PRIMARY INSPECTION

Name of Agency:	**Struell Lodge**
Agency ID No:	**10754**
Date of Inspection:	**23 October 2014**
Inspector's Name:	**Michele Kelly**
Inspection No:	**INO20557**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

General Information

Name of agency:	Struell Lodge
Address:	2 Ardglass Road Downpatrick BT30 6JG
Telephone Number:	02844513850
E mail Address:	marian.fitzsimons@setrust.hscni.net
Registered Organisation / Registered Provider:	Mr Hugh Henry McCaughey
Registered Manager:	Mrs Marian Rose Fitzsimons
Person in Charge of the agency at the time of inspection:	Mrs Marian Rose Fitzsimons
Number of service users:	6
Date and type of previous inspection:	Primary Announced Inspection 21 March 2014 09:00-14:00
Date and time of inspection:	23 October 2014 09:30- 16:15
Name of inspector:	Michele Kelly

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	3
Staff	3
Relatives	1
Other Professionals	2

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	6	2

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' finances and property are appropriately managed and safeguarded**
- **Theme 2 – Responding to the needs of service users**
- **Theme 3 - Each service user has a written individual service agreement provided by the agency**

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

The agency's progress towards full compliance with the requirement and recommendation made following the previous inspection was examined. The agency was assessed as fully compliant with both.

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

Struell Lodge provides domiciliary care service to six tenants in their own homes at two addresses in Ardmeen Green, Downpatrick. The agency works in partnership with the NIHE's Supporting People Programme.

The scheme works under the auspices of Oaklee Housing Association and the South Eastern Health and Social Care Trust as a domiciliary care agency (supported housing living service) Support is provided to adults aged 19 and over.

The scheme provides care and support for people with learning disability to enable them to live full and valued lives as independently as possible in their own home.

Summary of inspection

The announced inspection was undertaken on the 23 October 2014, 09:30 – 16:15. The inspector met with the registered manager, Mrs Marian Fitzsimons during the inspection at the agency's registered office, 2 Ardglass Road, Downpatrick, BT30 6JG.

The inspector had the opportunity to meet with three service users when they invited the inspector into their own homes. Three care staff were interviewed on the day of inspection. They confirmed they had received all mandatory training and were confident that all service users have a care and support plan which adequately addresses their needs. They expressed concerns about staffing levels which were discussed with the registered manager and referred to within this report.

The inspector made telephone contact with one relative who was very happy with the care and support offered to a particular service user stating that "the house is lovely and ….. has a lot of independence".

Two professionals within the HSC Trust contributed to the inspection process and confirmed they had an excellent working relationship with the service which they said works very well in supporting service users with a learning disability. One of the professionals highlighted how effectively staff within the service had managed a challenging health need experienced by a service user. Both said that staff within the agency were very good at responding to changes in need and support requirements and would seek advice appropriately if required.

Prior to the inspection, two staff members forwarded to RQIA completed questionnaires in relation to the quality of service provision. Examination of these questionnaires demonstrated satisfaction with the training offered by the trust and confirmation of their knowledge of the principles of supported living.

Detail of inspection process:

- **Theme 1 - Service users' finances and property are appropriately managed and safeguarded**

The agency has developed a range of policies and procedures for the management of service users' finances and agency staff could demonstrate their knowledge of these. The trust policy in relation to Service Users Finance is still in draft form and a recommendation is made to address this.

Service users have had an assessment of their ability to manage their finances and the outcomes of these were clear in the individual financial support plans. Where financial restrictions were in place to assist service users to manage money this was documented in risk assessments and care plans and reviewed at least annually. Service users have an agreement which clearly sets out their income, expenditure and any charges for which they are liable. They do not contribute from their personal income towards care and support provided to them by Struell Lodge staff.

The agency maintains the appropriate authorisations from the Social Security Agency in relation to those service users for whom the Trust is appointee.

The agency does not operate a transport scheme and service users take full responsibility for this expenditure.

The agency has been assessed as "Compliant" for this theme.

