# Primary Unannounced Care Inspection

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| **Name of Establishment:** | **Lowtherstown Court Day Care** |
| **Establishment ID No:** | **11006** |
| **Date of Inspection:** | **19 February 2015** |
| **Inspector's Name:** | **Priscilla Clayton** |
| **Inspection No:** | **20646** |

**The Regulation And Quality Improvement Authority**
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| **Name of centre:** | Lowtherstown Court Day Care |
| **Address:** | 55 Bridge Street<br>Irvinestown<br>BT94 1DT |
| **Telephone number:** | (028) 6862 8985 |
| **E mail address:** | m.tanner@beaconwellbeing.org.uk |
| **Registered organisation/ Registered provider:** | William Henry Murphy |
| **Registered manager:** | Margaret Tanner |
| **Person in Charge of the centre at the time of inspection:** | Margaret Tanner |
| **Categories of care:** | DCS-I |
| **Number of registered places:** | 16 |
| **Number of service users accommodated on day of inspection:** | 10 |
| **Date and type of previous inspection:** | 1 October 2013<br>Primary Announced Inspection |
| **Date and time of inspection:** | 19 February 2015<br>10.00am–3.00pm |
| **Name of inspector:** | Priscilla Clayton |

## 1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect day care settings. A minimum of one inspection per year is required.

This is a report of a primary inspection to assess the quality of services being provided. The report details the extent to which the standards measured during the inspection were met.

## 2.0 Purpose of the Inspection

The purpose of this inspection was to ensure that the service is compliant with relevant regulations and minimum standards and themes and to consider whether the service provided to service users was in accordance with their assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, procedures, practices and monitoring arrangements for the provision of day care settings, and to determine the provider's compliance with the following:

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

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

## 3.0 Methods/Process

Committed to a culture of learning, RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the minimum standards.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.

Specific methods/processes used in this inspection include the following:

- Analysis of pre-inspection information
- Discussion with the registered manager
- Examination of records
- Consultation with stakeholders
- File audit
- Tour of the premises
- Evaluation and feedback

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

**Consultation Process**

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

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| Service users | 10 |
| Staff | 2 |
| Relatives | Nil |
| Visiting Professionals | Nil |

Questionnaires were provided, prior to the inspection, to staff to find out their views regarding the service. Matters raised from the questionnaires were addressed by the inspector in the course of this inspection.

| Issued To | Number issued | Number returned |
|---|---|---|
| Staff | 2 | 2 |

**4.0 Inspection Focus**

The inspection sought to assess progress with the issues raised during and since the previous inspection and to establish the level of compliance achieved with respect to the following DHSSPS Day Care Settings Minimum Standards and theme:

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

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

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

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

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

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

The table below sets out the definitions that RQIA has used to categorise the service's performance:

| Guidance - Compliance Statements | | |
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| **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. |

## 5.0 Profile of Service

Lowtherstown Court Day Care Centre is situated in the centre of Irvinestown and is close to all amenities.

The Day Care Centre is owned and managed by Northern Ireland Association for Mental Health (Niamh) and operates from the Oaklee/Trinity Housing Association premises. The centre has use of a large multi-function room with a small adjoining kitchen, two disabled toilet areas, one disabled toilet area and shower and a hairdressing and chiropody room. The centre also has access to a bedroom on the first floor. There is a bed and hoist in the room, and this can be used for personal care for those more dependent service users.

There is a small sitting room on the ground floor which can be used for meetings and is available for relatives.

The centre has a capacity for the attendance of 16 service users each day. The centre opens on Tuesday, Thursday and Friday from 10.00am to 4.00pm daily of each week.

Transport is provided if necessary, through Fast Rural Transport following completion of a risk assessment.

A choice of a two course hot meal is also provided daily from an outside agency at a cost of £1.50 per day.

## 6.0 Summary of Inspection

The primary unannounced inspection of Lowtherstown Day Care Centre took place on 19 February 2015 between the hours of 10.00am and 3.00pm. The registered manager, Margaret Tanner and two project workers were on duty. Ten service users were in attendance at the centre.

