PRIMARY INSPECTION

Name of Agency:	**Praxis Care Group**
Agency ID No:	**10826**
Date of Inspection:	**25 September 2014**
Inspector's Name:	**Michele Kelly**
Inspection No:	**020474**

The Regulation And Quality Improvement Authority
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General Information

Name of agency:	Praxis Care Group
Address:	132 - 136 Thomas Street Portadown BT62 3AN
Telephone Number:	02838331196
E mail Address:	joeoneill@praxiscare.org.uk
Registered Organisation / Registered Provider:	Nevin Ringland
Registered Manager:	Joseph O'Neill
Person in Charge of the agency at the time of inspection:	Joseph O'Neill
Number of service users:	29
Date and type of previous inspection:	Primary Announced Inspection 12 August 2013
Date and time of inspection:	Primary Announced Inspection 25 September 2014
Name of inspector:	Michele Kelly 9:30am- 4:45pm

Introduction

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

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

Purpose of the inspection

The purpose of this inspection was to ensure that the service is compliant with relevant regulations, minimum standards and other good practice indicators and to consider whether the service provided to service users was in accordance with their assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, procedures, practices and monitoring arrangements for the provision of domiciliary care, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Domiciliary Care Agencies Regulations (Northern Ireland) 2007
- The Department of Health, Social Services and Public Safety's (DHSSPS) Domiciliary Care Agencies Minimum Standards (2011).

Other published standards which guide best practice may also be referenced during the inspection process.

Methods/process

Committed to a culture of learning, RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the Minimum Standards.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.

Specific methods/processes used in this inspection include the following:

- Analysis of pre-inspection information
- Discussion with the registered manager
- Examination of records
- Consultation with stakeholders
- File audit

- Evaluation and feedback

Any other information received by RQIA about this registered provider and its service delivery has also been considered by the inspector in preparing for this inspection.

Consultation process

During the course of the inspection, the inspector spoke to the following:

Service users	2
Staff	5
Relatives	2
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	16	14

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.

One requirement and five recommendations were identified on the last inspection of 12 August 2013. On this inspection the requirement was fully met and four of the five recommendations had been met. One recommendation is restated as a requirement.

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

Praxis Care, Locke House, 132 – 136 Thomas Street, Portadown, was opened in the autumn of 2009. The scheme receives funding from the Northern Ireland Housing Executive's (NIHE) Supporting People Programme for housing support and from the Southern Health and Social Care Trust (SHSCT) who commission the care provided to service users.

Praxis at Portadown provides supported accommodation for up to 31 tenants, seven of whom live in individual flats, and a further seven who live in a group setting.
The agency also provides a Dispersed Intensive Supported Housing (DISH) service to 17 service users who receive support within the local community. The service users are adults who are under the care of a consultant psychiatrist, and engage with community mental health team services.

Under the direction of the registered manager, Joe O'Neill, 15 staff provide a services including assistance and support in a range of activities, such as housekeeping, food preparation, support with daily living and social activities, maintaining their tenancy and budgeting.
During the day, staff are on site at Thomas Street between the hours of 8.00 am and 11.00 pm, with sleep over cover provided by one staff member between 11.00 pm and 8.00 am. .

Summary of inspection

The announced inspection was undertaken at the agency's registered office, 132 - 136 Thomas Street Portadown, 9:30am - 4:45pm. The inspector examined a range of care records and other documentation maintained by the agency and spoke at length with the registered manager, and five staff. The inspector also had the opportunity to meet with two service users and speak with two relatives. Two HSC Trust professionals also contributed to the inspection process.

In advance of the inspection fourteen staff returned to RQIA a completed questionnaire, these indicated that all of the service users have a care and support plan that has been prepared in conjunction with the HSCTrust and meets the individual needs of service users. Staff who returned a questionnaire confirmed they had received training in safeguarding vulnerable adults however six staff said this could be improved upon. Four staff also indicated that they had not received training in the supported living model of care and support. One staff member discussed concerns about the recent high staff turnover within the service and this matter was raised with the manager and other staff and is discussed within this report.
Staff members interviewed on the day of inspection said they felt supported but one did say; "It is difficult to keep on top of everything"

In view of issues raised by a relative and a service user regarding the amount of care and support available to service users, a recommendation is made to review the care provided to two service users. The relative in question spoke with the inspector by telephone on the day after the inspection. The inspector telephoned the registered manager to inform him of the relative's concerns and the inspector was assured that these matters would be addressed.

