Announced Primary Care Inspection

Name of Establishment:	**Woodlands Beacon Centre**
RQIA Number:	**11052**
Date of Inspection:	**13 November 2014**
Inspector's Name:	**Dermott Knox**
Inspection ID:	**IN020068**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1.0 General Information

Name of centre:	Woodlands Beacon Centre
Address:	48c Molesworth Street Cookstown BT80 8PA
Telephone number:	(028) 8676 6619
E mail address:	dorothy.devlin@beaconwellbeing.org
Registered organisation/ Registered provider:	Miss Rose Anne Reynolds NI Association for Mental Health
Registered manager:	Miss Dorothy Devlin
Person in Charge of the centre at the time of inspection:	Miss Dorothy Devlin
Categories of care:	DCS-MP
Number of registered places:	20
Number of service users accommodated on day of inspection:	14
Date and type of previous inspection:	20 March 2014 Primary Announced Inspection
Date and time of inspection:	13 November 2014 10:30a.m. – 4:45p.m.
Name of inspector:	Dermott Knox

2.0 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.

3.0 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.

4.0 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.

5.0 Consultation Process

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

Service users	5
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	7	1

6.0 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		
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.

7.0 Profile of Service

Woodlands Day Centre is held in a two storey house situated in Molesworth Street, within walking distance of the main street through Cookstown. The centre is in listed building premises that were formerly part of the town's railway station.

The Day Centre is one of fourteen Day Support Services run by Northern Ireland Association for Mental Health (NIAMH), throughout Northern Ireland.

The Woodlands Centre has two floors and includes an open plan kitchen and sitting room, a utility area, woodwork and craft room, a small living room and a quiet room which service users can use as required. The second floor includes an activities room, two offices and a toilet. Outside, there is a well-equipped courtyard leading through a doorway into a semi-enclosed garden. Members and staff have been resourceful in developing the garden with raised beds, a polytunnel, soil and manure, with most of these being donated by local businesses, farmers etc.

The centre is staffed and operational on Monday, Wednesday, Thursday and Friday and can accommodate up to twenty service users per half-day session. Wednesday is for younger members and the other days cater for all ages. The service is not staffed on a Tuesday, though service users have "a member led" day so that they have a place to meet for mutual support.

There are cooking facilities in the centre and some meals are provided. Tea and coffee are available throughout the day.

8.0 Summary of Inspection

This announced inspection of Woodlands Beacon Centre was undertaken on 13 November 2014 between the hours of 10.30am and 4.45pm. The registered manager was available throughout the inspection period.

There was evidence to show that compliance had been achieved with the three recommendations made at the previous inspection. The focus of the current inspection was on one standard and two themes chosen from the Day Care Settings Minimum Standards 2012 and The Day Care Settings Regulations (N I) 2007. Prior to the inspection the provider submitted a self-assessment of the centre's performance in respect of these. During the inspection the following evidence sources were used:

- Discussion with service users
- Discussions with managers, staff members and a social work student on placement
- Observation of practice
- Examination of a sample of service users' file records including evidence of behaviour management and support assessments, complaints record, staff training record, staff records including supervision and appraisal, incident and accidents records, evidence of service user consultation, monthly monitoring records; statement of purpose; service users' guide and policies & procedures
- A tour of the premises

Service users spoke about the benefits of attending the centre and it was evident that most people were at ease in that environment. Overall, they were very satisfied with the supportive

service and confirmed that they would speak with the registered manager or staff members when they had anxieties or concerns.

Comments from staff during the inspection, confirmed that satisfactory arrangements were in place with regard to supervision, staff training and management arrangements. Satisfaction and professional awareness was also indicated with regard to responses to service users' behaviour, confidentiality and recording.

There are no requirements or recommendations arising from this inspection and the management and staff are commended for the provision of a high quality day care service.

The inspector is grateful to service users and staff who were welcoming and helpful throughout the inspection process.

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 organisation had well-written policies and procedures for Confidentiality, The management of records, Recording and reporting, Data protection, and Storage and destruction of closed files and these were available for staff reference. Records were securely stored and confidential information was used and communicated in a professional manner. Staff demonstrated good awareness of confidentiality issues.

