The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Positive Futures - Windermere**

Provider: **Positive Futures**

Date of Inspection: **15 September 2025**

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider:	Positive Futures
Responsible Person:	Ms Agnes Lunny
Registered Manager:	Mrs Elizabeth Hollinger
Service Profile – Positive Futures Windermere Supported Living Service is a domiciliary care agency (supported living type) which provides personal care and housing support to individuals who reside in the Lisburn area. At the time of the inspection there were 10 individuals in receipt of a service.	

2.0 Inspection summary

An unannounced inspection was undertaken on 15 September 2025 between 10.15 am and 4.40pm by a care Inspector.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards, and to assess progress with the areas for improvement identified during the last care inspection on 09 July 2024.

The inspection examined the agency's governance and management arrangements, reviewing areas such as staff recruitment, professional registrations, staff induction and training and adult safeguarding. The reporting and recording of accidents and incidents, complaints, whistleblowing, Deprivation of Liberty Safeguards (DoLS), service user involvement, restrictive practices and Dysphagia management were also examined.

As a result of this inspection two areas of improvement identified in the previous inspection relating to care reviews and staff supervision were assessed as having been addressed by the provider. This is discussed in more detail in section 4.4 and 4.7.

This inspection established that care delivery was safe and that effective and compassionate care was delivered to service users. However, improvements were required to ensure the effectiveness and oversight of certain aspects of the agency. As a result of this inspection, three areas for improvement were identified. These relate to the management of medication errors, accident and incident recording and quality monitoring reports. This is discussed in more detail in sections 4.1, 4.2 and 4.7. Further details of the findings of this inspection are outlined in the main body of the report.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the agency was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the provider to ensure compliance with legislation, standards and best practice.

To prepare for this inspection we reviewed information held by RQIA about this agency. This included the previous area for improvement issued, registration information, and any other written or verbal information received from service users, relatives, staff or the commissioning Trust.

Information was provided to service users, relatives, staff and other stakeholders on how they could provide feedback on the quality of services. This included questionnaires and an electronic survey.

3.2 What people told us about the service and their quality of life

Through active listening, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

We approached relatives, staff and HSC professionals to seek their views of visiting and working within Positive Futures Windermere Supported Living Service.

One relative who spoke with the inspector indicated that they were grateful for the staff and for the support provided to their loved one however, there were some concerns raised about service user compatibility and difficulties getting in contact with the service by phone. This was discussed with the manager who gave assurances that they would seek to engage directly with staff and relatives to address these concerns.

Another relative contacted for feedback described how management had made positive changes within the service which has led to improvements for service users including increased activities and trips out in the community. Staff were reported to be caring and gentle in their approach.

Staff who spoke with the inspector spoke positively about the approachability and support of management and that they felt the service was well- led. Staff said the care provided to service users was safe, effective and compassionate and that staff morale was good with good teamwork.

One HSC professional contacted for feedback on the service said that they were satisfied with the care delivery, that communication with the service had improved following change in management but there were still some outstanding matters that required a response. This was discussed with the manager who agreed to liaise directly with those concerned to address any issues raised.

One written response to the service user questionnaire indicated that service users were satisfied with the care provided by the service.

4.0 Inspection findings

4.1 Staff Recruitment, Induction and Training Arrangements

A review of the agency's staff recruitment records confirmed that all pre-employment checks including criminal record checks (AccessNI) were completed and verified before staff members commenced employment and had direct engagement with service users.

Review of a sample of the most recently appointed staff, evidenced that staff had completed a structured orientation and induction, having regard to NISCC's Induction Standards for new workers in social care. There was a robust, structured, induction programme which included shadowing of a more experienced staff member. This was reviewed periodically and signed off to ensure competence in carrying out the duties of their job in line with the agency's policies and procedures.

The agency maintained an electronic record of all staff training; however a review of this record, evidenced a number of staff required refresher training in several mandatory training areas such as Fire Safety, DoLS, Medicines Management and Dysphagia. The manager took immediate steps to address this and provided confirmation following the inspection that staff have completed these training modules or are booked on to the next available date. This will be reviewed at a future inspection. Staff confirmed that they were provided with opportunities to complete training commensurate with their role.