Following discussion with staff, the registered manager and a member of trust staff regarding the complex nature of the challenges sometimes experienced within the service a requirement is made in the quality improvement plan to review on call arrangements within the agency.

Detail of inspection process:

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

Service users' finances and property are not managed by agency staff and agency staff do not act on behalf of service users. Service users do not contribute from their personal income towards their care or support.

The agency provided supporting evidence of documentation currently in place to ensure each individual service user has in place the following:

- Transport Agreement
- Domiciliary Care Agreement
- Service User Handbook
- Care Support Agreement
- Bills Agreement

The above arrangements were discussed with the registered manager during the inspection. Service users do not make any personal contribution to the cost of their care or support. Two service users have voluntary restrictions in place to enable them to budget safely. Both service users have consented to these practices and have been assessed a having capacity. The charging survey was discussed during the inspection and the registered manager advised the inspector that some of the detail returned within the survey had changed since it was submitted to RQIA. The inspector advised the manager to review the survey for accuracy and it has since been resubmitted to RQIA.

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

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

The inspector examined a range of care records and found these to be comprehensive. It was evident that service users had been involved in their development and ongoing review. The agency's training records were examined and because of issues raised within questionnaires a recommendation is made to ensure staff training needs are met.
The inspector examined a document which was described as "House Rules". There was a reference in the document to the kitchen being locked at 10 pm to service users. The manager explained this was an out of date document and confirmed that the kitchen was no longer locked to service users at night.
It is recommended that this document is reviewed to reflect the current position.

Two recommendations were made with regard to this theme.

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

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

The individual's weekly entitlement to care and support hours is not outlined within their service agreement. It was recommended that the care and support plans of two service users are reviewed following comments made by them or their relatives.
In view of issues raised regarding the amount of care and support available to service users and the complex nature of the challenges sometimes experienced within the service two requirements and a recommendation were made to address this theme.

The agency has been assessed as "Not Compliant" with this theme

Additional matters examined

Monthly Quality Monitoring Visits by the Registered Provider

The reports of the monthly quality monitoring visits undertaken on behalf of the registered manager were examined and had been completed by a Praxis assistant director. Four reports were viewed and contained evidence of contact with staff, service users and their representatives. Visits had been announced and unannounced and action plans had been developed.

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.

The survey was discussed during the inspection and the registered manager advised the inspector that some of the detail returned within the survey had changed since it was submitted to RQIA. The inspector advised the manager to review the survey for accuracy and submit the completed survey to RQIA which was actioned on 26 November 2014. The registered manager did confirm that agency staff do not act on behalf of service users and are available to offer advice and support with budgeting. It was discussed that two service users who have capacity have agreed to restrictions being put in place to help them manage their budgets. Both individuals have family involvement in their financial affairs. This matter is discussed further within this report. Another service user has affairs managed by the Office of Care and Protection and a relative acts as appointee.

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.

Statement of Purpose

The Statement of Purpose revised on 8 August 2014 outlines the range and nature of services provided.

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	Regulation 5 (1)	The registered person must ensure that the statement of purpose is reviewed / amended to reflect the current services being provided. The completed document must be sent to RQIA 12 October 2013	The statement of purpose was reviewed on 8 August 2014 and is reflective of current services provided**.**	**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	Standard 1.1	It is recommended that the agency review the use of cameras within the scheme, and if necessary align them with individual risk assessment, ensuring there continued use has no impact on people's individual human rights in their own home.	The agency did review the use of cameras in corridors and stair wells and the issue was discussed at Group living meetings on 28 October and 26 November 2013 with tenants who expressed a wish for the cameras to remain to enhance their need for safety and security. The manager confirmed that the review included individual risk assessments and the potential risk from others who enter the building.	**Once**	**Fully met**
2	Standard 3.2	It is recommended that the agency review the use of the "sign in and out book" within the scheme, and if necessary align them with individual risk assessment, ensuring the continued use has no impact on people's individual human rights in their own home.	A review of the use of the sign in book had been undertaken with Praxis health and safety department and individual risk assessments developed. Following the review a decision was made to continue the use of the book as a safeguarding measure in the event of fire.	**Once**	**Fully met**

