



The Regulation and
Quality Improvement
Authority

2010/2011 INSPECTION YEAR

DAY CARE SETTINGS

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1. Background

In April 2009 RQIA introduced a revised approach to inspections of day care settings, domiciliary care agencies, nursing homes and residential homes. The methodology built on existing inspection practice by introducing a number of new elements.

For 2010 - 2011, this approach has been further developed taking into account practice learning during 2009 - 2010.

This document provides guidance about the values underpinning RQIA's inspection approach and gives direction about how staff and providers should use RQIA inspection tools in practice.

RQIA staff should read this guidance in conjunction with the Policy and Procedure for the Inspection of Establishments and Agencies within the Regulated Sector (2008).

2. Principles Underpinning Inspection

RQIA's approach to regulation reflects our 2009 - 2012 Corporate Strategy. This strategy sets out our value proposition:

"RQIA provides independent assurance about the quality, safety and availability of health and social care services in Northern Ireland, encourages continuous improvements in those services and safeguards the rights of service users.

RQIA has identified four core activities to support our vision of being a driving force for positive change in health and personal social services in Northern Ireland:

- **Improving Care:** we encourage and promote improvements in the safety and quality of services through the regulation and review of health and social care.
- **Informing the Population:** we publicly report on the safety, quality and availability of health and social care.
- **Safeguarding Rights:** we act to protect the rights of all people using health and social care services.
- **Influencing Policy:** we influence policy and standards in health and social care.

Consistent with our strategic approach, a number of principles that are characteristic of good regulatory practice have been identified¹. These lead to the following practice recommendations:

2.1 Focus on Outcomes

Inspection should consider “service delivery to the end users of the services rather than concentrating on internal management arrangements”.

This means that, for example, policies and procedures can only be considered to be fully in place when:

(a) the policy or procedure clearly states the desired service user outcomes of the policy or procedure,

and

(b) inspectors are able to access evidence to show how the policy or procedure impacts on the service provided to users.

The criteria in each Minimum Standard often focus on the processes necessary to achieve good outcomes. It is important that inspection staff take steps to identify outcome-based evidence to validate compliance with the standards. The possibility of overlooking outcomes when considering statements such as those within the criteria has been clearly described:

“The risk is that attention becomes focused primarily on minimum standards, inputs and processes, rather than regulation promoting improved outcomes and encouraging the sector to strive for improved standards.”²

2.2 User Perspective

Inspection should “focus on the experience of those for whom the service is provided, as well as on internal management arrangements”.

This recommendation builds on the first point, making it clear that inspectors should place significant emphasis on the directly reported experience of service users. This experience can validate the authenticity of apparent operational arrangements and, where it can be accessed, should be cited in reports as strong evidence of the degree of compliance with standards. This will mean that Inspectors will seek to identify how compliance with a particular criterion should affect service delivery and will then seek verification from users. Comments

¹ Better Regulation Task Force (2003), Principles of Good Regulation.

² Duncan (2007) Journal of Care Services Management, vol. 2, no.1, pp. 17-27, Inspecting for Improvement.

used by users about relevant parts of service delivery should then be quoted or summarised within the report.

2.3 Self-assessment

Service providers are responsible for the quality of care provided and for demonstrating that quality of care. Therefore, it is important to note that it is the responsibility of the provider to demonstrate on the self-assessment how they are meeting both the standard and criteria.

Self-assessment by providers is a key part of the inspection process. It is important that evidence is established to underpin the self-assessment, whether this is cited by the provider in their self-assessment, or identified by the inspector during the inspection.

The practice requirement “inspectors should challenge the outcomes of managers’ self-assessments” makes it clear that, in all instances, inspectors should seek to find evidence that either confirms, or refutes, the provider's self-assessment. Such evidence should be specified in reports.

2.4 Evidence

Reports should specify the evidence that has been taken into account in reaching judgements.

Evidence to underpin the inspector's judgement should be identified during the inspection, and should be cited in the report. The “evidence, whether quantitative or qualitative, should be validated and credible”.

The credibility of evidence can be established primarily by validation - the process of triangulation or corroborating evidence by information from a different source. Credible and validated evidence that a policy on training, for example, is in place could be sought from:

- training records and curriculum
- discussion with staff that indicates that they are appropriately knowledgeable or skilful discussion with service users that indicates the relevant task is being carried out competently.

2.5 Follow-Up Evidence from Previous Requirements and Recommendations

An inspection will commence with the inspector requesting evidence that requirements and/or recommendations from a previous report have been met to the inspector's satisfaction. Thus, it is important for the provider to ensure they are prepared and are able to evidence how these requirements/recommendations have been met in full.