Three members of staff shared their views about working in the centre, the recording and reporting arrangements, supervision and the quality of service provided and the comments were entirely positive. There was evidence to show that service users were well involved in the care planning and review processes and a range of records in a sample of four files had been signed by the service user to indicate his or her involvement and agreement with the content.

Progress notes for each person were written regularly, generally by a staff member, though, in several cases, the member had written some of his or her own notes. These presented a clear record of each member's involvement in planned activities and in the recovery programme.

The 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

Woodlands Beacon Centre has a written policy and guidelines on the use of restrictive practices, dated May 2013. Physical restraint does not form part of staffs' response to any member's presenting behaviours and NIAMH's policy states they do not train staff for such a response. The policy on the Management of Violent or Potentially Violent Members emphasises the use of calming and diffusing skills with a focus on keeping people safe. Written copies of the policies and guidance were available to the staff team for reference and it was evident that staff were familiar with the documents. The inspector observed the use of good communication skills and supportive relationship building by staff members throughout the day of this inspection and this was reflected in the written records of direct work with those who attend the centre.

The working atmosphere within the centre provided evidence of the constructive methods in use to empower members in building greater control of their own functioning. Members spoke

of how attendance at the centre assisted them to develop confidence and provided an important structure to their day. They also spoke of gaining skills in a range of daily living skills such as cooking and of the satisfaction gained from arts and crafts work.

Discussions with staff confirmed a good awareness of restrictive practices and of the importance of recognising how ascribed power could be misused if staff were not tuned in to this possibility. Staff presented as being committed to using the most empowering approaches in their work with the members. Observations of interactions during the inspection confirmed that members responded positively to each other and to the staff and it was evident that good levels of trust had developed between them.

The centre was judged to be operating in compliance with the criteria in 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.

Records showed that the registered manager has the necessary qualifications and experience to take charge of the centre and that there is a project worker who is qualified and competent to assume responsibility for the centre in the manager's absence. This project worker is currently undertaking assessment for the QCF Level 5 and it is encouraging to note that NIAMH supports staff to gain qualifications which prepare them for potential future responsibilities.

Staff working in the centre had acquired a range of vocational qualifications commensurate with their roles and responsibilities and mandatory training was up to date.

The organisation had systems in place for supervision and performance appraisal and staff confirmed that they felt supported by the management team. Records of staff supervision were detailed, relevant and well-written. Staff commented positively on the performance appraisal system and on the motivational aspect of its implementation.

NIAMH has standardised monitoring arrangements in place for day centres that include monthly monitoring visits. The monitoring reports relating to the previous three months were examined and were found to address all of the matters specified in regulations. The organisational structure was clearly set out in the statement of purpose which had been updated to include details of the recently appointed registered persons.

The centre was judged to be compliant with all of the criteria in this theme.

9.0 Follow-Up on Previous Issues

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation of Compliance
1	15.3	Reviews should be completed four weeks after commencement and held in response to a change of circumstances. Thereafter reviews should be completed on an annual basis.	Records of reviews were up to date and satisfactory. The manager confirmed that an initial review was held approximately four weeks after a new member started to attend. The timing can vary in proportion to the frequency of an individual's attendance.	Compliant
2	15.4	Information for review should be further developed to ensure that the review covers all aspects of care and include input from community professionals.	Where possible, reviews included input from community based professionals, but some members did not have a continuing link with those services.	Compliant
3	15.6	All care plans should be updated and signed off in accordance with guidance.	Care plans in all four of the member's files that were examined had been signed appropriately.	Compliant

