

Day Care Inspection Report

26 January 2017



Magherafelt Day Centre

Type of service: Day Care Service
Address: 57 Hospital Road, Magherafelt, BT45 5EG
Tel no: 02879365075
Inspector: Priscilla Clayton

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Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Magherafelt Day Centre took place on 26 January 2017 from 10.15 to 15.30 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the day centre was delivering safe, effective and compassionate care and if the service was well led.

Analysis of responses from service users (3), staff (5) and relatives (3) within satisfaction questionnaires returned to RQIA following the inspection were all positive in regard to the provision of safe, effective, compassionate and well led care. No issues or concerns were recorded.

(Northern Ireland) 2007, the Day Care Settings Minimum Standards 2012.

Is care safe?

There was evidence to confirm that the centre was providing safe care at the time of the inspection. This was gained from service users and staff who spoke with the inspector; records examined, availability of associated policies/procedures, accident/incident records and staff training.

One recommendation made related to ensuring the revised NHSCT policy on adult safeguarding is available to staff and that staff refresher training is provided.

Is care effective?

Evidence on the provision of effective care was gained from discussion with staff, service users, one relative, care records, minutes of service users meetings, minutes of staff meetings, audits conducted, monthly monitoring reports and completed satisfaction questionnaires returned to RQIA within the timescale.

Two recommendations were made for improvement within this domain.

One recommendation made related to ensuring that an analysis is undertaken of the responses within the annual quality audit in order to determine the level of satisfaction with the service and if necessary an action plan developed to address issues. The second recommendation made related to ensuring that the changed needs of service users are reflected within the care plans as this was not evident in one care plan examined.

Is care compassionate?

There was strong evidence that the care provided was compassionate from observation of staff interactions with service users, discussions with staff, service users and one relative who met with the inspector. Staff explained that there was a culture/ethos within the centre which supported core values as reflected within the service user guide and statement of purpose.

Care records examined reflected choices and preferences in the provision of care.

There was a range of policies and procedures in place which supported the delivery of compassionate care.

No requirements or recommendations were made in this domain.

Is the service well led?

There was evidence that the service was well led. This was obtained from records examined including; internal quality audits, provision of staff supervision/appraisal, staff meetings, staff mandatory training and professional development and positive feedback received from service users, staff, service users and one relative who spoke with the inspector.

No requirements or recommendations were made in this domain.

This inspection was underpinned by The Day Care Settings Regulations

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Eileen Doyle, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 14 January 2016.

2.0 Service details

Registered organization/registered person: Northern HSC Trust/Dr Anthony Baxter Stevens	Registered manager: Eileen Doyle
Person in charge of the service at the time of inspection: Eileen Doyle	Date manager registered: 24 September 2008

3.0 Methods/processes

Prior to inspection RQIA analysed the following records:

- Previous inspection report and quality improvement plan
- Accident/incident notifications
- Correspondence.

During the inspection the inspector met with the manager, all service users, three care staff and one relative.

The following records were examined during the inspection:

- RQIA registration certificate
- Statement of purpose
- Service user guide
- Selection of policies and procedures including those in respect of adult safeguarding, whistleblowing, staff recruitment, complaints and infection prevention and control
- Staff training
- Staff meetings
- Staff supervision and appraisal
- Service user meetings
- Monthly monitoring visits
- Staff duty roster
- Care records x 3
- Complaints
- Accidents/incident.
- Fire risk assessment
- Annual quality review report.

Fifteen satisfaction questionnaires were given to the manager for distribution to service users (five), staff (five) and relatives (five) and return to RQIA. Eleven questionnaires were returned within the timescale; three from service users, five from staff and three from relatives.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 14 January 2016

The most recent inspection of the centre was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last care inspection dated 14 January 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 Ref: Standard 10.7 Stated: First time	The Registered Manager should ensure there is a three week menu plan for lunch for service users in Magherafelt Day Centre.	Met
	Action taken as confirmed during the inspection: The manager explained that she held a meeting with the Mid Ulster Hospital catering manager to discuss the provision of rotating menus. As a result a “tasting” session was held with discussions held with service users. Subsequently three weekly seasonal menus were agreed and provided each day. Service users who spoke with the inspector gave positive feedback on meals provided.	
Recommendation 2 Ref: Standard 17.10 Stated: First time	The Registered Person should ensure the designated person undertakes monthly monitoring visits of Magherafelt Day Centre. The monthly monitoring reports are retained and made available for inspection purposes.	Met
	Action taken as confirmed during the inspection: Monthly monitoring visit were undertaken. Copies of monitoring reports were retained within the centre.	