2.6 Core Criteria

RQIA is responding to feedback that assessment of large numbers of criteria and the associated issues of inspection time committed to desktop checking reduce time for getting user/resident feedback.

This has led to the risk of taking too narrow a focus because of time constraints. Accordingly, we have reviewed selected standards for each service type and, where appropriate, have identified a number of core criteria in order to assist the process of the inspection and to ensure sufficient time is available to gather and validate the experience of service users. This approach will also ensure that inspectors take time to review the overall operation of individual services alongside detailed assessment against identified criteria.

The core criteria for announced inspections will be clearly identified in advance to service providers. The criteria will then be used thus:

- Providers will continue to complete self-assessment documents for all criteria for report inclusion
- Inspectors will assess all core criteria on inspection. On the basis of the self-assessment return made, or on the basis of their judgement during the inspection, they may select other criteria against which they will inspect if necessary. This may occur if, for example, it is deemed by the inspector that elements of the core criteria have not been achieved.

Criteria which have **not** been identified as core criteria will contribute further to the evaluation of the service from the service user's perspective.

3. Levels of Achievement

3.1 General

The model used by RQIA asks both service providers and inspectors to rate the inspected service's level of achievement for each criterion within the inspected standard. It is important that inspectors make sure that their selected levels are based on evidence.

Guidance for use of these levels can be found in section 5. The assessment should also consider the achievement level that appears appropriate before any possible regulatory action is taken into account.

3.2 Regulatory Action

Normally, where a criterion is not fully achieved, full achievement would be desirable.

For this reason, the following practice should be followed:

- In situations where a criterion is assessed by the inspector as neither "not applicable" nor "fully achieved", in most circumstances either a recommendation or requirement, as appropriate, will be made.
- In a few situations where a criterion is found by the inspector to be neither "not applicable" nor "fully achieved " and where the inspector judges that it would not be appropriate to make a recommendation or requirement, the reasons for deciding not to take regulatory action should be stated in the relevant part of the report.

Regulatory action taken will vary according to the nature and content of each individual Minimum Standard and decisions about enforcement must be reached on an individual case basis.

4. Maturity matrix

The model requires both service providers and inspectors to provide an overall summation of the service's performance against the Maturity Matrix for each Minimum Standard. Guidance on the terms used within the Maturity Matrix can be found in section 5.

4.1 Relationship between Achievement Levels and Maturity Level

Inspectors must bear in mind that the criteria used are to be considered as indicators of compliance with the relevant standard, but not as a checklist which, if complete, proves compliance.

It is also important to recognise that the Maturity Level is not simply an averaging out of achievement levels for each of the criteria. At the same time, evidence of significant degrees of non-compliance with the criteria must impact on consideration of the service's achievement against the standard statement as a whole.

The following points should be considered:

- When one or more criteria are assessed at "partially achieved" or below, services should generally be assessed as "aware", "responding" or "developing" against the overall standard.
- Where there is reason to assess outside the suggested range, the relevant section of the report must contain a clear statement explaining why this decision has been taken.

5. Guidance - Levels of Achievement

Level of Achievement	Definition	Guidance Note	Resulting Action in Inspection Report
Not applicable	The criterion is not applicable to this service setting.	A reason must be clearly stated in the assessment contained within the Inspection Report.	A reason must be clearly stated in the assessment contained within the Inspection Report.
Unlikely to be achieved	The criterion is unlikely to ever be achieved.	A reason must be clearly stated in the assessment contained within the Inspection Report.	A reason must be clearly stated in the assessment contained within the Inspection Report.
Not achieved	The criterion is unlikely to be achieved in full prior to end of March 2011. For example, the service has only started to develop a policy and implementation will not take place until after March 2011.	The definition states that implementation will not occur before end of March 2011. This level should be used in all instances where a plan showing service user impact of the necessary actions by that date cannot be convincingly demonstrated to the inspector.	In most situations this will result in a requirement or recommendation being made within the Inspection Report.
Partially achieved	Work has been progressing satisfactorily and the service is likely to have achieved the criterion prior to end of March 2011. For example, the service has developed a policy and will have completed implementation by end of March 2011.	The definition states that implementation is likely to occur before end of March 2011. This level should be used in instances where a plan showing service user impact of the necessary actions by that date can be convincingly demonstrated to the inspector.	In most situations this will result in a requirement or recommendation being made within the Inspection Report.
Substantially achieved	A significant proportion of action has been completed to ensure the service performance is in line with the criterion. For example, a policy has been developed and implemented but a plan to ensure practice is fully embedded has not yet been put in place.	At this level, the service user impact of the policy/procedure can be demonstrated across the service. However, processes to systematically review the user impact are not yet in place.	In most situations this will result in a requirement or recommendation being made within the Inspection Report.
Fully achieved	Action has been completed that ensures the service performance is fully in line with the criterion. For example, a policy has been developed, implemented, monitored and an ongoing programme is in place to review its effectiveness.	At this level, processes for monitoring, review and reformulation of the necessary actions on the basis of user impact can be demonstrated.	In most situations this will result in an area of good practice being identified and being made within the Inspection Report.

