PRIMARY INSPECTION

Name of Agency:	**Lisburn Supported Living Service**
Agency ID No:	**12180**
Date of Inspection:	**30 May 2014**
Inspector's Name:	**Audrey Murphy**
Inspection No:	**18174**

The Regulation And Quality Improvement Authority
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General Information

Name of agency:	Lisburn Supported Living Service
Address:	Thompson House Hospital 19-21 Magheralave Road Lisburn BT28 3BP
Telephone Number:	028 92633316
E mail Address:	Claire.hughes@setrust.hscni.net
Registered Organisation / Registered Provider:	South Eastern HSC Trust Mr Hugh McCaughey
Registered Manager:	Mrs Margaret O'Kane (Acting)
Person in Charge of the agency at the time of inspection:	Mrs Margaret O'Kane
Number of service users:	14
Date and type of previous inspection:	7 August 2013, Pre-registration inspection
Date and time of inspection:	30 May 2014 9:30 am – 5:30 pm
Name of inspector:	Audrey Murphy

Introduction

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

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

Purpose of the Inspection

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

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

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

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

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

Methods/Process

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

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

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

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

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	20	5

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	5
Staff	4
Relatives	1
Other Professionals	0

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

Following the agency's pre-registration inspection of 7 August 2013, one requirement was made. The agency was assessed during this inspection as having fully met this 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

Lisburn supported living is a domiciliary care which provides care and support to service users to live as independently as possible within the local community. Services are provided within a number of properties in the Greater Lisburn area. All properties are owned by housing associations and service users are tenants of the property in which they live.

The agency works in partnership with the NIHE's Supporting People Programme, the SEHSCT and with a number of housing associations.

Agency staffing consists of a recently appointed manager, a deputy manager, senior support staff and support staff.

Summary of Inspection

The announced inspection was undertaken on 30 May 2014, 9:30 am – 5:30 pm at the agency's registered office, Thompson House Hospital, 19-21 Magheralave Road, Lisburn.

The inspector examined a range of documentation and records maintained by the agency and was facilitated by agency staff to visit a number of service users in their own homes. The inspector spoke with several agency staff, service users and with the relative of a service user who provided very positive feedback in relation to the quality of service provision.
The inspector observed agency staff engaging with service users in a warm, friendly and supportive manner.

In advance of the inspection, agency staff were invited to submit to RQIA a completed questionnaire and five questionnaires were returned. Staff who returned a questionnaire confirmed they had received training in safeguarding vulnerable adults and rated the effectiveness of this as either 'good' or 'very good'. Staff also indicated that the training could be improved and that it should be more in depth.

Staff who contributed to the inspection confirmed they had received training in human rights and that all of the service users have a care and support plan which adequately addresses their needs.

Staff provided comments on the nature of the supported living service provided included:

"Its aim is about working in partnership with the service user to help empower them to be as independent as possible."

"Supporting individuals on individual basis, so support is tailored to individual needs, support service user led according to their needs and wishes, giving people choice dignity and respect and offering opportunities to try experiences and activities properly."

Detail of inspection process:

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

The agency has developed a range of policies and procedures for the management of service users' finances and agency staff could demonstrate their knowledge of these. Service users have all 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.

There were a number of requirements and recommendations made with regard to this theme. Further development of the draft policies is necessary to include lone working arrangements and service users should be supported to pay their household bills, in accordance with the aims and objectives of the agency, as outlined within the statement of purpose.

Service users must not be charged for the utility costs associated with areas of their home to which they have little access to and do not have exclusive possession of.

The agency has been assessed as 'Moving Towards Compliance' 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 and it was evident that service users had been involved in their development and on-going review.

The agency's training records were examined and there was insufficient evidence within these that agency staff had undertaken training in the mandatory areas.
Two requirements and two recommendations were made with regard to this theme;

The agency has been assessed as 'Not Compliant' with theme.

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

Service users have been issued with an individual agreement which outlines their allocation of care and support from agency staff.

Service users have all had their needs reviewed by the HSC Trust and have been fully involved in the preparation for review meetings.

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

Additional matters examined

Monthly Quality Monitoring Visits by the Registered Provider

The reports of the monthly quality monitoring visits undertaken on behalf of the registered provider were examined and had been completed by a manager from within the SEHSCT.

The deputy manager advised that an action plan is developed following the visit with goals set. The deputy manager also completes monitoring visits across Trust regulated services and advised that she values the feedback from the monitoring officer.

