Primary Announced Care Inspection

Name of Establishment:	**Woodvale Beacon Centre**
Establishment ID No:	**11061**
Date of Inspection:	**28 April 2014**
Inspector's Name:	**Dermott Knox**
Inspection No:	**17707**

The Regulation And Quality Improvement Authority
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Name of centre:	Woodvale Beacon Centre
Address:	32 Ballymoney Road Ballymena BT43 5BY
Telephone number:	(028) 2564 2383
E mail address:	woodvale@beaconwellbeing.org
Registered organisation/ Registered provider:	Miss Rose Anne Reynolds
Registered manager:	Mr Alexander McKeown
Person in Charge of the centre at the time of inspection:	Mr Alexander McKeown
Categories of care:	DCS-MP, DCS-MP (E)
Number of registered places:	25
Number of Members accommodated on day of inspection:	16
Scale of charges (per week):	All day charge for tea/coffee, toast and biscuits £1.00. Lunch £3.00 and dessert £1.00
Date and type of previous inspection:	20 May 2013 Primary Announced
Date and time of inspection:	28 April 2014 10:15am – 4:15pm
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 Members 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:

Members	7
Staff	3+ 1 volunteer
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	5	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

The Northern Ireland Association for Mental Health (Niamh) was founded by Lady Margaret Wakehurst in 1959. The original name 'Beacon House' is the name of the Niamh central office building in Belfast. The beacon symbol is that of the hand of friendship holding the lamp of life. Niamh works to promote the mental well-being of everyone in society.

Niamh is a long established mental health organisation comprising three elements, Compass, Beacon and Carecall. Beacon provides a range of person-centred services across Northern Ireland based on the Beacon Social Care Model for recovering mental health. These Services include day support, supported housing, home support and advocacy. The Beacon element embraces the recovery principles for people who have experienced mental ill health and the service enables individuals to find and maintain hope, re-establish a positive identity and take responsibility and control for themselves. It also promotes service user involvement and personal development through a range of activities and community based opportunities.

The Woodvale Beacon Centre is a three storey end of terrace house situated on the Ballymoney Road close to the town centre of Ballymena. It comprises of a sitting room, an activity area; dining area; kitchen, an art and craft room; room 101 (used for meetings with Members, by the multi-disciplinary team or for discussions), an education and training room; a manager's office; a general office and a room in the process of being converted into a clerical office.

The centre opening hours are listed as follows:

Staff led sessions;

Monday	9.30am - 4.30pm
Wednesday	9.30am - 1.00pm
Thursday	9.30am - 4.30pm

Service user led sessions;

Tuesday	9.30am - 4.30pm
Friday	9.30am - 4.30pm – with the support of a volunteer worker

Summary of Inspection

A primary announced inspection was undertaken in Woodvale Beacon Centre on 28 April 2014 from 10:15am to 4:15pm. Prior to the inspection the service provider submitted a self-assessment of the day centre's performance in the one standard and two themes forming the focus of the inspection. The following evidence sources were accessed during the inspection:

- Analysis of pre-inspection information and questionnaires
- Discussion with the registered manager, staff and Members
- Examination of a sample of service user individual file records including evidence of behaviour management and support assessments; the complaints record; staff training record; individual staff records; incidents and incident and accidents record; evidence of service user consultation, monthly monitoring records; the centres statement of purpose; Members guide and policies & procedures
- Tour of the premises.

The inspector met with the manager, a volunteer and three staff, one of whom worked on a peripatetic basis, regarding the standards and their views about team working, management support, supervision and the overall quality of the service provided. Seven members held discussions with the inspector regarding their experiences of the service and their views on the support provided.

Three completed questionnaires were returned by staff members, who reported satisfactory arrangements were in place with regard to NISCC codes of practice; supervision; staff training; staffing and management arrangements; responding to members' behaviour; confidentiality and recording. Positive comments were made regarding the quality of care provided, including: "we provide a good quality of care and always have time to offer advice and support when required"; "--- have seen top quality service provision in Woodvale in my (time) here". Overall the discussions with staff provided a very positive view of the care provided in the centre and indicated a commitment by staff, not only to comply with the standards for day care settings, but to seek continuous improvements.