Guidance - Maturity Matrix

Level of Maturity	Definition	Guidance
Aware	The service is aware of the issues to be addressed but are unable to demonstrate decisions/actions to address them.	For the overall standard there is little evidence of a coherent approach to dealing with the practice area.
Responding	The service recognises the key issues and has identified options that are prioritised, although there is no evidence of strategic direction.	A plan has been developed addressing this area, but there is no evidence of service impact of the plan.
Developing	The service is taking steps to address the key issues through the development of strategic plans with evidence of good practice across the organisation.	Across this standard area, a plan is being taken forward with evidence from practice of the impact of policy.
Practising	The strategic agenda is being progressed and monitored by the service with significant evidence of continuous improvement across the organisation.	Good practice in this standard area is being monitored, evaluated, and revised according to the needs of service users.
Leading	The service is leading the strategic agenda through the implementation of innovative practice that is shared across and beyond the organisation to others, enabling realisation of long term sustainability.	In addition to the good practice evident at Practising level, the service is developing innovative practices that can be shown as being made available to other services.

Guidance - Standards

Standard 2 : The centre offers a structured programme of varied activities and events, related to the service users need for day care services

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
	Inspectors to refer to - Regulation 18 (2) (h) (i) (ii), schedule 5 (16) of The Day Care Setting Regulations (Northern Ireland) 2007	
2.1, 2.3 and 2.11	<ul style="list-style-type: none"> • Review how the centre seeks service user suggestions and wishes to determine the content of the activity programme, which provides a positive outcome for and enables them to realise as far as possible their potential for full and independent lives. • Review the diversity of the activity programme, ensuring that the activities are engaging, purposeful, enjoyable, age and culturally related and promote healthy living. • Review use of in house and community based activities ensuring that the activity is provided in the most appropriate setting and facilitates community inclusion. • Consider the frequency of the activity programme review ensuring that it is undertaken at least annually and that it meets service users changing needs with improvements made where necessary. 	<ul style="list-style-type: none"> • Discuss what systems are used to seek service user's involvement in the planning of the activity programme e.g. service user committees, suggestion boxes, group discussions, questionnaires. • Discuss the diversity of activities available to ensure that they are engaging, purposeful, enjoyable, age and culturally appropriate and promote healthy living. • Discuss if activities are both in house and community based, provided in the most appropriate setting and facilitating community inclusion. • Discuss the review of activity programme frequency and service users input to this review. Illustrate how the centre adapts the activity programme to meet the changing needs of the service users making improvements where necessary.
2.2	<ul style="list-style-type: none"> • Review the activities available ensuring that the programme offers opportunities for group and individual activities. • Review that the activity programme is flexible and allows for service user choice. 	<ul style="list-style-type: none"> • Discuss how the activity programme is designed to offer opportunities for group and individual activities giving examples if possible. • Discuss the flexibility of the activity programme to ensure that there is good service user choice available.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
2.4	<p>Inspectors to refer to - Regulation 18 (2) (h) (i) (ii), schedule 5 (16) of The Day Care Setting Regulations (Northern Ireland) 2007</p> <ul style="list-style-type: none"> • Review the management of supported employment or volunteer placements organised by the day centre. • Review how the day centre determines the appropriateness of any organisation to provide such placements. • Review how staff from the organisation providing supported or volunteer placement is made aware of the general and individual needs of the service users placed with them. 	<ul style="list-style-type: none"> • Discuss how the centre manages supported or volunteer placements. • Discuss how the day centre determines that an organisation is suitable to support the placement of a service user on supported or volunteer placement. • Discuss how organisations providing supported or volunteer placements are made aware of the general and individual needs of the service users placed with them.
2.5	<ul style="list-style-type: none"> • Review that the service users have access to appropriate equipment, aids and staff or others to enable them to participate in the activities of their choice. 	<ul style="list-style-type: none"> • Discuss how availability of equipment, aids and support from staff and others enables service users to participate in the activities of choice.
2.6	<ul style="list-style-type: none"> • Review the duration of activities and the daily timetable to ensure that it takes into account the needs and abilities of the service users participating. 	<ul style="list-style-type: none"> • Discuss how the duration of each activity and the daily timetable takes into account the needs and abilities of the service users.
2.7 and 2.8	<ul style="list-style-type: none"> • Review how the day centre monitors effectiveness of a person contracted in to provide activities. • Review how the registered manager ensures that this person has adequate skills to deliver the activity required. • Review how information is communicated to the contracted in activity person in respect of the changed needs of service users prior to an activity commencing and that there is a system in place to receive timely feedback. 	<ul style="list-style-type: none"> • Discuss how Centre monitors effectiveness of person contracted-in to deliver activities and that this person has necessary skills to do so. • Discuss how the centre staff communicate to the contracted in activity person in respect of the changed needs of service users prior to an activity commencing and that there is a system in place to receive timely feedback.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
2.9 and 2.10	<p>Inspectors to refer to - Regulation 18 (2) (h) (i) (ii), schedule 5 (16) of The Day Care Setting Regulations (Northern Ireland) 2007</p> <ul style="list-style-type: none"> • Review communication systems between the centre and the organisation which enable the flow of information regarding the changing needs of service users and that there is an effective system for timely feedback. • Review how the long term placement of a service user within a college, supported employment or volunteer placement is monitored ensuring continued suitability for service users. 	<ul style="list-style-type: none"> • Discuss how two way communications are maintained between the various organisations providing supported employment, volunteer placements or college setting ensuring that there is a system to receive timely feedback on issues raised. • Discuss how effective communication systems between the centre and organisations providing placements are monitored to ensure continued suitability for service users.
2.11	<ul style="list-style-type: none"> • Review how the centre reviews the activity programme ensuring that it is reviewed at least annually ensuring that it meets the changing interests and needs of the service users with improvements made as required. 	<ul style="list-style-type: none"> • Discuss the activity programme review process detailing frequency of review to ensure that it meets the changing interests and needs of the service users with improvements made as required.
2.12	<ul style="list-style-type: none"> • Review that the programme of activities is displayed in a suitable format and in an appropriate location so that service users know what is scheduled. 	<ul style="list-style-type: none"> • Discuss how the activity programme is displayed in a suitable format and in an appropriate location so that service users know what is scheduled.