The deputy manager stated that the process keeps a focus for the management of the service, particularly with regard to service users' feedback, financial assessments, complaints and incidents.

The inspector examined the reports available from September 2013 and noted the following:

- there wasn't a report available to reflect any quality monitoring undertaken in December 2013.
- the reports reflected consultations with service users, their relatives and agency staff
- the views of professionals involved with the service were not documented within the reports
- one report had been completed by the manager of the supported living service (April 2014)
- one report had been completed by the deputy manager of the support living service (January 2014).

The inspector raised concerns about the manager and deputy manager undertaking quality monitoring of the service and was advised that this occurred during periods when the monitoring officer wasn't available.

The registered person is required to ensure that quality monitoring is not undertaken by by staff who have day to day operational responsibility for the service.

It was also recommended that the views of professionals who are involved with the service are sought and documented during the quality monitoring visits.

Charging Survey

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

At the time of the inspection, there were 14 service users, ten of whom had been assessed as lacking capacity to manage their finances. There were corporate appointee arrangements in place for those service users who are unable to manage their finances and one service user had been referred to the Office of Care and Protection.

Four service users were noted to have varying levels of staff and family support.

The inspector was advised that service users do not pay for any of their care or support costs.

Statement of Purpose:

The agency's Statement of Purpose was examined and discussed during the inspection. The registered person is required to review the statement of purpose with regard to the following:

- The statement of purpose contains inappropriate and institutional terms in including 'patients', 'the facility' and 'the home'.
- The organisational chart did not reflect the current management structure
- The use of restrictive practice must be included within the description of the range and nature of services provided

The inspector would like to thank the service users, a service user's relative and agency staff of Lisburn Supported Living Service for their full cooperation and warm welcome 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.	15 (6) (a)	The registered person must ensure that the agency guidelines on safeguarding vulnerable adults include the action to be taken should an allegation of abuse be made against a staff member including referral to NISCC or NMC and ISA if the allegation is upheld.	The agency's adult safeguarding procedure was examined and had been amended to include the arrangements for ensuring that NISCC, NMC and ISA are advised of allegations against staff members.	**One**	**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	
The service provides each tenant with a serivce user guide detailing the service to be delivered, Each service user is supported to complete an Adult Supported Living Financial Support assessment and an individual Financial agreement. These are used alongside the service user agreement detailing the individual financial support required, the charges in respect of the service provided and how this is to be paid. All services provided are tailored to the assessed needs of the service users. The agency are currently developing a financial policy specifically related to adult disability supported living service, this is currently in draft form. The Agency is currently a member of a Regional Working Group which will produce guidance for staff in relation to the management of sevice users finances in supported living.	Moving towards compliance
Inspection Findings:	
All of the service users have had a financial assessment and there were financial support plans in place. Each service user has a financial agreement and these outline the service users' income and expenditure. Agreements outline the arrangements for daily checks of the service users' money and explicitly state that there are no charges made for care or support received. The agreements have been signed by service users and their representatives and outline the service users' rights to advocacy, to complain and to be consulted. Service users who share their accommodation were noted to have agreements in place for weekly payments into a grocery account. The inspector was advised that service users can opt out of these arrangements. The agreements clearly set out what the service users is responsible for paying for. The inspector examined a draft "Service User Financial Support Policy / Procedure" – published in April 2014. The document references RQIA transport guidance and DHSSPS circulars. The document sets out the arrangements for each service user to have a financial support assessment including reference to their capacity to manage their finances and a financial risk assessment. It also sets the arrangements for acting on behalf of service users, best interests arrangements for those who lack capacity and the use of PPP accounts and appointeeship. The agency's draft policy and procedures outline the record keeping requirements including the role of senior staff in overseeing transactions and the role of the registered manager in checking ledgers at least once every two months.	Moving Towards Compliance

