The Regulation and Quality Improvement Authority

Primary Unannounced Care Inspection

Name of Establishment:	**Limavady Community Development Initiative**
Establishment ID No:	**10992**
Date of Inspection:	**4 March 2015**
Inspector's Name:	**Dermott Knox**
Inspection No:	**20653**

The Regulation And Quality Improvement Authority
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Name of centre:	Limavady Community Development Initiative
Address:	Roe Valley Hospital 24a Benevenagh Drive Limavady BT49 0AQ
Telephone number:	(028) 7776 5438
E mail address:	daycare@lcdi.co.uk
Registered organisation/ Registered provider:	Mr Damien Corr Limavady Community Development Initiative
Registered manager:	Ms Geraldine Jones
Person in Charge of the centre at the time of inspection:	Ms Geraldine Jones
Categories of care:	DCS-PH
Number of registered places:	23
Number of service users accommodated on day of inspection:	5
Date and type of previous inspection:	9 October 2013 Primary Unannounced Inspection
Date and time of inspection:	4 March 2015 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	4
Staff	1
Relatives	1
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 by mail following inspection	3

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

Limavady Community Development Initiative is a voluntary organisation and registered charity, which has thirteen projects in operation. The organisation has a management committee, a general manager, and a number of project co-ordinators. Each project then employs its own staff and there are volunteers in some of the projects.

The Day Centre known as the LCDI Day Centre is based in the site of the former Roe Valley Hospital in Limavady. It operates in an old building, with a modern sunroom attached and with access to a sheltered walled garden, exclusively for the use of the day centre.

Placements to the Centre are funded through the Western Health and Social Care Trust for people residing in the Limavady Borough Council Area.

The centre is opened three days per week, Tuesday, Wednesday and Friday, from 10.00am until 3.30pm.

Summary of Inspection

A primary, unannounced inspection was carried out at LCDI Day Centre, on Wednesday 4 March 2015, by an inspector from the Regulation and Quality Improvement Authority. The focus of the inspection was to assess the centre's compliance with one standard and two themes selected from the Day Care Settings Minimum Standards 2012. The registered manager completed a self-assessment of the centre's compliance with these standards and submitted it to RQIA within two weeks of the inspection visit. An overview of the inspection findings can be found below. Seven requirements made at the previous inspection had all been addressed satisfactorily. Of the seven recommendations also made at that inspection, three had not been fully implemented and these matters are restated in the Quality Improvement Plan accompanying this report.

The inspector met for discussions with four of the five service users attending on that day. Service users were engaged in a range of table-top activities, including dominoes and word quizes in a group with centre staff. Discussions were also held with the manager, one staff member and a relative/carer of one service user. Time on the inspection visit was divided between meetings with service users, relatives and staff, discussions with the manager, and examination of selected records.

Standard 7: Individual service user records and reporting arrangements.

Three service user's files were examined during the inspection and were found to contain documents addressing all of the matters required. Files contained some records of the involvement of service users and/or their carer/s, at stages including referral, assessment, care planning and review processes. However, there were several examples of documents having no signatures or dates, the absence of dates being notable across a wide range of documents.

It is a matter of concern that practice in this area remains unsatisfactory, having been identified as an area for improvement in the previous inspection in February 2014.

There were a number of different formats in use for gathering assessment information and for the presentation of care plans, with the latter being particularly confusing. While assessment information was fairly well organised, individual care plans presented broad objectives in a format which made it difficult to establish clear connections to the assessment information.

Some of the terminology in service users' records indicated the need for improvement in this area of practice. It is recommended that the care plan format should be revised, taking account of the matters specified in Standard 5.2.

Review reports were prepared involving the relevant service users and there was written evidence to show that review decisions were carried forward into the care plans.

The centre has suitable, secure arrangements in place to ensure the safety and confidentiality of service users' personal information. The manager and staff demonstrated their awareness of the reporting procedures and the necessity for keeping accurate, legible, dated and signed records of any notifiable events. Examples of notifications of events were examined and were satisfactory.

The centre was judged to be moving toward compliance with this standard.