- **Theme 2 – Responding to the needs of service users**

The agency has in place comprehensive care/support plans. Reviews and risk assessments were in place and were up to date. These care plans reflect the input of the HSC trust and the thoughts and views of the service users and their representatives and explicitly highlight the human rights of service users. The agency's staff training records were examined and reflected uptake in training in the mandatory areas. Staff who returned questionnaires confirmed they had attended mandatory training and found it to be effective. The inspector viewed the statement of purpose and it is recommended that the references to another supported living facility should be removed from the statement of purpose.

The agency has been assessed as "Compliant" for this theme.

- **Theme 3 - Each service user has a written individual service agreement provided by the agency**

Service users have been issued with an individual agreement which outlines their allocation of care and support from agency staff. Staff who met with the inspector described how all care needs are met but stated that they did not know if social needs are always met because of a perceived lack of staff. A requirement is made to address this matter.

Service users have all had their needs reviewed by the HSC Trust and have been fully involved in the preparation for review meetings. Examination of service user files did not always provide evidence of attendees at review meetings. It is recommended that all signatures of those present are recorded to confirm attendance or reasons are provided for non-attendance or inability to provide a signature.

The agency has been assessed as 'Substantially Compliant' with this theme.

Additional matters examined

Monthly Quality Monitoring Visits by the Registered Provider
The reports of quality monitoring visits undertaken on behalf of the registered provider were examined. The announced and unannounced reports reflected engagement with the service users, staff, service users' representatives and HSC Trust professionals involved in the service.

The agency's reporting template includes references to training, supervision and appraisal. There was evidence of action plans being developed during the monitoring visit and actions from previous monitoring visits being monitored and progressed.

Charging Survey
At the request of RQIA and in advance of this inspection, the agency submitted to RQIA a completed survey in relation to the arrangements for charging service users.

At the time of the inspection, there were six service users, all of whom had been assessed as lacking capacity to manage their finances. There were corporate appointee arrangements in place for those service users who are unable to manage their finances.

The returned survey shows that no service user is paying for additional care services that do not form part of the HSC trust's care assessment. The inspector was advised that service users do not pay for any of their care or support costs.

Statement of Purpose:
The agency's statement of purpose was examined and reflected the nature and range of services provided by the agency at the time of the inspection. It is recommended that the references to another supported living facility should be removed from Struell Lodge statement of purpose.

The agency's statement of purpose was reviewed in May 2013.

Care reviews
The registered manager completed and returned to RQIA a questionnaire which sought information about the role of the HSC Trust in reviewing the needs and care plans of service users during the period 1 April 2013 – 31 March 2014 (in accordance with In accordance with the DHSSPS Circular HSC (ECCU) 1/2010 "Care Management, provision of services and charging guidance").

The returned survey states that all service users eligible for review have had their review completed. This was verified by the inspector on examination of the records as well as during discussions with a member of the HSC Trust staff interviewed.

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

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	23. (1)	The registered person shall establish and maintain a system for evaluating the quality of the services which the agency arranges to be provided. This requirement relates to the recording of announced and unannounced monitoring visits on the current documentation.	Monthly monitoring reports were examined and contain detail in relation to the status of the visit being announced or unannounced.	**Once**	**Fully met**

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Number of Times Stated	Inspector's Validation Of Compliance
1	1.1	The agency should review each individuals care assessments to ensure that if restrictive practices are in place with regards finances and medication these are recorded appropriately in line with individual capacity.	Individual care assessments have been reviewed and if restrictions in relation to finance or medications have been assessed as necessary. These have been appropriately recorded in line with individual capacity.	**Once**	**Fully met**

