Primary Announced Care Inspection

Name of Establishment:	**Arden Centre**
Establishment ID No:	**10746**
Date of Inspection:	**20 October 2014**
Inspector's Name:	**Dermott Knox**
Inspection No:	**20477**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

Name of centre:	Arden Centre
Address:	Scroggy Road Limavady BT49 0AR
Telephone number:	(028) 7772 2123
E mail address:	irene.smyth@westerntrust.hscni.net
Registered organisation/ Registered provider:	Ms Elaine Way CBE Western Health and Social Care Trust
Registered manager:	Ms Irene Smyth
Person in Charge of the centre at the time of inspection:	Ms Irene Smyth
Categories of care:	MAX, DCS-MP, DCS-MAX
Number of registered places:	20
Number of service users accommodated on day of inspection:	14
Date and type of previous inspection:	2 October 2013 Primary Announced Inspection
Date and time of inspection:	20 October 2014 10:30am–4:30pm
Name of inspector:	Dermott Knox

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	6
Staff	2
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	3	1

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

Arden Day Centre is operated by the Western Health and Social Care Trust and is part of the Rehabilitation and Recovery Team within the Mental Health Programme of Care. The centre is open on four days of the week, from 9.30am–4.30pm and closes on Wednesdays to enable outreach work to take place. A range of programmes and social activities are provided, aimed at the promotion of positive mental health and aiding recovery by encouraging independence and social interaction.

Care and support is provided to a maximum of 20 service users per day and some 53 clients overall benefit from the service. While the age range is predominately 18 to 65 years there are a few long term service users who are now over the age of 65 years.

The centre is located in the grounds of Scroggy Road Health Centre and has been in operation since 1990. The facility is on two floors with a day room and kitchen, recreation room with pool table, interview/quiet room, TV lounge, toilets, utility room and an enclosed yard.

Summary of Inspection

A primary announced inspection was undertaken in Arden Day Centre on Monday 20 October 2014 from 10:30am until 4:30pm. Prior to the inspection the service provider submitted a self-assessment of the centre's performance in the one standard and two themes forming the focus of the inspection. There were five requirements from the previous inspection and evidence of compliance with two of these was confirmed by the manager. There was substantial compliance with another two requirements and the Trust was judged to be moving toward compliance with the remaining matter.

The inspector was introduced to most of the members attending the centre and met for discussions with six people. Individual discussions were also held with the acting manager and one staff member regarding the standards, team working, management support, supervision and the overall quality of the service provided. One completed questionnaire was returned by a staff member, who reported that staffing arrangements were challenging since the retirement of the previous manager, although there continued to be good management support from the acting manager and provision of a caring service in the centre.

Overall, discussions with service users and with staff contributed a positive view of the service provided in the centre and indicated a strong commitment by the manager and the staff to work in support of recovery plans for service users. There was evidence from discussions and in written records to indicate a high level of inclusion and involvement of service users in decision making with regard to the care provided. Service users spoke highly of the support they experienced and the opportunities provided by the staff for their motivation and development. There are four requirements and two recommendations arising from this inspection.

The inspector wishes to acknowledge the open and constructive approach of the manager and staff throughout the inspection process. Gratitude is extended to members, who welcomed the inspector to the centre and contributed positively to the evaluation of the service provided.

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 well- written policies and procedures regarding data protection and confidentiality, recording and reporting, consent, and a procedure for processing requests for access to client files. The policies and procedures are available for staff reference. The registered person had arrangements in place to review policies and procedures in order to ensure that they were up to date and accurate.

In the sample of four service user care records examined, there were many examples of service users having signed to indicate their involvement and agreement with the content. Files were structured and maintained in accordance with the Trust's procedures and current good practice.

Staff members were knowledgeable of the reporting requirements and were confident of reaching sound decisions in this aspect of the work due to the supports available from colleagues and management. Good quality progress notes for service users were being kept, as were records of reviews and individual care plans.

Arden Centre was judged to be operating in compliance with this standard.

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

The WH&SCT has a written policy and guidelines on the use of restrictive interventions, which was available to members of staff. Both the written records and discussions with staff confirmed that there had not been any use of restraint or of restrictive interventions in the centre. There were regular multi-disciplinary planning meetings for discussion of service user's progress and the manager confirmed that these were positive and supportive in good decision making.

Staff discussed the use of good communication and the importance of developing good understanding of each individual's needs and preferences. MAPA training had been provided for staff who confirmed that they had never needed to use any restrictive practices with service users in the centre. Two service users confirmed their awareness of their rights and said that they were always treated with respect by staff members.

While the service provider regards this theme as 'Not applicable' in Arden Centre, the evidence of staff promoting and protecting service users' human rights was available. The centre is judged to be operating in compliance 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.

Staff records showed that the registered manager and the staff nurse are appropriately qualified and experienced to take charge of the centre. Training for most aspects of this role had been provided for the acting manager, although training for annual performance appraisal was overdue.