Standard 8: Responses to service users are appropriate and based on an understanding of individual service user's conduct, behaviours and means of communication

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
8.1 and 8.6	<p>Inspectors to refer to - Regulation 14 (3) (4) (5), 19 (1) schedule 4 (3) (j) & schedule 5 (10) (b) 7 Regulation 29 (1) (d), (2) of The Day Care Setting Regulations (Northern Ireland) 2007</p> <ul style="list-style-type: none"> • Review staff training records to ensure that staff have a knowledge and understanding of each individual service user's usual conduct, behaviours and means of communication, and responses and interventions of staff promote positive outcomes for service users. • Review training records to ensure that when a behavioural management plan is in place for any service user that staff are provided with additional training, guidance and support as necessary. • Review how information on service user's progress is passed from one staff team to another. 	<ul style="list-style-type: none"> • Discuss staff training in relation to ensuring that all staff have knowledge of each individual service user's usual conduct, behaviours and means of communication. • Discuss additional training which supports and guides staff in the management of service users particular behavioural management plans ensuring that all staff applies a consistent approach to the management of behavioural issues. • Discuss how information on service user's progress is passed from one staff team to another.
8.2	<ul style="list-style-type: none"> • Review policy documentation to ensure that it clearly illustrates service user's right to develop and maintain personal relationships with people of his or her choice is respected unless a service user is assessed as lacking capacity to consent to such a relationship. • Review policy to ensure that it clearly illustrates that should a service user lack ability to consent to a particular relationship then information and guidance should be sought on ensuring his or her protection. 	<ul style="list-style-type: none"> • Discuss policy on "responding to service user's behaviour" giving illustration of how the service user's right to develop and maintain personal relationships with people of his or her choice is respected. • Discuss how if service user is lacking capacity to consent to such a relationship that information and guidance is sought on ensuring his or her protection.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
8.3	<p>Inspectors to refer to - Regulation 14 (3) (4) (5), 19 (1) schedule 4 (3) (j) & schedule 5 (10) (b) 7 Regulation 29 (1) (d), (2) of The Day Care Setting Regulations (Northern Ireland) 2007</p> <ul style="list-style-type: none"> • Review policy document to ensure that it fully details the steps to be followed should a service user's behaviour be uncharacteristic. • Review assessment / care plan documentation of any service user who might display erratic behavioural issues to ensure that staff are adhering to policy and procedures. • Review reporting procedures to ensure that all incidents of uncharacteristic behaviours are reported to the relevant persons as detailed in the behavioural management plans. 	<ul style="list-style-type: none"> • Discuss how centre will manage uncharacteristic behaviours displayed by service users illustrating clearly the procedure to be followed in: <ul style="list-style-type: none"> - Seeking explanation - Taking necessary action - Reporting matter to registered manager or staff in charge at the time and the service user's carer where appropriate. - Monitoring situation and where necessary make contact with any relevant professional or service.
8.4 and 8.5	<ul style="list-style-type: none"> • Review service user's plans to ensure that when there is an identified need for a consistent approach or response from staff, this is detailed in the service users care plan. • Review that the service user's representative is informed of the approach or response to be used. • Ensure that when a service user has a specific behaviour management programme, this is approved by an appropriately trained professional and forms part of the care plan. 	<ul style="list-style-type: none"> • Discuss the management plans for dealing with service users who need a consistent approach or response from staff and where appropriate that the service user's representative is informed of the response or approach to be used. • Discuss behavioural management programmes and the involvement of appropriately trained professionals as required. • Discuss how behavioural management programmes are integrated into the care plan documentation.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