All staff had been provided with training in relation to medicines management. Competency assessments were undertaken with staff to ensure that they were proficient in administration of medications and these were refreshed annually. From reviewing medication errors which occurred since the last inspection, it was not clear from records if there had been a robust analysis of the medication incidents to identify what if any, further training or competency assessments were required to ensure staff remained competent in assisting with medication. An area for improvement has been identified.

4.2 What are the systems in place for identifying and addressing risks?

The agency's provision for the welfare, care and protection of service users was reviewed. The organisation's adult safeguarding policy and procedures were reflective of the Department of Health's (DoH) regional policy and clearly outlined the procedure for staff in reporting concerns. The organisation had an identified Adult Safeguarding Champion (ASC).

Staff were required to complete adult safeguarding training during induction and every two years thereafter. Staff who spoke with the inspector had a clear understanding of their responsibility in identifying and reporting any actual or suspected incidences of abuse and the process for reporting concerns in normal business hours and out of hours.

Discussions with the manager established that they were knowledgeable in matters relating to adult safeguarding, the role of the ASC and the process for reporting and managing adult safeguarding concerns. The agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding. A review of safeguarding records evidenced that these were managed appropriately. The manager was aware that RQIA must be informed of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI).

The agency's governance arrangements for the management of accidents/incidents was examined and confirmed that an incident/accident reporting policy and system was in place. On review of related records however, it was identified that documents were not consistently stored in one place with some reports being filed in service user records only. There was an electronic tracker to record incidents and accidents however, those occurring before a certain date were not available to view during the inspection. It was also difficult to ascertain the type of incident that had occurred due to recording of circumstantial information within the incident type. It was evident that the tracking and reviewing of incidents and accidents was impacted by the differing methods of reporting and recording. This has been identified as an area for improvement.

There were systems in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

4.3 Mental Capacity Act / Deprivation of Liberty Safeguards (DoLS) and Restrictive Practice

The Mental Capacity Act (Northern Ireland) 2016 (MCA) provides a legal framework for making decisions on behalf of service users who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, service users make their own decisions and are helped to do so when needed. When service users lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

There were arrangements in place to ensure that service users who required high levels of supervision or monitoring and restriction had had their capacity considered and, where appropriate, assessed. The service maintained a register of all service users subject to DoLS and reviewed this on a regular basis to ensure that any deprivations of liberty were proportionate, necessary and applied for no longer than is necessary in line with the MCA legislation. A review of a sample service user records where DoLS were in place, evidenced that some care records contained details of assessments completed and agreed outcomes as developed in conjunction with the relevant HSC Trust representative. One record reviewed however, required a DoLS careplan. The manager provided assurances that this would be followed up immediately with the relevant professional to ensure that all documentation pertaining to DoLS remains up to date. This will be reviewed at a future inspection.

There was a policy in place for the use of restrictive interventions and any restrictive practices applied such as locked safes for medication were reviewed regularly alongside the support plan, care review and included multidisciplinary input for the safety and well-being of the individual.

4.4 Management of Care Records and Care delivery

Service users' needs were assessed when they were first referred to the agency and before care delivery commenced. Following this, initial assessment care plans were developed to direct staff on how to meet service users' needs and included any advice or recommendations made by other healthcare professionals.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the service users' needs. The service users' care plans contained details about their likes and dislikes and the level of support they may require. The details of care plans were shared and signed by service users and/or their representatives as appropriate. There was also evidence of regular contact with service users and their representatives, in line with the commissioning trust's requirements. An area for improvement identified at the previous inspection related to care reviews which had not been undertaken in line with policies and procedures. A review of care reviews during this inspection confirmed that there were no outstanding reviews and the manager advised that staff record when care reviews are due on an electronic diary to ensure these are arranged in a timely way. On this basis the area for improvement was deemed to have been met by the provider.

There was a daily handover at the beginning of each shift and staff recorded regular evaluations about the care and support provided on a template. This included information about any changes to the service users' care needs so that staff could assist them as needed accordingly. There was a system in place for recording the management of individual service users' monies in accordance with the guidance.

