Primary Unannounced Care Inspection

Name of Establishment:	**Ernvale Beacon Centre**
Establishment ID No:	**11097**
Date of Inspection:	**30 July 2014**
Inspector's Name:	**Margaret Coary**
Inspection No:	**16581**

The Regulation And Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
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Name of centre:	Ernvale Beacon Centre
Address:	35 Mill Street Enniskillen BT74 6AN
Telephone number:	028 6632 2995
E mail address:	ernvale@beaconwellbeing.org
Registered organisation/ Registered provider:	NI Association For Mental Health Miss Rose Ann 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:	14
Number of service users accommodated on day of inspection:	10
Date and type of previous inspection:	22 May 2013 Primary Announced
Date and time of inspection:	30 July 2014: 11.15 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	**7**
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**	**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

Ernvale Beacon Day Centre is a purpose built centre and is located within walking distance to Enniskillen town centre and local town amenities.

The day centre is one of 14 day support services which operate throughout Northern Ireland by a charitable organisation, Northern Ireland Association for Mental Health (NIAMH).

On a day to day basis the centre is managed by Ms Finola Crudden.

The centre currently provides care and therapeutic intervention for up to 14 persons over 18 years old who have an enduring mental health illness. The service is delivered over four days per week between office hours. Individuals attend on designated days; however a "drop in service" is also available to its service users.

As well as providing a valuable social function, the centre provides meals, training and other activities as well as allowing professionals to monitor the progress being made by individual service users.

Beacon Day Support promotes service user involvement and personal development through a range of support and opportunities.

Close links have been established with a wide range of statutory and voluntary agencies including the Trust's Community Mental Health Team.

Summary of Inspection

This is the report for the primary unannounced inspection of Ernvale Beacon Centre.

This unannounced inspection was carried out on 30 July 2014 from 11.15 hours -15.00 hours. The aim of the inspection was to consider whether the services provided to service users were in compliance with legislative requirements and day care minimum standards.

The inspector will refer to the service users as "members" throughout the report as this is the preferred title by those who attend the centre.

On the day of this unannounced inspection, the Manager, Ms Finola Crudden was at another Beacon Centre so the inspector was assisted with the inspection by two staff members; Ms Chrissie Lynch, Project Worker who was "in charge" and Ms Geraldine Higgins, Support Worker. The inspector explained the inspection process to the staff and feedback was given at the end of the process.

A completed self-assessment document was submitted by Ms Crudden following 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/service user interaction throughout the inspection process.
Discussion with seven service users.
Four completed staff questionnaire.
Verbal contribution from two staff members in relation to any other information that was requested.

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.

  The inspector examined three members' files, these were clear, detailed and person centred and reflected that Human Rights were respected at all times.

  The inspector has made three recommendations from this standard. The first is in relation to discussing access to records with staff and ensuring that all appropriate policies and procedures are read and signed-off. The second ensures that access to records information is included in the file and the third pertains to ensuring that all care plans are regularly updated and signed.

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

- **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 users.

  The inspector has made one recommendation in relation to training on Prader Willi Syndrome so that staff skills will be enhanced in their day to day practise.

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

Environment

The inspector toured the premises and found the facility to be welcoming, 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 observed staff to be caring and supportive and members were relaxed and comfortable in their surroundings.

There were four completed staff questionnaires and these reflected that staff were satisfied and positive about the centre and the training and supervision according to their individual roles.

There were 10 members present on the day of inspection. The members enjoyed a yoga session on the morning of the inspection. This was led by a qualified tutor.

The inspector met with a group of seven members after the session had finished and discussed their views on life at the centre. Those present were vocal and positive about the ongoing support they received from staff and all agreed that the centre was “member” led with those in attendance having major input in to the activities and programmes within Ernvale. One lady commented that she “couldn’t wait to return to the centre after the holidays”.

Those present were aware that records were maintained and stated that they were encouraged to write in their own case files and found this to be therapeutic. All stated that they knew that they could access their notes and comments were made about the “open” policy within the centre whereby staff would assist with any requests for information and were always ready to help.

