PRIMARY INSPECTION

Name of Agency:	**Cranny Close**
Agency ID No:	**11979**
Date of Inspection:	**11 September 2014**
Inspector's Name:	**Michele Kelly**
Inspection No:	**INO020291**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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General Information

Name of agency:	Cranny Close
Address:	4 Cranny Close Omagh BT79 0BE
Telephone Number:	02882251727
E mail Address:	denise.ohagan@westerntrust.hscni.net
Registered Organisation / Registered Provider:	Elaine Way
Registered Manager:	Denise O'Hagan
Person in Charge of the agency at the time of inspection:	Denise O'Hagan
Number of service users:	11
Date and type of previous inspection:	Primary Announced Inspection 10 June 2013
Date and time of inspection:	Primary Announced Inspection 11 September 2014 From 9:15 am – 5:00 pm
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	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	12	12

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

Eight requirements and five recommendations were made at the time of the previous inspection. Examination of these matters concluded that seven requirements were now compliant and one will be restated. Two of the five recommendations will also be restated in the quality improvement plan following this inspection.

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

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

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

Profile of service

Cranny Close is a domiciliary (supported living) service providing care and support for up to sixteen service users with enduring mental health needs. Accommodation is provided by Helm Housing Association in four bungalows (three service users in each bungalow) and four individual flats. Service users have a separate tenancy with Helm Housing. Care and support is provided by eighteen staff (eight nurse qualified and ten support workers) employed by the Western HSC Trust. Those staff members who are registered nurses do not provide any nursing services other than the administration of insulin. Services provided can include assistance with personal care, social support, maintaining a tenancy and social inclusion with the overall goal of promoting good mental health and enhanced quality of life.

Summary of inspection

Detail of inspection process:

The announced inspection was undertaken on the 11 September 2014, 9:15am – 5:00pm.
The inspector met with the registered manager, Ms Denise O'Hagan during the inspection at the agency's registered office, 4 Cranny Close, Omagh, BT79 0BE.

The inspector had the opportunity to meet with two service users who had invited the inspector into their homes and with one other in the grounds of the scheme. Five care staff were interviewed by the inspector 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.

The inspector also spoke to two representatives who were very happy with the care and support offered to their relatives by the staff in Cranny Close.

A professional who was visiting the service contributed to the inspection process and confirmed she had an excellent working relationship with the service which she believes works very well in supporting service users with mental health needs. She said that staff within the agency were good at responding to changes in need and support requirements. Another professional was telephoned after the inspection and confirmed she visits weekly to administer depot medication. She confirmed she had no concerns about the service and said the care provided was excellent.

Prior to the inspection twelve staff members forwarded to RQIA completed questionnaires in relation to the quality of service provision. Seven staff commented within returned questionnaires that improvements could be made to the Vulnerable Adult training. Three staff commented that they had not had training in supported living. Some staff have not had Human Rights Training and a requirement is restated in relation to these matters.

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.
Service users do not contribute from their personal income towards care or support and the service operates a "Pay as You Live" scheme.
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. Service users have an agreement which clearly sets out their income, expenditure and any charges for which they are liable. One service user's affairs are under The Office of Care and Protection and a relative acts as appointee. The service acts as an agent for five other service users within Cranny Close. Individual details regarding the level of financial support were evident in care and support plans examined. Records confirm procedures are adhered to.

There were no requirements or recommendations made with regard to this theme.

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 person -centred and it was evident that service users had been involved in their development. However the registered manager stated that the process of annual reviews of care in conjunction with external HSC Trust professionals had just been initiated. The inspector advised the registered manager that the information recorded on this review lacked detail and the content should be revised to ensure that the report adequately refers to:
Any matters regarding the current care plan; general changes in the service user's situation; and details of important events.

A requirement is also restated in relation to mandatory training for staff as some had not completed Human Rights and Vulnerable Adult training at the time of inspection. A recommendation to evaluate training in relation to Vulnerable Adults is made following review of returned questionnaires.

The inspector also noted the historic use of recording equipment to monitor the physical health of an individual service user, the inspector was concerned that this restrictive measure would impact on the freedoms of another tenant in the property and therefore a requirement is made with regard to this practice.

The agency has been assessed as," Not compliant" with this theme.

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

Service users have not been provided with a breakdown of the care and support hours which have been allocated to them individually. This matter was included within the quality improvement plan on the last inspection(June 2013) and will therefore be restated as a requirement will a recommendation to ensure service users are given an amended support agreement detailing hours allocated to them.

The agency has been assessed as “Not compliant” for 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 reports reflected engagement with the service users, staff, service users' representatives and HSC Trust professionals involved in the service.