8.7	<p>Inspectors to refer to - Regulation 14 (3) (4) (5), 19 (1) schedule 4 (3) (j) & schedule 5 (10) (b) 7 Regulation 29 (1) (d), (2) of The Day Care Setting Regulations (Northern Ireland) 2007</p> <ul style="list-style-type: none"> • Review Policy on "Responding to Service User's Behaviour" to clarify procedure to be followed where any incident is managed outside the scope of the agreed care plan. • Review records of management of behaviours which challenge to ensure that where any incident has been managed outside the scope of a service user's care plan that this was recorded and reported if appropriate to the service user's representative and relevant professional or services, and followed, if necessary, by a multi professional review of the service user's care plan. 	<ul style="list-style-type: none"> • Clarify procedure to be taken should an incident occur outside the scope of the care plan, the recording and reporting process including referral to a multi professional for review of the care plan. • Ensure records are available to evidence that the procedures have been appropriately followed.
8.8	<ul style="list-style-type: none"> • Review policy on use of restraint to ensure that it clearly illustrates that restraint is only used as a last resort to protect the service user or other persons when less restrictive strategies have been unsuccessful. • Review records maintained ensuring that when restraint has been deployed that the records reflect that information has been forwarded to RQIA as required. 	<ul style="list-style-type: none"> • Discuss policy on restraint to illustrate that it is only used as a last resort by appropriately trained staff to protect the service user or other persons when other less restrictive strategies have been unsuccessful. • Clarify records maintained when restraint is used.

Standard 13: Protection of Vulnerable Adults

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
13.1	<p>Inspectors to refer to - Regulation 14 (3), Schedule 3 (5), Schedule 4 (j) of The Day Care Setting Regulations (Northern Ireland) 2007</p> <ul style="list-style-type: none"> • Review policy document to ensure that it is in accordance with legislation, DHSSPS guidance, regional protocols and local procedures issued by Health and Social Services Boards and Trusts. 	<ul style="list-style-type: none"> • Policy document to be maintained in accordance with legislation, DHSSPS guidance, regional protocols and local procedures issued by Trusts.
13.2	<ul style="list-style-type: none"> • Review induction programme to ensure that the procedures for protecting vulnerable adults are included. 	<ul style="list-style-type: none"> • Discuss induction programme giving confirmation that details of protection of vulnerable adults are included.
13.3 and 13.9	<ul style="list-style-type: none"> • Review training schedule to check that refresher training on vulnerable adults is maintained at least every 3 years. • Review training records to ensure that all staff have received training in protection of vulnerable adults. • Check staff are able to discuss protection of vulnerable adults training i.e. <ul style="list-style-type: none"> - protection from abuse - indicators of abuse - responding to suspected, alleged or actual abuse - reporting suspected, alleged or actual abuse. 	<ul style="list-style-type: none"> • Discuss content of training programme. • Discuss how centre insures that staff can demonstrate knowledge of specifics of protection of vulnerable adult training i.e. Discussed in formal supervision, staff meetings etc. • Discuss frequency of training and evidence of compliance with training schedule.
13.4 and 13.5	<ul style="list-style-type: none"> • Review all records of suspected, alleged or actual incidents of abuse for evidence of reporting process. Cross reference with Provider procedures and legislation. • Review time line of reporting to ensure that it is within appropriate acceptable limits. • Review referral to regulatory bodies NISCC, NMC, Access NI, ISA Vetting and Barring scheme. 	<ul style="list-style-type: none"> • Discuss procedure followed when suspected, alleged or actual incidents of abuse are reported illustrating referral to relevant persons and agencies as required. • Include NISCC, NMC, Access NI, ISA Vetting and Barring scheme etc. • Discuss time line for reporting.
13.6	<ul style="list-style-type: none"> • Review investigations concluded to ensure all relevant persons notified of outcome. 	<ul style="list-style-type: none"> • Clarify process for notification of all relevant persons / agencies of outcome of investigation.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
13.7	<p>Inspectors to refer to - Regulation 14 (3), Schedule 3 (5), Schedule 4 (j) of The Day Care Setting Regulations (Northern Ireland) 2007</p> <ul style="list-style-type: none"> Review all written documentation in respect of suspected, alleged or actual incidents of abuse. Records should include details of investigation, outcome and actions taken. 	<ul style="list-style-type: none"> Clarify management of records in respect of investigation, outcome and details of action to be taken.
13.8	<ul style="list-style-type: none"> Review documentary evidence of outcomes of investigation where any shortcomings in system have required additional safeguards to be established. 	<ul style="list-style-type: none"> Clarify if comprehensive review of complete investigation and plan of action is undertaken to identify any shortcomings of process and how this could be avoided in future.