THEME 1 - SERVICE USERS' FINANCES AND PROPERTY ARE APPROPRIATELY MANAGED AND SAFEGUARDED	
Statement 1: **The agency maintains complete and up to date records in respect of the terms and conditions of the provision of personal care** • The agency provides to each service user a written guide, including a personalised written agreement detailing the specific terms and conditions in respect of any specified service to be delivered, including the amount and method of payment of any charges to the service user; • The individual agreement details all charges payable by the service user to the agency, the services to be delivered in respect of these charges and the method of payment; • Where service users pay for additional personal care services which do not form part of the HSC trust's care assessment, documentation exists confirming that the HSC trust are aware of any arrangements in place between the agency and the service user; • The individual agreement clarifies what arrangements are in place to apportion shared costs between the agency and the service user(s). This includes those costs associated with any accommodation used in connection with agency business, where this is conducted from the service users' home; • There are arrangements in place to quantify the costs associated with maintaining any unused areas within the service users' home which they do not have exclusive possession of; • The service user guide/ individual agreement clarifies what the arrangements are for staff meals while on duty in the service users' home; • Where the agency is involved in supporting a service user with their finances or undertaking financial transactions on the service user's behalf, the arrangements and records to be kept are specified in the service user's individual agreement; • The agency has a policy and procedure in place to detail the arrangements where support is provided by agency staff to enable the service users to manage their finances and property; • The agency notifies each service user in writing, of any increase in the charges payable by the service user at least 4 weeks in advance of the increase and the arrangements for these written notifications are included in each service user's agreement 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	
All service users have a tenancy agreement, terms and conditions of service provsion and a service user`s guide detailing the service to be delivered. Each service user is supported to complete an Adult Supported Living Financial support assessment and an individual agreement detailing the individual financial support required. There are no charges to tenant`s for additional personal care services,the agency does not use any part of the tenant`s home to conduct their business and staff on duty return to the main office for meals When staff support tenants with their finances or undertake financial transactions on the tenant`s behalf transactions are recorded with two signatures and regular reconciliation of monies is completed. The agency is currently a member of a Regional Working group which will produce guidance for staff in relation to the management of service users finances in supported living.	Moving towards compliance
Inspection Findings:	
All of the service users have had a financial assessment and there were financial support plans in place. Each service user has a financial agreement and these outline the service users' income and expenditure. Agreements state that there are no charges made for care or support received. The agreements have been signed by service users and their representatives and outline the service users' rights to advocacy, to complain and to be consulted. Staff do not have office accommodation within any of the homes of service users and the registered manager confirmed that staff provide their own food for consumption while on duty. There is no assessed need for night cover in any of the accommodation within the service, and there is no staff sleepover room in any of the properties. The inspector viewed a draft "Service User Financial Support Policy / Procedure" – published in April 2014. The document references RQIA transport guidance and DHSSPS circulars. The document sets out the arrangements for each service user to have a financial support assessment including reference to their capacity to manage their finances and a financial risk assessment. It also sets the arrangements for acting on behalf of service users, best interests' arrangements for those who lack capacity and the use of "Patients Private Property accounts (PPP) and appointee ship. It was recommended that the agency's financial policy and procedures include the accountability arrangements for staff in lone working situations.	Substantially Compliant

THEME 1 - SERVICE USERS' FINANCES AND PROPERTY ARE APPROPRIATELY MANAGED AND SAFEGUARDED	
Statement 2: **Arrangements for receiving and spending service users' monies on their behalf are transparent, have been authorised and the appropriate records are maintained:** • The HSC trust's assessment of need describes the individual needs and capabilities of the service user and the appropriate level of support which the agency should provide in supporting the service user to manage their finances; • The agency maintains a record of the amounts paid by/in respect of each service user for all agreed itemised services and facilities, as specified in the service user's agreement; • The agency maintains a record of all allowances/ income received on behalf of the service user and of the distribution of this money to the service user/their representative. Each transaction is signed and dated by the service user/their representative and a member of staff. If a service user/their representative are unable to sign or choose not to sign for receipt of the money, two members of staff witness the handover of the money and sign and date the record; • Where items or services are purchased on behalf of service users, written authorisation is place from the service user/their representative to spend the service user's money on identified items or services; • There are contingency arrangements in place to ensure that the agency can respond to the requests of service users for access to their money and property at short notice e.g.: to purchase goods or services not detailed on their personal expenditure authorisation document(s); • The agency ensures that records and receipts of all transactions undertaken by the staff on each service user's behalf; are maintained and kept up-to-date; • A reconciliation of the money/possessions held by the agency on behalf of service users is carried out, evidenced and recorded, at least quarterly; • If a person associated with the agency acts as nominated appointee for a service user, the arrangements for this are discussed and agreed in writing with the service user/ their representative, and if involved, the representative from the referring Trust. These arrangements are noted in the service user's agreement and a record is kept of the name of the nominated appointee, the service user on whose behalf they act and the date they were approved by the Social Security Agency to act as nominated appointee;	**COMPLIANCE LEVEL**