3	Standard 3.2	It is recommended that the agency review the use of the visitor's book within the scheme, and if necessary align them with individual risk assessment, ensuring the continued use has no impact on people's individual human rights in their own home.	A review the use of the visitor's book had been undertaken with Praxis health and safety department and individual risk assessments developed. Following the review a decision was made to continue the use of the book as a safeguarding measure in the event of fire.	**Once**	**Fully met**
4	Standard 1.1	It is recommended that the following is actioned by the registered manager in line with good practice issues in supported living: Each tenant should have in place an agreement specifying the number of support hours available to them individually.	This recommendation has not been actioned. This recommendation will be restated as a requirement.	**Once**	**Not met**
5	Standard 1.1	The agency should ensure that the human rights of all service users are explicitly outlined in care records.	Examination of care plans evidenced that the human rights of service users have been considered in care records.	**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	
Each service user is provided with individualised agreements. These include a Support Agreement, a Domicillary Care Agreement, a Service User Handbook and a Bills Agreement. These documents outline the services available and the Bills Agreement specifically details the costs of the service. These documents are supplemented by the Statement of Purpose. Service users do not pay for additional personal care services which are not part of the Trust's care assessment. Service users pay for electricity and heating in their own bedsits and communal areas. Praxis Care pays for the office and staff use of electricity as well as maintenance. Within our Service User Guide and Statement Of Purpose details are listed with regards to what arrangements are in place for staff meals while on duty in the service users' home. The financial support provided is detailed within the individualised Assessment and Plan as well as the Risk Assessment. A regular financial capability assessment is also undertaken for each service user. Praxis Care has policies and procedures in place to support service users to manage their finances with protocols for best practice. Four weeks notice is provided in writing in relation to any changes to charges payable by the service user.	Compliant
Inspection Findings:	
Service users have been issued with a Domiciliary Care Agreement and this reflects the charges payable by the individual to the agency. The agreement also outlines the contributions from the HSC Trust and the NIHE's Supporting People programme for personal care and housing support provided by the agency. Service users do not make any personal contribution to the cost of their care or support. Costs are itemised within the service agreements and within the Tenants' Guide. The agreement advises services users that they will be notified four weeks in advance of any changes in charges. Agency staff do not share the food purchased by the service users. The inspector was shown a separate kitchen which can be used by staff to prepare meals. The charging survey was discussed during the inspection and the registered manager advised the inspector that some of the detail returned within the survey had changed since it was submitted to RQIA. The inspector advised the manager to review the survey for accuracy and submit the completed survey to RQIA. This resubmitted survey was received on 26 November 2014.	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	
Within the Application Form, Risk Assessment and the individualised reviews regarding our service users, the Statutory Keyworkers are aware of the support provided in relation to managing the service user finances as well as being involved in the decision making process. All support plans detail the type and level of support with regards to the service user's finances and all relevant policies and procedures are followed . All service users have access to their personal money and staff are there to support them should any issues arise with regards to their monies, benefits, etc. The service users are also able to access their money at any time. This agency does not operate a bank account on behalf of any service users. The manager and assistant director audit the records of the tenants who have staff involvement in the management of their finances.Any concerns around a service users capacity would necessitate liaising with the statutory keyworker and a review would be held.	Compliant
Inspection Findings:	
The agency does not act as appointee for any services user. Some service users require support from agency staff to manage their finances and care records contain evidence of financial assessments and support strategies undertaken to help service users who have assessed needs to budget and manage their money. Tenants' financial records are reconciled and audited monthly by senior Praxis staff. Two service users who have capacity have agreed to restrictions being put in place to help them manage their budgets. Both individuals have family involvement in their financial affairs. This matter is discussed further within this report. Another service user has affairs managed by the Office of Care and Protection and a relative acts as appointee.	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	
Procedures for the storage of money and valuables are as per Praxis Care Policy and Procedures. Currently there are no money or valuables deposited by service users for safekeeping. Any restrictions in relation to service users accessing their monies are clearly documented in their Support Plan.	Compliant
Inspection Findings:	
As discussed previously two service users have voluntary restrictions in place to enable them to budget safely. Both service users have consented to these practices and have been assessed a having capacity. One service user who spoke to the inspector reported that they did not wish to handle their money independently and preferred agency staff to provide them with support.	Compliant

A service user's relative who participated in the inspection confirmed that their views had been taken into consideration in relation to their relative's financial support plan and advised the inspector support from agency staff was of benefit to their relative. Another service user who was noted to be experiencing a restriction in accessing their finances had been assessed as able to handle money which was made available in small amounts and it was evident that this had been agreed by the service user. The agency's care records contained details of the financial assessments and care plans which included the service users' consent to these practices.	