Standard 14: All complaints are taken seriously and dealt with promptly and effectively.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
14.1 and 14.2	<p>Inspectors to refer to - Regulation 24, schedule 3(4), schedule 5(9) of The Day Care Setting Regulations (Northern Ireland) 2007</p> <ul style="list-style-type: none"> • Seek evidence that complaints procedure is: <ul style="list-style-type: none"> - Meeting requirements of Health and Social Services Trust's complaints procedure. - Publicised in facility and service user guide. - Copy is given to service users and family members. - That complaints information refers clearly how to make a complaint and who to contact outside the organisation if they remain dissatisfied with outcome of investigation. - Ensure that the right to contact NI Ombudsman is included if complainant is not satisfied with the outcome of the complaint investigation. - Ensure that the name and contact details of Regulation and Quality Improvement Authority is illustrated on complaints procedure. • Review evidence that organisation enables and encourages service users to make complaints via service user meetings, relatives meetings, annual satisfaction surveys etc. 	<ul style="list-style-type: none"> • Discuss complaints policy ensuring that it is in line with Health and Social Services Trust's complaints procedures. • Discuss that complaints information is signposted around facility. • Discuss that a copy of leaflets and guidance on the making of a complaint is made available to all service users and family members. • Discuss that complaints policy and procedure makes reference to service users being able to access the NI Ombudsman should they remain unsatisfied with the outcome of the Centre's or Trust's complaints investigation. • Discuss that service users are encouraged and enabled to make complaints as required evidencing via service users meetings, relatives meetings, annual quality assurance surveys etc.
14.3	<ul style="list-style-type: none"> • Review complaints procedure to clarify that documentation refers to: <ul style="list-style-type: none"> - step by step guidance on making a complaint; - the timescales involved; - an outline of the function of RQIA with contact details; - referral information on the function and contact details for NI Ombudsman should the complainant not be satisfied with the outcome of the Centre or Trust's investigation. 	<ul style="list-style-type: none"> • Discuss that complaints procedure clearly illustrates: <ul style="list-style-type: none"> - step by step guidance on making a complaint; - the timescales involved; - an outline of the function of RQIA with contact details; - referral information on the function and contact details for NI Ombudsman should the complainant not be satisfied with the outcome of the Centre or Trust's investigation.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
	Inspectors to refer to - Regulation 24, schedule 3(4), schedule 5(9) of The Day Care Setting Regulations (Northern Ireland) 2007	
14.4	<ul style="list-style-type: none"> • Review customer awareness training to ensure that all staff are aware of how to receive a complaint and report this to the Manager or other appropriate person pass on to appropriate person for management. • Review induction records for evidence that issue is covered. 	<ul style="list-style-type: none"> • Discuss evidence of how staff are trained in customer awareness to ensure they know how to appropriately receive, report and record a complaint from a service user, family member or member of the public.
14.5	<ul style="list-style-type: none"> • Review complaints training for staff who deals directly in the management and investigation of complaints and in the application of the complaints procedure. 	<ul style="list-style-type: none"> • Discuss that extended training in the management and investigation of complaints is provided to all staff directly involved in this task.
14.6	<ul style="list-style-type: none"> • Review complaint records to ensure that complaints are investigated and responded to within 28 days and when not possible that the complainant is kept informed of any delays. 	<ul style="list-style-type: none"> • Discuss that the complaints procedure ensures that complaints are investigated and responded to within 28 days and the complainant is advised of any delays if applicable.