Two requirements and four recommendations were made at the previous inspection conducted on 1 October 2013. With the exception of one recommendation improvements had been actioned. The one outstanding recommendation, which is work in progress, relates to the development of a policy/procedure in respect of monthly monitoring visits. (Regulation 28)

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

During the inspection the inspector met with service users and staff, discussed the day to day arrangements in relation to the conduct of the day centre and standard of care provided to service users, observed care practice, review of two staff questionnaires, examined a selection of records and carried out a general inspection of the day care environment.

## 7.0 Inspection findings

### Standard 7 – Individual service user records and reporting arrangements.

Policies and procedures on Confidentiality, Data Protection and Management of Records were in place and available to staff who demonstrated knowledge and understanding of good professional practice in regard to recording and record keeping including assessment, care

planning and review. Care records examined reflected user/representative consultation in regard to assessment and care planning, care reviews and other necessary documents as set within Day Care Settings Minimum Standards (DHSSPS) 2012.

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

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

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

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

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

### Theme 2 - Management and control of operations.

There was a defined management structure which clearly defines lines of accountability, specifies roles and details responsibilities for areas of activity which was reflected within the Statement of Purpose.

The inspector reviewed the arrangements in place in regard to the management and control of operations. The registered manager, Margaret Tanner, is supported at senior management level by the area service manager. At operational level support is provided by two project workers.

Supporting evidence of the level of compliance with this theme was obtained from associated policies/procedures, examination of a sample records maintained including for example; staff induction records, staff appraisal, supervision, staff meetings, mandatory training, staffing This is to be commended levels/procurement, complaints, competency and capability assessments and discussion with staff and service users.

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

## Conclusion

The registered manager and staff are to be commended on the outcome of this inspection. Compliance was achieved in Standard 7 and Themes 1and 2.

Three recommendations, one of which has been reiterated from the previous inspection, were made as a result of this inspection. Details of improvements to be made are contained within the appended Quality Improvement Plan.

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

## 8.0 Follow-Up on Previous Issues

| No. | Regulation Ref. | Requirements | Action Taken - As Confirmed During This Inspection | Inspector's Validation Of Compliance |
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| 1 | 28 (4) (5) | The registered provider must consult with service users representatives where services users are unable to give an opinion on the conduct of the centre and make comment within the report.<br><br>A copy of the monthly monitoring report is available on request to a service user or his representative. | Examination of reports dated October, November and December 2014 evidenced that service users were consulted.<br><br>Copies of the reports were available to service users/ representatives. | Compliant |
| 2 | Regulation 5 | The registered person shall produce a written service user guide document on the day care setting which shall include all components listed under this regulation. | Service User Guide had been reviewed and revised. This was dated September 2014. | Compliant |

| No. | Minimum Standard Ref. | Recommendations | Action Taken - As Confirmed During This Inspection | Inspector's Validation Of Compliance |
|---|---|---|---|---|
| 1 | 15.5 | It is recommended that the review report addresses the following:<br><br>• progress in attaining any personal outcomes sought by the service user;<br>• the service user's views about their care and support;<br>• any changes in the service user's carer's situation;<br>• details of important events including incidents or accidents occurring since the previous review, and how they were addressed;<br>• any matters regarding the current care plan, revision of objectives, expected outcomes and associated timeframes where relevant, and management of risks;<br>• the need for any rehabilitation or specialist services;<br>• current transport arrangements and any changes required;<br>• the need or wish to move on from the service; and<br>• any other relevant matters regarding services and facilities provided by the day care service, or others. | Examination of three reports randomly selected evidenced that the format of review records had been changed to included information as recommended.<br><br>The manager confirmed that the new format is used as each service user has a review undertaken | Compliant |
| 2. | 21.8 | The registered manager should develop a training record which is compliant with standard 21.8 and provides detail of the content of all training attended by staff in this day care setting. | The centre has developed a staff training matrix which reflected training provided. | Compliant |
| 3 | 17.10 | A policy/procedure should be in place which outline the purpose, content and process of the Regulation 28 unannounced and announced visits. | The manager reported that the development of this policy/ procedure was work in progress. | Not compliant |