It was recommended that the agency's financial policy and procedures include the accountability arrangements for staff in lone working situations. The arrangements for staff to avail of meals and breaks were discussed and the inspector was advised that agency staff do not eat service users' food and that breaks are provided for staff to avail of a meal, which they supply themselves. This is also outlined within the agency's policy which states: 'Staff are not permitted to eat service users' food. Staff must bring their own meals and snacks to work'. The importance of clear boundaries was discussed with agency staff and it was evident that staff had engaged with service users and sought their views with regard to 'house rules' and service users' expectations when receiving care and support from agency staff. The arrangements for those service users who share their accommodation with others to budget for and pay household bills were discussed. The inspector was advised that for these service users, utility bills are paid directly from their PPP account, which is administered by Trust finance staff, and the service users do not receive their original bill, nor are they involved in the payment of it. The promotion of the service users' independence was discussed with agency staff and it was acknowledged by agency staff that service users were not experiencing this essential aspect of maintaining a tenancy. It was recommended that these arrangements are reviewed and that service users' are supported to become more independent, in accordance with the aims and objectives outlined with the agency's Statement of Purpose. It was noted that several service users have a staff 'sleep over' room within their home and the arrangements for the utility costs associated with this provision were discussed. Agency staff confirmed that service users would not have access to or exclusive possession of these areas of their home. The inspector was advised that the agency had not been making any contributions towards the service users' utility payments and that there were no arrangements in place for apportionment of these costs. The inspector was further advised that the Trust is engaging with the DHSSPS and other Trusts regionally in relation to this matter. The registered person is required to ensure that service users are not being charged for agency staff use of areas of the premises to which service users have little access to and do not have exclusive possession of.	

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

• If a member of staff acts as an agent, a record is kept of the name of the member of staff, the date they acted in this capacity and the service user on whose behalf they act as agent; • If the agency operates a bank account on behalf of a service user, written authorisation from the service user/their representative/The Office of Care and Protection is in place to open and operate the bank account, • Where there is evidence of a service user becoming incapable of managing their finances and property, the registered person reports the matter in writing to the local or referring Trust, without delay; If a service user has been formally assessed as incapable of managing their finances and property, the amount of money or valuables held by the agency on behalf of the service user is reported in writing by the registered manager to the referring Trust at least annually, or as specified in the service user's agreement.	
Provider's Self-Assessment	
A financial support assessment is carried out with each service user, that details the financial support needs of the service user. A financial agreement is drawn up with the service user. The agency keeps statements of all transactions completed on the service users behalf as detailed in the services users individual agreement. All transactions for the distribution of money to services users and spending of this money are signed by the service user and a staff member. All service users are supported to complete an individual financial agreement that details services purchased by/on behalf of the service user, these are signed by the service user and reviewed at least yearly. This agreement also details how services users can access their money at short notice. The agency keeps records and reciepts of all transactions and a reconcilliation is carried out on a quarterly basis. All service users who have an appointee have the arrangements for this noted in their Financial agreement. For service users who are, or become incapable of managing their finances a Vulnerable Adults referal will be made and safeguarding procedures followed resulting in the opening of a Patient's Private Property account if required.	Moving towards compliance
Inspection Findings:	
As outlined in the self-assessment, a financial support assessment has been undertaken with each service user and financial support plans were in place. It was noted that several service users had been assessed as lacking the capacity to manage their finances and the inspector was advised that a number of these assessments were for review. The inspector was further advised that a service user was demonstrating increasing independence with regard to their finances and was no longer likely to require an appointee.	Substantially Compliant

The service users' income and expenditure is included within their support plans and financial agreements and there was evidence of transactions being signed by service users and agency staff. The agency maintains the appropriate authorisations from the Social Security Agency in relation to those service users for whom the Trust is appointee.	

<table>
<tr><th colspan="2">THEME 1 - SERVICE USERS’ FINANCES AND PROPERTY ARE APPROPRIATELY MANAGED AND SAFEGUARDED</th></tr>
<tr><td>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.</td><td>COMPLIANCE LEVEL</td></tr>
<tr><td>Provider’s Self-Assessment</td><td></td></tr>
<tr><td>The service does not provide a safe place within the agency permises for the storage of money or valuables. All service users money and valuables are kept within their own homes and service users have access to these.</td><td>Not applicable</td></tr>
<tr><td>Inspection Findings:</td><td></td></tr>
<tr><td>As outlined in the self-assessment, the acting manager confirmed that the agency does not provide a safe place within the agency premises for the storage of money or valuables.</td><td>Not Applicable</td></tr>
</table>

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

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

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

INSPECTOR'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Moving Towards Compliance