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	
A transport agreement is presented to each service user and signed if required. Service users are encouraged to avail of the local taxi and public transport services. If a staff member accompanies them this cost will be recouped from the service user. Occasionally, some service users will avail of staff cars to get to their destination. In both cases the journey is logged and at the end of each month an invoice is generated and presented to the service user to recoup the staff cost incurred as a result of the journey. If more than one service user is involved the staff cost is divided equally between them. Occasionally, journeys are made by staff on the behalf of and at the request of a service user e.g. bringing items to them while they are in hospital, these are also logged and the cost recouped at the end of each month. The current applicable rate is 40p per mile. The agency records and stores copies of each staff member's insurance and MOT (if applicable) certificates as well as a copy of their driving licence. This agency does not have a scheme vehicle.	Compliant
Inspection Findings:	
The agency's transport policy outlines the costs and terms and conditions of use and service users have a transport agreement. If staff use their own vehicles to transport tenants they can claim reimbursement and service users are invoiced for costs currently at 40p per mile. Payments are logged and receipted. The agency ensures that staff vehicles which may be used to transport service users have met legal requirements for road worthiness.	Compliant

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

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

THEME 2 – 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	
All service users have a completed assesment and plan which identify their individual needs, risks,support and interventions required taking into consideration their human rights. This is reviewed on an annual basis or more often when changes are highlighted. All assessments are client centred and at each review the statutory keyworker contributes along with the service user and their representative (if applicable). When completing monthly monitoring visits, the person carrying them out also speaks to service users and statutory keyworkers in order to ascertain their views on the service being provided and their comments are recorded. Daily notes, monthly review summaries and annual reviews are completed for each individual service user.	Compliant
Inspection Findings:	
A range of care records were examined by the inspector. These evidenced that service users' needs and risks were clearly documented by agency staff and had been reviewed by the HSC Trust. The care records of four service users were examined and contained daily progress notes and key worker summaries of the individual's progress towards aspects of their care and support plan. It was evident from these records and from discussions with agency staff and service users that staff make referrals to 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.	Compliant

Agency staff described excellent working relationships with the HSC trust and advised the inspector that they could contact the trust at any time in relation to any changing needs identified. This was verified by the member of trust contacted by the inspector following the inspection who said: " ..Staff network with me all the time", "I don't know anywhere else where my client's needs could be met". Another professional visited the agency on the day of inspection and said, "we would struggle to help some clients if Praxis wasn't here". This person also said they had no concerns about the service and emphasised the good communication between the agency and the HSCTrust.	

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 receive comprehensive induction training and additional training is provided which reflects the needs of the service. Through staff meetings, supervision and appraisal training is discussed and reviewed. There is a need to improve staff understanding of the principle of restrictive practice and the effects it may have on a service user's human rights. The agency has developed a training presentation which I plan to discuss at the next staff meeting. The agency provides a range of policies and procedures which all staff can access via our EDMS system. This allows staff to access the most up to date version including guidance in helping them best address the needs of our service users. Staff recognise the importance of keeping up to date with the policies and procedures in an effort to support good practice. Regular reference is made to the staff need to highlight poor practice. All staff are registered with a regulatory body such as NISCC or NMC, each of which have their own specific code of conduct.	Substantially compliant

Inspection Findings:	
The agency's staff training records were examined and reflected uptake in training in the mandatory areas. Five staff were spoken to on the day of inspection and they expressed satisfaction with induction and training courses. The registered manager explained that supervision takes place on ten occasions each year and staff files demonstrated this. 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 described their understanding of restrictive practice. Agency staff who participated in the inspection outlined their responsibility in raising concerns about poor practice and the inspector was shown a presentation to be delivered to all staff in relation to restrictive practices as part of cascade training. Six staff indicated in questionnaires that the training provided for safeguarding vulnerable adults could be improved. Suggestions included more detail and time for discussion was required. One respondent commented that "more advanced instruction is necessary for higher grades" Four staff also indicated they had not had training in the supported living model of care. A recommendation is made regarding this theme.	Substantially 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	
Any care practices which could be deemed restrictive are discussed and agreed with and by the service users - monthly SU meetings are held during which these practices can be debated. Within our scheme we have a Statement of Purpose and Service User Handbook which outlines our service. All service users have individualised support plans detailing the support and care being offered. Staff also involve the service user when completing the monthly review summary which highlights all care and support received during the previous month. Each service user has the choice to either decline or continue with the support being offered. All service users are offered a copy of their support plan and information in relation to what external potential sources of support are available should the wish to avail of same.	Compliant

