Primary Announced Care Inspection

Name of Establishment:	**Scraboview Beacon Centre**
Establishment ID No:	**10713**
Date of Inspection:	**5 March 2015**
Inspector's Name:	**Priscilla Clayton**
Inspection No:	**20647**

The Regulation And Quality Improvement Authority
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Name of centre:	Scraboview Beacon Centre
Address:	81 Victoria Avenue Newtownards BT23 7ED
Telephone number:	(028) 9181 1035
E mail address:	scraboview@beaconwellbeing.org
Registered organisation/ Registered provider:	William Henry Murphy
Registered manager:	Darren Lawless
Person in Charge of the centre at the time of inspection:	Darren Lawless
Categories of care:	DCS-MP
Number of registered places:	20
Number of service users accommodated on day of inspection:	20
Date and type of previous inspection:	25 March 2014 Primary Announced Inspection
Date and time of inspection:	5 March 2015 10.30am–3.30pm
Name of inspector:	Priscilla Clayton

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.

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.

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.

Consultation Process

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

Service users	10
Staff	3
Relatives	Nil
Visiting Professionals	Nil

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	4	2

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.

Profile of Service

Scraboview Beacon Centre is one of fourteen NIAMH facilities providing day support, care and therapeutic intervention to people with a range of mental health issues.

The aim of the service is to provide help to members to achieve and maintain independent living in the community through promotion of good mental health through personal involvement within a "therapeutic environment of warmth, acceptance and understanding".

Facilities within the centre includes: two lounges, one on the ground floor and another on the first floor. An art/craft room, toilet/shower room, kitchen and staff office are available.

The centre is a three storey house close of the centre of the town. It is open from 9.00am to 3.30pm Monday to Thursday with a morning session, which is service user led, on Friday. Scraboview Beacon Centre covers part of the South Eastern Health and Social Care Trust catchment area including Hollywood, Bangor, Comber, Ballywalter, Donaghadee and Greyabbey.

The centre is manager by Darren Lawless who has been in post since 2009 and is registered with RQIA

Summary of Inspection

The primary announced inspection of Scraboview Beacon Centre took place on 5 March 2015 between the hours of 10.30am and 3.30pm. The registered manager, Darren Lawless and a team of five staff were on duty.

Three requirements made at the previous inspection conducted on 25 March 2014 had been addressed.

Prior to the inspection, the registered manager completed a self-assessment of the standard criteria outlined in the standards to be inspected. The comments provided by the registered manager in the self- assessment were not altered in any way by RQIA.

During the inspection the inspector met with service users and staff, discussed the day to day arrangements in relation to the conduct of the day centre and standard of care provided to service users. In addition observation of care practice, review of two staff questionnaires returned to RQIA, examined a selection of records and general inspection of the day care environment took place.

7.0 Inspection findings

Standard 7 – Individual service user records and reporting arrangements.

Policies and procedures on Confidentiality, Data Protection and Management of Records were in place and available to staff who demonstrated knowledge and understanding of good professional practice in regard to recording and record keeping. Care records examined reflected user/representative consultation in regard to assessment, care planning, care reviews and other necessary documents as set within Day Care Settings Minimum Standards (DHSSPS) 2012.

The supporting evidence gathered through the inspection process concluded that Scraboview Beacon Centre was compliant with Standard 7. This is to be commended.

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

The inspector reviewed the arrangements in place for responding to service user's behaviour. The centre had a policy and procedure which reflected best practice guidance in relation to management of actual and potential aggression, restraint, seclusion and human rights. Through observation, review of documentation and discussion with staff and service users, confirmation was obtained that restraint would only ever be used as a last resort and that no form of restrictive practice was in place.

Staff training in challenging behaviour was being provided annually. Staff who spoke with the inspector demonstrated knowledge of the policy and procedure to follow should challenging behaviour ever arise.

The supporting evidence gathered through the inspection process concluded that Scraboview Beacon Centre was compliant with Theme 1. This is to be commended.

Theme 2 - Management and control of operations.