There was some evidence of action plans being developed during the monitoring visit but these were not reflective of all content within the report. There was also evidence of material being copied verbatim from one month to the next. These matters are discussed within a letter sent to the registered provider regarding concerns about the quality of information recorded including the lack of information regarding the monitoring of restrictive measures.

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 arrangement for charging service users.
The survey was discussed during the inspection and the registered manager confirmed that no service user is paying for additional services that do not form part of the HSC Trust's care assessment. The registered manager confirmed that agency staff do not act on behalf of the other service users as appointees but are in receipt of monies as an agent for five service users whose financial assessment concluded they needed support with budgeting and managing money. The agency ensures they keep income and expenditure records and all transactions have two signatures and there are weekly reconciliations. One service user's affairs are under The Office of Care and Protection. The registered manager confirmed that a relative acts as appointee for this person. A capacity assessment was not available in this service user's file on the day of inspection but the manager confirmed a psychiatrist had undertaken this.

Care Reviews.

The registered manager did not complete and return 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 (in accordance with the DHSSPS Circular HSC (ECCPU)1/2010 “Care management, provision of services and charging guidance”
This matter is discussed within the report and quality improvement plan.

Statement of Purpose
The agency's statement of purpose has been revised and forwarded to RQIA in advance of the inspection. The statement continues to reflect the range and nature of services provided.

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	16 (4)	The registered manager must ensure that all staff attends one to one formally recorded supervision meetings on a quarterly basis in accordance with policies and procedures. (Minimum Standard 13.3)	**In staff files quarterly face to face supervision sessions are recorded with group supervision on other occasions.**	**Once**	**Compliant**
2	22 (5) (a)	The registered person must ensure that the agency's complaints policy includes the address and contact details for RQIA. (Minimum Standard 15.4)	**Examination of the complaints policy verified this had been actioned.**	**Once**	**Compliant**
3	14 (a,b,c,d,e)	The registered manager must ensure that the service user agrees to the issue of key to the accommodation to any member of staff and that the service user agrees any specific access arrangements. (T1:2, Minimum Standard 1.1, 4.2)	**There is evidence in service user files that they have consented to staff having keys to accommodation and have agreed to staff accessing their accommodation to perform night checks.**	**Once**	**Compliant**

4	15 (2) (b)	The registered manager must ensure that care and support plans and related interventions are consistent with service users' current assessed needs, removing any reference to a nursing task/role. (T1:3, Minimum Standard 3.3)	**Care and support plans have been reviewed are consistent with service users' needs but there is still reference to "nursing" assessment and named nurse on older documentation. The manager confirmed that new templates which do not refer to nursing tasks/roles are now available for use and as reviews are undertaken these will be evident in service user files**	**Once**	**Compliant**
5	14 (a, b, c)	The registered manager must ensure that comprehensive risk assessments and related care plans include contingency arrangements in case of non-adherence to agreed risk managements interventions. (T1:3, Minimum Standard 3.3)	**There is evidence of contingency plans in care plans examined.**	**Once**	**Compliant**
6	14 (a, b, c)	The registered manager must ensure that risks assessments that highlight a risk include risk management interventions and related care plans. (T1:3, Minimum Standard 3.3)	**Three service user files examined had risk management interventions and related care plans**	**Once**	**Compliant**

7	16 (2) (a)	The registered person must develop a plan to urgently address gaps in mandatory training needs of all staff, with particular reference to: management of challenging behaviours; first aid; medication; infection prevention and control; moving and handling; and managing service users' monies. The plan must demonstrate how mandatory training needs of staff will be met by 31 August 2013. A copy of the plan must be forwarded to RQIA by 28 June 2013.	**There are still some gaps in mandatory training which the registered manager is planning to address. Human Rights and Vulnerable Adult training is scheduled for October 2014. This requirement is restated.**	**Once**	**Moving towards compliance**
8	HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order (2003) 2 (2)	It is recommended that all documentation including but not limited to the Statement of Purpose, the Service User Guide, and the induction checklist is reviewed to ensure that references to nurses' roles and nursing tasks are removed.	**These documents have been reviewed and references to nursing tasks and roles removed.**	**Once**	**Compliant**