4.3 Is care safe?

Discussion with the manager confirmed that staff employed were sufficiently qualified, competent and experienced to meet the assessed needs of service users in attendance each day. Staff who met with the inspector demonstrated good understanding of their roles and responsibilities in meeting the needs of service users and associated policies and procedures in the running of the centre.

The manager explained that one full time care assistant's post has been vacant since October 2016 and two part time posts were expected to be filled shortly with one advertised and the other through redeployment. Three consistent agency staff had been commissioned until appointments are made. The manager and staff confirmed that staffing levels were satisfactory to meet the needs of service users.

Competency and capability assessments of staff in charge when the manager is out of the centre were undertaken and recorded by the manager. Review of two assessments showed that assessments were signed/dated by the staff member and manager.

Staff working in the centre each day alongside hours worked was recorded within the duty roster.

The manager confirmed that staff employment records were held within the Northern Health and Social Care Trust (NHSCT) human resource department and that all appointments made were in keeping with the trust policy/procedures, legislation and day care standards; all necessary documentation, including Access NI, was checked and in place before a new employee would commence work.

The manager confirmed that all care staff were registered with the Northern Ireland Social Care council and that registration dates were recorded. Monitoring of re-registration dates will be undertaken by the manager.

Electronic corporate policies and procedures on staff recruitment, selection and induction were in place and available to staff.

Induction records reviewed contained a comprehensive account of the standard to be achieved. Induction programmes were noted to be signed and dated by the staff member and mentor on the achievement of each indicator.

Mandatory staff training was discussed with the manager and staff. Training provided included adult safeguarding and whistleblowing. Staff confirmed that mandatory training was ongoing. Other professional development training provided included; dysphasia, deprivation of liberty, reporting and recording, dementia awareness and complaints handling.

The manager confirmed that no safeguarding allegations were currently active and should any arise the correct procedure would be followed in accordance with NHSCT policy and procedure. Staff training in the safeguarding was provided on a two yearly basis. Staff who spoke with the inspector demonstrated good understanding and knowledge of the procedure currently in place. One recommendation was made in regard to review and revision of the adult safeguarding policy to ensure this is in keeping with Department of Health (DOH) new regional policy and procedure titled Prevention and Protection in Partnership, July 2015. Staff refresher training on the new policy will be necessary.

The manager and staff confirmed that with the exception of the key pad opening of dementia unit doors no restrictive practice takes place in the centre. The use of a key pad opening device in the dementia unit was deemed necessary in respect of the safety and wellbeing of service users in this unit. Electronic policies and procedures on restrictive practice were in place and available to all staff.

Necessary infection protection and control measures were in place with a good standard of hygiene observed throughout the centre. Measures included, for example; "seven step" hand hygiene notices positioned at all wash hand basins, availability of disposable gloves and aprons, provision of staff training in infection, prevention and control, and availability of electronic trust policies/procedures on infection prevention and control.

The centre had a policy on risk management which was dated 2014. Risk assessments in respect of safe working practices included for example; COSHH, fire safety, moving and

handling, falls prevention and dysphasia. The manager confirmed that all risks identified were reflected within care plans with interventions in place to minimise the identified risk.

An inspection of the centre was undertaken. All areas were observed to be clean, tidy, fresh smelling, organised and appropriately heated. COSHH substances were noted to be securely stored. All fire doors were closed and exits unobstructed.

The centre's fire risk assessment, dated 18 March 2016, was reviewed. No recommendations for action were made. No changes had occurred since the previous assessment. Weekly and monthly fire safety equipment checks were being recorded when checked. Fire safety and fire drills were provided and recorded.

The manager and three care staff who met with the inspector gave positive feedback in regard to the provision of safe care and confirmed that staff training, supervision, appraisal and staff meetings were provided and ongoing. Staff also explained that there was very good multi-professional working in the planning and monitoring of care.

