Primary Announced Care Inspection

Name of Establishment:	**Rosewood Beacon Centre**
Establishment ID No:	**11066**
Date of Inspection:	**11 September 2014**
Inspector's Name:	**Margaret Coary**
Inspection No:	**IN020050**

The Regulation And Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
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Name of centre:	Rosewood Beacon Centre
Address:	90 Tamlaght Road Omagh Co Tyrone BT78 5BB
Telephone number:	028 8224 5571
E mail address:	rosewood@beaconwellbeing.org
Registered organisation/ Registered provider:	NI Association for Mental Health
Registered manager:	Mrs Delia Devlin
Person in Charge of the centre at the time of inspection:	Mrs Delia Devlin
Categories of care:	DSC-MP
Number of registered places:	80
Number of service users accommodated on day of inspection:	10
Date and type of previous inspection:	10 December 2013 Primary Announced
Date and time of inspection:	11 September 2014: 10.45 hours -15.00 hours
Name of inspector:	Margaret Coary

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	**8**
Staff	**3**
Relatives	**0**
Visiting Professionals	**1**

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**	**1**

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

Rosewood Beacon Centre is a three-storey house situated in a residential area in Omagh and within walking distance from the town centre. It is easily accessible by car and has adequate parking space. The town's local bus service stops outside the building on an hourly basis.

The centre is managed on a day-to-day basis by Mrs Delia Devlin and provides care and therapeutic intervention for up to 80 persons in the greater Omagh area who have a psychiatric illness. The service is delivered from 10am-4pm on Tuesday, Wednesday and Thursday.

Individuals can attend a number of sessions each week. The centre hold an evening session on a Thursday from 7pm-9pm, these sessions are held for a six week period and can take place several times throughout the year.

There is a kitchen in the premises and service users have access to tea and coffee making facilities at any time.

Summary of Inspection

This is the report for the primary announced inspection of Rosewood Beacon Centre.
This announced inspection was carried out on 11 September 2014 from 10.30 hours to 14.30 hours.

The aim of the inspection was to consider whether the services provided to members were in compliance with legislative requirements and day care minimum standards.

The inspector was made welcome by the Manager of the centre, Mrs Delia Devlin. The inspector had a short meeting and agreed the inspection process with Mrs Devlin. Feedback was given at the end of the inspection.

Evidence was validated during the inspection by the following methods:

Review and scrutiny of a variety of records pertaining to each standard.
Discreet observation of staff/member interaction throughout the inspection process.
Discussion with eight service users.
One completed staff questionnaire.
Verbal contribution from three staff members in relation to any other information that was requested.

A completed self-assessment document was submitted by Mrs Devlin prior to the inspection and this also formed part of the inspection process.
There was one requirement and five recommendations made from the last inspection. The inspector verified that these had been completed and evidence confirmed that all had been fully achieved.

The Day Centre prefer to use the term members as opposed to service users.

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 have appropriate policies and procedures in place which are accessible and available to staff, some of these included; Guidance for Maintaining Professional Boundaries, Guidance in relation to Confidentiality and Access to records, Data Protection Policy and Policy for Assessment, Care-planning and Review.

The inspector talked with three staff members about their practise and opinions regarding confidentiality and the management of members' personal information. The inspector found that the staff were fully informed and aware of their roles and responsibilities in relation to those in their care.

The inspector examined a selection of three members' files and found that information was person centre, detailed and informative incorporating advice from other professionals.

The inspector has made one recommendation pertaining to recording in relation to access to records.

The inspector noted that the centre has good systems in place for reporting and discussion with staff verified that they were familiar with the reporting policy.

The centre has achieved a substantially compliant level of achievement for Standard 7.

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

  The centre do not use restrictive practise at present, however, policies and procedures are in place and are available for staff consultation should the need arise.

  The inspector found that the centre have relevant training in place and have established good communication systems with other professionals in relation to managing specific behaviours.

  The centre have achieved Substantially Compliant level of achievement for 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.

  The inspector found that there were robust arrangements 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 service members.

