled staff members. 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:	
A number of tenancy agreements were examined and had been issued to service users by Triangle Housing Association. The tenancy agreements reflected the rental and service charges and the tenant's rights in relation to security of tenure. The agency has undertaken a 'Real Tenancy Test' exercise on behalf of the supported living service users. This focuses on key issues relating to choices, control and consultation. Outcomes of these Tests provide evidence that service users are consulted about where they live, with whom and in relation to the support they receive. Agency staff have also undertaken individual work with service users in relation to the REACH standards. Action plans have been drawn up and include timescales and review dates. 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 outline the breakdown of care and support hours available to the individual and 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 agreements also outline the costs associated with living in a shared house. The Support Agreements 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. 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	Compliant

houses that are not accessible to the service users – i.e. the staff sleep over bedroom. Agency staff who participated in the inspection advised that they treat the service users' homes with respect and that where staff provide a 'sleep over' service, administrative duties are carried out in the staff sleep over bedroom. Service users also provided confirmation that agency staff treat their homes with respect.	

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

Everyone supported (who consented to participate) has a Real Tenancy Test and associated action plan. All of the people we support have completed a “Relationship Circle" (a person centred tool) which identifies the staff they do or do not want to support them in their home. This is used to inform staff rotas.	
Inspection Findings:	
The service users’ support agreements clearly outline the inputs of agency staff into the service users’ homes and, where appropriate, 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 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. There was evidence of a small number of service users experiencing compatibility issues in relation to sharing their home and of agency staff liaising with the relevant HSC Trust staff regarding this. Service users who participated in the inspection also indicated that they had their own keys. Staff who met with the inspector advised that they don’t have keys for the homes of people supported however keys can be accessed and used in emergency situations. Staff also stated that they seek access to service users’ homes by ringing the doorbell rather than entering uninvited. There were records of ‘Issues with People we support’ – these outlined some of the compatibility issues arising from the experiences of three service users receiving a supported living service at the same address. Issues arising included use of language, swearing. The agency had also received a number of complaints in relation to the compatibility issues within one household and these had been shared with the HSC Trust. Agency staff confirmed that while these issues have been brought to the attention of the HSC Trust, progress towards resolving the issues has been slow. It was evident from agency records that the service users involved were very satisfied with the input they received from Positive Futures in relation to supporting them to resolve these matters.	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. Processes to support positive risk taking are 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. Bromford Assessment Plans and Active Support Plans are in place which enable greater levels of autonomy and independence. In addition, the Service is currently in the process of introducing a Distance Travelled Model. If a person wishes to no longer be supported by the Service or if they wish to change tenancy, they are	Compliant

supported to do so. This is detailed in our Move on and Termination of Tenancy Guidance. 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 assessment of care and support needs of service users was noted to have been regularly updated by agency staff and reflected in the care and support plans. Risk assessments were in place for individual service users and risk management plans had been endorsed by the HSC Trust. There was evidence of staff matching being completed for each of the service users and agency staff confirmed that the outcome of these assessments is implemented. Agency staff also stated that service users can choose who supports them and that this is reviewed regularly. Service users reported they were very happy with the quality of the support provided by agency staff and described the range of opportunities they have on an on-going basis to comment on the services provided.	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. Bromford Assessment Plans are in place for each of the people supported in the Service. 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:	
A number of key policies and procedures have been developed by the agency to reflect the ethos of	Compliant

supported living. The agency has explicitly stated within a number of policy documents the service users' rights in relation to their care, their ability to choose where to live and who to live with and their right to remain within their home if care needs change. The agency has also undertaken a number of exercises to examine the service users' experience of 'real tenancy'. Agency staff have developed with service users very detailed portfolios which reflect the individuals care and support arrangements. It was evident from these that each service user is supported uniquely and has been fully involved in the planning and review of their support. Agency staff use person centred tools such as 'What's working / not working', 'A good day' / 'A bad day', and a decision making agreement. There was also evidence of the individual service users' preferences in relation to the matching of their support staff. Communication charts and learning logs were also in use. Service users described their ability to opt in or out of shared living arrangements and in particular their ability to choose their own groceries and activities, independently of other service users.	

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

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

THEME 2 - ASSESSMENTS, CARE PLANS, REVIEWS AND CARE PRACTICES REFLECT CONSIDERATION OF THE SERVICE USERS' HUMAN RIGHTS	
Statement 1 Service users participate in their needs assessment, care planning and reviews • Service users with communication needs have their communication needs assessed and there is a plan in place to promote the service user's ability to meaningfully engage in the assessment of their needs and care planning, and in the review of their needs and services; • Where there are communication needs identified, there are appropriate arrangements in place to promote effective communication; • Service users with significant communication needs are supported by non-agency representatives in the assessment and review of their needs and in care planning; • Service users are provided with information in an accessible format in relation to their human rights.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Where people we support have specific communication needs, these are assessed with the relevant professionals (eg Speech and Language Therapist) and a plan put in place to promote meaningful engagement and communication with the individual. Where appropriate, an individual's representative may assist in the identification and review of their needs. People supported participate in their needs assessment through the use of a range of person centred tools, including Communication Charts, Learning Logs, Participation Groups and House Meetings. 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:	
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'. Communication assessments were in place for all service users and there were individualised user friendly methods of sharing information with service users evident, e.g. memory box and use of photographs. The agency also maintains and easy read version of 'Understanding Your Human Rights' and there was evidence that this 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 clear Challenging Bad Practice (Whistleblowing) Policy in place for staff and a complaints procedure for the people we support.	Compliant