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| 4 | 17.10 | To enhance the quality of the monitoring reports, the assistant director should include audits outcomes /recommendations of working practices within the monthly monitoring report for the month the audit was completed. | Information as recommended was reflected within monthly monitoring reports examined. | Compliant |

| **Standard 7 - Individual service user records and reporting arrangements:**<br><br>**Records are kept on each service user's situation, actions taken by staff and reports made to others.** | |
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| **Criterion Assessed:**<br>7.1 The legal and an ethical duty of confidentiality in respect of service users' personal information is maintained, where this does not infringe the rights of other people. | **COMPLIANCE LEVEL** |
| **Provider's Self-Assessment:** | |
| The legal and ethical duty of confidentiality in respect of service users personal information is maintained in accordance with NIAMH policies and procedures covering Confidentiality(RP/07), Data Protection(CS/06), Storage and Destruction of Closed Files(MA/14) and Safeguarding Vulnerable Adults(BS/2).<br>NIAMH Data Protection Policy gives individual service users the right to have access to personal information relating to themselves where this information is being held or processed by NIAMH as outlined in 5.02.<br>Confidentiality in respect of obtaining, handling, use of, storage and retention of service user information and documentation is detailed in Sections 2.0 to 2.4 of NIAMH Confidentiality Policy, RP/07(a). All service user personal information held at scheme is stored in individual files within a locked cabinet. These procedures are supported by Safeguarding Vulnerable Adults Policy, BS/2, Sections 5.3 and 5.4. Good practice in relation to the Storage and Destruction of Closed Files is described in NIAMH Policy MA/14.<br>Staff understanding of their legal and ethical duty is assessed and evidenced in Section A of the Induction and Foundation Framework undertaken by all staff prior to being confirmed in post, and in the "New Employee Orientation & Induction" workbook completed by staff as part of their induction.<br>The DHPSSPS Code of Practice on Protecting the Confidentiality of the Service User is available on scheme to provide additional practical guidance on decision-making regarding the disclosure of service user personal informati | Compliant |
| **Inspection Findings:** | **COMPLIANCE LEVEL** |
| The centre had a policy/procedure on Confidentiality which was dated September 2014. The policy on Data Protection was dated 2011.<br><br>Records retained were being securely stored. | Compliant |

| **Criterion Assessed:**<br>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.<br><br>7.3 A record of all requests for access to individual case records/notes and their outcomes should be maintained. | **COMPLIANCE LEVEL** |
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| **Provider's Self-Assessment:** | |
| 7.2 Current information in R/R/101 is contained in Beacon Member Notes p.19. A new draft referral procedure expands on this in R/R/102 Sections 7 and 14. In both sections members are reminded that they have open access to their files; they are also encouraged to input to their files participatively and by writing their own notes for example. Section 14 of R/R/102 contains additional information for Beacon Members wishing to access their files following discharge from the service.<br>The Beacon Members Guide also provides relevant information to all new members. Sections 1.3 and 1.5 outline both content and open access arrangements to members files.<br>Members are asked to provide or withhold consent for other people to see their files - this is recorded and held in the individual member's file.<br><br>7.3 Section 6.0 of Corporate Policy no. CS/06 on Data Protection covers the right of access to personal information in relation to Individual Subject Data Requests. | Substantially compliant |
| **Inspection Findings:** | **COMPLIANCE LEVEL** |
| Four care records randomly selected evidenced that consultation with the service user/representative had taken place with care plans signed.<br><br>When necessary a record of disclosure would be retained in accordance with the centre's policy/procedure. | Compliant |

| **Criterion Assessed:** | **COMPLIANCE LEVEL** |
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| 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:<br><br>• Assessments of need (Standards 2 & 4); care plans (Standard 5) and care reviews (Standard 15);<br>• All personal care and support provided;<br>• Changes in the service user's needs or behaviour and any action taken by staff;<br>• Changes in objectives, expected outcomes and associated timeframes where relevant;<br>• Changes in the service user's usual programme;<br>• Unusual or changed circumstances that affect the service user and any action taken by staff;<br>• Contact with the service user's representative about matters or concerns regarding the health and well-being of the service user;<br>• Contact between the staff and primary health and social care services regarding the service user;<br>• Records of medicines;<br>• Incidents, accidents, or near misses occurring and action taken; and<br>• The information, documents and other records set out in Appendix 1. | |
| **Provider's Self-Assessment:** | |
| Individual case records are contained in the Beacon Members Personal File in accordance with Beacon Policy Number R/R/101(p.7,8) and titled Policy and Procedure for Referral and Attendance in Beacon Day Support. Beacon Members, staff members and referral agents work together through the processes outlined above to ensure a meaningful and holistic intervention. An individuals recovery journey is about change and Beacon consider that it is essential to record information that chronicles this. R/R/101 contains guidance for staff on the information and recording required to assess, plan and review the delivery of care and support to all our members with relevant appendices designed to provide the information required in Appendix 1 of the Standards, Schedule 4 of the Regulations. A separate Serious Incident Reporting Policy CS/07 provides an Incident Form and Flow Chart with clear guidance for recording and reporting. At present in Day Care we don't administer medication | Substantially compliant |