THEME 2 – RESPONDING TO THE NEEDS OF SERVICE USERS	
Statement 1: **The agency responds appropriately to the assessed needs of service users** • The agency maintains a clear statement of the service users' current needs and risks. • Needs and risk assessments reflect the input of the HSC Trust and contain the views of service users and their representatives. • Agency staff record on a regular basis their outcome of the service provided to the individual • Service users' care plans reflect a range of interventions to be used in relation to the assessed needs of service users • Service users' care plans have been prepared in conjunction with the service user and their HSC Trust representative(s) and reflect appropriate consideration of human rights.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
The agency maintains comprehensive careplans that outline the service users current care and support needs and risks. All care and support plans along with risk assessments are drawn up using a multi disiplinary team approach , this also includes service user and/or representatives input. Feedback from service users is obtained via monthly tenant meetings and via feedback surveys. Service users play an active role in the process and in supporting others to put across their views. Support staff record assessment on a daily basis and monthly reviews are carred out with services users to record the outcomes and obtain their views of the service provided. A multi-disciplinary team approach is adopted to respond to the needs of service users, involving other professionals and staff who work closely with individuals. Monthly monitoring visits are carried out by a monitoring officer. Care and support plans reflect the full range of interventions as assessed for the individual, including consideration of Human rights. Human Rights awareness sessions have been carried out with all service users, along with an assessment of each individual's understanding of what rights they have, support will be provided on an individual basis.	Substantially compliant
Inspection Findings:	
The inspector examined a range of service users' records including needs and risk assessments and care plans. Each service user was noted to have an 'All about Me' folder which contains this information and the individual's support agreement.	Substantially Compliant

Service users have a person centred support plan and this outlines in detail the individual's support arrangements. The person centred support plans were reflective of the individuals' wishes and preferences and it was evident that service users had been fully involved in their development. A service user's relative who contributed to the inspection complemented staff on the person centred and sensitive approach to caring for their relative. There were a range of person centred interventions evident within care records and these were in accordance with the assessed needs and risks of service users and in accordance with the HSC Trust assessment of needs. Agency staff maintain daily progress records for each service user and also keep records of appointments attended and meetings with key workers. Service users each have a key worker who completes a monthly summary of the service user's progress against their care and support plan. Service users have received information about human rights and agency staff have participated in human rights training. The care records had been written in a manner that reflects human rights considerations. The inspector noted the individual work a student social worker had undertaken with service users specifically in relation to their human rights and the recommendations following this.	

THEME 2 – RESPONDING TO THE NEEDS OF SERVICE USERS	
Statement 2: **Agency staff have the appropriate level of knowledge and skill to respond to the needs of service users** • Agency staff have received training and on-going guidance in the implementation of care practices • The effectiveness of training and guidance on the implementation of specific interventions is evaluated. • Agency staff can identify any practices which are restrictive and can describe the potential human rights implications of such practices. • The agency maintains policy and procedural guidance for staff in responding to the needs of service users • The agency evaluates the impact of care practices and reports to the relevant parties any significant changes in the service user's needs. • Agency staff are aware of their obligations in relation to raising concerns about poor practice	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
All staff within the service attend the mandatory training appropriate to their job role, records of all training are maintained and a training needs analysis is carried out on a monthly needs analysis. Additional training needs are assessed throught supervision and apprasial and needs are meet on an ongoing basis throughout the year. Training effectiveness is monitored through staff meetings, supervision and apprasial. The agency has a policy "Policy for managing violence and agression and use of restraint", all staff also complete training on Care and Responsibility. The agency has guidance for staff on care planning and reviews to meet the needs of service users. The impact of care practices are evaluated and reviewed dependant on the service user need. The service is represented at the Adult Disability Person Centred Review Working Group. The learning from this group is shared through group supervision and team meetings. Monthly meetings with Behaviour Support Team focus on supporting staff to understand and implement positive behaviour approaches and tailored training sessions are aimed at increasing knowledge and skills of support staff team. The service has a "whistle blowing policy" and all staff are aware of their responsibilities in relation to highlighting any incidence of poor practice.	Substantially compliant