10.0 Inspection Findings

Standard 7 - Individual service user records and reporting arrangements: **Records are kept on each service user's situation, actions taken by staff and reports made to others.**	
Criterion Assessed: 7.1 The legal and an ethical duty of confidentiality in respect of service users' personal information is maintained, where this does not infringe the rights of other people.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
The legal and ethical duty of confidentiality in respect of service users personal information is maintained in accordance with NIAMH policies and procedures covering Confidentiality(RP/07), Data Protection(CS/06), Storage and Destruction of Closed Files(MA/14) and Safeguarding Vulnerable Adults(BS/2). NIAMH Data Protection Policy gives individual service users the right to have access to personal information relating to themselves where this information is being held or processed by NIAMH as outlined in 5.02.. Confidentiality in respect of obtaining, handling, use of, storage and retention of service user information and documentation is detailed in Sections 2.0 to 2.4 of NIAMH Confidentiality Policy, RP/07(a). All service user personal information held at scheme is stored in individual files within a locked cabinet. These procedures are supported by Safeguarding Vulnerable Adults Policy, BS/2, Sections 5.3 and 5.4. Good practice in relation to the Storage and Destruction of Closed Files is described in NIAMH Policy MA/14. Staff understanding of their legal and ethical duty is assessed and evidenced in Section A of the Induction and Foundation Framework undertaken by all staff prior to being confirmed in post, and in the "New Employee Orientation & Induction" workbook completed by staff as part of their induction. The DHPSSPS Code of Practice on Protecting the Confidentiality of the Service User is available on scheme to provide additional practical guidance on decision-making regarding the disclosure of service user personal information.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The provider's comprehensive self-assessment was verified through examination of selected written evidence in policies, procedures, review reports and progress notes. Staff who were interviewed demonstrated in discussion a clear understanding of their duty of confidentiality regarding 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:	
7.2 Current information in R/R/101 is contained in Beacon Member Notes p.19. A new draft referral procedure expands on this in R/R/102 Sections 7 and 14. In both sections members are reminded that they have open access to their files; they are also encouraged to input to their files participatively and by writing their own notes for example. Section 14 of R/R/102 contains additional information for Beacon Members wishing to access their files following discharge from the service. The Beacon Members Guide also provides relevant information to all new members. Sections 1.3 and 1.5 outline both content and open access arrangements to members files. 7.3 Section 6.0 of Corporate Policy no. CS/06 on Data Protection covers the right of access to personal information in relation to Individual Subject Data Requests.	Moving towards compliance
Inspection Findings:	**COMPLIANCE LEVEL**
There was strong evidence to demonstrate that some members accessed their own files regularly and contributed to their own progress notes. Assessments, support plans and review reports had consistently been signed by the relevant member.	Compliant

Criterion Assessed:	**COMPLIANCE LEVEL**
7.4 Individual case records/notes (from referral to closure) related to activity within the day service are maintained for each service user, to include: • Assessments of need (Standards 2 & 4); care plans (Standard 5) and care reviews (Standard 15); • All personal care and support provided; • Changes in the service user's needs or behaviour and any action taken by staff; • Changes in objectives, expected outcomes and associated timeframes where relevant; • Changes in the service user's usual programme; • Unusual or changed circumstances that affect the service user and any action taken by staff; • Contact with the service user's representative about matters or concerns regarding the health and well-being of the service user; • Contact between the staff and primary health and social care services regarding the service user; • Records of medicines; • Incidents, accidents, or near misses occurring and action taken; and • The information, documents and other records set out in Appendix 1.	
Provider's Self-Assessment:	
Individual case records are contained in the Beacon Members Personal File in accordance with Beacon Policy Number R/R/101(p.7,8) and titled Policy and Procedure for Referral and Attendance in Beacon Day Support. Beacon Members, staff members and referral agents work together through the processes outlined above to ensure a meaningful and holistic intervention. An individuals recovery journey is about change and Beacon consider that it is essential to record information that chronicles this. R/R/101 contains guidance for staff on the information and recording required to assess, plan and review the delivery of care and support to all our members with relevant appendices designed to provide the information required in Appendix 1 of the Standards, Schedule 4 of the Regulations. A separate Serious Incident Reporting Policy CS/07 provides an Incident Form and Flow Chart with clear guidance for recording and reporting.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Each of the four files examined contained relevant information and records in compliance with this criterion.	Compliant