• If a member of staff acts as an agent, a record is kept of the name of the member of staff, the date they acted in this capacity and the service user on whose behalf they act as agent; • If the agency operates a bank account on behalf of a service user, written authorisation from the service user/their representative/The Office of Care and Protection is in place to open and operate the bank account, • Where there is evidence of a service user becoming incapable of managing their finances and property, the registered person reports the matter in writing to the local or referring Trust, without delay; If a service user has been formally assessed as incapable of managing their finances and property, the amount of money or valuables held by the agency on behalf of the service user is reported in writing by the registered manager to the referring Trust at least annually, or as specified in the service user's agreement.	
Provider's Self-Assessment	
A financial support assessment is completed with each service user that details the financial support needs of the service user. A financial agreement is drawn up with the tenant. The agency maintains records of all transactions completed on the tenant`s behalf as detailed in the service users individual agreement. All transactions for the distribution of money to service users are signed by the service user and a staff member or two staff members if the service user is unable to sign. All service users are supported to complete an individual financial agreement that details services purchased by or on behalf of the service user, these are signed by the service user and reviewed annually. This agreement also details how service users can access their money at short notice. The Agency maintains records and receipts of all transactions and a reconciliation is carried out on a quarterly basis.All service users who have an appointee have the arrangements for this detailed in their financial agreement. All of the current service users have had a capacity assessment completed and have been assessed as requiring support. The agency has opened PPP accounts for each service user with a named corporate appointee.	Compliant

Inspection Findings:	
The agency maintains the appropriate authorisations from the Social Security Agency in relation to those service users for whom the Trust is appointee. Documents outline the individual responsibilities of the corporate appointees as well as staff and show clear procedures to be followed when handling service users' monies. The manager outlined how these procedures are implemented. As stated in the self-assessment, a financial support assessment has been undertaken with each service user and financial support plans were in place. . Each service user has a "Patients Private Property account (PPP).	Compliant

THEME 1 - SERVICE USERS' FINANCES AND PROPERTY ARE APPROPRIATELY MANAGED AND SAFEGUARDED	
Statement 3: **Where a safe place is provided within the agency premises for the storage of money and valuables deposited for safekeeping; clear, up to date and accurate records are maintained:** • Where the agency provides an appropriate place for the storage of money and valuables deposited for safekeeping, robust controls exist around the persons who have access to the safe place; • Where money or valuables are deposited by service users with the agency for safekeeping and returned, a record is signed and dated by the service user/their representative, and the member of staff receiving or returning the possessions; • Where a service user has assessed needs in respect of the safety and security of their property, there are individualised arrangements in place to safeguard the service user's property; • Service users are aware of the arrangements for the safe storage of these items and have access to their individual financial records; • Where service users experience restrictions in access to their money or valuables, this is reflected in the service user's HSC trust needs/risk assessment and care plan; A reconciliation of the money and valuables held for safekeeping by the agency is carried out at regular intervals, but least quarterly. Errors or deficits are handled in accordance with the agency's SVA procedures.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
A safe is provided for the safe storage of money only. Only three senior staff and the manager have access to the safe. Each service user has a locked bedroom for the security of their property and valuables. Service users are aware of the arrangements for the safe storage of money and have access to financial records and additional money when requested.Individual service user reconciliation of money held for safekeeping is carried out weekly.	Compliant

Inspection Findings:	
As outlined in the self-assessment a safe is provided for the storage of money. Access to this safe is limited to particular staff members and the manager confirmed reconciliations are carried out weekly. In each house individual service users can lock valuables in their bedrooms. The registered manager outlined an incident where a sum of money had gone missing within a service user's home. The inspector was satisfied that the agency had taken steps to investigate the situation and safeguard the service user's property. The matter has been reported to the trust adult safeguarding team, PSNI and RQIA.	Compliant