A "safeguarding vulnerable adults policy" all staff receive training in this area.	
Inspection Findings:	
The agency's training records were examined and reflected that not all staff have had their mandatory training in accordance with the timescales outlined RQIA's Guidance on mandatory training for providers of care in regulated services, 2012. In particular, the records evidenced that only some staff had completed training in safeguarding vulnerable adults, fire safety and challenging behaviour. None of the staff had completed training in handling service users' finances. The inspector was advised that the training records had not been updated and that while they reflected low uptake in some of the mandatory areas, this training was reported to have been completed by staff. There were two requirements made with regard to this; the registered person must ensure that agency staff receive appropriate training and that the agency's training records are kept up to date. The agency maintains a 'Policy for the Management of Violence and Aggression and Use of Restraint' which was examined during the inspection. Agency staff who returned a questionnaire indicated that restrictive practices are only undertaken when risks have been identified. Staff who participated in the inspection described a variety of arrangements in place for identifying and addressing changing needs; these included staff supervision, team meetings and close working relationships with multi-disciplinary professionals who are also based within Thompson House Hospital.	Not Compliant

THEME 2 – RESPONDING TO THE NEEDS OF SERVICE USERS	
Statement 3: **The agency ensures that all relevant parties are advised of the range and nature of services provided by the agency** • Service users and their relatives and potential referral agents are advised of any care practices that are restrictive or impact on the service users' control, choice and independence in their own home. • The agency's Statement of Purpose and Service User Guide makes appropriate references to the nature and range of service provision and where appropriate, includes restrictive interventions • Service users are advised of their right to decline aspects of their care provision. Service users who lack capacity to consent to care practices have this documented within their care records. • Service users are provided with a copy of their care plan (in a format that is appropriate to their needs and level of understanding) and receive information in relation to potential sources of (external) support to discuss their needs and care plan. • The impact of restrictive practices on those service users who do not require any such restrictions.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
The service has a Statement of Purpose and a Service User Guide which include the nature and range of services provided. Restrictive interventions are limited within the service,and based on individual assessment. Where they are necessary to support a service user to live safely in his/her own home, the intervention is detailed in their care plan and risk assessment. Service users are provided with copies of their care plan and information about risk assessments in an understandable format. Risk assessments and care plans are kept under review. Restrictive practices have been discussed with staff and training is organised for 3 June 2014.	Substantially compliant
Inspection Findings:	
The agency's statement of purpose and service user guide were examined during the inspection and outline the broad range and nature of services provided. As outlined earlier, the statement of purpose must be further developed to include the use of restrictive practices, as appropriate.	Substantially Compliant

The agency's referral arrangements were discussed and a referral pathway has been developed which includes transition planning and compatibility assessments. Some service users were noted to be experiencing interventions that were impacting on their ability to live more independently. The service users' care records clearly outlined the range of needs and risks identified and there were comprehensive risk assessments in place which included consideration of the individuals' human rights. Agency staff had undertaken an evaluation of restrictive practices on other service users and the outcome of one of these was discussed with agency staff. The use of a monitoring system on an internal door was discussed with agency staff and it was evident that while this intervention was necessary, there was potential for the audible alarm to compromise the privacy of the service user and to disturb another service user. The provision of a more discreet monitoring system was discussed and it was recommended that agency staff liaise with HSC Trust colleagues in relation to this. As outlined in the self-assessment, service users have access to their care and support plans within their own homes.	

THEME 2 – RESPONDING TO THE NEEDS OF SERVICE USERS	
Statement 4 **The registered person ensures that there are robust governance arrangements in place with regard to any restrictive care practices undertaken by agency staff.** • Care practices which are restrictive are undertaken only when there are clearly identified and documented risks and needs. • Care practices which are restrictive can be justified, are proportionate and are the least restrictive measure to secure the safety or welfare of the service user. • Care practices are in accordance with the DHSSPS (2010) Circular HSC/MHDP – MHU 1 /10 – revised. Deprivation of Liberty Safeguards. (DOLS) – Interim Guidance. • The agency evaluates the impact of restrictive care practices and reports to the relevant parties any significant changes in the service user's needs. • The agency maintains records of each occasion restraint is used and can demonstrate that this was the only way of securing the welfare of the service user (s) and was used as a last resort. • Restraint records are completed in accordance with DHSSPS (2005) Human Rights Working Group on Restraint and Seclusion: Guidance on Restraint and Seclusion in Health and Personal Social Services. • The agency forwards to RQIA and other relevant agencies notification of each occasion restraint is used • The registered person monitors the implementation of care practices which are restrictive in nature and includes their on-going assessment of these practices within the monthly quality monitoring report	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Care practices that are restrictive such as those related to financial safeguarding or admininstration of medication are detailed in service user financial agreement and individual care plan. Physical restraint is not used within the service. Regular liaison with Behaviour Support Team has led to reduction in incentive plans within the service, re-focusing on Active Support Model. Staff training to take place on 3rd June 2014. One service user is subject to a Promoting quality Care, the care planning process for him in accordance with the Adult Disability Service Promoting Quality Care ISO Procedures.	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 including behaviour support and there were behaviour support plans in place for some service users. Where service users require enhanced support and supervision, there were appropriate comprehensive risk assessments and management plans in place and there was evidence of service user involvement in care and support plans.	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
	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	
Service users are provided with a service user guide and are supported to complete a service user agreement that details the care the agency provides. A detailed account of the support and care provided is avaliable within the care and support plan. Training is booked for 04th June to provide staff with further detail on the care and support split and how this is provided to the individual service user.The agency has guildlines for assessment and care planning and service user agreements, these are shared with and are avaliable for all staff.	Moving towards compliance
Inspection Findings:	
Service users have a care and support agreement in place and some of the service users who met with the inspector were able to describe their allocation of care and support hours from staff	Substantially 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 Care provided by the agency to the service users is funded by the HSC Trust and detailed in the individual service users agreement. None of the service users who use this service pay for care from their income.	Moving towards compliance
Inspection Findings:	
Service users who met with the inspector demonstrated their understanding of the care they receive from the Trust. From the agency's charging survey, service users' finance agreements and discussion with agency staff it was evident that service users do not pay for any aspect of their care or support.	Compliant

