Primary Unannounced Care Inspection

Name of Establishment:	**Beacon Centre**
Establishment ID No:	**11062**
Date of Inspection:	**12 March 2015**
Inspector's Name:	**Dermott Knox**
Inspection No:	**20480**

The Regulation And Quality Improvement Authority
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Name of centre:	Beacon Centre
Address:	20 Clarendon Street Derry BT48 7ET
Telephone number:	(028) 7126 9677
E mail address:	clarendon@beaconwellbeing.org
Registered organisation/ Registered provider:	Mr William Henry Murphy
Registered manager:	Ms Allison Foley
Person in Charge of the centre at the time of inspection:	Ms Allison Foley
Categories of care:	DCS-MP
Number of registered places:	30
Number of members accommodated on day of inspection:	28
Date and type of previous inspection:	4 October 2013 Primary Announced Inspection
Date and time of inspection:	12 March 2015 10:45am–4:45pm
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	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	4	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 Beacon Centre in Clarendon St. is operated by the Northern Ireland Association for Mental Health (NIAMH), a charitable organisation. The registered manager is Ms Allison Foley. The centre is one of 14 NIAMH day support services which operate throughout Northern Ireland.

Clarendon Street Beacon Centre, located close to the city centre, opened in its current location in 1991, prior to which it was in Bishop Street. The geographical area covered includes Cityside, Waterside and outlying rural areas. The manager and staff work closely with a wide range of statutory and voluntary agencies and help to organise a number of community based initiatives.

The centre occupies a large, four storey house on Clarendon Street, which has a main lounge, kitchen, dining area and 2 WC's on the ground floor. The first floor has a spacious and comfortably furnished room in which music sessions and other activities are held. There is a bathroom, a utility room and an office on the second floor and a computer room and the manager's office on the top floor of the house. There is no passenger lift in the building, a fact that limits availability of the service to those who are independently mobile. A separate, mews building to the rear houses a pottery and art room on the first floor.

The Clarendon Street centre is registered to provide a maximum of 30 places per day for persons over 18 years of age, who have an enduring mental illness. The service is delivered over four weekdays and one Sunday session, which includes the provision of a cooked lunch. Individuals usually attend on designated days, however a drop-in service is also available. Close links have been established with a wide range of statutory and voluntary agencies, including NIAMH's Community Mental Health Team.

Summary of Inspection

A primary unannounced inspection was undertaken in Beacon Centre, Derry on Thursday 12 March 2015 from 10:45am until 4:45pm. In advance of the inspection, the service provider had submitted a self-assessment of the centre's performance in the one standard and two themes forming the focus of the inspection. This had been completed in excellent detail and was very helpful in the inspection process.

The inspector met for discussions with five members who attend the centre, either in small groups, or individually in informal settings. Individual discussions were held with the manager and two staff regarding the standards, team working, management support, supervision, monitoring and the overall quality of the service provided and informally with a third staff member.

Discussions with all contributors elicited positive views of the service provided in the centre and indicated a strong commitment by the manager and the staff team to comply with, or to exceed, the minimum standards for day care settings. Members spoke highly of the staff and of the service they provided. Observed practice, during the day, indicated that members had developed trusting and supportive relationships with staff and that they enjoyed and benefited from their participation in the centre's programmes and activities.

There was evidence from discussions and in written records to indicate a high level of involvement of members and their carers in discussions regarding their care plans and the activities in which they participated. Work with members centred around a 'Recovery' model, seeking to enhance the resilience of each person in working toward their goals.

The premises were reasonably well-maintained and several members commented on the homeliness being a positive factor. The limitations of having many stairs and no lift were also discussed.

The inspector wishes to acknowledge the constructive approach of the manager and staff throughout the inspection process and to thank the members who contributed their views on the quality of the service.