14.7	<ul style="list-style-type: none"> • Review records of complaints to ensure they include details of all communications with complainants and the results of any investigation, action taken and the level of each complainant's satisfaction with the outcome. 	<ul style="list-style-type: none"> • Discuss that all records are maintained appropriately to evidence details of all communications with complainants, the result of investigations and the action taken. • Does the complaints record state if the complainant is satisfied with the outcome of the Centre's investigation?
14.8	<ul style="list-style-type: none"> • Review procedure for dealing with complaints to ensure that the outcomes and actions taken following the investigation are used to improve the quality of services provided (Learning outcomes). • Review policy to ensure it reflects that when required a summary of all complaints, outcomes and actions taken are made available to RQIA. 	<ul style="list-style-type: none"> • Clarify that the procedure for managing complaints also includes a learning outcome for the organisation as a result of action planned following the completion of investigations. • Clarify that the policy reflects that when required a summary of all complaints, outcomes and actions taken is made available to RQIA.
14.9	<ul style="list-style-type: none"> • Review records of complaints to ensure that time line is reflective of 28 days schedule. 	<ul style="list-style-type: none"> • Clarify that all complaints are managed as required within 28 days.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
14.10	<p>Inspectors to refer to - Regulation 24, schedule 3(4), schedule 5(9) of The Day Care Setting Regulations (Northern Ireland) 2007</p> <ul style="list-style-type: none"> Review records of complaints investigated to ensure that records are complete and include information on details of communications with complainants, the results of investigations and the action taken. 	<ul style="list-style-type: none"> Discuss that all records are maintained appropriately to evidence details of all communications with complainants, the result of investigations and the action taken. Does the complaints record state if the complainant is satisfied with the outcome of the Centre's investigation?
14.11	<ul style="list-style-type: none"> Review policy document to ensure that it reflects co operation between registered provider and HSC Trust, the Regulation and Quality Improvement Authority or NI Commissioner for complaints. Review records of complaints already investigated for evidence of correspondence between agencies as detailed above. 	<ul style="list-style-type: none"> Clarify the role of the Centre in co-operating with the HSC Trust, the Regulation and Quality Improvement Authority and the NI Commissioner for complaints in respect of complaints investigations. Discuss if records are available in Centre to evidence this co-operation.
14.12	<ul style="list-style-type: none"> Review complaints policy to ensure that it reflects the registered providers responsibility in respect of statutory functions of the Centre to notify the Regulations and Quality Improvement Authority directly should a complaint be made. Review any time line evidence of previous complaints raised. 	<ul style="list-style-type: none"> Clarify the Centre's responsibility to refer directly to Regulation and Quality Improvement Authority should a complaint be raised in respect of the statutory functions within the Centre. Discuss if evidence is available in the Centre.
14.13	<ul style="list-style-type: none"> Review policy document to ensure that it details action to be taken should a complaint relate to abuse, exploitation or neglect of a vulnerable adult and that the "Safeguarding Vulnerable Adults" and the Regional Policy and Procedural Guidance is activated. Review complaints records for evidence that these policies and procedures have been followed. 	<ul style="list-style-type: none"> Clarify the Centre's responsibility should a complaint relate to abuse, exploitation or neglect of a vulnerable adult and that the "Safeguarding Vulnerable Adults" and the Regional Policy and Procedural Guidance is activated. Discuss if evidence is available in the Centre.