THEME 3 - EACH SERVICE USER HAS A WRITTEN INDIVIDUAL SERVICE AGREEMENT PROVIDED BY THE AGENCY	
Statement 3 **Evidence inspected confirms that service users' service agreements, care plans are reviewed at least annually confirming that service users/representatives are in agreement with the care provided and the payment of any fees.** • Service users/representatives confirm that their service agreement, care plans are reviewed at least annually by the commissioning HSC Trust, and confirm that they are in agreement with the care provided and the payment of any fees. • Records and discussion with staff confirm that the agency contributes to the HSC Trust annual review. • Records and discussion with staff confirm that reviews can be convened as and when required, dependent upon the service user's needs and preferences. • Records confirm that service users' service agreements, care plans are updated following reviews. Authorisation from the HSC Trust and consent from the service user/representative is documented in relation to any changes to the care plan or change to the fees paid by the service user.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
The HSC trust is involved in a yearly multi disiplinary review of the service provided including care plan reviews. A review report is completed by each service userand their key worker prior to their yearly review and brought to the review for discussion. Service user needs and preferences are taken into consideration when arranging Reviews. Careplans are updated after reviews and Service user agreement is updated yearly.	Moving towards compliance
Inspection Findings:	
In advance of the inspection and at the request of RQIA, the agency returned to RQIA a summary of HSC Trust reviews of service users' needs and care plans undertaken in the period 1 April 2013 to 31 March 2014. The inspector was advised that agency staff develop a review schedule for the year and all service users' reviews are attended by agency staff and HSC Trust staff and that reviews are not held unless the HSC Trust attend.	Substantially Compliant

Service users meet with their key worker prior to the meeting and bring to the meeting information prepared by the service user and agency staff. Senior care staff take records of their meeting with the service user and share these during the meeting. The inspector was advised that agency staff prepare a person centred document after the meeting which includes an action plan reflecting the points discussed during the review. It was unclear from the agency's records whether the HSC Trust professional attending the review endorsed the action plan or whether all aspects of the individuals' care and support needs and plans were discussed during the review. The inspector was advised that agency staff and Trust colleagues are developing a single record which will reflect the outcome of review meetings and any changes that are necessary to the care and support plan.	

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

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

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Margaret O'Kane, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

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

Enquiries relating to this report should be addressed to:

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

Quality Improvement Plan

Announced Primary Inspection

Lisburn Supported Living Service

30 May 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 Margaret O'Kane, Acting 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.	23 (1)	(1) The registered person shall establish and maintain a system for evaluating the quality of the services which the agency arranges to be provided. This requirement refers to the agency's monthly quality monitoring visits and reports which must not be undertaken by staff who have day to day operational responsibility for the service.	One	Implemented with immediate effect.	From the date of inspection
2.	5 (1)	The registered person shall compile in relation to the agency a written statement (in these Regulations referred to as "the statement of purpose") which shall consist of a statement as to the matters listed in Schedule 1. This requirement refers to the areas for development of the statement of purpose as outlined within the report.	One	Completed	Two months from the date of inspection – 25 July 2014
3.	14 (d)	Where the agency is acting otherwise than as an employment agency, the registered person shall make suitable arrangements to ensure that the agency is conducted, and the prescribed services arranged by the agency, are provided— (d) so as to ensure the safety and security of service users' property, including their homes;	One	Service users have access to all parts of their homes. In one house a sleep- in member of staff occupies a bedroom to sleep whilst the person they are supporting is also sleeping in th e adjacent room. The room the staff member sleeps in is available for services users to	Three months from the date of inspection – 22 August 2014

