Primary Unannounced Care Inspection

Name of establishment:	**Abbeyview Beacon Centre**
RQIA number:	**10712**
Date of inspection:	**17 July 2014**
Inspector's name:	**Maire Marley**
Inspection number:	**20079**

The Regulation And Quality Improvement Authority
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1.0 General information

Name of centre:	Abbeyview Beacon Centre
Address:	17 Abbey Street Armagh BT61 7DY
Telephone number:	(028) 3752 8771
Email address:	c.lester@beaconwellbring.org
Registered organisation/ Registered provider:	William Murphy NI Association for Mental Health
Registered manager:	Cheryl Murphy
Person in Charge of the centre at the time of inspection:	Brenda McKeown
Categories of care:	DCS-MP
Number of registered places:	20
Number of service users accommodated on day of inspection:	15
Date and type of previous inspection:	29 August 2013 Primary Announced Inspection
Date and time of inspection:	17 July 2014 10.00am - 4.00pm
Name of inspector:	Maire Marley

2.0 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 day care settings. 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.

3.0 Purpose of the inspection

The purpose of this inspection was to ensure that the service is compliant with relevant regulations and minimum standards and themes 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 day care settings, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Day Care Settings Regulations (Northern Ireland) 2007
- The Department of Health, Social Services and Public Safety's (DHSSPS) Day Care Settings Minimum Standards (January 2012)

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

4.0 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
- tour of the premises
- evaluation and feedback.

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

5.0 Consultation process

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

Service users	12
Staff	4
Relatives	0
Visiting professionals	0

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	5	2

6.0 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 DHSSPS Day Care Settings Minimum Standards and theme:

- **Standard 7 - Individual service user records and reporting arrangements:**

  Records are kept on each service user's situation, actions taken by staff and reports made to others.

- **Theme 1 - The use of restrictive practice within the context of protecting service user's human rights**

- **Theme 2 - Management and control of operations:**

  Management systems and arrangements are in place that support and promote the delivery of quality care services.

The registered provider and the inspector have rated the centre's compliance level against each criterion and also against each standard and 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.

7.0 Profile of service

Abbeyview Beacon Centre is one of fourteen Day Care Centres operating under the auspices of Northern Ireland Association for Mental Health (NIAMH). The centre was first established in 1992 and provides a range of therapeutic support services for adults with mental health needs.

The facility is situated in a central location within Armagh City close to all main city amenities. Referral to the centre is made through Social Services in the Southern Health and Social Care Trust and through general practitioners.

A maximum of twenty members (members) can be accommodated each week day. The centre is open Monday to Thursday 9.00am – 5.00pm and on Friday 9.00am – 4.00pm.

The accommodation consists of a large lounge, dining room, kitchen, activity room, toilets/ wash room, and two administrative offices.

8.0 Summary of inspection

This unannounced primary care inspection of Abbeyview Beacon Centre was undertaken by Maire Marley on 17 July 2014 between the hours of 10.00am and 4.00pm. The registered manager was on leave and Mrs Brenda McKeown, project worker was the designated person in charge and was available throughout the inspection.

The requirement and two recommendations made as a result of the previous inspection in August 2013 were examined. Observations and discussion demonstrated that the centre had in the main responded positively however the requirement in regard to monthly reports is restated as there was not sufficient evidence available on the day of inspection to confirm compliance. Details of the actions taken can be viewed in the section following this summary.

The focus of the inspection was to assess the centre's compliance with the one standard and two themes chosen from the Day Care Settings Minimum Standards 2012 and The Day Care Settings Regulations (Northern Ireland) 2007. During the inspection the inspector used the following evidence sources;

- Discussion with staff
- Discussion with service users
- Observation of practice
- Examination of a sample of service user individual file records including evidence of behaviour management and support assessments; the complaints record; staff training record; individual staff records; incidents and incident and accidents record; evidence of service user consultation, monthly monitoring records; statement of purpose; service users guide and policies & procedures
- Tour of the premises

Following the inspection the provider submitted a self-assessment of the one standard and two themes inspected. The registered provider's responses were examined and were not altered in any way by the RQIA.