The defined management structure was reflected within the centre's Statement of Purpose.

The registered manage is supported at senior management level by the service support team manager, who meets with the registered manager on a regular basis. At operational level support is provided by project workers, support workers, peripatetic staff, two volunteers and clerical staff.

Supporting evidence of the level of compliance with this theme was obtained from examination of associated policies/procedures, random sample of records including, for example; staff induction, staff appraisal, supervision, staff meetings and mandatory training. In addition staffing levels/procurement was discussed and complaints records, competency and capability assessments and discussion with staff and service users were undertaken.

The manager confirmed that no complaints were received since the last inspection.

Examination of supporting evidence and discussion with staff and service users evidenced that the centre was compliant with Theme 2.

Conclusion

Feedback on the outcome of the inspection was given to the registered manager on conclusion of the inspection.

The registered manager and staff are to be commended on the outcome of this inspection. Compliance was achieved in Standard 7 and Themes1and 2.

Two recommendations made as a result of this inspection are contained within the appended Quality Improvement Plan.

The inspector wishes to thank the service users, staff and the registered manager for their assistance and co-operation throughout the inspection.

Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	Regulation 20(1)(a)	The registered person shall ensure that, at all times, suitably qualified, competent and experienced persons are working in the day centre in such numbers as are appropriate for the care of service users. This should be reviewed as a matter of urgency.	The manager confirmed that all new employees attend Essential Regional Training. Training is also provided to volunteers. Records of training were retained in the centre. The manager confirmed that staffing levels are sufficient to meet the needs of service users in attendance and that these would always be increased if deemed necessary. Relief staff is available as required. Examination of the staff duty roster evidenced staff on duty each day.	Compliant
2	Regulation 16(2)(b)	The registered person must ensure that all members' care plan reviews are completed at least annually.	Examination of a random sample of three care records evidenced that reviews had taken place.	Compliant
3	Regulation 29(1)(d)	An event that adversely affects the wellbeing or safety of a service user must be reported to RQIA, without delay.	This information has been notified to RQIA as required.	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:	
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 on scheme to provide additional practical guidance on decision-making regarding the disclosure of service user personal information.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The centre has a policy/procedure on Confidentiality which was dated September 2014. The policy on Data Protection was dated 2011. Records retained were being securely stored.	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 Current information in R/R/101 is contained in Beacon Member Notes p.19. A 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 input to their files participatively and by writing their own notes for example. 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**
Information as illustrated by the manager in the self- assessment was verified through discussion with the manager and staff. When necessary a record of any disclosures would be retained in accordance with the centre's policy/procedure. Four care records randomly selected evidenced consultation with the service user/representative with care plans had taken place and were signed by the service user / representative.	Complaint

Criterion Assessed:	**COMPLIANCE LEVEL**
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.	
Provider's Self-Assessment:	
Individual case records are contained in the Beacon Members Personal File in accordance with Beacon Policy Number R/R/101(p.7,8) and titled Policy and Procedure for Referral and Attendance in Beacon Day Support. Beacon Members, staff members and referral agents work together through the processes outlined above to ensure a meaningful and holistic intervention. An individuals recovery journey is about change and Beacon consider that it is essential to record information that chronicles this. 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 with relevant appendices designed to provide the information required in Appendix 1 of the Standards, Schedule 4 of the Regulations. A separate Serious Incident Reporting Policy CS/07 provides an Incident Form and Flow Chart with clear guidance for recording and reporting.	Substantially compliant

Inspection Findings:	**COMPLIANCE LEVEL**
Examination of four care records evidenced information as contained in this criterion and as illustrated by the manager were comprehensive, individualised and person centred. Policies/procedures were in place for Assessment, Care planning and Review.	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:	
R/R/101 currently notes in 2 locations (p.17,19) that a note is to be recorded at least at every fifth visit. This is standard practice across all our day care provision.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Examination of four service user care records evidenced that written evaluations had been made in accordance with this criterion. One recommendation made related to ensuring staff cease to leave spaces between each recorded entry.	Complaint