The members talked about the positive effect attendance at the centre had made to their every-day lives, one person commented on the improvement in her self- confidence which she attributed to the help and support she got from staff at Ernvale.

The inspector commends the manager and staff for their ongoing encouragement and dedication which has enhanced and improved the lives of the members.

The inspector has made four recommendations from the standard and themes inspected.

The inspector wishes to thank the staff and members for their cooperation and assistance with 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 the inspection which was undertaken on 22 May 2013.		

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 the inspection which was undertaken on 22 May 2013.		

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, 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. This information was accessible for staff consultation.	Compliant

The inspector examined a selection of three 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 appropriate risk assessments and follow-up information recorded in care plans. The inspector talked with two staff members and was satisfied that they were fully aware of the importance of ensuring confidentiality and their role regarding quality recording and the management of service user information. The inspector noted that the Service User Agreement included information regarding confidentiality of service user records and personal information and access to records. The inspector found that The Statement of Purpose and The Service Users Guide reflected that the members' human rights were considered at all times. The inspector concluded that recording practises and storage of information were reflective of current national guidelines.	
Criterion Assessed: 7.2 A service user and, with his or her consent, another person acting on his or her behalf should normally expect to see his or her case records / notes. 7.3 A record of all requests for access to individual case records/notes and their outcomes should be maintained.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
7.2 Current information in R/R/101 is contained in Beacon Member Notes p.19. A new draft referral procedure expands on this in R/R/102 Sections 7 and 14. In both sections members are reminded that they have open access to their files; they are also encouraged to input to their files participatively and by writing their own notes for example. Section 14 of R/R/102 contains additional information for Beacon Members wishing to access their files following discharge from the service. The Beacon Members Guide also provides relevant information to all new members. Sections 1.3 and 1.5 outline both content and open access arrangements to members files. 7.3 Section 6.0 of Corporate Policy no. CS/06 on Data Protection covers the right of access to personal information in relation to Individual Subject Data Requests.	Moving towards compliance
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector looked at policies and procedures relating to access to records and found that these were relevant and accessible for staff guidance. Some examples were Policy on Disclosure Applications and Disclosure information	Substantially compliant

and Telephone, Internet and Email Policy. The inspector talked with two staff members and found that there was some confusion regarding the process to follow regarding access to records. The inspector has made a recommendation that this is discussed at a staff meeting and staff members sign-off all appropriate policies. The inspector noted that files examined reflected that there is some information regarding who takes ownership of individual files and recorded member consent regarding whether they want to write up progress notes, however, the inspector found that this did not include access to information, therefore, the inspector also recommends that a record of access to information including date, who applied for access and outcome of request, is retained in each member's file.	
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:	
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.	Substantially compliant

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.	
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector looked at 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, however, the inspector noted that information in care plans was not regularly updated, there is a recommendation that all information is regularly reviewed and signed-off by the manager. The inspector also looked at a selection of monitoring inspection records and found that working practises were reviewed and a service improvement plan completed following monitoring visits. This is good practise.	Substantially 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 inspector confirmed that regular entries were made for each member and as recorded earlier a number of members also record their own progress notes. This is good practise and demonstrates person centred care.	Compliant