Two questionnaires were returned by staff who reported satisfactory arrangements were in place with regard to NISCC codes of practice, supervision, staff training, staffing and management arrangements. Staff reported "I really enjoy working here". Satisfaction was also reported in regard to responding to service users' behaviour; confidentiality and recording. Staff commented positively in regard to the quality of care provided which the they described as: "excellent, high standards of care", "service users dictate the range of activities".

The inspector greeted all of the service users who were in the day care setting at the time of the inspection and spoke directly with eight service users to gather evidence for the standard inspected and the two themes. Service users presented at ease in their environment and spoke highly of the staff team, opportunities provided and the support and encouragement gained from attending the centre. Service users were aware that if they had any concerns or issues they could approach any of the staff or the registered manager who is based in the centre.

Standard 7 - Individual service user records and reporting arrangements: Records are kept on each service user's situation, actions taken by staff and reports made to others.

The centre has written policies and procedures pertaining to recording and reporting, data protection, access to records and confidentiality. The policies and procedures were available for staff reference.

The inspector spoke with three members of staff regarding the standards inspected, their views about working in the centre and the quality of service provided. Positive comments were made in regard to the maintenance of records and the recording and reporting arrangements in this day care setting.

The organisation encourages service users to record their recovery journey in their individual records. Whilst this is commended it is recommended that these arrangements are clearly outlined in the management of records policy.

The inspector concluded that staff record as and when required and there was evidence that services users are involved in the process when possible.

There were examples in care plans of service users having signed the record to indicate their involvement and agreement with the content.

Observations of service users, discussion with staff, and the review of eight service user's individual files provided evidence that the centre is performing well regarding storage of service user's information, recording procedures and reporting information on to professionals involved in the service users' care.

A recommendation was made to revise and update an identified service user's assessment and care plan.

Based on the evidence reviewed the inspector assessed the centre as substantially compliant in this standard.

Theme 1 - The use of restrictive practice within the context of protecting service user's human rights

Abbeyview Beacon Centre has a clear policy and procedure on the use of restrictive practices, which states there is no restrictive practice or restraint within this day care setting.

The Deprivation of Liberty Safeguards (DoLS), document was discussed with staff. The designated person in charge was advised on the value of including reference to the guidance in the policy on the use of restrictive practices. It was also recommended that staff receive awareness training on the guidance.

Evidence available from discussions with service users, staff and a review of the written records, verified that there had not been any instances of practices such as restraint or seclusion in the centre.

Staff presented as committed to responding to behaviour in the least restrictive manner and demonstrated knowledge of service users assessed needs and spoke of the use of calming techniques to de-escalate behaviours. Staff consulted were knowledgeable in regard to each person's identified needs and preferences. They recognised the importance of approaching service users in a sensitive, supportive manner and were aware of individual signs that would indicate a service user was not feeling their usual self.

Observations of group interactions during the inspection confirmed that service users were very supportive of one another and identified strongly with the centre, its ethos and its staff.

Abbeyview Beacon Day Centre was assessed as substantially compliant with this theme.

Theme 2 - Management and control of operations: Management systems and arrangements are in place that support and promote the delivery of quality care services.

The organisational structure and reporting arrangements were clearly set out in the statement of purpose for the day care setting. Staff confirmed their awareness of the reporting arrangements within the organisation in the event of a notifiable incident.

Staff were clear in regard to their roles and responsibilities and there was evidence that the management arrangements are suitable with appropriate policies in place for the operation of the day care centre.

There was evidence from discussions with staff to confirm that members of the team work supportively and well with one another. Staff reported that the registered manager had systems in place for supervision and performance appraisal and staff expressed that they felt supported by the management team. These records were not available for inspection. All records required by regulations must be available for inspection at all times.