		This requirement refers to the charges made to service users for utility costs associated with agency staff use of areas of the premises to which service users have little access to and do not have exclusive possession of.		occupy at all other times.	
4.	16 (2)	The registered person shall ensure that each employee of the agency— (a) receives training and appraisal which are appropriate to the work he is to perform;	One	A Training timetable has been implemented to ensure that all staffs' mandatory training is completed by 22 August 14 (with exception of a staff member who requires Safeguarding Children training, this training has been booked for 5.9.14, which is the earliest date available. All staff receive annual appraisals.	Three months from the date of inspection – 22 August 2014
5.	21 (1)	The registered person shall ensure that the records specified in Schedule 4 are maintained, and that they are- (a) kept up to date, in good order and in a secure manner; This requirement refers to the agency's staff training records.	One	All training records are up to date.	Three months from the date of inspection – 22 August 2014

Recommendations **These recommendations are based on The Domiciliary Care Agencies Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the Registered Person may enhance service, quality and delivery.**					
No.	**Minimum Standard Reference**	**Recommendations**	**Number Of Times Stated**	**Details Of Action Taken By Registered Person(S)**	**Timescale**
1.	8.11	The registered person monitors the quality of services in accordance with the agency's written procedures and completes a monitoring report on a monthly basis. This report summarises any views of service users and/or their carers/representatives ascertained about the quality of the service provided, and any actions taken by the registered person or the registered manager to ensure that the organisation is being managed in accordance with minimum standards. This recommendation refers to the inclusion within the monthly quality monitoring reports of the views of professionals involved in the service.	One	Implemented with immediate effect	From the date of the inspection
2.	8.15	There are written accounting and financial control procedures that meet professional standards of good practice and legislative requirements and provide safeguards against errors or fraud.	One	Disability Servcies are represented at the DHSSPS working group on managing service users finances, and the Regional statutory managing service users finances working	Three months from the date of inspection – 22 August 2014

		This recommendation refers to the further development of agency financial policies and procedures with regard to the accountability arrangements for staff in lone working situations.		group. Both groups are meeting on an ongoing basis and the issue of staff lone working is being addressed through the sharing of good practice across Trusts.	
3.	8.16	Services are delivered in accordance with the statement of purpose as approved by the Regulation and Quality Improvement Authority at the time of registration. This recommendation refers to the arrangements in place to support service users to receive and pay their household bills.	One	Requests have been made to utility companies and service providers e.g. Sky, to issue houshold bills. Each tenant will receive a copy of household bill and any bills that they are individually responsible for paying.	Four months from the date of inspection – 19 September 2014
4.	12.8	It is recommended that there is a written training and development plan that is kept under review and is updated at least annually. It reflects the training needs of individual staff and the aims and objectives of the agency. This recommendation refers to the arrangements in place for ensuring that all staff receive mandatory and other relevant training.	One	All mandatory training will be completed as required by end August 2014. (with exception of a staff member who requires Safeguarding Children training, this training has been booked for 5.9.14, which is the earliest date available.	Three months from the date of inspection – 22 August 2014
5.	1.1	It is recommended that the values underpinning the standards inform the philosophy of care and staff of the agency consistently demonstrate the integration of these values within their practice. This recommendation refers to the use of a door monitoring system in a service user's	One	Review of service users Promoting Quality Care plan meeting has been arranged to consider the de-activation of the Alarm on bedroom door	Three months from the date of inspection – 22 August 2014

		home. It is recommended that this is reviewed with the HSC Trust and that the impact on all service users of an audible alarm sounding is evaluated.			

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	Margaret O'Kane
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Brendan Whittle brendan.whittle@setrust.hscni.net

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	✓	Audrey Murphy	23 July 2014
Further information requested from provider			