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:	
The relevant guidance is outlined in a number of documents with an introduction to relevant policies and procedures an important part of the Induction process for new staff and a key component of the Induction and Foundation Framework (Units B, C). In addition staff are introduced to key mechanisms for communication within the organisation and the scheme. 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 and phone book, minutes of staff 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.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Information as illustrated in the manager's self-assessment was verified. A range of policies and procedures pertaining to communication, confidentiality, consent, management of records, monitoring of records, recording and reporting care practices and service user agreement were in place and are consistent with this criterion and are available for staff reference. Staff demonstrated awareness of their roles and responsibilities to report/refer information and record the outcomes achieved. Care records examined evidenced collaboration with other professionals in the planned care of service users. Care records examined provided evidence of regular monitoring of care, action taken and outcomes in this regard.	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:	
Relevant guidance is contained in the section on Beacon Member Notes of R/R/101 Policy and Procedure on the Referral and Attendance in Beacon Day Support p.19.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Four care records randomly selected and examined evidenced that these were eligible, current, dated and signed. There was evidence of ongoing signed review by the registered manager.	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** 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 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**
Information as illustrated by the manager in the self-assessment was verified through discussion with the registered manager and staff. Examination of accident/incident records confirmed that there have not been any episodes of challenging behaviour and that no service user has ever been subjected to any form of restrictive practice or seclusion. Policies and procedures on Managing Challenging Behaviour and Restraint were in place and available to staff. Staff demonstrated knowledge of the procedure to follow should incidents in regard to challenging behaviour arise.	Compliant

Records of staff training evidenced that training in challenging behaviour and restraint had been included and undertaken as reflected within the mandatory training programme retained in the centre. Resource information on Deprivation of Liberty Safeguards (DOLS) was available to staff who demonstrated awareness in this regard.	
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 sholud 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 QC/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 (QC/4, Appendix 4).	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Information as illustrated by the manager in the self- assessment was verified through discussion and examination of associated policy/procedures. The manager demonstrated knowledge of the procedure to follow should restraint ever have be used in the interest of health and safety and the requirement to notify the care manager and RQIA. The manager confirmed there were no service users presenting with behavioural problems and restraint was not used.	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 managers and their direct reports complete a performance and development review that is linked to an competence profile 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. The management structure of each scheme is outlined in the Statement of Purpose. Section 2.0 identifies the number and qualifications of staff, Section 5.0 outlines the structure of the facility. Each facility will employ different grades of staff including Scheme Managers, Project Workers, Support Workers, Clerical Staff and Peripatetic Staff. Job	Compliant

descriptions detail the specifics of each role, lines of accountability and areas of activity. Scheme specific areas of activity will be reflected in Centre Programmes and Activity Schedules. Numbers of staff reflect a balance between number of sessions, numbers of users and programme of delivery.	
Inspection Findings:	**COMPLIANCE LEVEL**
The organisational structure of the centre was reflected within the Statement of Purpose. The registered manager is supported in his role by the area service manager. At operational level support is provided by a small team of project workers who receive on going mandatory training in accordance with RQIA recommendations. Records of staff training were retained and examined. The centre had a comprehensive policy/procedure on the Recruitment and Selection of Staff. No new staff has been required/appointed since 2010. There was evidence of induction programme for new staff which is signed by the employee and the manager when deemed competent in each of the areas/factors listed. Staff meetings are held on a regular basis with minutes recorded. Staff supervision is provided six monthly with records retained. This may be provided more frequently if required. Staff appraisal takes place on an annual basis with records retained by the manager.	**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 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. 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.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Information as illustrated by the manager was evidenced through examination of records retained on supervision and appraisal. The centre has a policy/procedure on supervision which was dated 1 September 2013. Staff confirmed that supervision was provided monthly. Regular monthly staff meetings take place with minutes recorded. The manager retains a range of records including staff supervision and appraisal.	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 of 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**
Records of staff training, supervision, appraisal and staff meetings were retained. The manager confirmed that staff left in charge of centre when the manager is off has competency and capability assessments completed. The centre's policies and procedures were readily available to staff. Staff demonstrated knowledge commensurate with their role and responsibilities, confirmed their qualifications and regarded themselves as suitably qualified, experienced and in receipt of suitable training to undertake their work.	Complaint

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
	Complaint

9.0 Additional Areas Examined

9.1 Complaints

The manager confirmed that no complaints had been received since the previous inspection. Confirmation of a "nil" return in the complaints template was forwarded by the registered manager to RQIA prior to the inspection.