There was evidence of the monitoring arrangements that included unannounced monitoring visits and a yearly quality review. However the records presented for inspection only included visits from January 2014 until March 2014. It is required that visits are undertaken monthly and that the monthly monitoring reports are further developed to provide an informative view of the records examined, audits of practice, the number of service users interviewed and their views, the number of representatives interviewed and their views and the number of staff interviewed and their views on the selected theme of the monitoring inspection.

Two requirements and one recommendation were made in relation to this theme. Based on the evidence reviewed the inspector has assessed the centre as substantially compliant in this theme.

Additional Areas Examined

The inspector undertook a tour of the premises, reviewed the complaints record and examined eight service users individual files, validated the registered manager's pre inspection questionnaire, reviewed the staff questionnaires and viewed the environment. This did not reveal any further areas of improvement.

The inspector wishes to acknowledge the staffs' open and constructive approach throughout the inspection process. Gratitude is also extended to the service users who welcomed and engaged with the inspector during the inspection.

As a result of this inspection a total of one requirement and three recommendations have been made. One requirement from the previous inspection is also restated in this report. Details can be found in the Quality Improvement Plan attached to this report.

9.0 Follow-up on previous issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	Regulation 28 (4) (a)	It is required that monthly monitoring visits include opinions from health professionals who act as representatives of the members of the scheme.	A review of the presented reports found that the last report was dated 13 March 2014. Several sections in the report had not been completed. There was no evidence that the opinions from health professionals who act as representatives of the members of the scheme had been sought. This requirement is restated.	Not compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	Standard 15.5	It is recommended that an audit of care files is undertaken to ensure that all risk assessment documentation is consistent across policies and procedures and fully completed following review of support plans.	Information in the returned QIP, review of care records and discussion with staff confirmed that the registered manager had completed audits of care files.	Compliant
2	Standard 13.2	It is recommended that the local procedure developed to provide details of local safeguarding arrangements for the centre includes contact details of identified professionals available for staff to report concerns to.	On the day of inspection staff consulted were fully aware of the procedures for reporting concerns. The contact details for relevant professionals were available to the staff team.	Compliant

Standard 7 - Individual service user records and reporting arrangements: **Records are kept on each service user's situation, actions taken by staff and reports made to others.**	
Criterion Assessed: 7.1 The legal and an ethical duty of confidentiality in respect of service users' personal information is maintained, where this does not infringe the rights of other people.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
In Abbeyview Beacon Centre the legal and ethical duty of confidentiality in respect of service users personal information is maintained in accordance with NIAMH policies and procedures covering Confidentiality(RP/07), Data Protection(CS/06), Storage and Destruction of Closed Files(MA/14) and Safeguarding Vulnerable Adults(BS/2). NIAMH Data Protection Policy gives individual service users the right to have access to personal information relating to themselves where this information is being held or processed by NIAMH as outlined in 5.02.. Confidentiality in respect of obtaining, handling, use of, storage and retention of service user information and documentation is detailed in Sections 2.0 to 2.4 of NIAMH Confidentiality Policy, RP/07(a). All service user personal information held at scheme is stored in individual files within a locked cabinet. These procedures are supported by Safeguarding Vulnerable Adults Policy, BS/2, Sections 5.3 and 5.4. Good practice in relation to the Storage and Destruction of Closed Files is described in NIAMH Policy MA/14. Staff understanding of their legal and ethical duty is assessed and evidenced in Section A of the Induction and Foundation Framework undertaken by all staff prior to being confirmed in post, and in the "New Employee Orientation & Induction" workbook completed by staff as part of their induction. The DHPSSPS Code of Practice on Protecting the Confidentiality of the Service User is available at scheme to provide additional practical guidance on decision-making regarding the disclosure of service user personal information.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The day care setting had policies in place in regard to confidentiality that were available to the staff team. Discussion with staff confirmed that they have adequate knowledge about the duty of confidentiality and their role and responsibility in the management of service users' personal information. Records requested on the day were stored securely.	Compliant