Discussions with members elicited positive comments regarding the support experienced and the care provided by the staff. Members discussed their understanding of records kept in the day care setting about them and confirmed that they had confidence in the staff members to keep records safely and to protect confidential information. Some members stated that they had access to their records on request but that this normally occurred when they were contributing to their progress notes or review records. Eight recommendations from the previous inspection, on the 20 May 2013, had been fully met.

Standard 7 - Individual service user records and reporting arrangements: Records are kept on each service user's situation, actions taken by staff and reports made to others.

The centre has written policies and procedures pertaining to confidentiality, recording and reporting, data protection, consent, and, storage and destruction of closed files. The policies and procedures were available for staff reference. The registered person had arrangements in place to audit policies and procedures with regard to the requirements of the minimum standards, in order to ensure that they were up to date and accurate.

In the sample of four service user care records examined, there were numerous examples of members having signed to indicate their involvement and agreement with the content. A number of members had declined to have their photograph included in their file and this had been recorded and signed by both staff and the member. This sense of developing ownership of the records, in terms of regularly contributing to them and having some control over what is included, is commendable.

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

The Northern Ireland Association for Mental Health (NIAMH) has a policy and clear guidelines on the use of restrictive practices, which states that staff are not to use physical restraint or physical intervention with service users. The evidence available from members, staff and the written records, verified that there had not been any instances of such practices in the centre. Staff discussed the use of good communication, calming and diffusing techniques, for which training is provided, and the importance of developing good understanding of their members' needs and preferences. They expressed the view that the development of trusting working relationships helps members to seek support before acting in a way that might be harmful to themselves, or threatening to others. NIAMH also has a written policy and procedures for 'Dealing with Violence at Work', and staff confirmed their understanding of the procedures.

The centre was judged to be operating in compliance with this theme.

Theme 2 - Management and control of operations: Management systems and arrangements are in place that support and promote the delivery of quality care services.

Staff records showed that the registered manager and the support workers are appropriately qualified and experienced to take charge of the centre. Training for key aspects of this role had been provided. NIAMH has developed an 'Employee Competency Framework' against which each staff member's competence is assessed. This is a well-constructed framework and a useful staff development tool.

There was evidence from discussions with staff to confirm that members of the staff team work supportively and well with one another. The manager demonstrated a detailed understanding of the developmental needs of each staff member and had good systems in place for supervision, appraisal and promoting staffs' learning. Records of staff training and supervision were comprehensive and up to date.

The staffing structure and reporting arrangements were clearly set out in writing in the statement of purpose, for reference by all stakeholders. Staff presented as being knowledgeable, appropriate to their roles, responsibilities and experience, and keen to improve their skills in the work.

Monitoring arrangements are standardised across NIAMH services and there was good evidence to indicate compliance with the standards in this area.

Additional Areas Examined

A comprehensive Quality Report for 2012/13 was available for inspection. A wide range of evaluative data was presented in a clear and informative style and this is commendable.

On the basis of the evidence presented two recommendations are made in the Quality Improvement Plan, accompanying this report. These were discussed with the manager at the conclusion of the inspection, as potential improvements to an already good quality service.

The inspector wishes to acknowledge the work undertaken by the manager and staff in preparation for this inspection and their open and constructive approach throughout the inspection process. Gratitude is also extended to members, who warmly welcomed the inspector to the centre and contributed to the evaluation of the service provided.

Follow-Up on Previous Issues

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	4.3	**Assessments** The manager must ensure the two identified service user's assessments are signed by all relevant parties (additional information section refers).	The identified assessments had been signed by the relevant people.	Compliant
2	5.2	**Care Plans** It is recommended the manager ensure the identified service user's care plan is updated to reflect that staff prompting or reinforcing is needed concerning medication as detailed in his/her assessment (additional information section refers).	The identified care plan had been updated and the manager confirmed that staff were aware of the issue.	Compliant
3	8.4	**Members' Annual Quality Assurance Questionnaires** It is recommended the manager ensures Members' annual quality assurance questionnaires encompass all areas of the service provision, and in particular programmes/activities/outings (follow up on previous issues refers).	New questionnaires had been drawn up to seek a more comprehensive range of information.	Compliant
4	14.10	**Complaints Records** The manager must ensure the identified area of dissatisfaction from early December 2012 is fully investigated, records made of same and action taken where appropriate (additional information section refers).	The identified matter had been fully investigated with the outcome being that a new dishwasher was purchased and installed. One member commented on how well it was working.	Compliant