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Number of Times Stated	Inspector's Validation Of Compliance
1	4.1	It is recommended that the registered manager ensures that referral processes detailed in the service user guide and the statement of purpose are reviewed to ensure that they do not indicate that the service provider has some control over allocation of housing.	**Information within the service user guide and statement of purpose indicates that Helm Housing confirms tenancy application outcomes and their Housing Officer explains the tenancy agreement with each service user.**	**Once**	**Compliant**
2	4.1	It is recommended that the registered manager ensures that support agreements specify the individually agreed minimum number of support hours available to all service users.	**This recommendation has not been actioned.** **This recommendation will be restated as a requirement.**	**Once**	**Not compliant**
3	4.2	It is recommended that the registered manager ensures that the amended support agreement documentation is issued to service users.	**This recommendation has not been actioned.** **This recommendation will be restated as a requirement.**	**Once**	**Not compliant**

4	4.2	It is recommended that the registered manager formalises processes of consultation with service users in relation to who they might share their accommodation with.	**This process of consultation is outlined in the Statement of Purpose.**	**Once**	**Compliant**
5	3.3	It is recommended that the registered manager ensures that the terminology used in care plans is reviewed to ensure that they are written in a consistent person-centred manner.	**Care plans examined on the day of inspection were written in a person centred manner.**	**Once**	**Compliant**

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.	**COMPLIANCE LEVEL**

Provider's Self-Assessment	
There are written agreements in place with regard to the services provided, as shown in the care and support plans, tenancy agreements .The clients have a choice to opt in or out of Pay AsYou Live, but all clients pay for heating, lightening and maintenance and a record is kept for each client.Any sevices eg Sky, telephones in the houses, etc are paid for and supplied by the clients The clients do not pay any personal care cost and no shared costs between the clients and the agency. Within the clients handbook the costs are listed.Staff meals are provided by staff . Any increases are discussed with the clients and recorded	Moving towards compliance
Inspection Findings:	
The registered manager explained that Cranny Close operates a "Pay As You Live" procedure for tenants who make a weekly financial contribution of £55 per week for the purchase of groceries. In addition to PAYL expenses the service users also contribute £35 per week for heating and electricity and £10 towards a fund for decorating and purchasing communal items. These payments are kept in a locked cash box stored in each bungalow so that grocery bills can be divided equally among those tenants who share accommodation and agree to this process. A record is made for each PAYL withdrawal from their personal funds. Groceries are receipted and attached to the expenditure sheets in each cash box. Each bungalow maintains an expenditure sheet and grocery cash balance which is signed by two staff members. The registered manager undertakes regular financial checks and the HSCTrust audits all practices. Each service user has been assessed regarding management of finances and each file has an agreement to charges document signed by the service user.	Compliant

<table>
<tr><th colspan="2">THEME 1 - SERVICE USERS’ FINANCES AND PROPERTY ARE APPROPRIATELY MANAGED AND SAFEGUARDED</th></tr>
<tr><td>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;
• If a member of staff acts as an agent, a record is kept of the name of the member of staff, the date</td><td>COMPLIANCE LEVEL</td></tr>
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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	
The clients have personalised care /support plans which outlines the needs of the individual, their capabilities and support required to be able to manage their own finances. The agency records all monitory transactions between the agency and the client.A receipt is produced. The clients have their own bank or post office accounts and can access their monies at all times. All withdrawals by the client are signed for by the client on the recording sheet. BSO carry out an annual audit . All monies are checked on a daily basis by 2 members of staff, one of which is the safe key holder. The Registered Manager does monthly reconcilliations on the recording sheets.	Moving towards compliance
Inspection Findings:	
The inspector examined a number of records detailing financial arrangements within the service. One service user has affairs managed by The Office of Care and Protection and a relative acts as appointee. As stated in the self-assessment the agency supports five service users to manage their finance and individual details regarding the level of support were evident in care and support plans examined. Monies are stored safely in service users' homes within a locked cupboard behind a locked door and are checked daily by two members of staff. The registered manager also confirmed she does a monthly check and reconciliation of tenant's monies and expenditures.	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	
All staff who have access to the Agency Safe are aware of the safe storage of monies and valuables. All items stored in the safe are recorded and are signed in and out by 2 members of staff. The clients personal monies a re not kept in the unit safe All clients have a yearly financial risk assessment and on the basis of this, those who have an identified need a budgeting and financial support plan is completed.	Moving towards compliance
Inspection Findings:	
The registered manager confirmed that the agency safe is not used for individual tenant monies but can be used to store contributions to scheme heating, electricity and maintenance costs; Denise O'Hagan outlined the process of staff accessing the safe and verified that two staff members check deposits and removals of any money and valuables from the safe. Staff interviewed were able to confirm procedures in place for handling tenant's monies	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 (staff) vehicles, meet the relevant legal requirements regarding insurance and road worthiness.	**COMPLIANCE LEVEL**