Criterion Assessed: 7.2 A service user and, with his or her consent, another person acting on his or her behalf should normally expect to see his or her case records / notes. 7.3 A record of all requests for access to individual case records/notes and their outcomes should be maintained.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
7.2 In accordance with Niamh Referral and Review policy R/R/101and our Beacon Member Handbook members are encouraged to open access to their notes. Our new draft referral procedure expands on this in R/R/102 Sections 7 and 14. In both sections members are reminded that they have open access to their files; they are also encouraged to have input to their files participatively and by writing their own notes for example or being involved in the writing of their notes. Section 14 of R/R/102 contains additional information for Beacon Members wishing to access their files following discharge from the service. The Beacon Members Guide also provides relevant information to all new members. Sections 1.3 and 1.5 outline both content and open access arrangements to members files. 7.3 Section 6.0 of Corporate Policy no. CS/06 on Data Protection covers the right of access to personal information in relation to Individual Subject Data Requests.	Moving towards complian
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector reviewed a sample of eight individual service user records and the findings indicated that the records are maintained in compliance with Regulation 19 Schedule 4. The day care setting had policies and procedures pertaining to the access to records, communication, confidentiality, consent, management of records, monitoring of records, recording and reporting care practices. Staff consulted confirmed that the policies are readily available and accessible to them for reference. Discussion with staff and review of eight service user individual records found that service users are encouraged as far as possible to accept ownership of their records and daily recordings. Service users are encouraged to record their recovery journey in their individual records. It is recommended that clear arrangements are in place in regard to the ownership agreements.	Substantially compliant

Criterion Assessed: 7.4 Individual case records/notes (from referral to closure) related to activity within the day service are maintained for each service user, to include: • Assessments of need (Standards 2 & 4); care plans (Standard 5) and care reviews (Standard 15); • All personal care and support provided; • Changes in the service user's needs or behaviour and any action taken by staff; • Changes in objectives, expected outcomes and associated timeframes where relevant; • Changes in the service user's usual programme; • Unusual or changed circumstances that affect the service user and any action taken by staff; • Contact with the service user's representative about matters or concerns regarding the health and well-being of the service user; • Contact between the staff and primary health and social care services regarding the service user; • Records of medicines; • Incidents, accidents, or near misses occurring and action taken; and • The information, documents and other records set out in Appendix 1.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
In accordance with Niamh Policy & Procedures and Day Care Standards,the Beacon member guide and Abbeyview's statement of purpose - all individual Abbeyview members case records are contained in their own Beacon Members Personal File . Beacon Members, staff members and referral agents ,where applicable, work together through the processes outlined above to ensure a meaningful and holistic intervention is provided. An individuals recovery journey is about change and Beacon consider, as an area of good practice, that it is essential to record information that chronicles this-this includes,whre possible, an Individuals self reflection on member notes and also recorded joint validation of key working sessions . Policy R/R/101 contains guidance for staff on the information and recording required to assess, plan and review the delivery of care and support to all our members. A separate Serious Incident Reporting Policy Q&G/4 - CS/07 provides an Incident Form and Flow Chart with clear guidance for recording and reporting.	Substantially compliant

Inspection Findings:	**COMPLIANCE LEVEL**
There was evidence in the random sample of care files examined that each service user had a care record in accordance with this criterion. Records viewed were up to date and it was noted that staff recorded changes in the service user's needs or behaviour and detail the action taken by staff. Records viewed confirmed that a formal care review takes place at least once a year.	Substantially compliant
Criterion Assessed: 7.5 When no recordable events occur, for example as outlined in Standard 7.4, there is an entry at least every five attendances for each service user to confirm that this is the case.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
In accordance with Niamh policy R/R/101and also the Daycare setting standards all Abbeyviw staff are familiar with and follow outlined recording procedures that also outline that a note is to be recorded at least every fifth visit. This is standard practice across all our day care provision.As an area of Good practice Abbeyview staff meet with individual members on a regular basis to discuss and write up member notes that informs the individuals support plan and also adds information for individual review planning.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
A sample of service user care records examined provided evidence that individual care records have a written entry at least once every five attendances. The records viewed were satisfactory.	Compliant