Criterion	Evidence by (Inspector's guidance)	Provider guidance for evidencing achievement of standard
14.14	<ul style="list-style-type: none"> Review complaints policy document to ensure that it reflects that the Centre will provide a summary of all complaints, outcomes and actions taken to the Regulation and Quality Improvement Authority if requested. 	<ul style="list-style-type: none"> Clarify that the Centre will provide a summary of all complaints, outcomes and actions taken to the Regulations and Quality Improvement Authority if requested.
14.15	<ul style="list-style-type: none"> Review records of complaints for evidence that information gained as a consequence of investigations is used to improve quality of services. 	<ul style="list-style-type: none"> Clarify how information from complaints is used to improve the quality of services.
14.16	<ul style="list-style-type: none"> Review policy document to ensure that it reflects that the complainant has the right to approach the NI Commissioner of Complaints if they remain dissatisfied with the outcome of the relevant complaints procedure. 	<ul style="list-style-type: none"> Clarify that the Centre's complaints policy illustrates that the complainant has the right to approach the NI Commissioner of Complaints if they remain dissatisfied with the outcome of the investigation / procedure.

6. Inspection Process

6.1 Six weeks prior to the inspection date

A member of the admin staff will contact the Registered Manager to confirm the Centre's email address.

An email then will be sent to the confirmed address containing the notification letter, self assessment document and professionals list. If the Centre does not have an email address, the above documentation will be sent to the Registered Manager in hard copy.

The Registered Manager will also receive a package which will include the Centre's staff and service user's questionnaires as well as guidance regarding the distribution of the questionnaires. Copies of a poster will be included for display in the centre advising service users of the inspection date.

A hard copy of the notification letter will also be sent to the Registered Provider so that they are aware of the inspection date.

6.2 Two weeks prior to the inspection

Please return the self assessment document and professionals list to the Care team by the date stated on the notification letter to allow time for the Inspector to prepare for the inspection.

6.3 Day of Inspection

During the inspection, the Inspector will be validating the Centre's completed self assessment document. Please have copies of any evidence stated in the self assessment available on the day of inspection.

The Inspector will ask the Registered Manager to complete a questionnaire regarding the inspection process to be returned to the Care Team.

6.4 Post inspection

It is the aim of the Authority to issue the draft report within 4 weeks of the inspection date to the Registered Manager and Registered Provider.

Please complete the Quality Improvement Plan completing the actions taken by the Registered Provider section, in detail, and return to the Care Team by the date stated on the letter.

If no amendments are received in writing by the date stated, the report will be considered as final and will be made available to the public if requested.

7. Frequently Asked Questions

Q: Can word count and spell check be used in the self assessment document?

A: Due to the limitations of Microsoft Word, word count and spell check cannot be used in the self assessment document when drop downs are being used. If you wish to use these facilities, it is possible to copy information from a word document into the self assessment document.

Q: How do you complete the self assessment document?

There is a grey text box inserted in the Provider's self assessment box for each criterion as shown below.

PROVIDER'S SELF-ASSESSMENT	
Please outline (in no more than 200 words) how you	
Criterion Assessed:	10.1 Staff have knowledge and understanding of each individual resident's usual co
Provider's Self Assessment:	Please enter the establishment's evidence for the above criterion here.
Inspection Findings: FOR RQIA INSPECTORS USE ONLY	

Drop down menus have been inserted for the achievement levels for each criterion and maturity matrix for the four standards as shown below:

	Inspection No
ACHIEVEMENT LEVEL	MATURITY LEVEL
<div style="border: 1px solid black; padding: 5px;"> Not Applicable ▾ Not Applicable Unlikely to be Achieved Not Achieved Partially Achieved Substantially Achieved Fully Achieved </div>	<div style="border: 1px solid black; padding: 5px;"> Aware ▾ Aware Responding Developing Practising Leading </div>

Q: The inspection date on the notification letter does not suit.

A: If the inspection date does not suit, please contact the Care Team administrative staff on (028) 9051 7500 as soon as the problem arises. It may be possible to reschedule the inspection with agreement from the Inspector.

Q: I am unsure what evidence to record in the self assessment document for each criterion.

A: Guidance regarding the evidence RQIA are looking for under each standard is contained in section 3 of the guidance booklet, however if you are still unclear please contact the Inspector carrying out the inspection or the Duty Inspector.

Q: I am having problems completing the documentation on line or emailing the returns to RQIA.

A: Please contact the Care Team administrative staff on (028) 9051 7500 to discuss your problems. If necessary the documentation can be returned on paper.

Q: I am unable to complete the inspection documentation by the date stated on the notification letter:

A: RQIA ask for the documentation to be returned 2 weeks before the inspection to allow time for pre-inspection preparation. If you cannot return the documentation by the stated date, please contact the Care Team administrative staff on (028) 9051 7500 to arrange a new deadline for the documentation.

Q: Contact details for the Care Team

A: CARE TEAM EMAIL ADDRESS - Care.Team@rqia.org.uk

CARE TEAM TELEPHONE NUMBER - (028) 9051 7500

8. Appendices

Appendix 1 - Professionals List

REGULATION AND QUALITY IMPROVEMENT AUTHORITY

PROFESSIONALS WHO FREQUENTLY VISIT THE ESTABLISHMENT EXCLUDING GENERAL PRACTITIONERS

NAME OF ESTABLISHMENT:

DATE:

PLEASE WRITE CLEARLY IN BLOCK CAPITALS AND PROVIDE FULL
NAMES AND ADDRESSES (INCLUDING POSTCODES)

NAME AND FULL POSTAL ADDRESS	NATURE OF PROFESSION
Name: Address: Postcode:	
Name: Address: Postcode:	
Name: Address: Postcode:	
Name: Address: Postcode:	
Name: Address: Postcode:	

Signed _____

Position _____