There was evidence from discussions with staff to confirm that members of the staff team work supportively and well with one another. Systems were in place for supervision and promoting staffs' learning. Records of staff training and supervision were well-presented and up to date, with formal supervision sessions being provided with a frequency in compliance with the minimum standard requirement. The content of supervision records should be expanded.

The staffing structure and reporting arrangements were clearly set out in writing in the statement of purpose, for reference by all stakeholders. Staffing was below the usual complement following the retirement of the previous manager. Staff presented as being knowledgeable, competent and confident in their roles and responsibilities and their learning in specific areas of interest was encouraged and facilitated where possible. The staff office was equipped with up to date literature, appropriate for staff's learning and development.

Monitoring arrangements are standardised across the WH&SCT day care services and the three monitoring reports examined, addressed all of the required matters. In recent months, some monitoring has been carried out by peer managers of other facilities and monitoring reports reflected the detail of their involvement and enthusiasm for the promotion of good practice.

The evidence indicates that the centre is substantially in compliance with this theme.

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)(c)	The registered person must ensure that overdue training in First Aid is provided for staff at the earliest possible time.	One staff member has attended first aid training and all staff have now been scheduled to attend Basic Life Support training. Qualified nurses in the team should also be provided with refresher training in first aid.	Substantially compliant
2	Regulation 26(2)(b)	The flooring in one toilet should be replaced.	This has been completed.	Compliant
3	Regulation 14(1)(a)	There is inadequate control on entry to the building, making it potentially unsafe for service users and staff. This should be improved urgently.	While no changes to the entrance access arrangements have been made, the manager explained that Estates Department has assessed the situation. The registered person should ensure that this matter is risk assessed and any necessary work is completed.	Moving toward compliance
4	Regulation 18(2)(a)	The telephone system is inadequate for the efficient running of the centre and for staff to maintain effective communications with other agencies and supporting professionals. This should be improved urgently.	The acting manager explained that staff could make outgoing calls through the adjoining Mental Health office and emergency calls directly from the Arden premises.	Substantially compliant
5	Regulation 20(2)	The registered person must ensure that formal, recorded supervision with the manager of the centre is carried out, in accordance with the minimum standards.	There was written evidence to show that supervision sessions for the acting manager have been held regularly during 2014.	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:	
Confidentiality is maintained at all times. Case notes are kept in locked filing cupboard, clients are able to speak to staff confidentially in separate rooms when necessary from others.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Records in the Arden Centre were being kept securely and there was good evidence to show that staff were acutely aware of the duty of confidentiality in their work. Staff made sure that any service user was facilitated to talk privately to them when this need was indicated.	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:	
The Care is client led and as such clients are involved in development, assessment,care plans, multidisciplinary reviews and all these documents are signed by client after client reads same. Staff are trained in record management policy. No requests have been made to acess case notes, if this occurred staff would follow Trust Pilicy.	Compliant

Inspection Findings:	**COMPLIANCE LEVEL**
The provider's self-assessment was verified through examination of four service users' records and from discussions with a number of staff and service users. Records of reviews included written evidence of preparatory work between key workers and service users, showing that they were actively encouraged to present their views and preferences. A wide range of records, including contracts, assessments, care plans and review reports had been signed by service users, indicating their participation in agreeing the content.	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:	
All individual records are maintained in keeping with standard 2,4,5 ,15 and Appendix 1, except photographs when clients declined to have photograph in their files they would sign form to say so.Any changes in a client's behaviour or needs are reported to person in charge of the centre at that time. She would assess same and if necessary report to the Referral Agent or if a crisis to the Recovery Team.This would be recorded in the clients notes.This would also be reported and discussed at the next weekly Recovery Team Meeting.	Compliant

Inspection Findings:	**COMPLIANCE LEVEL**
The sample of four service user's records, examined at this inspection, provided evidence of compliance with this criterion. All of the required records were in place and the general standard of record keeping was good.	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:	
Clients activities are recorded on a daily or weekly basis.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Progress records for each service user were being completed on at least a weekly basis and the records sampled were found to be sufficiently detailed and well written. There was evidence to show that service users were involved in and informed of the content of some of the records.	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:	
Good communication is maintained with the relevant professionals and all matters reported appropriatly.Acting Manager or Staff Nurse attend weekly Team Meetings of Limavady Recovery Team.	Compliant

Inspection Findings:	COMPLIANCE LEVEL
There was evidence of excellent communications within the small staff team in Arden Centre and this ensured that there were regular opportunities for consultation on any matters which a staff member thought should be reported. As stated in the provider's self-assessment, weekly attendance at the Recovery Team meetings, along with community based professionals also provided good opportunities for clarification of any concerns about service user related matters.	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:	
Staff are trained in record keeping and the above standards are maintained.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The sample of records examined at this inspection were of a good standard, legible, accurate, up to date and all had been signed and dated by the person making the entry. Auditing of records was carried out by the manager and records were sampled each month by the monitoring officer.	Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE DAY CARE SETTINGS COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	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:	
Restraint is not practised in the day care setting.	Not applicable
Inspection Findings:	**COMPLIANCE LEVEL**
Following referral to Arden Centre, service users are taken through the centre's induction process and sign a contract. This includes agreement to the acceptable social norms of the group. There was no evidence or indication that restraint had or would ever be used in the centre. Staff were aware of emergency procedures should they need to summon assistance.	Compliant