5	15	**<u>Service User's Annual Review Documentation</u>** It is recommended the registered persons: (a) amends the centre's service policy and procedures to reflect standard 15.3 regarding the initial review of Members' placements and ensures the initial review of their placement takes place in accordance with this; (b) the annual review preparation form completed by staff with Members contains all of the relevant areas specified in standard 15.5 which includes a summary of any accidents, untoward incidents; significant events; achievements or changes in living circumstances since the service user's previous annual review of their placement. If there have been no changes since their previous review then the relevant sections of the report should state this (standard 15.5 refers).	The written policy and procedures on reviewing members' placements had been revised to ensure it complied with the minimum standards. Recent review reports addressed all of the matters identified in Std. 15.5.	Compliant

6	17.10	**Monthly Monitoring Reports** The registered person must ensure Woodvale Beacon Centre's monthly monitoring reports states: (a) whether the visit is announced or unannounced; (b) the numbers of Members interviewed and their views and opinions about the quality of the service; (c) the numbers of staff interviewed and a summary of their comments; (d) an overview of the environment from a health and safety, fire safety; infection control, décor, cleanliness, tidiness viewpoint (regulation 28 and standard 17.10 refers).	The pro-forma for monthly monitoring reports had been revised to comply with this recommendation.	Compliant

7	21.8	**Staff Training Record** It is recommended the manager ensure the staff training record contains: (a) staff signatures for each training session attended; (b) a summary of the content of the training session (follow up on previous issues refers).	NIAMH had introduced a revised form of record for each training event, which included a summary of the content of the course, the staff member's signature and the qualifications of the training facilitator.	Compliant
8	25.1	**Environment** The registered persons are advised to source and eradicate the identified malodour in the male WC (additional information section refers).	The identified WC had been repainted and deep cleaned in order to overcome this problem.	Compliant

Standard 7 - Individual service user records and reporting arrangements: **Records are kept on each service user's situation, actions taken by staff and reports made to others.**	
Criterion Assessed: 7.1 The legal and an ethical duty of confidentiality in respect of Members' 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 Members 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 Members 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 self-assessment was verified through examination of a sample of the identified policy, procedures and guidance documents and from discussions with the manager and staff members. Each member's agreement is sought before written information about them is shared with anyone outside of the NIAMH employees and referring Trust personnel, who need to know. Access to individual's files, for inspection purposes, had been agreed by the relevant Beacon members.	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 complian
Inspection Findings:	**COMPLIANCE LEVEL**
In the sample of four service user care records examined, there were numerous examples of members having signed to indicate their involvement and agreement with the content. A number of members had declined to have their photograph included in their file and this had been recorded and signed by both staff and the member. This sense of developing ownership of the records, in terms of regularly contributing to them and having some control over what is included, is commendable. It is recommended that staff should reflect the degree of involvement by noting members' access to their files, on any occasions on which the member does not sign it themselves.	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**
The provider's self-assessment was verified through examination of four members' records, all of which were found to be well-organised and complete in all of the matters identified in this criterion. Records were relevant to the assessed needs and the support plan for each person and had been signed regularly by the member.	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**
A sample of four care records provided evidence that written entries were made at least once every five attendances for each of those members. Some members attended irregularly, making it difficult to check accurately the relationship of record entries to attendances at the centre. It is recommended that NIAMH develop a system to ensure ease of monitoring of the levels of record keeping.	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. 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**
The provider's comprehensive self-assessment was verified through examination of a sample of the relevant policy and procedure documents, which were of a high standard. These included, Safeguarding Vulnerable Adults, Beacon Member Safety/Risk/Vulnerability and Incident Reporting and Management. Follow up action on any reported event was noted in the Regulation 28 monthly monitoring report.	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**
A sample of four service user records was examined and all were found to be legible, accurate, up to date and signed and dated by the person making the entry. Staff who met with the inspector confirmed their understanding of the recording requirements. They were aware that records were audited by the manager and also that they were sampled by the monitoring officer. Staff confirmed that record keeping was discussed in staff meetings and in supervision.	Compliant