Criterion Assessed: 7.6 There is guidance for staff on matters that need to be reported or referrals made to: • The registered manager; • The service user's representative; • The referral agent; and • Other relevant health or social care professionals.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
All Staff are made aware of relevant policy /procedures ,reporting and recording procedures right from their induction as new staff within Niamh. to ratify this further this area is a key component of the Induction and Foundation Framework (Units B, C)for new staff.. In addition staff are introduced to key mechanisms for communication within the organisation and Abbeyview. These include the staff section of the organisations website, the policy and procedure manual and the emergency procedures file; included within the scheme are the communication book, scheme diary , minutes of staff meetings,Centre meetings,staff files and member files. For ease of access a number of policy documents include lists of numbers and flow charts that may be displayed on office notice boards, for example BS/4 Protection of Children and Reporting of Suspected Abuse requires a list of relevant contacts for Gateway Teams and Designated Officers to be displayed. BS/2 Safeguarding Vulnerable Adults includes a Reporting Flowchart as does QG/4 Incident Reporting and Management Policy and Procedure. Personal information on members and their contacts is updated annually at review using Appendix 3, Beacon Member Information Record, of Policy RR/101 Beacon Referral and Attendance Policy. Other relevant policies include BS/1 Beacon Member Safety/Risk/Vulnerability, BS/14 Consent Policy, HS/13 RIDDOR Policy and QG/3 Complaints Procedure.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector viewed the policies and procedures pertaining to communication, confidentiality, consent, management of records, monitoring of records, recording and reporting care practices. Staff consulted were fully familiar with issues that required to be reported to Trusts, representatives, other primary health care teams and statutory organisations.	Substantially compliant

Criterion Assessed: 7.7 All records are legible, accurate, up to date, signed and dated by the person making the entry and periodically reviewed and signed-off by the registered manager.	
Provider's Self-Assessment:	
As outlined in Niamh Referral and review policy all Abbeyview staff follow the relevant guidance contained on how to record all necessary recordable events.As outlined in our Draft revised poicy and also in line with RQIA Day Care setting standards the Manager periodically reviews Member notes , Support Plans ,Reviews and Signs these off to verify the following of procedures by Abbeyview Staff in a competant and effective manner..	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
A sample of service user individual records were reviewed and found to be legible, accurate, up to date, signed and dated by the person making the entry. Staff consulted were aware of their responsibility in relation to maintaining accurate records and the purpose of such records. Staff spoken with and who completed inspection questionnaires confirmed that procedures are in place to achieve this criterion.	Substantially compliant

PROVIDER'S OVERALL ASSESSMENT OF THE DAY CARE SETTINGS COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	**COMPLIANCE LEVEL**
	Substantially compliant

INSPECTOR'S OVERALL ASSESSMENT OF THE DAY CARE SETTINGS COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	**COMPLIANCE LEVEL**
	Substantially compliant

Theme 1: The use of restrictive practice within the context of protecting service user's human rights **Theme of "overall human rights" assessment to include:**	
Regulation 14 (4) which states: **The registered person shall ensure that no service user is subject to restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other service user and there are exceptional circumstances.**	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
NIAMH's policy on the use of restraint is set out in BS/2 Guidance on Restrictive Practice. This policy states clearly that staff are not to use "physical restraint" or "physical intervention" to restrain service users in any situation. Any physical intervention should only be the minimum used as a last resort to enable staff to get away for their own or others safety. If a situation is deemed serious enough to require physical intervention the police must be called. This guidance is reinforced by BS/16 Policy and Procedures for Dealing With Violence at Work, Section 6.2, g, which states that "the staff member should never attempt to restrain the service user". This guidance is explained in Section 6.3,a&b, of the policy, " The legal position on physical restraint", which states that "NIAMH staff are not trained in restraint techniques and therefore to ensure their own safety and that of the service user should not attempt to restrain the service user in any circumstances". In incidences where physical support is required to manage an incident of violence at work the staff member will summon the police. (6.2,f). All Abbeyview staff receive training on Personal Safety/ Calming and Diffusing. This training focuses on skilling staff to prevent work related violence rather than on how to use/apply restraint techniques.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
A written Policy on Restraint was examined and clearly states there are no restrictive practices within the day centre as detailed in the provider's self- assessment. Staff reported that restraint, restriction or seclusion had never been used in the centre and there were no records of such practices. Staff confirmed that the focus is always on de-escalation and diffusing situations and all staff consulted reported that they had never had an occasion to restrain a service user. Discussion with service users, staff and a review of care plan resulted in a recommendation that an identified service	Substantially compliant