Criterion Assessed: 7.5 When no recordable events occur, for example as outlined in Standard 7.4, there is an entry at least every five attendances for each service user to confirm that this is the case.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
R/R/101 currently notes in 2 locations (p.17,19) that a note is to be recorded at least at every fifth visit. This is standard practice across all our day care provision.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The manager confirmed that all NIAMH day care facilities have adopted this practice standard and this was verified through examination of four members' files and from discussion with two staff.	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:	
The relevant guidance is outlined in a number of documents with an introduction to relevant policies and procedures an important part of the Induction process for new staff and a key component of the Induction and Foundation Framework (Units B, C). In addition staff are introduced to key mechanisms for communication within the organisation and the scheme. These include the staff section of the organisations website, the policy and procedure manual and the emergency procedures file; included within the scheme are the communication book, scheme diary and phone book, minutes of staff meetings, staff files and member files. For ease of access a number of policy documents include lists of numbers and flow charts that may be displayed on office notice boards, for example BS/4 Protection of Children and Reporting of Suspected Abuse requires a list of relevant contacts for Gateway Teams and Designated Officers to be displayed. BS/2 Safeguarding Vulnerable Adults includes a Reporting Flowchart as does QG/4 Incident Reporting and Management Policy and Procedure.	Compliant

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.	
Inspection Findings:	**COMPLIANCE LEVEL**
The centre had clear and well-written policies and procedures on recording and reporting, as identified above by the provider. Written reports of significant events were well-detailed and verified that reports had been copied to the relevant agencies and individuals.	Compliant
Criterion Assessed: 7.7 All records are legible, accurate, up to date, signed and dated by the person making the entry and periodically reviewed and signed-off by the registered manager.	
Provider's Self-Assessment:	
Relevant guidance is contained in the section on Beacon Member Notes of R/R/101 Policy and Procedure on the Referral and Attendance in Beacon Day Support p.19.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
There was a good standard of recording in the sample of files examined at this inspection and records generally were signed, dated, legible and up to date.	Compliant

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

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

Theme 1: The use of restrictive practice within the context of protecting service user's human rights **Theme of "overall human rights" assessment to include:**	
Regulation 14 (4) which states: **The registered person shall ensure that no service user is subject to restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other service user and there are exceptional circumstances.**	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
NIAMH's policy on the use of restraint is set out in BS/2 Guidance on Restrictive Practice. This policy states clearly that staff are not to use "physical restraint" or "physical intervention" to restrain service users in any situation. Any physical intervention should only be the minimum used as a last resort to enable staff to get away for their own or others safety. If a situation is deemed serious enough to require physical intervention the police must be called. This guidance is reinforced by BS/16 Policy and Procedures for Dealing With Violence at Work, Section 6.2, g, which states that "the staff member should never attempt to restrain the service user". This guidance is explained in Section 6.3,a&b, of the policy, " The legal position on physical restraint", which states that "NIAMH staff are not trained in restraint techniques and therefore to ensure their own safety and that of the service user should not attempt to restrain the service user in any circumstances". In incidences where physical support is required to manage an incident of violence at work the staff member will summon the police. (6.2,f). All staff receive training on Personal Safety/ Calming and Diffusing. This training focuses on skilling staff to prevent work related violence rather than on how to use/apply restraint techniques.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Woodlands Beacon Centre has a written policy and guidelines on the use of restrictive practices, dated May 2013. Physical restraint does not form part of staffs' response to any member's presenting behaviours and NIAMH's policy states they do not train staff for such a response. The policy on the Management of Violent or Potentially Violent Members emphasises the use of calming and diffusing skills with a focus on keeping people safe.	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:	
BS/16, Policy and Procedures for Dealing with Violence at Work, states clearly that staff sholud never attempt to restrain a service user (6.2,g). In incidences where restraint would be required, police assistance would be called to do so (6.2,f). In such circumstances staff would follow the investigation and recording requirements detailed in 6.4 of the Policy and record details in accordance with QC/4, Incident Reporting and Management Policy and Procedure. RQIA would be notified of all incidents requiring the involvement of the police in the use of restraint (QC/4, Appendix 4).	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
NIAMH, and the staff team in Woodlands Beacon Centre have expressed their opposition to the use of physical restraint with any service user and there was no evidence to suggest that such practice had ever been used.	Not applicable