9.2 Staff Questionnaires/views

Two of the four staff questionnaires distributed prior to inspection was completed and returned to RQIA within the timescale. Responses from staff were positive with the exception of one staff who indicated they were not aware of the guidance document on Restraint and Seclusion in Health and Personal Social Services. This was discussed with the manager who confirmed that discussion and information sharing on this subject had taken place prior to the inspection and staff was now fully informed. This was verified by staff who spoke with the inspector. Positive comments were received from staff on the provision of care, resources available, training and supervision/appraisal.

9.3 Registered Manager Questionnaire.

A questionnaire was completed and returned to RQIA by the registered manager on 9 March 2015. Review of the information provided confirmation that governance and management arrangements including staff appraisal, staff supervision/appraisal, policies and procedures, responding to service users' behaviour and staff response to care practice were in place. Positive responses were recorded by the manager.

9.4 Staff questionnaire/views

The inspector spoke with staff on duty and reviewed two staff questionnaire returned to RQIA. within the timescale. Responses from staff who spoke with the inspector and review of the questionnaire evidenced that the provision of care was good, restraint not used and that no service user presented with behavioural management issues.

9.5 Service user views

The inspector spoke with service users in attendance at the centre. Responses were positive in regard to all aspects of care and facilities. Staff were commended by service users on the good care, activities and attention provided. No issues or concerns were raised or indicated.

9.6 Statement of Purpose

The centre's Statement of Purpose and Service User Guide were in place and available to service users.

9.7 Monthly Monitoring Reports

Monthly monitoring visits were being conducted in accordance with Regulation 5 of The Day Care Setting Regulations (Northern Ireland) 2007.

9.8 Accident/Incidents

Records of accidents/incidents were being reported to RQIA as required. It was recommended that a central log is retained in the centre for ease of access so that manager can readily identify any trends or patterns.

9.9 Environment

An inspection of the internal and external environment was undertaken. Areas identified for improvement included cleaning of skirting boards which were observed to be dusty and the general inappropriate storage of items. The manager confirmed that storage of items would be sorted and a cleaning schedule had been developed so that staff are aware of their responsibility to ensure all areas within the home is kept clean and hygienic at all times.

Externally, work to improve the patio area to the rear of the centre was planned to commence on 9 March 2015. When completed this area and the garden is to be kept tidy, safe and suitable for and accessible to all service users.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Darren Lawless 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:

Priscilla Clayton
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 Announced Care Inspection

Scraboview Beacon Centre

5 March 2015

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 Darren Lawless, registered manager, on completion of 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.

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	Standard 7.5	**Daily progress notes** It is recommended that the registered manager ensure all staff ceases to leave spaces between each recorded entry within daily progress notes.	One	Following the inspection and on receipt of subsequent QIP the registered manager reminded all staff that no spaces are to be left between entries in member's notes. Where a space occurs a line and initial should be placed in said space.	16 March 2015
2	Standard 25.1	**Cleaning schedule** The registered manager must ensure that the building is kept clean and hygienic at all times. Items within the manager's office to be appropriately stored or removed. Ref: 9.10	One	As discussed on the day of inspection, the registered manager and his team were working on decluttering/cleaning the centre as identified in monthly monitoring visit. A cleaning schedule had been agreed and has now been introduced. Items have since been stored/removed where appropriate.	16 March 2015

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	Darren Lawless
Name of Responsible Person / Identified Responsible Person Approving Qip	Billy Murphy

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	✓	P.Delgrw	21/4/15
Further information requested from provider			