THEME 1 - SERVICE USERS' FINANCES AND PROPERTY ARE APPROPRIATELY MANAGED AND SAFEGUARDED	
Statement 4: **Arrangements for providing transport to service users are transparent and agreed in writing with the service user/their representative:** • The needs and resources of the individual service user are considered in conjunction with the HSC Trust assessment; • The charges for transport provision for an individual service user are based on individual usage and are not based on a flat-rate charge; • Service users have the opportunity to opt out of the transport scheme and the arrangements for opting out are detailed within the agency's policies and procedures; • Written agreement between the service user and the agency is in place, detailing the terms and conditions of the transport scheme. The agreement includes the charges to be applied and the method and frequency of payments. The agreement is signed by the service user/ their representative/HSC trust where relevant and a representative of the service; • Written policies and procedures are in place detailing the terms and conditions of the scheme and the records to be kept; • Records are maintained of any agreements between individual service users in relation to the shared use of an individual's Motability vehicle; • Where relevant, records are maintained of the amounts of benefits received on behalf of the service user (including the mobility element of Disability Living Allowance); • Records detail the amount charged to the service user for individual use of the vehicle(s) and the remaining amount of Social Security benefits forwarded to the service user or their representative; • Records are maintained of each journey undertaken by/on behalf of the service user. The record includes: the name of the person making the journey; the miles travelled; and the amount to be charged to the service user for each journey, including any amount in respect of staff supervision charges; • Where relevant, records are maintained of the annual running costs of any vehicle(s) used for the transport scheme; • The agency ensures that the vehicle(s) used for providing transport to service users, including private	**COMPLIANCE LEVEL**

(staff) vehicles, meet the relevant legal requirements regarding insurance and road worthiness. Where the agency facilitates service users to have access to a vehicle leased on the Motability scheme by a service user, the agency ensures that the above legal documents are in place; • Ownership details of any vehicles used by the agency to provide transport services are clarified.	
Provider's Self-Assessment	
The service does not provide a transport scheme for service users. Service users use public transport as and when required.	Not applicable
Inspection Findings:	
As stated in the self-assessment the agency does not provide a transport service. Service users access public transport as required.	Not applicable

PROVIDER'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	**COMPLIANCE LEVEL**
	Moving towards compliance

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

THEME 2 – RESPONDING TO THE NEEDS OF SERVICE USERS	
Statement 1: **The agency responds appropriately to the assessed needs of service users** • The agency maintains a clear statement of the service users' current needs and risks. • Needs and risk assessments reflect the input of the HSC Trust and contain the views of service users and their representatives. • Agency staff record on a regular basis their outcome of the service provided to the individual • Service users' care plans reflect a range of interventions to be used in relation to the assessed needs of service users • Service users' care plans have been prepared in conjunction with the service user and their HSC Trust representative(s) and reflect appropriate consideration of human rights.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
The agency maintains comprehensive person centred care plans that outline the service user's current care and support needs and risks. Multi disciplinary reviews are carried out approximately 6 weeks after moving in, then annually or earlier if the tenant has any issues or changes to their needs.. Service users are consulted through monthly tenants meetings, service users surveys, monthly key worker meetings, monthly monitoring visits, audits, inspections and indivdual reviews. Care and support plans reflect the full range of interventions as assessed for the individual, including consideration of Human Rights. Staff have received Human Rights training and Human Rights awareness sessions have been carried out with all service users.	Compliant

Inspection Findings:	
The service users care records were examined and contained needs and risk assessments and support plans. The agency's care records contained specific reference to the service users' human rights and it was evident that staff had developed the documentation to ensure the process of assessing and planning care was comprehensive and robust. It was evident from these records and from discussions with agency staff and service users, that staff make referrals to external HSC trust staff in response to changing needs. Service users were noted to have annual reviews and the attendance of HSC trust staff at these meetings was evident in some service users' files. Agency staff described excellent working relationships with the HSC Trust and advised the inspector that they could contact trust colleagues at any time in relation to any changing needs identified. This was verified by two members of trust staff contacted by the inspector.	Compliant