user's risk assessment should be revised and updated to include clear guidance for staff in the event of episodes of behaviour that challenges. The day centre has policies and procedures pertaining to: the assessment, care planning and review; managing aggression and challenging behaviours; recording and reporting care practices; reporting adverse incidents; responding to service users behaviour; restraint and seclusion; and untoward incidents which are available for staff reference. Discussion with staff regarding service user's human rights revealed staff are aware of service user's rights, however required information on the Deprivation of Liberty Standard (DOLS) guidance produced by the Department. It is recommended that staff obtain awareness training on the DOLS guidance.	
Regulation 14 (5) which states: **On any occasions on which a service user is subject to restraint, the registered person shall record the circumstances, including the nature of the restraint. These details should also be reported to the Regulation and Quality Improvement Authority as soon as is practicable.**	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
BS/16, Policy and Procedures for Dealing with Violence at Work, states clearly that staff should never attempt to restrain a service user (6.2,g). In incidences where restraint would be required, police assistance would be called to do so (6.2,f). In such circumstances staff would follow the investigation and recording requirements detailed in 6.4 of the Policy and record details in accordance with QG/4, Incident Reporting and Management Policy and Procedure. RQIA would be notified of all incidents requiring the involvement of the police in the use of restraint (QG/4, Appendix 4). To date no Abbeyview staff have been involved in incidences where restraint has been required.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Records examined and discussions with service users and staff on duty confirmed the information detailed in the provider's self-assessment.	Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE DAY CARE SETTING COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Compliant

INSPECTOR'S OVERALL ASSESSMENT OF THE DAY CARE SETTING COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Compliant

Theme 2 – Management and Control of Operations **Management systems and arrangements are in place that support and promote the delivery of quality care services.** **Theme covers the level of competence of any person designated as being in charge in the absence of the registered manager.**	**COMPLIANCE LEVEL**
Regulation 20 (1) which states: **The registered person shall, having regard to the size of the day care setting, the statement of purpose and the number and needs of service users -** **(a) ensure that at all times suitably qualified, competent and experienced persons are working in the day care setting in such numbers as are appropriate for the care of service users;** **Standard 17.1 which states:** **There is a defined management structure that clearly identifies lines of accountability, specifies roles and details responsibilities for areas of activity.**	
Provider's Self Assessment:	
Niamh's Recruitment Policy and Procedure R/P/04 uses a competency based selection process to recruit individuals with the qualifications, experience and character requirements that accord with Schedule 2 of The Day Care Setting Regulations (NI) 2007, and Part III Section 21 Fitness of Workers. In addition they meet the requirements of current employment legislation and good employment practice (as outlined in RP/07/1.3). Ongoing competence of staff is monitored and enabled via Supervision (R/P/39) and the group competency based Performance Management System (PMS). Twice a year the manager and their direct reports complete a performance and development review that is linked to a Competency Framework and agree objectives and actions that are designed to enhance each staff members personal development in the context of their personal aspirations, the nature of the service they are delivering, and the overall organisational strategy. Measurement of each staff member against the Competency Framework would determine suitability of being in charge in the absence of the Manager. The person designated as being in charge is highlighted on the staff rota. The management structure of Abbeyview is outlined in the Statement of Purpose. Section 2.0 identifies the number	Compliant