| **Inspection Findings:** | **COMPLIANCE LEVEL** |
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| Examination of four care records evidenced that information as contained in this criterion and as illustrated by the manager were comprehensive, individualised and person centred.<br><br>Policies/procedures in place included Assessment, Care planning and Review. | Compliant |
| **Criterion Assessed:**<br>7.5 When no recordable events occur, for example as outlined in Standard 7.4, there is an entry at least every five attendances for each service user to confirm that this is the case. | **COMPLIANCE LEVEL** |
| **Provider's Self-Assessment:** | |
| R/R/101 currently notes in 2 locations (p.17,19) that a note is to be recorded at least at every fifth visit. For some members, notes are recorded more often that this to reflect ongoing issues or support provided | Substantially compliant |
| **Inspection Findings:** | **COMPLIANCE LEVEL** |
| Examination of a random sample of service user care records verified that written evaluations was made for each individual service user at least once in every five attendances. Records were legible, dated and signed.<br><br>One recommendation made related to ensuring staff cease to leave spaces between each recorded entry. | Compliant |

| **Criterion Assessed:**<br>7.6 There is guidance for staff on matters that need to be reported or referrals made to:<br><br>• The registered manager;<br>• The service user's representative;<br>• The referral agent; and<br>• Other relevant health or social care professionals. | **COMPLIANCE LEVEL** |
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| **Provider's Self-Assessment:** | |
| The relevant guidance is outlined in a number of documents with an introduction to relevant policies and procedures an important part of the Induction process for new staff and a key component of the Induction and Foundation Framework (Units B, C). In addition staff are introduced to key mechanisms for communication within the organisation and the scheme. These include the staff section of the organisations website, the policy and procedure manual and the emergency procedures file; included within the scheme are the scheme diary and phone book, minutes of staff meetings, staff files and member files.<br>For ease of access a number of policy documents include lists of numbers and flow charts that may be displayed on office notice boards, for example BS/4 Protection of Children and Reporting of Suspected Abuse requires a list of relevant contacts for Gateway Teams and Designated Officers to be displayed. Staff have been required to use these recently in response to disclosures made within the scheme. BS/2 Safeguarding Vulnerable Adults includes a Reporting Flowchart as does QG/4 Incident Reporting and Management Policy and Procedure.<br>Personal information on members and their contacts is updated annually at review using Appendix 3, Beacon Member Information Record, of Policy RR/101 Beacon Referral and Attendance Policy. Other relevant policies include BS/1 Beacon Member Safety/Risk/Vulnerability, BS/14 Consent Policy, HS/13 RIDDOR Policy and QG/3 Complaints Procedure. | Compliant |
| **Inspection Findings:** | **COMPLIANCE LEVEL** |
| Policies and procedures pertaining to communication, confidentiality, consent, management of records, monitoring of records, recording and reporting care practices and service user agreement are in place. These were consistent with this criterion and were available for staff reference. Staff demonstrated awareness of their role and responsibility to report and refer information and to record the outcome. Care records examined evidenced collaboration with other professionals in planned care and provided evidence of regular monitoring of care, action taken and outcomes. | Compliant |

| **Criterion Assessed:**<br>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. | |
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| **Provider's Self-Assessment:** | |
| Relevant guidance is contained in the section on Beacon Member Notes of R/R/101 Policy and Procedure on the Referral and Attendance in Beacon Day Support p.19. Members are encouraged to be active in recording their notes or where they prefer no to do this, to be aware of what has been recorded and to sign to confirm agreement. The registered manager reviews member files and at least one file is reviewed as part of monthly monitoring procedures - as outlined at the last inspection monthly monitoring should include an assessment of a member review. | Compliant |
| **Inspection Findings:** | **COMPLIANCE LEVEL** |
| Four care records randomly selected and examined evidenced that these were eligible, current, dated and signed.<br><br>There was evidence of ongoing signed review by the registered manager. | Compliant |