Criterion Assessed:	**COMPLIANCE LEVEL**

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.	
Provider's Self-Assessment:	
The relevant guidance is outlined in a number of documents with an introduction to relevant policies and procedures an important part of the Induction process for new staff and a key component of the Induction and Foundation Framework (Units B, C). In addition staff are introduced to key mechanisms for communication within the organisation and the scheme. These include the staff section of the organisations website, the policy and procedure manual and the emergency procedures file; included within the scheme are the communication book, scheme diary and phone book, minutes of staff meetings, staff files and member files. For ease of access a number of policy documents include lists of numbers and flow charts that may be displayed on office notice boards, for example BS/4 Protection of Children and Reporting of Suspected Abuse requires a list of relevant contacts for Gateway Teams and Designated Officers to be displayed. BS/2 Safeguarding Vulnerable Adults includes a Reporting Flowchart as does QG/4 Incident Reporting and Management Policy and Procedure. Personal information on members and their contacts is updated annually at review using Appendix 3, Beacon Member Information Record, of Policy RR/101 Beacon Referral and Attendance Policy. Other relevant policies include BS/1 Beacon Member Safety/Risk/Vulnerability, BS/14 Consent Policy, HS/13 RIDDOR Policy and QG/3 Complaints Procedure.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector confirmed that there were appropriate policies and procedures in place in relation to reporting, and as stated in the self- assessment, information was on display on the office notice board and accessible for staff consultation. The inspector found that the files examined reflected that appropriate referrals were made to other professionals and the advice recorded and followed up in assessments and care plans; however there is a previous recommendation to ensure that information is updated in all instances. The inspector talked with a group of seven members who all confirmed that there was excellent communication	Substantially compliant

within the centre and they were informed at all times.	
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**
The inspector found that records inspected were legible, up to date signed and dated by the person making the entry and reviewed and signed- off by the manager, as stated, there is a previous recommendation that the records are reviewed on a more regular basis.	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**
	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). 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**
Not inspected on this occasion.	Not Applicable

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
Not inspected on this occasion.	Not Applicable

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**
	Not Applicable.

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 talked with the staff member who has responsibility for the centre in the absence of the manager and was satisfied that she was aware and informed of her responsibilities; however, found that she has not completed a competency and capability assessment. The inspector has made a recommendation that a competency and capability assessment is carried out and maintained in the staff members' file. 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, Suicide Awareness and Self harm**,** Personality Disorder and Keeping Adults Safe. The inspector has made a recommendation that staff receive training on Prader Walli Syndrome to enhance staff skills in their day to day practise. The inspector verified that staff supervision is held on a regular basis and that staff appraisals have taken place. 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 found that the rota was outlined in accordance with guidelines and there were sufficient staff on duty at all times. 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. Staff Supervision Records form part of Monthly Monitoring.	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 two staff members and observation of staff supervision/appraisal records and returned staff questionnaires.	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).	Compliant

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.	
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector looked at staff records and verified that staff had the relevant qualifications and training. The inspector talked with two staff both of whom confirmed that they could ask for additional training and it would be provided. The inspector was satisfied that they were aware of their roles and responsibilities in relation to the members in their care.	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

Additional Areas Examined

Complaints

The inspector examined the complaints record and the accidents and incidents record and was satisfied that these were managed in accordance with guidance.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Chrissie Lynch, Project Worker and Ms Geraldine Higgins, Support Worker 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

The Regulation and Quality Improvement Authority

QUALITY IMPROVEMENT PLAN

PRIMARY UNANNOUNCED INSPECTION

ERNVALE BEACON CENTRE

30 JULY 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 Ms Chrissie Lynch, Project Worker and Ms Geraldine Higgins, Support Worker either during or after the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

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	7.2	Access to records to be discussed at a staff meeting and staff members sign-off all appropriate policies.	One	Access to records discussed at staff meeting.Staff signed off all appropriate policies on Wednesday 3rd September '14	Three months
2	7.3	A record of access to information including date, who applied for access and outcome of request should be retained in each member's file.	One	A record of access to information including date, who applied for access and outcome of request has been inserted in each file from 3rd September 2014	Three months
3	7.4	All care plans to be regularly updated and signed off.	One	All support plans have been updated and signed off. Registered Manager will continue to monitor on a regular basis. Support Planning in Review policy & procedure has been discussed at staff meeting on Wednesday 3rd September 2014	Ongoing
4	17.1	Staff to receive training on Prader Walli Syndrome to enhance staff skills in their day to day practise.	One	Training has been arranged for staff in conjuction with Knockmore supported living and will be delivered during September 2014. A record of the training will be added to staff members training records	Three months

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	Finola Crudden
Name of Responsible Person / Identified Responsible Person Approving Qip	

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Margaret Gray	2/09/2014
Further information requested from provider			