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:	
The agency's training records were examined and provided confirmation that all agency staff had received training in human rights and in restrictive practices. The human rights of service users were noted to have been explicitly referenced with the agency's risk assessments / needs assessments and care / support plans. Restrictive practice risk assessments also outlined human rights considerations and these had been endorsed by the HSC Trust. Discussions with agency staff and service users provided evidence that service users' human rights are upheld and that service users are free from inhuman and degrading treatment. There was evidence from speaking with staff and from examination of agency records that care practices which had previously resulted in restrictions had been reviewed and as a result, service users were experiencing more access to areas within their home, more access to their personal property and more independence. Agency staff were noted to be undertaking 3 monthly review meetings with service users, in accordance with the agency's Person Centred Review Policy and Guidance – August 2012. A number of the 3 monthly review meeting minutes were examined and reflected consideration of 'What's working right now' and 'what is not working right now'. Issues arising and things that need to change were noted. Issues discussed included compatibility issues, restrictive practice assessments and privacy. The records of these discussions were very detailed and reflected service user involvement and agency staff's empowerment of the individual. All of the staff who returned a questionnaire to RQIA indicated that service users' views are taken into account and that staff and managers are respectful of the decisions made by service users.	Compliant

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. Restrictive practice assessments had been completed with service users and 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? The service users' risk assessments and restrictive practice assessments had been signed off by agency staff and by HSC Trust representatives. Agency staff described a range of care practices which are restrictive in nature and were being implemented in the homes of service users. These included securing medication in the homes of service users, locking COSHH cupboards locking a cutlery drawer. It was noted that service users who shared their home were experiencing restriction in their access to their cutlery drawer and a cupboard as a result of the needs of one particular service user. However, the restrictions were noted to have been agreed between the service users and their social workers and had been signed by all parties. 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:	
There was some evidence through discussion with the registered manager of capacity assessments being undertaken in relation to dietary restrictions and personal relationships. The outcome of these was evident within the service users' person centred plans and reflected the agency's promotion of the individual's right to self determination and autonomy. There was also evidence of the views and cooperation of service users being sought through the use of person centred tools including 'what's working / what's not working'. However, the individuals' capacity to consent to care practices which are restrictive in nature was not available during the inspection. 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 arrangements in place for evaluating the quality of services provided by the agency were discussed with the registered manager. As outlined in the self assessment, the agency has a number of systems in place for quality monitoring. 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 agency has developed a 'checklist' and report format which includes the views of service users, their representatives, staff and any professionals involved. Guidance on completion of the monthly report suggests that the individual undertaking the monitoring does not consult with the same service users each time and that suggestions for quality improvement are checked and signed off. 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. 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 service users also confirmed that they had the registered manager's contact details and would not hesitate to contact her if needed. 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. Service users when asked about 'what's not working / what makes you unhappy/ sad / angry?' made reference to days out with other service users, parties, Friday night groups, 'good staff', holidays.	Compliant

Service users when asked about 'what's not working / what makes you unhappy/ sad / angry?' made reference to more activities during the day, more independence, feeling lonely and 'staff telling what to do'. In relation to 'What Choices to you get to make each day?' service users reported they choose what to have for breakfast, 'where I do my food shopping', 'what to watch on television', 'where I work'. 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 January 2013 were examined and reflected a number of key strengths within the service and some recommendations including completion of financial capacity assessments and recording. Planned and actual completion dates were also noted. Other methods of quality monitoring within the service included team meetings and house meetings. The agency staff who participated in the inspection 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. Agency staff reported they have weekly team meetings.	

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 eight 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. 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. The date of the October 2012 quality monitoring visit was not specified on the report and it was difficult to ascertain on the November 2012 and February 2013 reports which service users had been consulted. The report of the February 2013 quality monitoring visit did not reflect any contact with service users' relatives or outline a reason why this wasn't undertaken.	Moving Towards Compliance

A recommendation has been made with regard to monthly quality monitoring reports 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.	
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:	
As stated in the inspection findings for Statement 1, the agency has developed a 'checklist' and report format which includes the views of service users, their representatives, staff and any professionals involved. 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'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. All of the agency staff who returned a questionnaire confirmed that they had received training in the safeguarding of vulnerable adults. Agency staff also reported they felt their knowledge of the reporting procedures to be good or excellent	Compliant

The staff training records were examined reflected uptake by all agency staff in training in safeguarding vulnerable adults. There was also some evidence within service user meetings of the agency's safeguarding vulnerable adults policy being discussed. 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. Positive Futures has undertaken a Learning from Winterbourne View Serious Case Review across all of the supported living services. There have been a number of organisational and service specific actions identified for the organisation in relation to this and there was evidence that this had been discussed with agency staff. Training records also contained confirmation that training had been undertaken by agency staff in managing challenging behaviour, record keeping, epilepsy, complaints and compliments, risk assessment, restrictive practices and active support. 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. Agency staff who returned a questionnaire indicated that their knowledge of the procedures for responding to safeguarding concerns where either very good or excellent and none of the staff who returned a questionnaire provided any suggestions for improving the quality of the training.	