  The inspector confirmed that staff at the centre have regular supervision and annual appraisals and training records reflected that mandatory training had been completed and additional training provided.

  There were good monitoring arrangements in place and the records confirmed that these were held in accordance with guidance.

The inspector has made two recommendations from this standard. The first is to ensure that a policy and procedure is maintained outlining arrangements in the absence of the manager and the second is in relation to more detail on the staff duty rota.

The centre have attained a substantially compliant level of achievement for Theme 2.

Environment

The inspector toured the premises and found the facility to be warm, clean and comfortable.

Staffing

There were sufficient staff on duty to meet the needs of members and the duty rota reflected that staffing was satisfactory. The inspector noted that staff had a good rapport with members and were respectful and kind.

There were 10 members present on the day of inspection. The members enjoyed a session regarding personal development with a tutor from South West College on the morning of the inspection and craft activities were held in the afternoon. There was also a music group in the community centre for some members which has commenced recently.

The inspector met with eight members during the course of the inspection, all commented on the support and care they receive from staff at the centre. One member stated that she loved the day centre, “if it wasn’t for this place I don’t know what I would do”; others praised the staff for the difference the support had made to their lives outside of the centre.

The inspector commends the staff for the positive contribution that the centre has provided to enhance the lives of the members.

There were three recommendations from this announced inspection.

The inspector wishes to thank the manager, staff and members for their co-operation and assistance with the inspection process.

Follow-Up on Previous Issues

No.	Regulation Ref.	Requirement	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	29 (d)	The registered person shall give notice to the Regulation and Improvement Authority without delay of the occurrence of any event in the day care setting which adversely affects the wellbeing or safety of any service user.	Incidents and accidents are now reported in accordance with procedures.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	15.2	The community professional should be invited to attend the review. Staff should receive updated training on the review process.	Community staff are invited to attend reviews and to provide a report if they are unable to attend. The inspector confirmed that the staff had received updated training on the review process.	Compliant Compliant
2	15.3	Information in review records should be signed by all those in attendance.	Records of review records reflected that they are now signed off by those in attendance.	Compliant
3	15.4	Information for review should be further developed.	The inspector examined review records which reflected that information had been developed in accordance with the standard.	Compliant
4	13.4	A competency and capability assessment should be completed for any staff member who is left in charge of the centre in the absence of the manager; this should reflect evidence of training and knowledge of the centre's policy / procedure including reporting in keeping with the commissioning trust protocol/procedure.	The inspector found that the centre now have a system in place to ensure the competency and capability of staff left in charge of the centre in the absence of the manager.	Compliant
5	17.10	Reviews to be monitored on a monthly basis.	The inspector examined monthly monitoring records which reflected that reviews are regularly monitored.	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 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 viewed the policies and procedures and confirmed that the centre had appropriate policies in place, some of those included were; Data Protection Policy, The Freedom of Information Act, Confidentiality, Policy for Disclosure Application and Disclosure Information and Policy for Assessment Care planning and Review. The policies and procedures are held in the office and are available for staff consultation. The inspector examined a selection of three members' files. 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	Compliant

appropriate risk assessments and follow-up information recorded in care plans. The inspector noted that members can record their own daily records if they choose to do so. The inspector talked with one member on an individual basis and met with a group of seven members. The inspector discussed their experiences regarding maintaining confidentiality and the role of staff members in relation to this. All had very positive comments about the centre and confirmed that they were treated very respectfully and their dignity and privacy respected at all times. One member commented on the importance of trust and stated that "the centre was a place where you could be yourself and know that you were safe". The inspector met with three staff members and was satisfied that they were fully aware of the importance of ensuring confidentiality and their responsibilities regarding quality recording and the management of members' information. The inspector found that The Statement of Purpose and The Members Guide reflected that human rights were considered at all times.	
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. Members are asked to provide or withhold consent for other people to see their files - this is recorded and held in the individual member's file. 7.3 Section 6.0 of Corporate Policy no. CS/06 on Data Protection covers the right of access to personal information in relation to Individual Subject Data Requests.	Substantially compliant