Service users who met with the inspector indicated that attending the centre was essential to them and how effective the activities, support provided and meeting up with others was in important to them. Service users meeting were being held on a regular basis with minutes recorded and retained. Minutes reflected consultation with service users in regard to the day to day arrangements within the centre.

Analysis of completed satisfaction surveys returned to RQIA within the timescale provided evidence from service users, staff and relatives that they were satisfied that the care provided was safe. No issues or concerns were recorded.

Areas for improvement

One recommendation made within this domain related to ensuring the revised NHSCT policy on adult safeguarding is made available to staff. Refresher training for staff on the new policy/procedure will be necessary.

Number of requirements	0	Number of recommendations	1
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4.4 Is care effective?

Three service users care records were provided by the manager for review. These were found to be in line with legislation and minimum care standards including, for example; holistic health and social care needs assessments which were complemented with risk assessments; person centred care plans and regular records of the health and wellbeing of the service user were contained within care records examined. Records of reviews held were in place which included participation of the service user and where appropriate their representative. There was recorded evidence of multi-professional collaboration in planned care. One recommendation made related to ensuring that the changed needs of service users are reflected within the care plans as this was not evident in one of the three care plans examined.

The manager explained the systems in place to promote effective communication between service users, staff and other stakeholders. This was evidenced within a number of sources including: discussions with staff and service users, care records examined; minutes of service

users' meetings, minutes of staff meetings, information notices displayed on health and social care and photographs of various activities and social events.

Staff confirmed that the modes of communication in use between the staff team, service users/representatives and other stakeholders were effective and that communication was enhanced through the "open door" arrangements operated by the manager and senior staff.

Service users who met with the inspector confirmed they were aware of whom to contact if they had any issues or concerns about the service and that staff were approachable and always willing to help and provided assistance when required.

The manager explained that the trust annual service users' quality assurance survey was undertaken during 2016. One recommendation made related to ensuring that an analysis of the responses is undertaken in order to determine the level of satisfaction with the service and if necessary an action plan developed.

One relative who afforded time to meet with the inspector made several complimentary comments about the staff and the effective care provided. No issues or concerns were raised or indicated.

Analysis of completed satisfaction surveys returned to RQIA from service users, staff and relatives provided evidence that they were satisfied that the care provided was effective.

Areas for improvement

Two recommendations for improvement were made within this domain.

One recommendation related to ensuring that an analysis of the responses within the annual quality survey is undertaken in order to determine the level of satisfaction with the service and if necessary an action plan developed. The second recommendation made related to ensuring that the changed needs of service users are reflected within the care plan as this was not evident within one of three care plans examined.

Number of requirements	0	Number of recommendations	2
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4.5 Is care compassionate?

The manager confirmed that there was a culture/ethos within the centre that supported the values of dignity and respect; independence; rights; equality and diversity; choice and consent of service users. This was reflected within the statement of purpose, service user guide, care records and minutes of service user meetings examined.

There was a range of policies and procedures available to staff which supported the delivery of compassionate care.

Observation of staff interactions with service users demonstrated that they were treated with dignity and respect. Staff confirmed their awareness of promoting service user rights, independence and dignity.

Discussions with staff, service users, review of care records and observation of staff practice and interactions confirmed that service users' needs were acknowledged and recorded.

There was evidence that service users were enabled and supported to engage and participate in a range of meaningful activities noted within care records, service user meetings and reviews of care.

Service users confirmed that they were consulted and felt very much involved about arrangements within their centre. Comments from staff, service users and one visitor were very positive in regard to the service provided. No issues or concerns were raised or indicated in this regard.

Analysis of completed satisfaction surveys returned to RQIA following the inspection provided evidence that service users, staff and relatives were satisfied that the care provided was compassionate.

Areas for improvement

No areas for improvement were identified within this domain.

Number of requirements	0	Number of recommendations	0
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4.6 Is the service well led?

Eileen Doyle, the Registered Manager of the centre explained that she felt very well supported in her role by the locality manager who provided supervision each month and visited the centre on a regular basis. At operational level support was provided by a mixed skill team of care and ancillary staff.