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:	
N/A	Not applicable
Inspection Findings:	**COMPLIANCE LEVEL**
Many service users had worked with staff to develop a Wellness Recovery Action Plan, a personalised and structured plan to aid their recovery. Service users talked with the inspector about their expectations of support from centre staff and the support and understanding that they gained from each other. Restraint does not have a part in this work.	Not applicable

PROVIDER'S OVERALL ASSESSMENT OF THE DAY CARE SETTING COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	**COMPLIANCE LEVEL**
	Not applicable

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:	
Yes our defined management structure is outlined in our statement of purpose.When I as Acting Manager was on annual leave I put measures in place agreed with my Line Manager so that the staff were competent with the numbers in the centre and extra support if needed from the Recovery Team.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Arden Centre has a well-established staff team whose members confirmed that they work supportively together. The staffing structure is clearly set out in the statement of purpose. Members of the community based recovery team work in an adjoining office and the manager confirmed a close working relationship with them. In the absence of the manager, the staff nurse employed in the centre takes responsibility for day to day management.	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 have received regular supervision in keeping withNMC guidelines and RQIA requirements.Acting Manager has supervisor traing and staff nurse has supervisee training	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Supervision sessions were being provided with the frequency required and records were available for inspection. The records should be expanded to provide an account of the discussions, decisions and any further actions required of either the supervisor or the supervisee. It was evident that the manager and staff worked closely together and that there was good management and colleague support.	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:	
Staff have appropiate qualifications and mandatory training is ongoing.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Arden centre has a very experienced staff team each of whom is appropriately qualified for the role and responsibilities that they undertake, with the exception that the acting manager has yet to be provided with training for carrying out annual performance appraisals of staff. These are due to be completed by the end of November 2014 and the registered person should ensure that the relevant training is provided.	Substantially 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
	Substantially compliant

Additional areas Inspected

Quality Survey

A report of the quality survey for the year 2012/2013 was available for inspection. A survey for the current year was in progress and the manager stated that the report would be completed in December 2014.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Irene Smyth, 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:

Dermott Knox
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

Arden Centre

20 October 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 Ms Irene Smyth, Registered manager, either during or after 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	Regulation 7(a)	The statement of purpose and the service user guide should be reviewed and revised, as per discussion with the acting manager.	One	The acting manager has started the process of reviewing the Statement of Purpose and the Service user guide in consultation with service users in the centre.	31 December 2014
2	Regulation 7(b)	A copy of the statement of purpose and of the service user guide should be sent to RQIA, preferably electronically.	One	The acting manager will forward a copy of the Statement of Purpose and the Service User Guide electronically before 31/12/14	31 December 2014
3	Regulation 14(1)(a)	The registered person should ensure that a risk assessment is carried out with regard to the unsupervised access to the centre and that any necessary measures are taken as soon as possible.	Two	19/11/14 The acting manager has completed a risk assessment of the building on behalf of the registered person, with the decision that a door security system is no longer suitable. This follows the implementation of the WHSCT Smoke Free Policy in March 2014, which has led to high frequency of service users leaving and entering the building for smoke breaks. If a security system was in place staff would constantly be activating it, leading to significant disruption to activity programmes.On entering the	31 December 2014

				front door a service user /member of the public should only have acess to the main day room where a member of staff is present during opening hours. Key pads are in place upstairs but not downstairs. Estates are no longer installing key pads ,so downstair doors other than the day room will be kept locked when not being used. A controlled door Protocol is being developed for use within Adult Mental Health & Disability Services Directorate facilities.	
4	Regulation 20(1)(c)(iii)	The registered person should ensure that the relevant training is provided for the acting manager to carry out annual staff appraisals.	One	The acting manager has appraisal on 27/11/14 and necessary training on doing appraisals on 3/12/14. Staff have been given dates for their appraisals in december.	28 November 2014

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 22.2	Records of staff supervision sessions should include greater detail of the matters discussed and of any further actions agreed on the part of either the supervisor or the supervisee.	One	This has been discussed with staff and agreed to be implemented.	Immediate and on-going.
2	Standard 21(4)	Qualified nurses in the day care team should be provided with refresher training in first aid.	Two	This has been discussed at operational management meetings. BLS training has been organised for December. The trained staff have agreed to do refresher training in house untill dates become available.	31 December 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	Anna Smyth
Name of Responsible Person / Identified Responsible Person Approving Qip	Elaine Hay

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes		9th Jan 2015
Further information requested from provider			