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.	Not Compliant

The records pertaining to the Positive Futures Foundation Programme (PFFP) were examined during the inspection and there were a number of staff who had completed this and others who were in the process of completing it. The section on 'Recognise and Respond to Abuse and Neglect' is in accordance with NISCC induction standards. All service users have within their needs assessment an assessment of their vulnerability and the interventions to be undertaken by agency staff to manage this. The registered manager discussed two safeguarding referrals that had been made to the HSC Trust in respect of one service user. The referrals had been made by agency staff following disclosures made to staff by a service user. Discussion with the registered manager and examination of the records provided confirmation that these concerns had been brought to the attention of the HSC Trust in a timely manner and had also been discussed with PSNI. The inspector discussed the Domiciliary Care Agencies Regulations (Northern Ireland) 2007 Regulation 15 (12) (b) with the registered manager and the requirement of the domiciliary care agency to notify RQIA of any incident of this nature which has been reported to the PSNI. The registered manager acknowledged the failure to notify these incidents to RQIA as an oversight and agreed to put in place measures to ensure that any subsequent incidents of this nature will be reported to RQIA in a timely manner.	

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 outcome of the HSC Trust's screening of the safeguarding referral was evident within the service users' records and the immediate protection plan was also within the service users' care records. Agency staff who participated in the inspection described in detail the immediate protection arrangements that had been put in place in conjunction with the HSC Trust and the service user.	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:	
Discussion with the registered manager, agency staff and examination of agency records provided evidence to support the self assessment. The protection plans in place were noted to be detailed and there was evidence of the service users being involved in their development. The documentation also provided evidence that the service user's rights and capacity were considered.	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:	
Discussion with the registered manager and examination of the records maintained by the agency provided evidence of close joint working arrangements between the agency, HSC Trust and the service user. A number of concerns remain in respect of the service users' vulnerability and as such the cases were not closed. There was evidence of on-going risk assessments and care / support plans in place to safeguard the service user. Agency staff had used a 'How best to support me' tool with the service user to outline the range of supports available.	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

Any other areas examined

Complaints

The agency's complaints records were examined for the period 1 January 2012 – 31 December 2012. There had been six complaints received during this period, five of which had been resolved locally. One complaint was noted to be on-going and related to compatibility issues within some service users' home. The service user's complaint was noted to have been in relation to the HSC Trust's response to these circumstances, rather than the agency. The service user consultation records reflected a high level of satisfaction with how agency staff were supporting the service user with this matter.
Two further complaints of this nature were received by the agency in 2013 and the registered manager described the engagement between the agency, the service use and the HSC Trust to resolve the matter.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Joanne Grimes, 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

PRIMARY ANNOUNCED INSPECTION

Sperrin Supported Living & Peripatetic Housing Support Services

28 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 Mrs Joanne Grimes, Registered Manager and Jo Corcoran, Positive Futures after 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, for the purpose of providing prescribed services to service users, so far as is practicable – (d) specify the procedure to be followed where a domiciliary care worker acts for, or receives money from, a service user. This requirement refers to the agency's charges for transport including the use of staff cars. Transport agreements to reflect charges and to be signed by the service user, their representatives and HSC Trust.	Two	A revised practice of invoicing mileage costs to people we support for journeys taken in the staff member's car is now included in the Expenses Claim Procedure. Mileage costs are paid through a formal invoicing process. The mileage rate, charged to people we support for using staff cars to undertake journeys, is now included in the Support Agreement, which is signed by the people we support and, where relevant, their representative and the HSC Trust representative.	Two months from date of inspection – 23 July 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	One	Capacity to consent to Restrictive Practices will be discussed and recorded with the individuals supported and / or their representatives, including any best interests discussion.	Four months from date of inspection – 17 September 2013

		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.			
3.	15 (12) (b)	The procedure referred to in paragraph (6) (a) shall in particular provide for – (b) the Regulation and Improvement Authority to be notified of any incident reported to the police, not later than 24 hours after the registered person - (i) has reported the matter to the police; or (ii) is informed that the matter has been reported to the police	One	RQIA will be informed of any Incident reported to PSNI.	Immediate and on-going

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 inclusion of the date on monitoring reports and the agency's engagement with service users and their relatives 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	Joanne Grimes
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			