Inspection Findings:	**COMPLIANCE LEVEL**
The inspector confirmed that there were relevant policies and procedures in place pertaining to Data Protection and Access to Personal Information as stated in the self-assessment. The inspector met with three staff members and was satisfied that they were fully aware of the procedures and processes to follow in relation to access to records. The inspector also had discussions with a group of eight members and met with one member on an individual basis, the inspector found that they were fully aware of the process to follow if they wanted access to their records. Several members confirmed that they completed their own attendance notes whilst others preferred that staff complete them but affirmed that they could have access to them if they wished to do so. The inspector noted that a record regarding access was not maintained in individual member's files and has made a recommendation that a record of access to information including date, who applied for access and outcome of request, is retained in each file. The inspector confirmed that information pertaining to access to records was included in the Beacon Members Guide and the Statement of Purpose as stated in the self-assessment.	Substantially 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 inspector examined a selection of three files, the inspector found that the records were person centred, detailed and informative incorporating communications and advice from allied health professionals. Risk assessments and care plans were regularly updated and appropriately signed off. The inspector found that reviews were held in accordance with guidance and information was person centred and focused on achieving best possible outcomes for members. The inspector also looked at a selection of monitoring inspection records and found that working practises were reviewed in accordance with the standard and any recommendations followed up and recorded in a service development plan. This is good practise. The inspector noted that the centre have good reporting systems in place as was evidenced in the policy and procedures manual and the accidents and incidents records.	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. For some members, notes are recorded more often than this to reflect ongoing issues or support provided.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector confirmed that regular entries were made for each service user and as previously stated a number of members complete their own records. As stated in the self-assessment there are more regular entries where appropriate.	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 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. Staff have been required to use these recently in response to disclosures made within the scheme. BS/2 Safeguarding Vulnerable Adults includes a Reporting Flowchart as does QG/4 Incident Reporting and Management Policy and Procedure.	Compliant

Personal information on members and their contacts is updated annually at review using Appendix 3, Beacon Member Information Record, of Policy RR/101 Beacon Referral and Attendance Policy. Other relevant policies include BS/1 Beacon Member Safety/Risk/Vulnerability, BS/14 Consent Policy, HS/13 RIDDOR Policy and QG/3 Complaints Procedure.	
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector confirmed that there were appropriate policies and procedures in place in relation to reporting and that this information was accessible to staff. The inspector talked with three staff members and noted that they were knowledgeable and informed about proper reporting. The inspector found that the three files examined reflected that appropriate referrals were made to other professionals and the advice recorded and followed up in assessments and care plans ensuring that care is person centred and individual. The inspector met with a community nurse who stated that communication between the centre and allied professionals is excellent with the members' needs considered a priority at all times. The inspector talked with eight members all of whom confirmed that there was excellent communication within the centre and that they were informed at all times.	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. Members are encouraged to be active in recording their notes or where they prefer no to do this, to be aware of what has been recorded and to sign to confirm agreement. The registered manager reviews member files and at least one file is reviewed as part of monthly monitoring procedures - as outlined at the last inspection monthly monitoring should include an assessment of a member review.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
As stated some of the Beacon members do complete their own notes whilst others prefer to have a member of staff complete their records and confirm agreement with the content. The inspector was satisfied that the records are regularly monitored as was evidenced in the monitoring records.	Compliant

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

INSPECTOR'S OVERALL ASSESSMENT OF THE DAY CARE SETTINGS COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Substantially 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). There have been no instances in the past year where staff have needed to call PSNI for support. 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 do not use restraint. The inspector viewed the training records and confirmed that staff have received appropriate training in calming and diffusing techniques. The inspector talked with three staff who stated that they were happy with training provided and were confident regarding managing challenging behaviour.	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). Restraint has not been used within Rosewood with any service user.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Restraint is not used in the Beacon Centre.	Not applicable