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

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

| **Theme 1: The use of restrictive practice within the context of protecting service user's human rights**<br><br>**Theme of "overall human rights" assessment to include:** | |
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| **Regulation 14 (4) which states:**<br><br>**The registered person shall ensure that no service user is subject to restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other service user and there are exceptional circumstances.** | **COMPLIANCE LEVEL** |
| **Provider's Self-Assessment:** | |
| NIAMH's policy on the use of restraint is set out in BS/2 Guidance on Restrictive Practice. This policy states clearly that staff are not to use "physical restraint" or "physical intervention" to restrain service users in any situation. Any physical intervention should only be the minimum used as a last resort to enable staff to get away for their own or others safety. If a situation is deemed serious enough to require physical intervention the police must be called. This guidance is reinforced by BS/16 Policy and Procedures for Dealing With Violence at Work, Section 6.2, g, which states that "the staff member should never attempt to restrain the service user". This guidance is explained in Section 6.3,a&b, of the policy, " The legal position on physical restraint", which states that "NIAMH staff are not trained in restraint techniques and therefore to ensure their own safety and that of the service user should not attempt to restrain the service user in any circumstances". In incidences where physical support is required to manage an incident of violence at work the staff member will summon the police. (6.2,f). There have been no instances in the past year where staff have needed to call PSNI for support.<br>All staff receive training on Personal Safety/ Calming and Diffusing. This training focuses on skilling staff to prevent work related violence rather than on how to use/apply restraint techniques. | Compliant |
| **Inspection Findings:** | **COMPLIANCE LEVEL** |
| The manager, staff and examination of accident/incident records confirmed that there have not been any episodes of challenging behaviour and that no service user has been subjected to any form of restrictive practice. Policies and procedures on Managing Challenging Behaviour and Restraint were in place and available to staff.<br><br>Staff demonstrated knowledge of the procedure to follow should incidents of challenging behaviour arise. | Compliant |

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| Examination of staff training records evidenced that training in challenging behaviour and restraint had been provided on 9 October 2014. Resource information on Deprivation of Liberty Safeguards (DOLS) was available to staff who demonstrated awareness of the subject.<br>.<br>Key pad door opening/closure was in place for security reasons and not used as a form of restraint. | |
| **Regulation 14 (5) which states:**<br><br>**On any occasions on which a service user is subject to restraint, the registered person shall record the circumstances, including the nature of the restraint. These details should also be reported to the Regulation and Quality Improvement Authority as soon as is practicable.** | **COMPLIANCE LEVEL** |
| **Provider's Self-Assessment:** | |
| BS/16, Policy and Procedures for Dealing with Violence at Work, states clearly that staff should never attempt to restrain a service user (6.2,g). In incidences where restraint would be required, police assistance would be called to do so (6.2,f). In such circumstances staff would follow the investigation and recording requirements detailed in 6.4 of the Policy and record details in accordance with QC/4, Incident Reporting and Management Policy and Procedure. RQIA would be notified of all incidents requiring the involvement of the police in the use of restraint (QC/4, Appendix 4). Restraint has not been used within Rosewood with any service user. | Compliant |
| **Inspection Findings:** | **COMPLIANCE LEVEL** |
| Information as illustrated by the manager in the self- assessment was verified through discussion with the manager and staff. Examination of policy/procedures was undertaken. The manager demonstrated knowledge of the procedure to follow should restraint ever be used and the requirement to notify RQIA. The manager confirmed there were no service users presenting with behavioural problems. | Compliant |