THEME 2 – RESPONDING TO THE NEEDS OF SERVICE USERS	
Statement 2: **Agency staff have the appropriate level of knowledge and skill to respond to the needs of service users** • Agency staff have received training and on-going guidance in the implementation of care practices • The effectiveness of training and guidance on the implementation of specific interventions is evaluated. • Agency staff can identify any practices which are restrictive and can describe the potential human rights implications of such practices. • The agency maintains policy and procedural guidance for staff in responding to the needs of service users • The agency evaluates the impact of care practices and reports to the relevant parties any significant changes in the service user's needs. • Agency staff are aware of their obligations in relation to raising concerns about poor practice	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
All staff within the service attend mandatory training as appropriate to their role, records and evaluation of training are maintained in staff personal files.Staff competency assessment has been completed with all senior staff. Additional training needs are assessed through annual appraisal, 8 weekly supervision, competency assessment and staff meetings. The agency has guidance for staff on care planning and reviews to meet the needs of service users.Any changes in the needs of service users are reported to the manager and other staff on a daily basis and concerns are reported to multi professional team as necessary. The impact of care practices are evaluated and reviewed dependant on the service user need. The agency has a working definition of `restrictive practice` and a restrictive practice assessment is completed for each service user. All staff have received Human Rights and Safeguarding vulnerable adults training. The agency has a `whistle blowing policy` and safeguarding vulnerable adults policy in place and all staff are aware of their responsibilities in relation to highlighting any incidence of poor practice.	Compliant

Inspection Findings:	
The agency's staff training records were examined and reflected uptake in training in the mandatory areas. Agency staff confirmed that they can access all of the trust policies and procedures. Staff who participated in the inspection advised the inspector that they felt they had received adequate training for their roles. Agency staff described their understanding of restrictive practice and could identify types of a restrictive practice. The agency has developed a policy on restrictive practice and this reflects the DHSSPS guidance on restraint and seclusion and references the Human Rights Act. Agency staff who participated in the inspection outlined their responsibility in raising concerns about poor practice.	Compliant

THEME 2 – RESPONDING TO THE NEEDS OF SERVICE USERS	
Statement 3: **The agency ensures that all relevant parties are advised of the range and nature of services provided by the agency** • Service users and their relatives and potential referral agents are advised of any care practices that are restrictive or impact on the service users' control, choice and independence in their own home. • The agency's Statement of Purpose and Service User Guide makes appropriate references to the nature and range of service provision and where appropriate, includes restrictive interventions • Service users are advised of their right to decline aspects of their care provision. Service users who lack capacity to consent to care practices have this documented within their care records. • Service users are provided with a copy of their care plan (in a format that is appropriate to their needs and level of understanding) and receive information in relation to potential sources of (external) support to discuss their needs and care plan. • The impact of restrictive practices on those service users who do not require any such restrictions.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
The service has a Statement of Purpose and a Service User Guide which include the nature and range of services provided. Restrictive interventions are limited within the service and based on individual assessment. Where they are necessary to support a service user to live safely in his/her home the intervention is detailed in their care plan and risk assessment. Service users are provided with a copy of their care plan and information about risk assessment in an understandable format. 4 referrals have been made to independent advocacy services .	Compliant

Inspection Findings:	
Some service users were noted to be experiencing interventions that were impacting on their ability to handle money or take control of medication. The service users' care records clearly outlined the range of needs and risks identified and there were comprehensive risk assessments in place which included consideration of the individuals' human rights. The agency's statement of purpose was examined during the inspection and it outlines the broad range and nature of services provided. The statement of purpose included references to another supported living facility. It is recommended that the references to another supported living facility should be removed from the document.	Substantially compliant