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

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

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

Numbers of staff reflect a balance between number of sessions, numbers of users and programme of delivery.	
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector checked the professional registration, qualifications, experience and evidence of competence of the registered manager and confirmed that the information met current guidelines. The inspector found that the centre have satisfactory arrangements in place regarding staff cover in the absence of the registered manager, however, the inspector noted that the centre do not have a policy and procedure in place in relation to absence of the registered manager, there is a recommendation in this regard. The inspector viewed the staff training record and noted that there had been a variety of training over the last 12 months some of which included, Personal Safety, Keeping Adults Safe, Motivational Interviewing, Mental Health Awareness Update, Data Protection for Managers and Managing Medicines. There is further training planned over the next 12 months. The inspector also verified that all staff had received mandatory training. The manager advised that the staff had talked to members as a group about “Keeping Myself Safe”. This had helped members understand the support which was available if they had any concerns in relation to safety issues and had positive outcomes for the members. The inspector commends the centre for this good work. The inspector examined records which reflected that staff supervision is held on a regular basis and that staff appraisals have taken place, this was also confirmed in discussion with three staff members. The inspector noted that Regulation 28 visits reflected that staffing was inspected and recorded as part of the inspection. The inspector also examined a number of copies of the staff duty rota and was satisfied that they were sufficient staff on duty at all times. The inspector noted however that the rota did not reflect the capacity in which staff members worked, there is a recommendation in relation to this. The inspector looked at the Statement of Purpose and confirmed that the management structure was included as stated in the self-assessment.	Substantially 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. In addition, the scheme manager has attended external supervision training orgnised by Health Improvement. Staff Supervision Records form part of Monthly Monitoring. Volunteers and students on long term placements will also receive supervision.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector verified that staff have supervision on a regular basis and that staff appraisals have taken place. This was confirmed through discussion with one staff member and observation of staff supervision/appraisal records.	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 qualifications, skills and experience required by the Personnel Specification for the role. Niamh provide an Essential Regional Training Schedule designed to meet the mandatory training requirements of RQIA and essential sector specific content. To ensure timescales match RQIA requirements all staff are required to attend training on the dates allocated with attendance being monitored on the HR IT System (Cascade) and reviewed in supervision to ensure compliance. 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). 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 inspector looked at staff records and verified that staff had the relevant qualifications and training. The inspector talked with three staff members who stated that all staff could ask for additional training and it would be provided. The inspector verified that the staff in the centre had relevant experience and training to perform their roles in an effective manner this was evidenced in training records and through discussion with three staff members. As stated earlier the inspector met with eight service users all of whom made positive comments about the centre and praised staff for their ongoing care and support.	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
	Substantially Compliant

Additional Areas Examined

The inspector looked at the accidents and incidents record and was satisfied that this was maintained in accordance with guidance.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Manager of the centre, Mrs Delia Devlin, 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:

Margaret Coary
The Regulation and Quality Improvement Authority
Hilltop
Tyrone & Fermanagh Hospital
Omagh
BT79 0NS

QUALITY IMPROVEMENT PLAN

PRIMARY ANNOUNCED INSPECTION

ROSEWOOD BEACON CENTRE

11 SEPTEMBER 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 Registered Manager Mrs Delia Devlin 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.

Statutory Requirements

This section outlines the actions which must be taken so that the Registered Person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Day Care Settings Regulations (NI) 2007

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
		No requirements were made as a result of this inspection.			

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	7.3	A record of access to information including date, who applied for access and outcome of request, should be retained in each file.	One	This is being implemented and a record sheet is being added to each member's file.	Ongoing
2	17.1	The centre should maintain a policy and procedure outlining the arrangements for the running of the centre in the absence of the manager.	One	A policy is being written by senior management and will be implemented within a month.	One month
3	17.1	The staff duty rota should reflect the capacity in which staff work.	One	Full names and job titles of all staff have been added to the duty rota.	Ongoing

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	Delia Devlin
Name of Responsible Person / Identified Responsible Person Approving Qip	Billy Murphy

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Maire Marley	08 December 2014
Further information requested from provider			