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

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

| Theme 2 – Management and Control of Operations<br><br>**Management systems and arrangements are in place that support and promote the delivery of quality care services.**<br><br>**Theme covers the level of competence of any person designated as being in charge in the absence of the registered manager.** | **COMPLIANCE LEVEL** |
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| **Regulation 20 (1) which states:**<br><br>**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 -**<br>**(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;**<br><br>**Standard 17.1 which states:**<br><br>**There is a defined management structure that clearly identifies lines of accountability, specifies roles and details responsibilities for areas of activity.** | |
| **Provider's Self Assessment:** | |
| Niamh's Recruitment Policy and Procedure R/P/04 uses a competency based selection process to recruit individuals with the qualifications, experience and character requirements that accord with Schedule 2 of The Day Care Setting Regulations (NI) 2007, and Part III Section 21 Fitness of Workers. In addition they meet the requirements of current employment legislation and good employment practice (as outlined in RP/07/1.3).<br>Ongoing competence of staff is monitored and enabled via Supervision (R/P/39) and the group competency based Performance Management System (PMS). Twice a year managers and their direct reports complete a performance and development review that is linked to an competence profile and agree objectives and actions that are designed to enhance each staff members personal development in the context of their personal aspirations, the nature of the service they are delivering, and the overall organisational strategy.<br>The management structure of each scheme is outlined in the Statement of Purpose. Section 2.0 identifies the number and qualifications of staff, Section 5.0 outlines the structure of the facility. Each facility will employ different grades of staff including Scheme Managers, Project Workers, Support Workers, Clerical Staff and Peripatetic Staff. Job | Compliant |

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| descriptions detail the specifics of each role, lines of accountability and areas of activity. Scheme specific areas of activity will be reflected in Centre Programmes and Activity Schedules.<br>Numbers of staff reflect a balance between number of sessions, numbers of users and programme of delivery. | |
| **Inspection Findings:** | **COMPLIANCE LEVEL** |
| The organisational structure of the centre was reflected within the Statement of Purpose. The manager confirmed she was supported in her role by the area service manager.<br><br>At operational level support to the manager is provided by a small team consisting of 2 project workers who hold Qualification Credit Framework (QCF) Level 3 and receive on going mandatory training in accordance with RQIA recommendations.<br><br>The centre had a comprehensive policy/procedure on the Recruitment and Selection of staff which was dated 1 September 2014. The manager confirmed no new staff has been required/appointed since 2010.<br><br>There was evidence of induction programmes for all new staff. These were signed by the employee and the manager when deemed competent in each of the activities/factors listed.<br><br>Staff meetings were held on a regular basis with minutes recorded. Staff supervision is provided six monthly or more frequently if required. Records on supervision were retained.<br><br>Staff appraisal takes place on an annual basis. Records were retained by the manager. | Compliant |

| **Regulation 20 (2) which states:**<br><br>• **The registered person shall ensure that persons working in the day care setting are appropriately supervised** | **COMPLIANCE LEVEL** |
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| **Provider's Self-Assessment:** | |
| All staff supervision takes place in accordance with the Supervision Policy R/P/39. Staff are supervised at a frequency and duration commensurate with their position and levels of responsibility as outlined in section 1.3 of the policy, with every staff member having a supervision contract and a shared responsibility for the process. The supervision process is designed with links to the organisation's Performance Management System. All managers attend a full day's training on supervision. Staff Supervision Records form part of Monthly Monitoring. | Compliant |
| **Inspection Findings:** | **COMPLIANCE LEVEL** |
| Information as illustrated by the manager was evidenced through examination of records on supervision and appraisal. The centre has a policy/procedure on supervision which was dated 1 September 2013. Staff confirmed that supervision was provided monthly.<br><br>Regular monthly staff meetings take place with minutes recorded. | Compliant |