and qualifications of staff, Section 5.0 outlines the structure of the facility. Abbeyview employs different grades of staff including Scheme Manager, Project Workers, Clerical Staff and Peripatetic Staff. Job descriptions detail the specifics of each role, lines of accountability and areas of activity.	
Inspection Findings:	**COMPLIANCE LEVEL**
The management structure is clearly set out in the centre's statement of purpose. The document includes staff experience and qualifications as detailed in the provider's self-assessment. The Registered Manager has obtained an NVQ 4 in Health and Social Care and QCF 5 in Leadership & Management. She has also completed the ILM Level 4 in Leadership & Management and holds a City & Guilds Certificate in Community Mental Health. The registered manager has 16 years' experience in providing support to individuals in a variety of settings. There was evidence that staff are encouraged to obtain a variety of training commensurate with their roles and responsibilities. Examination of the staffing duty rota, provided evidence that adequate staffing numbers were maintained in the day care setting. Discussion with staff working in the centre demonstrated that they were fully familiar with their role and responsibilities regarding the management arrangements of the day care setting. Staff expressed that they were supported in their roles through training and development opportunities, regular supervision, appraisal and staff meetings. Service users informed the inspector that they knew the management structure and were able to identify who they would talk to if they had any concerns. The organisation must undertake monthly monitoring visits to the day care setting in accordance with Regulation 28. The last monitoring report presented for inspection was dated 13 March 2014. Sections of the report had not been completed it is paramount that the monitoring visits are robust and include the views of service users, staff and where possible representatives. The report should provide an assurance that the minimum standards are fully implemented. Following the inspection the registered manager submitted evidence off the competency and capability assessment completed for staff members who manage the day care setting in the registered manager's absence. As previously stated in this report records required by regulations must be available for inspection at all times.	Substantially compliant

Regulation 20 (2) which states: • **The registered person shall ensure that persons working in the day care setting are appropriately supervised**	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
All Abbeyview staff supervision takes place in accordance with the Supervision Policy R/P/39. Staff are supervised at a frequency and duration commensurate with their position and levels of responsibility as outlined in section 1.3 of the policy, with every staff member having a supervision contract and a shared responsibility for the process. As an area of good practice we also have ongoing informal supervision on a regular basis through daily team meetings and formal Staff meetings.The supervision process is designed with links to the organisation's Performance Management System. All managers attend a full day's training on supervision. Staff Supervision Records form part of Monthly Monitoring. T	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The organisation had a range of policies and procedures pertaining to the management and control of operations, for example: absence of the manager; staff records and staff supervision and appraisal. The policies and procedures are available for staff reference and reflect day to day practice. Staff expressed that the management team were very approachable and supportive. A review of one staff member's training record confirmed that staff were provided with a range of training and confirmed that mandatory training was up to date. Staff reported that they are in receipt of regular supervision and annual appraisals as detailed in the provider's self-assessment. However on the day of inspection supervision records were not available to confirm the information provided. Records required by regulations should be available at all times for inspection.	Substantially compliant

Regulation 21 (3) (b) which states: • **(3) For the purposes of paragraphs (1) and (2), a person is not fit to work at a day care setting unless –** • **(b) he has qualifications or training suitable to the work that he is to perform, and the skills and experience necessary for such work**	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
In the first instance Niamh recruits staff with the quailifications, skills and experience required by the Personnel Specification for the role. Niamh provide an Essential Regional Training Schedule designed to meet the mandatory training requirements of RQIA and essential sector specific content. To ensure timescales match RQIA requirements all staff are required to attend training on the dates allocated with attendance being monitored on the HR IT System(Cascade) and reviewed in supervision, to ensure compliance. All new staff are required to complete a New Employee Orientation and Induction Handbook that in particular introduces staff to those policies, procedures and systems, knowledge which enables them to take charge in the absence of the manager. Staff also complete an Induction and Foundation Framework leading to an accredited qualification with the National Open College Network, that is either a level 2 or level 3 in Social Care and Mental Health (level is commensurate with grade). In addition and annually all grades of staff have access to opportunities for further development that include short courses with external providers and/or additional qualifications such as the Qualification Credit Framework (QCF) Level 3 in Health and Social Care, or QCF Level 5 in Leadership in Health and Social Care Services (Adults Management). The organisation is also currently developing 2 programmes to identify and develop future leadership talent through their 'Nurturing Talent' and 'Building Talent' Programmes for different grades of staff across the whole Niamh Group.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Staff reported that the registered manager is based in the centre and spends significant time each day working alongside other staff members and with service users, getting to know each of them well. Records viewed confirmed that mandatory was up to date. The registered manager had planned the training schedule for the 2014/15 year. Discussion with staff confirmed that the organisation promotes staff development and staff interviewed expressed satisfaction with the opportunities provided.	Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE DAY CARE SETTING COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Substantially compliant