Inspection Findings:	
The tenants guide and the statement of purpose describe the nature and range of the service provided. Information is available to service users about independent advocacy services available to them and/or their representative. Care plans in place are relevant to the individual and are in a format suitable to individual need. Service users are advised in their tenants' handbook of their right to decline aspects of their care provision. As discussed previously restrictions in relation to handling money are in place for two service users. These have been documented and agreed and only impact on the service user concerned.	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	
There are very few restrictive care practices undertaken by the agency. Any that are undertaken are clearly identified and documented in the service user's assessment and support plan. They are regularly evaluated as part of the review process and in consultation with the statutory keyworker. Restraint is not practiced in this scheme. The monthly monitoring report monitors the implementation of restrictive care practices.	Compliant

Inspection Findings:	
The restrictive practices in place in relation to finances are subject to regular review at care reviews and within monthly monitoring reports. Restrictions refer to two service users who have capacity and have agreed to restrictions being put in place to help them manage their budgets. Both individuals have family involvement in their financial affairs. One service user who spoke to the inspector reported that they did not wish to handle their money independently and preferred agency staff to provide them with support. During the inspection the inspector examined a document which was described as “House Rules”. There was a reference in the document to the kitchen being locked at 10 pm to service users. The manager explained this was an out of date document and confirmed that the kitchen was no longer locked to service users at night. The inspector advised that if the kitchen is required to be locked on occasions due to the need for adequate staff supervision written consent must be given by service users. It is recommended that this document is reviewed to reflect the current position.	Substantially compliant

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

INSPECTOR’S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Substantially 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 are provided with a support agreement and domicillary care agreement which details the type of service provided. The Statement of Purpose is also readily available. The Service User Handbook and each support plan indicates the level of agreed support available to each service user. It should, however, be noted that it can be very difficult to quantify the time provided to service users with complex needs whose requirements may change on a weekly if not daily basis. Staff have knowledge of the above agreements and through staff meetings, supervision, handovers, etc. service users' care and support is discussed. The service users agreement is consistent with the care commissioned by the Southern Trust. The Statement of Purpose, Service User Guide and each service user assessment and plan is completed as per Praxis Care's Policy and Procedures. Each service user's support plan is person-centred and details the support available to them.	Compliant

Inspection Findings:	
The individual's weekly entitlement to care and support hours is not outlined within their service agreement and a recommendation had been made with regard to this at the previous inspection. The registered person is required to ensure that service users' agreements include the allocation of care hours to each individual. The registered manager discussed the complex and changing needs of some service users and the impact of these on agency staff. He described strategies in place to cope with difficult situations. These included ensuring some service users' needs were always met with two agency staff present during support visits. This was consistent with the HSC Trust care plan and verified by a trust professional visiting on the day of inspection. The inspector was concerned about how the practice of two staff visiting can be managed overnight if required, as there is only one staff member on sleepover duties. The registered manager said that if the situation arose the staff member could alert emergency services if required and indicated difficulties with the particular service users had only happened in the day and evening. The inspector examined the incidents log and it was clear that the nature and frequency of incidents demonstrated that the service experienced challenges on a regular basis, most often during the day and evening. The manager confirmed that there was a clear protocol for staff on duty at night to follow in the event of having to respond to service users' needs, this included a crisis plan The inspector discussed the on call arrangements for sleep in staff to access if needed, and concluded that these should be reviewed to assess if a more formal on call system is required. At present there is an informal arrangement where a sleep in staff member can telephone the manager who is not officially on call and can also telephone the on call Assistant Director for the organisation. A requirement is made to address this matter. One staff questionnaire returned stated; "Care and services are of a very high standard however recent drastic staff turnover has been very unsettling for all". This matter was discussed with the registered manager who explained staff had moved from the service for career development. Staff members interviewed on the day of inspection said they felt supported but one did say ; " it is difficult to keep on top of everything".	Not complaint

The inspector telephoned a relative following the inspection who spoke of concerns they had regarding the amount of support offered to their relative. This person indicated that they believed more support should be available. The inspector informed the registered manager of these concerns in a telephone call on 26 September 2014. Mr O' Neill outlined the support already in place for this service user and agreed to review this following the relative's comments. Another service user who met with the inspector spoke of "feeling lonely" in the single occupancy property and said they liked the drop in facility offered by the service on a weekly basis. This person stated they do not have any support visits to their property. The registered manager confirmed that this person no longer required support visits to home, but as his property is close to the agency office regularly visits staff and other tenants and can access support when and if required. In a staff questionnaire returned a comment was made; "Service users with no further need for support are not moved on in a timely manner". It is recommended that both of the service users discussed within this statement have their care and support reviewed to ensure that assessed needs are being adequately met. In view of issues raised regarding the amount of care and support available to service users and as individuals do not have a breakdown of care and support hours a further requirement is also made to address this theme.	