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	
There is a Trust vehicle attached to Cranny Close which is there for the use of staff and used by clients if they need to be accompanying to any community activities. The running costs and the maintainence of the vehicle are managed by the Transport Department in the Western Health and Social Care Trust. Staff do not use their personal vehicles in relation to work or for escorting clients.	Substantially compliant
Inspection Findings:	
As outlined in the self-assessment tenants do have transport available to them. The HSC Trust maintains the vehicle and pays the full costs associated with the vehicle upkeep, maintenance and fuel.	Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Provider to complete

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 clients needs and risks are documented in the following way, referral forms , risk assessmnet , support and care plans . The WHSCT have initiated a process of reviews into the services commissioned in Cranny Close. Support and Care Plans are devised with key workers and support staff in collaberation with the clients and their relatives or chosen representatives when available. There is information on Human Rights displayed. Each client has a Human Rights Care Plan	Moving towards compliance
Inspection Findings:	
HSC Trust referral information informs the individual care plans and risk assessments. The care records are person centred and included specific reference to the service users' human rights. The registered manager confirmed that care reviews had not been completed annually for all service users. The agency had developed a new template for recording annual reviews and had implemented this with one service user. The inspector advised the registered manager that the information recorded on this review lacked detail and the template should be revised to ensure that the report refers to : Any matters regarding the current care plan; general changes in the service user's situation; and details of important events. The inspector spoke with an external HSC Trust professional who agreed that the new review process should be more robust. A recommendation is made with regard to this matter.	Moving towards compliance

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<tr><th colspan="2">THEME 2 – RESPONDING TO THE NEEDS OF SERVICE USERS</th></tr>
<tr><td>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</td><td>COMPLIANCE LEVEL</td></tr>
<tr><td>Provider’s Self-Assessment</td><td></td></tr>
<tr><td>The Agency completes Staff Training, Appraisals, Supervision in line with Western Health and Social Care Trust.
There are no restrictive practises in Cranny Close and staff are aware of the Western Health and Social Care Trust Policy.
The agency has Policies and Procedures in place . All clients have a Multi-DisiplinaryTeam Review.
Staff are aware of the policies in regard to of Incident Reporting, Whistleblowing, Vunerable Adults,</td><td>Moving towards compliance</td></tr>
<tr><td>Inspection Findings:</td><td></td></tr>
<tr><td>The agency’s training records were examined and provided uptake in a range of mandatory training areas. Staff have also had training in relation to handling service users’ cash (July and September 2014) Seven staff commented within returned questionnaires that improvements could be made to the Vulnerable Adult training. Three staff commented that they had not had training in supported living. Some staff have not had Human Rights Training while others require Vulnerable Adult updates. A requirement is restated in relation to these matters.</td><td>Moving towards compliance</td></tr>
</table>

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	
There are no restrictive practises carried out with in Cranny Close. The Statement of Purpose, Operational Policy and the Clients Handbook identify the range of services provided. All Care and Support plans are drawn up in collaberation with the Clients All clients are deemed capable at present. The clients are aware of the Advocacy provision	Moving towards compliance

Inspection Findings:	
The inspector examined four service user files and noted within one care plan the use of video and auditory monitoring of an individual service user. The practice had now ceased as the service user was hospitalised. The individual tenant concerned had signed the care plan agreeing to this measure but had not signed a form authorising consent for the use of recording equipment which was stored in the service user's file. The inspector discussed with the registered manager the impact of this restrictive measure on the other service user who shared the property. The inspector advised that this persons needs should have also been considered to determine if the use of recording equipment was impacting on their freedoms. The inspector telephoned the agency on 8 October 2014 and had a discussion with the registered manager about the service user who had been hospitalised. The registered manager confirmed that this person remains in hospital and that a care manager will be responsible for assessing needs and ensuring these can be met within Cranny Close before discharge. The registered manager verified that no recording equipment was in place in any service users' property within the agency. The inspector advised that any future use of restrictive practices must include an assessment of the impact of such restrictions on those service users who do not require such restrictions and must be discussed with the multi-disciplinary team and the service user and a representative to ensure that proposed measures are justifiable and proportionate. A requirement is made in relation to this.	Not 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 no restrictive pracitises in Cranny Close. Monthly Quality Monitoring is completed as per RQIA guidelines. .	Substantially compliant

Inspection Findings:	
As outlined in the self-assessment, physical restraint is not used within the service. Agency staff reported excellent working relationships with MDT colleagues and where service users require enhanced support and supervision, there were appropriate comprehensive risk assessments and management plans in place. Four monthly monitoring reports were examined, they lacked detail and statements were sometimes repeated verbatim from one month to the next. Action plans did not always address all the issues for improvement or interventions described within the report. There was also a lack of information regarding the monitoring of restrictive practices. It is required that monthly monitoring reports shall contain details of the measures necessary to improve the quality and delivery of the services which the agency arranges to be provided. It is also required that copies of monthly monitoring reports are forwarded to RQIA until further notice.	Not compliant

