Primary Unannounced Care Inspection

Name of Establishment:	**Castlecroft Beacon Centre**
Establishment ID No:	**11065**
Date of Inspection:	**10 March 2015**
Inspector's Name:	**Lorraine Wilson**
Inspection No:	**IN020656**

The Regulation And Quality Improvement Authority
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Name of centre:	Castlecroft Beacon Centre
Address:	64 Main Street Lisnaskea BT92 0JD
Telephone number:	028 6772 1838
E mail address:	castlecroft@beaconwellbeing.org
Registered organisation/ Registered provider:	Miss Rose Anne Reynolds
Registered manager:	Ms Finola Crudden
Person in Charge of the centre at the time of inspection:	Ms Chrissie Lynch, Project Worker
Categories of care:	DCS-MP
Number of registered places:	15
Number of service users accommodated on day of inspection:	Six during the morning 12 during the afternoon
Date and type of previous inspection:	07 May 2013 Primary Announced
Date and time of inspection:	10 March 2015 11.35 -16.45 hours
Name of inspector:	Lorraine Wilson

Introduction

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

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

Purpose of the Inspection

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

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

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

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

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

Methods/Process

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

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

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

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

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

Consultation Process

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

Service users	5 individually and to others in groups
Staff	3 including the manager
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	4

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

Castlecroft Day Care Centre is situated on the main street in the town centre of Lisnaskea. This Beacon Centre, operated by the NI Association for Mental Health, has been operational at this address for over 12 years and is close to all community amenities.

The responsible individual for the organisation is Miss Rose Anne Reynolds. Ms Finola Crudden is the registered manager for the centre.

Facilities include a common room/dining area, tutorial and private rooms, bathroom/toilets, and office accommodation for staff.

The centre is open 10.30 – 15.30 hours Tuesday, Wednesday and Friday each week. Castlecroft Day Care Centre aims to promote member involvement and personal development through a range of activities, work opportunities, and personal support. A maximum of 15 members can attend each day.

The registration certificate issued by the Regulation and Quality Improvement Authority (RQIA) was reviewed and was appropriately displayed.

Summary of Inspection

This primary unannounced inspection of Castlecroft Beacon Centre was undertaken by Lorraine Wilson on 10 March 2015 between 11.35 and 16.45 hours.

Ms Chrissie Lynch, Project Worker, was initially in charge of the centre and facilitated the inspection. Ms Finola Crudden, registered manager was in the centre during the afternoon, and met with the inspector.

Verbal feedback was provided to Ms Crudden on conclusion of the inspection.

Service users will be referred to as “members” throughout the report as this is the title preferred by those who attend the centre. The inspector was introduced to members attending the centre and met for discussions with five individually and spoke to others in small groups. There was good evidence from the discussions held and in the information recorded to indicate a high level of inclusion and involvement of members in decision making with regard to the day care provided. Members also spoke positively of the support they experienced and the opportunities provided by the staff for their enjoyment and development. There were no issues or concerns raised by members.

Individual discussions were also held with the registered manager and two staff regarding the standards, team working, management support, supervision and the quality of the service provided. The registered manager and staff provided an enthusiastic and positive view of the service.

A number of documents including a completed self-assessment were submitted to RQIA by Ms Crudden prior to the inspection. The documents were reviewed by the inspector and the required assurances were provided.

The inspection sought to assess progress with the issues discussed 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 themes:

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 appropriate policies and procedures regarding confidentiality, recording, reporting and data protection. Policies and procedures are available for staff reference.

Three members' files examined were person centred and reflected that Human Rights were respected. The files observed were legible, dated, and securely stored. Progress notes for service users were being kept, as were records of reviews. There was also recorded evidence of multi-professional collaboration and member/representative involvement in planned care and support.

Discussion with members confirmed they were aware that a personal record was maintained which they could access upon request. In addition, a record request template for access to information, including who applied for access and the outcome of the request was included in each member's file.

From a review of the available evidence, discussion with members and staff, the inspector can confirm compliance with Standard 7.

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

The centre has a written policy and guidelines on the use of restrictive interventions, which were available to staff in the centre. Resource and reference information on human rights, deprivation of liberty and restraint was available to staff.

Discussions with staff confirmed that there was no restraint used in the centre. Staff discussed the use of good communication, the use of diversion to quiet areas and calming techniques as well as the importance of developing good understanding of each member's needs and preferences.

Analysis of returned staff questionnaires confirmed that when responding to member's behaviour, staff will "use calming and diffusing practice". Staff responses also confirmed that Deprivation of Liberty Safeguards is used to direct and inform practice when responding to behaviours which may be challenging to others.

From a review of the available evidence, discussion with members and staff, the inspector can confirm compliance with Theme 1.

Theme 2 - Management and control of operations:

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

Robust management arrangements were in place to support and promote the delivery of quality care services and the manager and staff work well as a team to ensure best outcomes for members.