| **Regulation 21 (3) (b) which states:**<br><br>• **(3) For the purposes of paragraphs (1) and (2), a person is not fit to work at a day care setting unless –**<br>• **(b) he has qualifications or training suitable to the work that he is to perform, and the skills and experience necessary for such work** | **COMPLIANCE LEVEL** |
|---|---|
| **Provider's Self-Assessment:** | |
| In the first instance Niamh recruits staff with the qualifications, skills and experience required by the Personnel Specification for the role. Niamh provide an Essential Regional Training Schedule designed to meet the mandatory training requirements of RQIA and essential sector specific content. To ensure timescales match RQIA requirements all staff are required to attend training on the dates allocated with attendance being monitored on the HR IT System (Cascade) and reviewed in supervision to ensure compliance.<br>All new staff are required to complete a New Employee Orientation and Induction Handbook that in particular introduces staff to those policies, procedures and systems, knowledge of which enables them to take charge in the absence of the manager. Staff also complete an Induction and Foundation Framework leading to an accredited qualification with the National Open College Network, that is either a level 2 or level 3 in Social Care and Mental Health (level is commensurate with grade).<br>Annually all grades of staff have access to opportunities for further development that include short courses with external providers and/or additional qualifications such as the Qualification Credit Framework (QCF) Level 3 in Health and Social Care, or QCF Level 5 in Leadership in Health and Social Care Services (Adults Management).<br>The organisation is also currently developing 2 programmes to identify and develop future leadership talent through their 'Nurturing Talent' and 'Building Talent' Programmes for different grades of staff across the whole Niamh Group. | Compliant |
| **Inspection Findings:** | **COMPLIANCE LEVEL** |
| Information as illustrated by the manager in the self- assessment was verified through discussion with the manager and staff. Records of staff training, supervision, appraisal and staff meetings were being retained in the centre. The manager confirmed that staff left in charge of the day care setting when she is off duty is competent and capable to undertake this responsibility. Assessment of competency and capability were undertaken and retained.<br><br>The centre's policies and procedures are available for staff reference and reflect day to day practice.<br><br>Staff demonstrated knowledge commensurate with their role and responsibilities confirmed their qualifications and regard themselves as suitably qualified, experienced and in receipt of suitable training to undertake their role and responsibilities. | Compliant |

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

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

# 9.0 Additional Areas Examined

## 9.1 Complaints.

The manager confirmed that the centre has not received any complaints since the previous inspection.

## 9.2 Registered Manager Questionnaire

The completed questionnaire was returned to RQIA on 9 March 2015. Review of the information evidenced that governance and management arrangements were in compliance with good professional practice. Positive responses in all areas were recorded by the manager.

## 9.3 Staff questionnaire/views

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

## 9.4 Service user views

The inspector spoke with all service users in attendance at the centre. Responses were positive in regard to all aspects of care and facilities provided within the centre. No issues or concerns were raised or indicated.

## 9.5 Statement of Purpose

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

## 9.6 Monthly Monitoring Reports

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

## 9.7 Accident/Incidents

Records of accidents/incidents were being reported to RQIA as required. It was recommended that a central log is retained within the centre so that manager can readily identify any trends or patterns which require to be addressed.

## Quality Improvement Plan

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

**Priscilla Clayton**
**Inspector/Quality Reviewer**
**The Regulation and Quality Improvement Authority**
**9th Floor**
**Riverside Tower**
**5 Lanyon Place**
**Belfast**
**BT1 3BT**

# Quality Improvement Plan

## Primary Unannounced Care Inspection

### Lowtherstown Court Day Care Centre

### 19 February 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 Margaret Tanner, registered manager during and at the conclusion of the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

**Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.**

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that applicatio

**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 17.10 | **Policy/procedure**<br><br>A policy/procedure should be in place which outline the purpose, content and process of the Regulation 28 unannounced and announced visits. | Two | Policy QG5 re Procedures for monthly monitoring & annual monitoring amendment will be updated accordingly by timescale opposite. | 31 May 2015 |
| 2 | Standard 7.5 | **Care records**<br><br>One recommendation made related to ensuring staff cease to leave spaces between each recorded entry. | One | Discussed at Staff Meeting. Commenced and on-going from 13.03.15. | Immediate and ongoing |
| 3 | Standard 20.12 | **Accident/Incident Records**<br><br>Records of accidents/incidents were being reported to RQIA as required. It was recommended that a central log is retained in the centre for ease of access so that manager can readily identify any trends or patterns. | One | Central log completed and commenced on 13.03.15. | 30 April 2015 |

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

| | |
|---|---|
| **Name of Registered Manager Completing Qip** | Margaret Tanner |
| **Name of Responsible Person / Identified Responsible Person Approving Qip** | Billy Murphy |

| **QIP Position Based on Comments from Registered Persons** | **Yes** | **Inspector** | **Date** |
|---|---|---|---|
| Response assessed by inspector as acceptable | Yes | P.Clayton | 8/4/15 |
| Further information requested from provider | | | |