PROVIDER'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Provider to complete

INSPECTOR'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Not 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	
All Care and suppoprt plans are collaborated with the clients and with consent nominated persons. key workers and support staff are involved in the assessment process, care and support planning and all documents are signed or indicated if the client refuses. Care and support plans are available at Agency level.	Moving towards compliance
Inspection Findings:	
Care plans state the type of care and support provided and the manager and staff were able to describe the range of care and support provided to individuals. Three service users and two relatives expressed satisfaction with the support offered by staff within Cranny Close. Two professional who contributed to the inspection said they were very happy with the care and support offered to the tenants which one described as “excellent” and another said “ it is a fantastic service where needs are very well met”. Service users have not been provided with a breakdown of the care and support hours which have been allocated to them individually. This matter was included within the quality improvement plan on the last inspection (June 2013) and will therefore be restated as a requirement. A recommendation to ensure service users are given an amended support agreement detailing hours allocated to them will also be restated as a requirement.	Not Compliant

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 clients and their representatives are aware of the care and support that clients receive and that they do incurr any charges for this service.	Moving towards compliance
Inspection Findings:	
As outlined within the agency's charging survey, service users do not pay the agency for any care or support provided. Service users who participated in the inspection advised the inspector that they had been involved in their care and support planning and described some aspects of the care they receive from agency staff.	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 Service User's Agreement and Care and Support Plans are reviewed at least annually. The Western Health Social Care Trust have initiated a process of reviews into the services commissioned in Cranny Close. Support and Care Plans are devised with Key Workers and Support Staff in collaberation with the clients and their relatives or chosen representatives when available. Multidisciplinary reviews for each client are held annually or more often as required. All reviews are attended by those involved in the care of the client and at their request.	Moving towards compliance
Inspection Findings:	
As stated in the self-assessment an external HSC Trust professional has recently initiated involvement in reviews. Evidence of one review was shown to the inspector on a new template. This matter was discussed earlier within this report and a requirement has been made.	Not compliant

PROVIDER'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Provider to complete

INSPECTOR'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Not compliant

Any other areas examined

Complaints

The registered manager confirmed that there had been no complaints within the service**.**

Quality improvement plan

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

A completed Quality Improvement Plan from the inspection of this service has not yet been returned.

If you have any further enquiries regarding this report please contact RQIA through the e-mail address info@rqia.org.uk

Quality Improvement Plan

Announced Primary Inspection

Cranny Close

11 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 Mrs Denise O'Hagan 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	16 (2) (a)	The registered person must develop a plan to urgently address gaps in mandatory training needs of all staff, with particular reference to: Human Rights and Vulnerable Adult Training.	Twice		Within eight weeks of the inspection date, 6 November 2014
2	23 (4)	The registered person must ensure that the monthly monitoring report contains details which the registered person considers it necessary to take in order to improve the quality and delivery of services which the agency arranges to be provided. Refers to matters discussed within Theme 2 Statement 4	Once		Within eight weeks of the inspection date, 6 November 2014
3	23 (2)	The registered person must ensure that monthly monitoring reports are forwarded on a monthly basis to RQIA.	Once		Immediate and ongoing
4	15 (10)	The registered person must ensure that no service user is subject to restrictive intervention in place within the agency for another service user unless the impact of such procedures have been assessed and deemed the least restrictive and most proportionate response. All service users impacted by restrictive practices must agree to such measures.	Once		Within eight weeks of the inspection date, 6 November 2014

5	15 (2) (b) (c)	It is requires that the registered manager ensures that support agreements specify the individually agreed minimum number of support hours available to all service users.	Twice		Within twelve weeks of the inspection 4 December 2014
6	15 (2) (b) (c)	It is required that the registered manager ensures that the amended support agreement documentation is issued to service users.	Twice		Within twelve weeks of the inspection date, 4 December 2014

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	12.9	It is recommended that the registered manager evaluates the effectiveness of training in relation to Vulnerable Adults following feedback in returned questionnaires.	Once		Within twelve weeks of the inspection date, 4 December 2014
2	6.3	It is recommended that the registered manager ensures that the template used in the agency to record review meeting minutes refers in detail to: • any matters regarding the current plan; • general changes in the service users situation; and • details of important events including incidents or accidents occurring during the review period.	Once		Within twelve weeks of the inspection date, 4 December 2014

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			
Further information requested from provider			