The registered manager also manages another day service operated by Niamh in a nearby location. Confirmation was provided that there is qualified and experienced staff to take charge of the centre in the manager's absence. Competency and capability assessments were in place for these staff, and management training for aspects of the role had been provided.

Effective processes for staff supervision, appraisal and staff training were in place. Records of staff training were maintained and formal supervision sessions provided. It was positive to note that staff skill and learning in specific areas of interest was encouraged by the organisation and facilitated where possible. Staff meetings take place frequently with minutes recorded and retained.

The staffing structure and reporting arrangements were clearly set out within the Statement of Purpose, for reference by all stakeholders. The staff consulted were knowledgeable, competent and confident with regard to their roles and responsibilities.

Effective governance arrangements were evidenced and the inspector was assured that service improvement and development was promoted by the organisation.

There was good evidence of quality monitoring with frequent audits of the service being conducted, for example, auditing of complaints and incidents. This is commendable practice.

Monthly unannounced monitoring visits to the centre were undertaken by a designated manager on behalf of the responsible individual. Three monitoring reports examined, addressed all of the required matters in compliance with relevant regulations.

From a review of the available evidence, discussion with members and staff, the inspector can confirm compliance with Theme 2.

Care and Support Practices

The atmosphere in the centre was friendly and welcoming. Well planned, organised therapeutic activities were ongoing throughout the day. During the morning, some members were observed taking part in a drama class, whilst some members were out of the centre attending other groups. During the afternoon, the majority of members attended a first aid tutorial, where lively discussion took place between members and the tutor.

Very good relationships were evident between members and staff, and members were treated with dignity and respect.

Environment

The areas of the environment viewed presented as clean, organised, adequately heated and fresh smelling throughout. The sitting room and upstairs quiet room had recently been redecorated and was well presented. The remaining décor and furnishings were satisfactory.

Conclusion

The inspector wishes to acknowledge the open and constructive approach of the registered manager and staff throughout the inspection process. Gratitude is also extended to members, who welcomed the inspector to the centre.

Compliance was evidenced with the standards and themes inspected, and no requirements or recommendations were made during this inspection.

The inspector would also like to thank the four staff who returned completed questionnaires to inform the inspection process.

Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
		No requirements were made as a result of this inspection.		

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
		No recommendations were made as a result of this inspection.		

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 inspector evidenced that a range of corporate policies and procedures were available to staff in the centre. Examples of policies reviewed included Record Management, Confidentiality, Data Protection and Beacon Members Personal File Storage, Disclosure Information policy, Confidentiality Policy, IT Equipment and Data. Policy and a Policy and Procedure on Care Planning, Assessment and Review. Other resource documents in regard to ethical duty of confidentiality were also available to staff via staff policies.	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**
Three members' files were reviewed and the records reflected that information was recorded in line with guidance and all conveyed a person centred ethos ensuring that individual circumstances were included and appropriate risk assessments and follow-up information was recorded in care plans. There was also evidence of member's recording and contributing to their annual review. Discussion with members confirmed they were aware that a personal record was maintained which they could access upon request. In addition, a record request template for access to information, including who applied for access and the outcome of the request was included in each member's file. The inspector noted that as at the date of inspection, there had been no requests to access records. Service user agreements were maintained on file and the inspector noted that the agreement also included information regarding how to access to care records. To assist staff respond to a request for information under the data protection act, a flow chart was available. The inspector concluded that recording practises and storage of information were reflective of current national guidelines.	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**
Information as illustrated by the registered manager in the self- assessment was verified through discussion with staff and examination of three care records which confirmed that records were comprehensive with assessments including risk, care plans showing actual and potential needs and interventions to meet agreed objectives. There was good evidence of member/ representative consultation and multi-professional collaboration in planned care. The care plans	Compliant

examined had been regularly reviewed and signed off by the registered manager.	
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 inspector confirmed that entries were made for each member in accordance with the standards and several members also contributed by recording information in their individual records at least monthly, demonstrating empowerment for members and person centred care. The inspector also noted that when a member has not informed the centre of their nonattendance on their designated day, there is follow up and an entry is recorded by 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.	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.	
Inspection Findings:	**COMPLIANCE LEVEL**
Robust corporate policies and a range of flow charts with regard to reporting and management of events were evidenced during inspection. Two staff consulted presented as being confident and competent in their roles and clear in their reporting procedures to the manager, and other professional staff. Examination of care records evidenced good multi-professional collaboration in planned care, reporting and sharing of information with representatives of members in accordance with relevant legislative guidance and only if appropriate.	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 review of three members' care records evidenced that records were legible, current, signed and dated by the staff member and reviewed and as stated in criterion 7.4, had been signed off by the registered manager. In accordance with evidence based practice for improvement, the inspector noted that records audit and a data protection audit had recently been undertaken.	Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE DAY CARE SETTINGS COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Provider to complete