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

LCDI Day Centre provides a service to a number of people who have assessed care and health needs, some of whom are heavily reliant on other people for their personal care and mobility assistance. There is input to these service users' care by community based professionals such as nurses and speech and language therapists, requiring good communication and cooperation between the services.

Planned care for any individual's needs is reviewed regularly and action plans are discussed with the service user, his or her representative/s and relevant professionals, to ensure that interventions remain necessary and proportionate and do not infringe a service user's human rights. The manager described how physical assistance and guidance was given to some service users and discussed the definition of "restrictive practice" with regard to such actions.

There was evidence from the provider's self-assessment and from discussions with the manager to confirm that a degree of uncertainty prevailed concerning actions that constitute restrictive practices. It is recommended that the registered manager and staff members should engage in training on this matter at the earliest possible time, to ensure that they are working with a common understanding of the issues.

Records relating to each service user's needs, and the plans to meet these needs, were available, although the clarity of care plans was variable. One service user in the centre confirmed his involvement in decision making with regard to the care plan and the ways in which his safety might best be assured. Two service users confirmed that they were always treated with respect and kindness.

LCDI Day Centre was judged to be moving toward compliance with the criteria in this theme.

Theme 2 – Management and Control of Operations

LCDI Day Centre has a small complement of staff, each of whom has worked in the centre for many years. On the day of this inspection, staff were employed in sufficient numbers to meet the needs of the five service users attending on that day. Staff training records showed that most of the mandatory training was up to date. A requirement regarding training on restrictive practice has been made.

There was evidence of a good commitment to staff development, under the current management arrangements and staff expressed positive views of the support and supervision provided. The manager kept records of three-monthly supervision sessions which were up to date. Formal staff meetings were being held every two months. There was evidence to verify that a staff briefing with the manager was held every morning, in an effort to ensure that staff members were kept up to date with developments.

Monitoring visits and report preparation were carried out by a member of the Management Committee for the centre. Monitoring arrangements were satisfactory in terms of their regularity but monitoring did not appear to be identifying weaknesses in the management and performance of the centre, for example in the failure to provide the required range of policies and procedures, an issue that had been identified for improvement at the previous annual inspection. It is recommended that monitoring should be more rigorous and that monitoring reports should be expanded to include comment on RQIA's Quality Improvement Plans and any audits carried out within the centre that contribute to the overall quality assurance.

LCDI Day Centre was moving toward compliance with the standards in this theme.

Conclusion

A relaxed and supportive atmosphere was evident in the centre and there was both written and verbal evidence of constructive development programmes for service users and of positive relationships with staff members. Overall, there was evidence to indicate that LCDI Day Centre was moving toward compliance with the criteria in the standards which were the focus of this inspection. Three requirements and three recommendations for improvement were identified and these are set out in the accompanying Quality Improvement Plan, along with a timescale for their implementation.

The participation of service users, staff and the manager in the inspection process is gratefully acknowledged.

Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	Regulation 19(1)(a), Schedule 4(2)	The registered person shall ensure that a recent photograph of each service user is kept on file.	Each service user's file held a recent photograph of that person.	Compliant
2	Regulation 19(1)(b)	The organisation of service user files was poor and the registered person shall ensure that these records are kept securely.	Files had been reorganised and were satisfactory in terms of the arrangement and security of documents.	Compliant
3	Regulation 14(3)	The registered person shall ensure that the competence of the manager and staff is checked with regard to all aspects of the revised policy and procedures on safeguarding vulnerable adults.	Refresher training had been provided and the manager confirmed compliance with this requirement.	Compliant
4	Regulation 20(2)	Records of staff supervision were very brief. Discussion with the manager on this issue indicated the need for greater commitment on her part to the formal supervision process. The registered person shall ensure compliance with this regulation.	Records showed that formal supervision was held three monthly with each staff member. A staff member confirmed that supervision was up to date and supportive.	Compliant
5	Regulation 13(8)(a)	Two notices on the shower room wall presented information and guidance for service users in out-dated and condescending language. The manager removed these immediately, when this was brought to her attention. All notices and information boards should be assessed regularly for their necessity and appropriateness.	On a tour of the premises, there was no evidence of any inappropriate posters or notices being displayed.	Compliant