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	
All service users are given a copy of their individual service agreements which are discussed with and signed by them when commence their tenancy. There are no self funders currently within the scheme and the agency's Bills Agreement outlines the amount of costs payable. There are presently no service users who pay for additional hours.	Compliant
Inspection Findings:	
As outlined in the self-assessment, service users do not make contributions from their personal income towards their care or support. Domiciliary care agreements show evidence that the costs and service provided have been discussed with service users and their representatives as well as the HSC Trust. The documentation in place was signed off by the service users' representatives, HSC Trust staff and agency staff. The registered manager explained that one service user has personal care provided by the HSC Trust.	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	
The agency attempts to hold reviews at least annually. The service user, their family/representative (if applicable) their statutory keyworker attend this review. At this review the support plan as well as the service provision is discussed. A review report is completed and is signed off by the statutory representative and the service user. As per the Service User Guide, the Domicilliary Care Agreement and the Support Agreement, a review can be held at any time should either the service user, statutory representative or agency feel this is required. All records within the scheme confirm that the relevant agreements and support plans are reviewed and documented with service user and statutory representative involvement. Consent from the service user is also sought in relation to any change in fees.	Compliant

Inspection Findings:	
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.	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

In advance of the inspection and at the request of RQIA, the agency returned to RQIA a summary of all complaints received during the period 1 January 2013 – 31 December 2013. The agency has had four complaints during the last year; this was verified by returns sent to RQIA and examination of records held on site. Discussion with the manager and records examined show that all complaints were resolved satisfactorily.

Quality improvement plan

The details of the Quality Improvement Plan appended to this report were discussed with Joseph O'Neill, 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

Quality Improvement Plan

Announced Primary Inspection

Praxis Care Group

25 September 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 Joseph O'Neill, registered manager during the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Statutory Requirements

This section outlines the actions which must be taken so that the Registered Person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Domiciliary Care Agencies Regulations (NI) 2007

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	15(2) (c)	The registered person is required to ensure that each service user has in place an agreement specifying the number of support hours available to them individually.	Once	Each service user has an agreement in place specifying the number of support hours they are entitled to per week. Completed 7/1/15.	Within four months of the date of inspection 16 January 2015
2	16 (1) (d)	It is required that the registered person reviews the overnight on- call arrangements within the agency to ensure that staff on sleep in duties have access to support if required	Once	The current over night on call arrangements are as follows. The member of staff on sleep in will call the scheme manager who will assess the situation and provide the appropriate level of support required. In addition to this the named AD on call can be contacted for advice and support. If necessary there is the option of providing additional staff on site over night if the level of risk at scheme level, deems this as being necessary. In addition to this the current over night staffing levels are being reviewed by Praxis Care and the Trust.	Within four months of the date of inspection 16 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	12.4	It is recommended that the training needs of individual staff for their roles and responsibilities are identified and arrangements are in place to meet them. This recommendation refers, but is not limited to information in relation to safeguarding vulnerable adults and supported living model training discussed within Theme 2 Statement 2.	Once	All staff have completed restrictive practice training.	Within four months of the date of inspection 16 January 2015
2	4.3,	It is recommended that the care and support plans are reviewed and updated to reflect any changes in the need for service delivery. Refers to two service users discussed within Theme 3 Statement 1		The care and support plans for the 2 service users discussed have been reviewed and amended to reflect their current support needs as of the 19/12/14.	Within four months of the date of inspection 16 January 2015

3	4.2	It is recommended that the document ““House rules” is reviewed to ensure that it no longer refers to restrictions not in place in the homes of service users.		The document referring to "House Rules" was reviewed by service users on the 5/1/15. There are no longer references within this document that might suggest restrictive practice as there are no restrictive practices at scheme level. The ethos of the document now reflects an agreement which has been discussed and agreed by service users in relation to living in a group living.	Within four months of the date of inspection 16 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	karen Harding
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Andy Mayhew on behalf of Irene Sloan

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Michele Kelly	12/1/15
Further information requested from provider			