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

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

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

Job descriptions detail the specifics of each role, lines of accountability and areas of activity. Scheme specific areas of activity will be reflected in Centre Programmes and Activity Schedules. Numbers of staff reflect a balance between number of sessions, numbers of users and programme of delivery.	
Inspection Findings:	**COMPLIANCE LEVEL**
The provider's self-assessment was verified through examination of relevant policies and procedures, staff records covering qualifications and supervision and a sample of the PMS records. Staff confirmed that their competence in the job was assessed and that they had a clear understanding of the management structure and the lines of accountability.	Compliant
Regulation 20 (2) which states: • **The registered person shall ensure that persons working in the day care setting are appropriately supervised**	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
All staff supervision takes place in accordance with the Supervision Policy R/P/39. Staff are supervised at a frequency and duration commensurate with their position and levels of responsibility as outlined in section 1.3 of the policy, with every staff member having a supervision contract and a shared responsibility for the process. The supervision process is designed with links to the organisation's Performance Management System. All managers attend a full day's training on supervision. Staff Supervision Records form part of Monthly Monitoring.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The organisation had systems in place for supervision and performance appraisal and staff confirmed that they felt supported by the management team. Records of staff supervision were detailed, relevant and well-written. Staff commented positively on the performance appraisal system and on the motivational aspect of its implementation.	Compliant

Regulation 21 (3) (b) which states: • **(3) For the purposes of paragraphs (1) and (2), a person is not fit to work at a day care setting unless –** • **(b) he has qualifications or training suitable to the work that he is to perform, and the skills and experience necessary for such work**	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
In the first instance Niamh recruits staff with the quailifications, skills and experience required by the Personnel Specification for the role. Niamh provide an Essential Regional Training Schedule designed to meet the mandatory training requirements of RQIA and essential sector specific content. To ensure timescales match RQIA requirements all staff are required to attend training on the dates allocated with attendance being monitored on the HR IT System(Cascade) and reviewed in supervision, to ensure compliance. All new staff are required to complete a New Employee Orientation and Induction Handbook that in particular introduces staff to those policies, procedures and systems, knowledge of which enables them to take charge in the absence of the manager. Staff also complete an Induction and Foundation Framework leading to an accredited qualification with the National Open College Network, that is either a level 2 or level 3 in Social Care and Mental Health (level is commensurate with grade). In addition and annually all grades of staff have access to opportunities for further development that include short courses with external providers and/or additional qualifications such as the Qualification Credit Framework (QCF) Level 3 in Health and Social Care, or QCF Level 5 in Leadership in Health and Social Care Services (Adults Management). The organisation is also currently developing 2 programmes to identify and develop future leadership talent through their 'Nurturing Talent' and 'Building Talent' Programmes for different grades of staff across the whole Niamh Group.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The registered manager has the necessary qualifications and experience to take charge of the centre and there is a project worker who is qualified and competent to assume responsibility for the centre in the manager's absence. The project worker is currently undertaking assessment for the QCF Level 5. Staff had acquired a range of vocational qualifications commensurate with their roles and responsibilities and mandatory training was up to date.	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

11.0 Additional Areas Examined

Premises

The premises, within a listed building, were found to be clean, well decorated and comfortably furnished. Members stated that they enjoyed the environment and found it a comfortable and interesting place to come to. The members and the staff have contributed significantly to the development of the outdoor facilities which are comprised of a courtyard area and a large garden which is walled on three sides. The premises were viewed by members and staff to be well suited to their use as a day centre.

12.0 Quality Improvement Plan

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

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

No requirements or recommendations resulted from the announced inspection of Woodlands which was undertaken on 11 November 2014.

Please provide any additional comments or observations you may wish to make below:

NAME OF REGISTERED MANAGER COMPLETING	Dorothy Devlin
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING	Billy Murphy

Approved by:	**Date**
Dermott Knox	17/12/14