Standard 7 - Individual service user records and reporting arrangements:

Members' files were found to be well organised and to contain all of the information required by this standard. A record of each service user's involvement and progress was kept in good detail and the frequency of record keeping exceeded the requirement of the minimum standards. The Day Care Workers each held keyworker responsibility for a number of members' placements and maintained the records for those people. Records were regularly audited by the manager and were sampled by a senior manager during monitoring visits.

NIAMH's written policies and procedures for recording and for reporting events were available to staff in the centre. A new procedure on 'Accident, Incident and Near Miss' recording had been introduced in March 2014 and this provided good clarity and detail for each event. Notifiable events and the reporting of these are included in the staff training programme and staff members confirmed their confidence in following procedures accurately. Staff also reported that they had ready access to senior staff should they need to seek guidance. A sample of the notifications of significant events was found to be satisfactory.

Beacon Centre, Derry was operating in compliance with this standard.

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

The manager reported that restraint was not used in Beacon Centre, Derry with any service user and that no instances of restraint or restrictive practice had been recorded. The staff team had discussed the issue of restrictive practice and had reviewed their practice in light of the Deprivation of Liberty Safeguards. (DOLS) – Interim Guidance. DHSSPS 2010, and in consideration of each person's human rights.

When reviewing a service user's individual care plan, issues regarding any necessary calming and diffusing practices are discussed by the manager, keyworker, and the member. Action plans are discussed to ensure that all interventions are proportionate and do not infringe the individual's human rights. The centre has a security locked entrance/exit door, which can be operated by members, volunteers or staff. Staff and members confirmed that there was no use of restraint or seclusion and that members' human rights are protected.

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

Theme 2 – Management and Control of Operations

Monitoring arrangements put in place by NIAMH were regular and reports included the views of a number of members and of day care staff on the quality of the service and on their levels of satisfaction. Some monitoring visits were unannounced. Monitoring reports addressed, in good detail, all of the matters required by regulation. The centre also produces a comprehensive annual quality survey report which includes a range of comments by members.

Staffing of the centre was satisfactory, with group activities planned and clearly scheduled so that members' participation was, in most cases, programmed. Formal supervision of staff and annual appraisals were completed in accordance with NIAMH's procedures and in compliance with the minimum standards. Staff reported a high level of satisfaction and confidence in these arrangements. Staff training records confirmed that mandatory training requirements were met and that staff were afforded an excellent range of additional developmental opportunities.

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

Follow-Up on Previous Issues

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	Standard 17.11	The quality survey should be extended, as previously stated, to include broader, day to day quality issues.	The annual quality survey for 2014 had been expanded to gather a broader range of data. The survey content continued to be kept under review.	Compliant
2	Standard 21.9	Staff's views of the training provided were negatively affected by the lengthy travel required to attend, sometimes for just a half-day refresher course. It is recommended that training arrangements should be reviewed in order that training be provided in the most efficient and effective way possible.	The provision of training was being kept under review, with the aim of achieving the most efficient and effective model for staff. This was positively influenced by the expansion of NIAMH's responsibilities to include the staff of 'Insight', a service for adults who have a learning disability.	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 at Clarendon Street Beacon 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 comprehensive self-assessment was verified through examination of a number of the identified policies and procedures and members' records and from discussions with the manager and two staff.	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 contributing to their own notes alongside their keyworker. Section 14 of the policy (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 information to all new members on accessing their records 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.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
There was strong evidence of members' involvement in agreeing their care plans and review reports and in some cases contributing regularly to their own progress notes. Formal requests from members had not been necessary, as there was a high level of inclusion evident in everyday practice.	Compliant

Criterion Assessed: 7.4 Individual case records/notes (from referral to closure) related to activity within the day service are maintained for each service user, to include: • Assessments of need (Standards 2 & 4); care plans (Standard 5) and care reviews (Standard 15); • All personal care and support provided; • Changes in the service user's needs or behaviour and any action taken by staff; • Changes in objectives, expected outcomes and associated timeframes where relevant; • Changes in the service user's usual programme; • Unusual or changed circumstances that affect the service user and any action taken by staff; • Contact with the service user's representative about matters or concerns regarding the health and well-being of the service user; • Contact between the staff and primary health and social care services regarding the service user; • Records of medicines; • Incidents, accidents, or near misses occurring and action taken; and • The information, documents and other records set out in Appendix 1.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
Robust policies and procedures are in place at Clarendon Street Beacon centre to ensure that individual case records contain all the requirements detailed above. All information is 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. Regular assesment and reviews take place as outlined in the organisational policy. 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. It is an organisational requirement that an update of the support plan would take place following any hospital admission or incident.	Compliant