6	Regulation 18(2)(e)	The drain in the shower room was identified as the source of an unpleasant smell and should be cleaned and effectively disinfected.	The manager reported that the drains had been effectively cleaned and the unpleasant odour was no longer detectable.	Compliant
7	Regulation 13(7)	Supplies of paper towels, toilet rolls and toiletries in the shower room should be stored in an enclosed cupboard or similar container, in order to minimise infection risks.	A lockable cupboard had been supplied for the storage of toiletries.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	Standard 7.7	A number of documents in service users' files were either undated, or had incomplete dates. The registered person must ensure that records are accurate and complete.	All three of the service users' records examined contained documents that were either unsigned, undated, or both. This recommendation is re-stated.	Moving toward compliance
2	Standard 13.1	The registered person must ensure that the written policy and procedures for safeguarding vulnerable adults are accurate and up to date.	The policy and procedures on Safeguarding Vulnerable Adults had been revised.	Compliant
3	Standard 9.5	It was noted that woodworking, as a creative and fulfilling activity for some service users, was being carried out in parts of the premises that were unheated and potentially unusable in winter months. It is recommended that this activity be promoted and supported, if possible, through the provision of better facilities and equipment.	The unheated premises are no longer used by the day centre. Other craft activities are now provided in another part of the building.	Compliant
4	Minimum Standards, Appendix 2	The registered person must ensure that the full range of written policies and procedures is available for management's and staff's instruction and guidance.	The registered manager had developed a number of new policies and procedures, but many were still absent. This recommendation is re-stated.	Moving toward compliance
5	Standard 15.3	When no annual care review meeting is organised by the referring Trust, the manager should still ensure that a review of the placement and the care plan is arranged for the service user and that all relevant agencies and individuals are invited to contribute.	The manager had implemented this recommendation and records of reviews were up to date.	Compliant

6	Standard 15.3	The registered person should explore with referring Trusts the most effective approach to meeting Standard 15.3 and should ensure that this practice is implemented.	Records of review meetings, in the files examined, met the relevant criteria in this standard.	Compliant
7	Standard 17.10	It is recommended that future monthly monitoring should focus closely on the quality improvement issues identified in this report and, more generally, on compliance with the minimum standards.	The fact that two of the six recommendations above have not been fully implemented indicates that further work on this recommendation is necessary.	Moving toward compliance

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:	
All personal information held on clients and carers is treated as confidential. Personal information is given in confidence to the staff and if they are to retain the trust of the clients it is essential that it is managed properly and responsibly. In order to protect confidentialty staff in LCDI ensure that (a) Records are kept secure when not in use, (b) records for which they are responsible are only accessed by others on a need to know basis, (c) electronic records are subject to the same security as paper records and password protection is used. (d) when discussing clients, the conversations take place where they cannot be overheard by people who do not need access to the information. All staff have a responsibility to maintain the security of confidential information held on clients and their families and should report any cause for concern to their line manager..	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Service users' personal records were being kept securely and the manager and one staff member confirmed that the duty of confidentiality was maintained. Service users and one relative confirmed that they were confident of the confidentiality maintained by staff with regard to their personal information.	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:	
Our clients sign every page of their case records.They have input into their care plans, risk assessments and reviews. Case records are available at any time but in twenty years we have never been asked by a client or their carer to see them therefore we have had nothing to record.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
While there were examples of records having been signed by service users, there were also several on which the service user's signature was missing and should have been included.	Moving toward compliance

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 notes are maintained for each service user. The notes include assessment, care plans,(updated to record any changes in the clients routine, personal circumstances, health or behaviour) annual client reviews, risk assessments, incidents, accidents and near misses.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Each of the three service user's files that were examined contained an assessment of needs, although, in one file, this was very brief and did not present sufficient information on which to construct a satisfactory care plan. The remaining information required by this standard was present in each file, although there were many examples of documents lacking a date or a signature, or both.	Moving toward compliance