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

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

Theme 1: The use of restrictive practice within the context of protecting service user's human rights **Theme of "overall human rights" assessment to include:**	
Regulation 14 (4) which states: **The registered person shall ensure that no service user is subject to restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other service user and there are exceptional circumstances.**	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
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 Members 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**
The Northern Ireland Association for Mental Health (NIAMH) has a policy and clear guidelines on the use of restrictive practices, which states that staff are not to use physical restraint or physical intervention with service users. The evidence available from members, staff and the written records, verified that there had not been any instances of such practices in the centre. The provider's self-assessment was verified through examination of the identified policies and procedures and from discussions with members, staff and the manager.	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**
The manager, staff and two members confirmed that there was never any use of restraint, or restrictive practices in Woodvale Beacon Centre. Members said that their attendance at the centre was based on their own wishes and decisions and records showed examples of members having phoned to let staff know they would not be there for the scheduled session or sessions. Support plans were reviewed at least annually to ensure they remained necessary, proportionate, relevant and effective and did not infringe on the person's human rights. Staff confirmed that they adopt a person centred approach to their practice and this was reflected in the progress records and the review reports that were examined.	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

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 Members -** **(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 Members;** **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. Job	Compliant

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**
NIAMH has an excellent system, the "Employee Competency Framework" in use to assess the performance level of staff members in relation to their roles. Different levels are applied depending on the individual's job and responsibilities. There was written evidence to verify the provider's self-assessment, which identifies the components of the system giving confidence to managers and staff that each employee is equipped for the position to which they are appointed. Staff reported that they were confident in their work and clear about the lines of accountability. Staff presented as being confident in their working relationships with the members who attended the centre on the day of this inspection. Written records of work with members, either individually or in groups, provided further evidence of staffs' competence in responding appropriately to a wide range of presenting issues.	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**
Two staff files were examined, which included training records, performance management records and supervision contracts and records. Formal supervision for each staff member was carried out every two months and the records showed that there was good preparation for each session and wide-ranging content, which was recorded in good detail. Staff confirmed that they have frequent working contact with the manager on a day to day basis, providing opportunities for reflective discussions and knowledge development.	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 provider's comprehensive self-assessment was verified through examination of a sample of staff records, showing qualifications, previous experience, training completed and regular supervision. The manager and staff confirmed the thoroughness of the induction programme that each new staff member undertakes and the excellent training and development opportunities provided by NIAMH. Twice yearly performance appraisals helped to maintain a focus on each staff member's knowledge and skills development and helped to identify further development needs. The structure and implementation of the culture of continuous improvement is commendable.	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

Additional Areas Examined

Quality Evaluation

A comprehensive Quality Report for 2012/13 was available for inspection. A wide range of evaluative data was presented in a clear and informative style and this is commendable. Quality evaluation by NIAMH is conducted annually.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr Alex McKeown, 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:

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

Quality Improvement Plan

Primary Announced Care Inspection

Woodvale Beacon Centre

28 April 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Mr Alex McKeown, 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

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 13.4	Given the close working relationships of all the centre's staff with members who attend, it is recommended that training on Safeguarding Vulnerable Adults should be extended to include the clerical staff and others, as appropriate.	One	Clerical Worker included in training schedule for 2014/15 to complete Safeguarding Vulnerable Adults training.	30 June 2014
2	Standard 7.3	When a member accesses his or her file, it is recommended that this should be recorded, either by the member's signature or by a staff note in the progress notes. Members' signatures were already evident for some occasions.	One	Guidance given to staff on procedure for recording member file access requests in member notes.	6 June 2014

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

Name of Registered Manager Completing Qip	Alex McKeown
Name of Responsible Person / Identified Responsible Person Approving Qip	Liam Quigley

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	D Knox	13/6/14
Further information requested from provider	No	D Knox	13/6/14