Inspection Findings:	**COMPLIANCE LEVEL**
An examination of three members' files provided evidence of comprehensive, structured and well-detailed record keeping for each person. There was also good evidence of the members' involvement in their own care planning and in reviews of their participation and progress in the agreed programmes.	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 sample of member's records examined provided verification of compliance with this criterion.	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.	Compliant

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. Regular contact is maintained at Clarendon Street with the local G.P services and the Community Mental Health Team. The staff team have also attended training on all the above policies.	
Inspection Findings:	**COMPLIANCE LEVEL**
There was excellent written guidance for staff on matters to be reported to the parties identified in this criterion. The provider's self-assessment was verified through examination of a sample of the policies, procedures and guidance identified above.	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 for staff completing members records and administration 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 wide range of records was examined and provided evidence of a high standard of record keeping. Records were audited regularly, with any necessary improvements being clearly identified.	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. Normal working practise is that 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 techniques. This training focuses on skilling staff to prevent work related violence through deescalation rather than on how to use/apply restraint techniques.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
There was evidence in policies and from discussions with the manager, staff and members, to confirm that no restraint or seclusion was ever used in the centre. As stated in the provider's self-assessment above, various aspects of restrictive practice were covered in written policies and guidance, making the organisation's position very clear. Staff spoke confidently about the use of calming and diffusing techniques and members confirmed that they were always treated with respect, including when a stressful incident was being dealt with.	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 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). Staff at Clarendon Street are fully aware of the organisational policy and would work closely with members to resolve any issues/ concerns or behavioural issues before it results in an incident requiring police attendance.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
No instances of restraint had been reported or recorded.	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 a competence profile and agree objectives A new "Competence of person to be responsible for the scheme in the absence of the Manager" form has recently been introduced also. 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**
The centre's management and staffing structures were clearly set out in the statement of purpose. The manager and staff presented as being knowledgeable and confident in their roles and responsibilities and the lines of accountability. The centre complies with the requirement for a competence assessment of any staff member who may take charge of the centre in the absence of the manager.	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 at Clarendon Street Beacon Centre are supervised at a frequency and duration commensurate with their position, 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 the Monthly Monitoring undertaken by the service manager with responsibility for Clarendon Street.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Written records of supervision and appraisal were well-detailed and up to date. The manager and two staff discussed supervision arrangements and their high level of satisfaction with these. The centre has a training plan for staff which supports their development and assists them to undertake their various responsibilities. It is commendable that NIAMH is supporting experienced staff to gain leadership and management qualifications.	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 their 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 self-assessment was verified through examination of three staff files and from discussions with the manager and staff members. There was good evidence to confirm that staff development was strongly promoted and that evaluation of the quality of work in the centre was rigorous and regular.	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

Complaints

The format for recording complaints had been revised in May 2014, the new record providing more detailed and comprehensive information, including the outcome of each investigation and the level of satisfaction of the complainant. One complaint received since that date had been recorded in the new format and was found to be satisfactory.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Allison Foley, 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

The Regulation and Quality Improvement Authority

No requirements or recommendations resulted from the primary unannounced care inspection of Beacon Centre which was undertaken on 12 March 2015 and I agree with the content of the report.

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

SIGNED: Billy Murphy

NAME:
Registered Provider

DATE 16/04/2015

SIGNED: A. Foley

NAME: Alison Foley
Registered Manager

DATE 13/04/15

Approved by:	Date
M. Marley	23/4/15