INSPECTOR'S OVERALL ASSESSMENT OF THE DAY CARE SETTING COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Substantially compliant

11.0 Additional areas examined

Complaints

Staff consulted were fully aware of the complaints procedure and the action to take should a service user express dis-satisfaction with any aspect of the service. The review of the complaints records revealed that complaints were recorded along with action taken and the outcome of the action taken.

Statement of Purpose

A review of the statement of purpose found that the information contained in the document was satisfactory and in keepings with The Day Care Settings Regulations (Northern Ireland) 2007.

Environment

An inspection the day centre environment was undertaken. All areas were found to clean and fresh smelling. No issues were identified on this occasion.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Brenda McKeown project worker, 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:

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

The **Regulation** and **Quality Improvement Authority**

Quality Improvement Plan

Primary Unannounced Care Inspection

Abbeyview Beacon

17 July 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 Brenda McKeown project worker 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 Day Care Settings Regulations (NI) 2007

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	28 (3) (4) (a) (c)	**Monthly Visits** The registered provider must ensure that: (a) Monitoring visits are completed monthly (b) monthly monitoring visits include opinions from health professionals who act as representatives of the members of the scheme. (c) All sections in the monitoring report is fully completed	Two	(a) Monthly monitoring visits are completed on a monthly basis (b) The registered manager has discussed with the registered provider and will ensure that the opinions of health professionals who act as representatives of members at the scheme are sought by registered provider when carrying out the monthly monitoring visit. (c) The registered manager will ensure that all sections of the monitoring report are fully completed each month.	No later than 30 September 2014
2	19 3 (b)	**Records** The registered manager must ensure all records required by regulation are available for inspection.	One	The registered manager will ensure all records required by regulation are available for inspection.	Immediately and on-going

Recommendations

These recommendations are based on The Day Care Settings Minimum Standards January 2012. This quality improvement plan may reiterate recommendations which were based on The Day Care Settings Minimum Standards (draft) and for information and continuity purposes, the draft standard reference is referred to in brackets. These recommendations are also based on 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	14.4	**Assessment** The registered manager should ensure the assessment and care plan pertaining to an identified service user is updated to provide clear direction to staff in the 14.4event of episodes of behaviour that challenges. .	One	Assessment and Care Plan pertaining to identified service user will be updated as part of annual review due to take place in September 2014 and the registered manager will ensure it provides clear direction to staff in the event of episodes of behaviour that challenges.	No later than 30 September 2014
2	7.2	**Ownership agreements** The registered manager should ensure clear arrangements are in place in regard to the ownership agreements.	One	Clear arrangements in relation to Ownership Agreements will be included in the Management of Records Policy	No later than 30 September 2014
3	18.1	**Staff training** The registered manager must ensure that staff are in receipt of awareness training in the Deprivation of Liberty Safeguards (DOLS).	One	Awareness training in the Deprivation of Liberty Safeguards is scheduled to take place on 1st September 2014	No later than 30 September 2014

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

Name of Registered Manager Completing QIP	Cheryl Lester
Name of Responsible Person / Identified Responsible Person Approving QIP	

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable			
Further information requested from provider			