THEME 2 – RESPONDING TO THE NEEDS OF SERVICE USERS	
Statement 4 **The registered person ensures that there are robust governance arrangements in place with regard to any restrictive care practices undertaken by agency staff.** • Care practices which are restrictive are undertaken only when there are clearly identified and documented risks and needs. • Care practices which are restrictive can be justified, are proportionate and are the least restrictive measure to secure the safety or welfare of the service user. • Care practices are in accordance with the DHSSPS (2010) Circular HSC/MHDP – MHU 1 /10 – revised. Deprivation of Liberty Safeguards. (DOLS) – Interim Guidance. • The agency evaluates the impact of restrictive care practices and reports to the relevant parties any significant changes in the service user's needs. • The agency maintains records of each occasion restraint is used and can demonstrate that this was the only way of securing the welfare of the service user (s) and was used as a last resort. • Restraint records are completed in accordance with DHSSPS (2005) Human Rights Working Group on Restraint and Seclusion: Guidance on Restraint and Seclusion in Health and Personal Social Services. • The agency forwards to RQIA and other relevant agencies notification of each occasion restraint is used • The registered person monitors the implementation of care practices which are restrictive in nature and includes their on-going assessment of these practices within the monthly quality monitoring report	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Care practices that are restrictive such as those related to financial safeguarding or administration of medication are detailed in service user financial agreement and individual care plan. Physical restraint is not used within the service. One service user is subject to a promoting quality care and the care planning for this service user is in accordance with the Adult Disability Service, Promoting Quality Care ISO procedure.	Compliant

Inspection Findings:	
Agency staff confirmed that service users do not require any form of physical restraint. Where service users require enhanced support and supervision with medication management and finances, there were appropriate comprehensive risk assessments and management plans in place and there was evidence of service user involvement in care and support plans.	Compliant

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

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

THEME 3 - EACH SERVICE USER HAS A WRITTEN INDIVIDUAL SERVICE AGREEMENT PROVIDED BY THE AGENCY	
Statement 1 **Evidence inspected confirms that service users/representatives have written information and/or had explained to them the amount and type of care provided by the agency** • Service users/representatives can describe the amount and type of care provided by the agency • Staff have an understanding of the amount and type of care provided to service users • The agency's policy on assessment and care planning and the statement of purpose/service user guide describe how individual service user agreements are devised. • The agency's service user agreement is consistent with the care commissioned by the HSC Trust. The agency's care plan accurately details the amount and type of care provided by the agency in an accessible format.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Service users and if necessary their representative are aware of the type of care and support they receive. A record of care and support hours individual to each service user depending on assessed needs is included in care plans. Staff are fully aware of each service user`s care and support needs. The agency has in place referral information which forms part of the overall assessment and personal plan.The agency`s policy/procedure on assessment and care planning and the statement of pupose/service user guide describe how individual service user agreements are devised.	Compliant
Inspection Findings:	
As outlined in the self- assessment, service users have been provided with a breakdown of the care and support hours that have been allocated to them individually. Service users who spoke with the inspector were able to describe in their own words the amount and type of care and support provided by the agency. Staff who met with the inspector described how all care needs are met but stated that they did not know if social needs are met because of a perceived lack of staff. One staff member said that it was difficult to get "keyworker time" and it was not always possible to "sit down and talk to service users".	Moving towards compliance

These matters were discussed with the registered manager who described proposed measures to improve the staffing levels which included increasing hours of staff already employed by the service. Comments regarding staff concerns about staffing levels were included in the September monthly monitoring report. It is required that the registered provider is required to undertake a review of staffing levels and to ensure that there are at all times, adequate numbers of suitably skilled and experienced persons available to meet the assessed needs of service users.	

THEME 3 - EACH SERVICE USER HAS A WRITTEN INDIVIDUAL SERVICE AGREEMENT PROVIDED BY THE AGENCY	
Statement 2 **Evidence inspected confirms that service users/representatives understand the amounts and method of payment of fees for services they receive as detailed in their individual service agreement.** • Service users/representatives can demonstrate an understanding of the care they receive which is funded by the HSC Trust • Service users/representatives can demonstrate an understanding of the care which they pay for from their income. • Service users/representatives have an understanding of how many hours they are paying for from their income, what services they are entitled to and the hourly rate. • Service users/representatives have an understanding of how to terminate any additional hours they are paying for from their income • Service users/representatives have been informed that cancellation of additional hours they are paying for from their income will not impact upon their rights as a tenant.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Each service user has in place a support agreement that states the type and amount of care and support to be provided along with a breakdown of funding from Supporting People and Housing benefit. Service users do not make contributions from their personal income towards their care or support	Compliant
Inspection Findings:	
Service users who met with the inspector demonstrated their understanding of the care they receive from the Trust. From the agency's charging survey, service users' finance agreements and discussion with agency staff it was evident that service users do not pay for any aspect of their care or support.	Compliant