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:	
We record every three attendances whether there is a change or not and more often if neccessary.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The frequency of progress recording for service users was satisfactory.	Compliant
Criterion Assessed: 7.6 There is guidance for staff on matters that need to be reported or referrals made to: • The registered manager; • The service user's representative; • The referral agent; and • Other relevant health or social care professionals.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
There is a written guidance for staff on matters that need to be reported and it is attached to the daily record file.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Guidance for staff on the recording and reporting of notifiable events was satisfactory and readily available.	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:	
The records are hand written weekly, dated and signed. Records are periodically reviewed by the registered manager.	Compliant

Inspection Findings:	COMPLIANCE LEVEL
While there was evidence of some improvement in this practice, all three of the service users' records examined contained examples of documents that were either unsigned, undated, or both. A recommendation relating to this area was made at the previous inspection and this recommendation is re-stated in the Quality Improvement Plan accompanying this report.	Moving toward compliance

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
	Moving toward compliance

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:	
We have only needed to use non restrictive restraint e.g. manual guidance to assist a person walking. The staff are aware of the Human Rights Working Group paper on Restraint and Seclusion and if they had to restrain it would be by "using the minimum amount of force for the least amount of time" The staff have read the Restraint and Seclusion policy. We have had DOLS training.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
There was both written and oral evidence of training for staff with regard to restraint and seclusion and on the Deprivation of Liberty Guidance, DHSSPS 2010. However, there appeared to be a need for the development of greater understanding and clarity in this area of practice, for example in terminology used in the self-assessment, above and in the appreciation that physical support for a service user is not restraint.	Moving toward compliance

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:	
If restrictive restraint had to be used we would report it to RQIA and WHSCT. The family would be informed and the episode recorded in full in the incident book and the client's care record.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
There was evidence to show that the manager and staff had considered issues of restraint and seclusion with regard to the service provided in the centre. There had not been any reported events in which a service user was subject to restraint.	Not applicable

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

INSPECTOR'S OVERALL ASSESSMENT OF THE DAY CARE SETTING COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	**COMPLIANCE LEVEL**
	Moving toward compliance

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:	
All staff have a job description which details their roles and responsibilities. Our centre caters for low to medium disabilities and the majority of our clients need minimal care. We have three trained staff and one volunteer per day for up to fifteen clients. The ratio is usuallyl 1:3. The assistant manager is always on duty if the reg. manager is off. The assistant manager is undergoing Level 5 training at present. All three of our staff have been working in the centre for over 18 years and all are up to date with their mandatory training..	Compliant

Inspection Findings:	COMPLIANCE LEVEL
Staffing numbers in the centre were satisfactory and staff had been trained for their roles and responsibilities. However, monitoring did not appear to be identifying weaknesses in the management and performance of the centre, for example in the failure to provide the required range of policies and procedures, an issue that had been identified for improvement at the previous annual inspection. It is recommended that monitoring should be more rigorous and that monitoring reports should be expanded to include comment on RQIA's Quality Improvement Plans and any audits carried out within the centre that contribute to the overall quality assurance.	Moving toward compliance
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:	
Staff supervision is carried out three monthly and appraisals annually. The reg manager has quarterly appraisals with the provider and monthly one to one meetings. We have a Supervision policy. Manager and assistant manager have had supervision training	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
While evidence was presented to verify the stated supervision arrangements and the completion of annual appraisals, other developmental needs in the cohesive management of the centre raise concerns regarding the effectiveness of some of the supervision provided. The failure to provide the required policies and procedures and the confusion of some of the care plan content are examples of this.	Moving toward compliance

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:	
All the staff have undergone all mandatory training. We have also had various other training such as Diversity, person Centered planing, Understanding Groups etc. The staff are kept up to date with all disability issues such as Transforming your Care and the Daycare Review. They read Disability newsletters and pamphlets. The staff are very experienced with over 18 years working in disability..	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
There was evidence to verify that staff had been recruited in accordance with the organisation's procedures and that training requirements were met. One experienced staff member was engaged in work toward the QCF Level 5 in Leadership and Management and this is commendable.	Substantially compliant