There was a defined organisational and management structure that identified the lines of responsibility and accountability of staff within the centre. Information in this regard was reflected within the statement of purpose and service user guide.

The centre's current RQIA registration certificate was displayed in a prominent position. The manager confirmed that the centre operated in accordance with the regulatory framework and that the health and social care needs of service users were met in accordance with the centre's statement of purpose.

There was a range of electronic NHSCT corporate policies and procedures to guide and inform staff. Several policies were also held in hard copy format. Staff demonstrated awareness of policies including the policy and procedure relating to whistle blowing and adult safeguarding.

The centre had a comprehensive corporate complaints policy and procedure which was known by staff who met with the inspector. Leaflets titled "Your views matter" were displayed in various locations within the centre. Records of complaints received were reviewed and discussed with the registered manager. Complaints recorded were noted to be managed and resolved satisfactorily.

Several complimentary letters and cards received from relatives and service users were displayed.

The centre had an accident / incident policy which included reporting arrangements to RQIA. Accidents and incidents were noted to be effectively recorded within the corporate electronic datix system. Information entered into the system is passed electronically to the locality

manager and the NHSCT governance team who have responsibility for monitoring and audit. The manager confirmed that feedback is received in this regard with trends and patterns identified and further action required if necessary and when necessary learning from accidents/incidents was disseminated to all relevant parties. Monthly audits of accidents/incidents were undertaken and recorded by the manager.

The manager demonstrated knowledge of the procedure to follow regarding notifications of accidents and incidents to RQIA. Notifications received since the previous inspection was discussed with the manager. These had been recorded and managed satisfactorily.

Records of audits undertaken were retained by the manager. These included for example, audit of the environment, fire safety, care records, accidents/incidents, complaints and service user satisfaction survey. When required action plans to address identified issues are developed with action taken to address issues.

Monthly monitoring visits were being undertaken on behalf of the registered provider as required under regulation 28 of The Day Care Setting Regulations (Northern Ireland) 2007. Reports were available to service users, relatives, staff, trust representatives and RQIA.

There was evidence of effective working relationships with internal and external stakeholders recorded within care records and policies and procedures. Staff confirmed that the manager operated an “open door” policy and that staff meetings, supervision and appraisal were provided and ongoing. Discussion with staff confirmed that there were good working relationships and that the manager was always responsive to suggestions and/or concerns expressed.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Eileen Doyle, Registered Manager as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP 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 the Magherafelt day care setting. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Day Care Settings Regulations (Northern Ireland) 2007.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and Day Care Settings Minimum Standards 2012. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to web portal for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations

<p>Recommendation 1</p> <p>Ref: Standard 13.1</p> <p>Stated: First time</p> <p>To be completed by: 31 April 2017</p>	<p>The registered provider should ensure that review and revision of the adult safeguarding policy is undertaken to ensure this is in keeping with DOH policy/procedure titled Prevention and Protection in Partnership, July 2015. Staff refresher training will also be necessary.</p> <p>Response by registered provider detailing the actions taken: Staff refresher training is organised for Closure training day for all staff. Review and revision of all safeguarding policy/procedures are in line with DOH policy/procedure Prevention and Protection in Partnership 2015 and are available to staff.</p>
<p>Recommendation 2</p> <p>Ref: Standard 17.9</p> <p>Stated: First time</p> <p>To be completed by: 30 April 2017</p>	<p>The registered provider should ensure that an analysis of the responses recorded within the service user satisfaction survey is undertaken in order to determine the level of satisfaction with the service and if necessary an action plan is developed to address issues.</p> <p>Response by registered provider detailing the actions taken: An analysis of the responses from the service user satisfaction survey carried out by the trust governance department December 2015 is being undertaken and actions planned to include staff and service users. This will be incorporated in future trust governance satisfaction surveys.</p>
<p>Recommendation 3</p> <p>Ref: Standard 5.6</p> <p>Stated: First time</p> <p>To be completed by: 31 January 2017</p>	<p>The registered provider should ensure that changes in assessed needs of service users are reflected within the care plans.</p> <p>Response by registered provider detailing the actions taken: This record has been adjusted and the system for ensuring the ongoing changes in assessed needs of service users has been addressed and agreed with staff.</p>



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