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**
The centre's policy on the use of restraint is detailed in the Guidance on Restrictive Practice, which states that physical intervention or restraint is not permitted in the centre and this was also confirmed by staff on duty. Staff provided examples of the calming and diffusing action taken if a member requires a quiet area to deal with emotions such as anger or low mood. Detailed support plans were evidenced and agreed for two members when such occasions may arise.	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**
Information as illustrated in the self-assessment was verified through discussion with the registered manager and staff, who confirmed that no restraint is permitted, and the procedure was explained if restraint of a member should be required.	Compliant

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

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. 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.	Compliant

Inspection Findings:	COMPLIANCE LEVEL
The registered manager discussed her experience with the inspector and provided confirmation that in addition to a relevant certificate for the management of the service, she had also had achieved a management and leadership qualification. On this occasion, staff qualifications were not reviewed, as staff recruitment records are retained at the organisation's head office. The staff member who has responsibility for the centre in the absence of the manager met with the inspector and demonstrated a good awareness of her responsibilities when in charge. A competency and capability assessment completed by the registered manager was reviewed which confirmed that the staff member was competent to take charge of the centre in the absence of the registered manager. Staff training records examined confirmed that in addition to mandatory training, staff had opportunities to attend other training sessions to assist them in their specific role within the centre. Examples included specific sessions on mental health themes. Staff involved in management and leadership roles had also received enhanced training. Confirmation was provided that staff are encouraged and supported to develop their talent and skills through further training as part of an ongoing initiative within the organisation. The statement of purpose was reviewed and the management structure and staffing for the service was recorded. Rotas reviewed for a three week period confirmed there was sufficient staff on duty. Three monthly monitoring visits completed on behalf of the responsible individual of the organisation were reviewed, and evidenced that staffing arrangements were examined and information regarding staffing was recorded during each visit.	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	Compliant

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.	
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector verified that supervision is provided to staff on a regular basis and staff appraisals had taken place. This was also confirmed through discussion with two staff members, observation of staff supervision/appraisal records, returned staff questionnaires and monthly monitoring reports.	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**
Information as illustrated in the self-assessment was evidenced through examination of staff training records and discussion with the registered manager and staff. Competency and capability assessments for staff were in place.	Compliant

Staff were aware of their roles and responsibilities in relation to the members in their care and demonstrated sound knowledge.	

PROVIDER'S OVERALL ASSESSMENT OF THE DAY CARE SETTING COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Provider to complete

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

Additional Areas Examined

Complaints

The registered manager completed and returned the complaints proforma as requested prior to the inspection which confirmed that from 1 January to 31 December 2013, there were no complaints.

The inspector also reviewed complaints records retained in the centre which evidenced there was good oversight and management of complaints which were reviewed during monthly monitoring visits.

A review of complaints was also undertaken by the quality manager of the organisation in November 2014. This is good practice.

Statement of Purpose

The centre retains a Statement of Purpose in accordance with Regulation 4 of the Day Care Setting Regulations (Northern Ireland) 2007.

Monthly Monitoring Reports

The inspector reviewed three quality monitoring reports completed on behalf of the responsible individual and verified that these were undertaken in accordance with the required legislation.

Staff Questionnaires/Staffing

Four staff questionnaires which were issued during the inspection were returned to RQIA. During individual discussion with two staff and in returned questionnaires, staff responses were very positive about all aspects of the service.

Samples of comments included:

- “I love my job here, we are well supported and work well as a team, for the good of the members.”
- “The organisation is good to work for.”
- “I would describe the quality of care and day service provision in this centre as professional and of a high standard.”
- “A caring service.”

Members’ Views

The inspector met with members at various times during the inspection. Members spoke freely with the inspector and described many of the therapeutic activities provided including the drama club which many of the members enjoyed.

It was evident from the discussions that the centre provided many positive benefits to members who attended.

Samples of comments included:

- “I really enjoy it here and have been coming for years.”
- “I would come every day if I could.”
- “This place has been a real lifeline to me.”
- “The manager and staff are great.”

Quality Improvement Plan

The inspection outcome was discussed with Ms Finola Crudden, registered manager. As no requirements or recommendations were made, a Quality Improvement Plan has not been issued.

Where the inspection resulted in no recommendations or requirements being made the provider/manger is asked to sign the appropriate page confirming they are assured about the factual accuracy of the content of the report.

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:

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

No requirements or recommendations resulted from the **primary unannounced care inspection** of **Castlecroft Beacon Centre** which was undertaken on **10 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: Billy Murphy
Registered Provider

DATE 2/4/2015

SIGNED: Finola Crudden

NAME: Finola Crudden
Registered Manager

DATE 2/4/2015

Approved by:	**Date**
Lorraine Wilson	13/5/2015