PROVIDER'S OVERALL ASSESSMENT OF THE DAY CARE SETTING COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	**COMPLIANCE LEVEL**
	Provider didn't complete

INSPECTOR'S OVERALL ASSESSMENT OF THE DAY CARE SETTING COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	**COMPLIANCE LEVEL**
	Moving toward compliance

Additional Areas Examined

Policies and Procedures

The registered person must ensure that the full range of written policies and procedures is available for management's and staff's instruction and guidance.

Appropriate language in records

There were several examples in service users' records and in written procedures of the use of terms and expressions that may be regarded as less accurate than that which is expected in current good practice. These included the "Procedure in the event of Behavioural Problems", within which, at Stage 4, was stated, "If bad behaviour continues ----------".

In one service user's care plan, one of the stated needs was, "Single minded".
One service user was described as follows---- "can present with some behavioural issues ------", and the several references to generalised "behavioural issues" in this person's file had the effect of presenting a very negative image, in spite of the manager's verbal description of the individual as being mostly pleasant and polite.

All of the underlined terms in these examples were inappropriate in the context in which they were used.

The registered person should promote the use of more constructive and respectful language in written records for service users and in other documents, if necessary through the provision of further training for the manager and staff.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Geraldine Jones, Registered Manager, 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:

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

H. Hadley pp.

Dermott Knox
Inspector/Quality Reviewer

2/4/15

Date

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Primary Unannounced Care Inspection

Limavady Community Development Initiative

4 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 Mrs Geraldine Jones, 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
	Regulation 21(3)(b)	The registered manager and staff members should engage in further training on Restrictive Practice and Restraint, to ensure that they are working with a common understanding of the issues.	One	We have DOLS training which includes Restraint We will also have a talk from Soc. Worker to explain Restraint in more detail	29 May 2015
	Regulation 28(4)(b)	The registered person shall ensure that monitoring visits are carried out rigorously so that compliance with regulations and minimum standards is systematically examined and the findings are reflected in the monitoring reports.	Two	The monitoring visits will be more rigorous with more attention paid to the Q.I.P Care plans and policies will be checked monthly, by the monitoring officer. A copy of the QIP will be kept with the monitoring forms.	30 April and on-going

3	Standard 18.1	The registered person should ensure that the required range of written policies and procedures is provided in the centre, as identified in Appendix 2 of the Minimum Standards document.	Two	Reg Manager will provide missing policies and the policy Book will be complete.	29 May 201

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)	Timescal
1	Standard 7.7	A number of written records in service users' files were undated and/or unsigned. It is a matter of concern that practice in this area remains unsatisfactory, having been identified as an area for improvement at the previous inspection in February 2014. The registered person shall ensure that all service users' records, created by staff members, are appropriately signed and dated.	Two	Files will be checked at the monthly monitoring older documents will have an ammendment written and dated with the present date.	Immediate and on-goin
2	Standard 5.2	It is recommended that the care plan format should be revised and a single format used, taking account of the matters specified in Standard 5.2 and the advice given in discussion with the manager.	One	Care plans and action plans will be incorporated into one documet.	30 April 201

3	Regulation 13(8)(a)	The registered person shall promote the use of more constructive and respectful language in written records for service users, if necessary, through the provision of further training for those who write them.	One	Newly written documents will be checked monthly at the monitoring visits and edited if necessary. Older documents will be re written using more constructive language.	29 May 201

The registered provider / manager is required to detail the action taken, or to be taken, in response to the issue(s) raised in the Quality Improvement Plan. The Quality Improvement Plan is then to be signed below by the registered provider and registered manager and returned to:

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

SIGNED: _____ **SIGNED:** _____

NAME: Damien Corr. **NAME:** Geraldine Jones
Registered Provider **Registered Manager**

DATE 21 April 2015. **DATE** 21st April 2015.

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	M. Hanley	8/5/15
Further information requested from provider			