THEME 3 - EACH SERVICE USER HAS A WRITTEN INDIVIDUAL SERVICE AGREEMENT PROVIDED BY THE AGENCY	
Statement 3 **Evidence inspected confirms that service users' service agreements, care plans are reviewed at least annually confirming that service users/representatives are in agreement with the care provided and the payment of any fees.** • Service users/representatives confirm that their service agreement, care plans are reviewed at least annually by the commissioning HSC Trust, and confirm that they are in agreement with the care provided and the payment of any fees. • Records and discussion with staff confirm that the agency contributes to the HSC Trust annual review. • Records and discussion with staff confirm that reviews can be convened as and when required, dependent upon the service user's needs and preferences. • Records confirm that service users' service agreements, care plans are updated following reviews. Authorisation from the HSC Trust and consent from the service user/representative is documented in relation to any changes to the care plan or change to the fees paid by the service user.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Service users needs are reviewed annually or sooner if any changes occur.Care plans and service users agreements are updated following the review.	Compliant
Inspection Findings:	
In advance of the inspection and at the request of RQIA, the agency returned to RQIA a summary of HSC Trust reviews of service users' needs and care plans undertaken in the period 1 April 2013 to 31 March 2014. The inspector was advised that agency staff develop a review schedule for the year and all service users' reviews are attended by agency staff and external HSC Trust staff. Examination of service user files did not always provide evidence of attendees at review meetings. It is recommended that all signatures of those present are recorded to confirm attendance or reasons are provided for non-attendance or inability to provide a signature.	Substantially compliant

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

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

Any other areas examined

Complaints

The agency has had three complaints during the last year; this was verified by returns sent to RQIA and examination of records held on site. Discussion with the registered manager confirmed that all complaints had been resolved and that one incident concerning missing money was being appropriately investigated.

Quality improvement plan

The details of the Quality Improvement Plan appended to this report were discussed with Marian Fitzsimons, 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:

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Announced Primary Inspection

Struell Lodge

23 October 2014

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 Marian Fitzsimons during and 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	16(1) (a)	It is required that the registered provider undertakes a review of staffing levels and to ensure that there are at all times adequate numbers of suitably skilled and experienced persons available to meet the assessed needs of service users.	Once	Ongoing weekly review of staffing levels completed. Staff levels have been enhanced by the transfer of an additional support worker.	Three months from the date of inspection- 15 January 2015

Recommendations

These recommendations are based on The Domiciliary Care Agencies Minimum Standards (2011), 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	8.7	The registered manager should review the statement of purpose to ensure that it does not contain references to another agency.	Once	The statement of purpose has been reviewed and amended.	Two months from the inspection date-18 December 2014.
2	5.6	The registered manager should review all review reports to ensure appropriate signatures have been recorded or reasons detailed regarding their absence. Refers to but is not limited to signatures of all those attending annual reviews and confirming minutes.		All review reports have been reviewed and now have signatures or reasons detailing their absence.	Three months from the date of inspection-15 January 2015.
3	8.15	The registered person must ensure that there are written accounting and financial control procedures that meet professional standards of good practice and legislative requirements and provide safeguards against errors or fraud This recommendation refers to the further development of agency financial policies and procedures with regard to the accountability arrangements for staff in lone working situations.		The draft ISO procedure for Managing Service User Finances is to undergo further update following Regional Working group recommendations.	Three months from the date of inspection-15 January 2015.

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	Marian Fitzsimons
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Brendan Whittle, Director of Adult Services and Prison Healhcare

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable			
Further information requested from provider			

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	
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Michele Kelly	25/6/15
Further information requested from provider			