4.5 Management of Dysphagia and Recommendations for Eating, Drinking and Swallowing Documents (REDS)

A number of service users were assessed by Speech and Language Therapist (SALT) with recommendations provided and some required their food and fluids to be of a specific consistency. A review of training records confirmed that staff had completed training in Dysphagia and in relation to how to respond to choking incidents at induction and there were arrangements to complete refresher training every two years.

Discussions with staff and review of service users' care records reflected the multi-disciplinary input and the collaborative working undertaken to ensure service users' health and social care needs were met within the agency. Staff implemented the specific recommendations of the SALT which were recorded within care plans along with associated SALT dietary requirements. Staff were familiar with how food and fluids should be modified to ensure that the care received in the setting was safe and effective.

4.7 Managerial oversight and Governance

There has been no change in the management of the service since the last inspection. Staff commented positively about the manager and described them as supportive, approachable and able to provide guidance. Staff told us that they would have no issue in raising any concerns regarding service users' safety or care practices and that they were confident that the manager

or person in charge would address their concerns. There were procedures in place to appraise staff performance.

An area for improvement highlighted in the previous inspection related to staff supervision records which were not up to date in line with the agency policy. A review of staff supervision management identified that a colour- coded spreadsheet was in place to indicate when staff were due to have supervision. Review of same evidenced that some relief staff were outstanding supervision however the manager confirmed after the inspection that all staff have since completed their supervision. On this basis the area for improvement is deemed to have been addressed by the provider.

The agency was visited each month by a representative of the registered provider to consult with service users, their relatives and staff and to examine all areas of the running of the service. A review of a sample of reports of these visits highlighted that the number of medication errors/incidents had been incorrectly recorded in one report. Advice was also given in relation to ensuring that any areas for improvement included in the RQIA QIP are reviewed every month up to the next inspection. This has been identified as an area for improvement.

There was a range of policies available to direct staff in care delivery and support planning based on individual risk assessments. The annual quality report was reviewed and noted to include stakeholder feedback.

No incidents had occurred that required investigation under the Serious Adverse Incidents (SAI) procedure.

The agency's registration certificate was up to date and displayed appropriately along with current certificates of public and employers' liability insurance.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. No complaints were received since the last inspection.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	2	1

The area for improvement and details of the Quality Improvement Plan were discussed with Ms Elizabeth Hollinger, Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Domiciliary Care Agencies Regulations (Northern Ireland) 2007	
Area for improvement 1 **Ref:** Regulation 15 (7) **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall make arrangements for the recording, handling, safekeeping, safe administration and disposal of medicines used in the provision of care provided to service users This relates to the need to review all medication errors and to ensure staff are competent in this task. Ref: 4.1
	Response by registered person detailing the actions taken: This has been identified as a missed error that was picked up and managed at service level as per organisational policy and procedure. This was a human error in keying of data onto the report and process to prevent this happening again is in place. Manager will double check the QMV report against record matrix on receiving this each month.
Area for improvement 2 **Ref:** Regulation 23 (1) (2) (c) **Stated:** First time **To be completed by:** Immediately and ongoing	The Registered Person shall The Registered Person shall establish and maintain a system for evaluating the quality of the services which the agency arranges to be provided and supply a report that outlines the extent to which the agency provides good quality services for service users and how it has responded to recommendations made by RQIA. This relates to information contained within the monthly provider visit reports. Ref: 4.7
	Response by registered person detailing the actions taken: Section added to organisational monthly monitoring QMV report to reference areas for improvement from most recent inspections and ongoing monitoring and actions being carried out.

Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards 2021	
Area for improvement 1 **Ref:** Standard 10 **Stated:** First time **To be completed by:** Immediately and ongoing	The Registered Person shall ensure that there are clear and documented systems are in place for the management of records in accordance with legislative requirements. This relates to the need to ensure that there is a consistent approach to incident/ accident recording and reporting. Ref: 4.2
	Response by registered person detailing the actions taken: Matrix has been reviewed and section added to include more precise detail such as names of individuals involved and follow up action taken. This will be maintained by service manager and reviewed regularly to improve and monitor action taken.

Please ensure this document is completed in full and returned via the Web Portal

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