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Day Care Inspection Report
14 December 2016

Pavestone Centre

Type of service: Day Care Service
Address: 6a Rugby Avenue, Coleraine, BT52 1JL
Tel no: 02870347875
Inspector: Priscilla Clayton

1.0 Summary

An unannounced inspection of Pavestone Centre took place on 14 December 2016 from 10.25 to 16.30 hours

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the centre was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidence to confirm that the centre provided safe care. This was confirmed from service users and staff who spoke with the inspector; records examined, associated policies/procedures; accident/incident records and staff training.

Two recommendations made within the "Is care safe" domain related to review and revision of the adult safeguarding policy/procedure to reflect the new Department of Health regional policy including the named safeguarding "champion". The second recommendation made related to request for assessment by the trust estates department on the suitability of installing an automatic door opening device to promote the independence for one service user to gain access to the dining room.

Is care effective?

Evidence of the provision of care effective was gained from discussion with staff, service users, within care records examined, minutes of service users meetings, minutes of staff meetings, audits conducted and monthly monitoring reports.

One area identified for improvement within the "Is care effective" domain related to the service user satisfaction report and the inclusion of a summary of the action taken and improvements made as a result.

Is care compassionate?

There was strong evidence that the care provided was compassionate from observation of staff interactions with service users, discussions with staff and service users who met with the inspector. Staff explained that there was a culture/ethos within the centre which supported core values as reflected within the service user guide and statement of purpose.

There was a range of policies and procedures in place which supported the delivery of compassionate care.

No requirements or recommendations were made in the "Is care compassionate" domain.

Is the service well led?

There was evidence that the service was well led in records examined including audits undertaken, staff supervision/appraisal and responses from staff and service users and minutes of staff meetings. Positive results were shown within the annual quality report dated 2015-16.

One requirement made within the "Is the service well led" domain relates to the undertaking of monthly monitoring visits made on behalf of the registered provider and provision of a report on each visit.

This inspection was underpinned by The Day Care Setting Regulations (Northern Ireland) 2007, the Day Care Settings Minimum Standards 2012.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Rhoda Baxter, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent care inspection on 24 February 2016.

2.0 Service details

Registered organization/registered person: Northern HSC Trust/Dr Anthony Baxter Stevens	**Registered manager:** Rhoda Baxter MBE, MSc, T.Dip.
Person in charge of the service at the time of inspection: Rhoda Baxter	**Date manager registered:** 29 January 2014

3.0 Methods/processes

Prior to inspection the following records were reviewed:

- Previous care inspection report and quality Improvement plan (QIP) dated 24 February 2016
- Notifications of accidents/incidents
- Correspondence.

The inspector met with ten service users individually and with others in small group format.

An inspection of the internal and external environment of the centre was undertaken.

The following records were examined during the inspection:

- RQIA registration certificate
- Statement of purpose
- Service user guide
- Selection of policies and procedures including those in respect of, adult safeguarding, whistleblowing, restrictive practice, staff recruitment and selection, infection prevention and control
- Staff training
- Staff supervision and appraisal
- Service user meetings
- Audits/satisfaction surveys
- Monthly monitoring visits
- Staff duty roster
- Care records x 4
- Complaints
- Accidents/incident
- Fire risk assessment/equipment checks.

Fifteen questionnaires were given to the manager for distribution to staff (five), service users (five) and service user representatives (five). No questionnaires were returned to RQIA within the timescale.

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4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 24 February 2016

The most recent inspection of the service was an unannounced care inspection. The completed QIP was returned and approved by the inspector.

4.2 Review of requirements and recommendations from the last care inspection dated 24 February 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 26(2)(c)	The registered person must ensure the faulty motor in the Viking 800 hoist is replaced so it can be used with service users who are assessed to need it.	**Met**

Stated: First time	**Action taken as confirmed during the inspection**: The Viking 800 hoist had been repaired and a replacement motor installed.	
Requirement 2 **Ref**: Regulation 29 **Stated:** First time	The registered manager must: (a) Notify RQIA of accidents and untoward incidents as per Regulation 29. (b) With regards to the above, RQIA must be notified retrospectively of the three safeguarding vulnerable adult referrals and outcomes of the investigations.	**Met**
	Action taken as confirmed during the inspection: (a) No accidents/incidents which require to be notified to RQIA had occurred since the previous inspection. (b) RQIA had been notified retrospectively of three alleged safeguarding issues within the timescale requested.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 4 **Stated:** First time	The registered manager should ensure the identified service user's assessment is updated. Systems should be in place to ensure service user's assessments are current, reviewed at least yearly or when changes occur.	**Met**
	Action taken as confirmed during the inspection: The manager reported that the reassessment referred to in this recommendation had to be postponed on two occasions due to non-attendance of the service user and that this was the cause of the initial delay. The reassessment and care plan revision was completed on 02 February 2016. Systems were in place to ensure reviews are conducted. .	
Recommendation 2 **Ref**: Standard 5.3 and 5.6 **Stated:** First time	The registered manager should ensure: (a) All service users' care plans are signed and dated by the service user, the member of staff responsible for completing it and the registered manager. If the service user declines to sign or is unable to sign; but agrees with the content of the care plan and staff signing this on their behalf; then this	**Met**

	should be recorded on the care plan. The identified service user's care plans are updated so they fully and accurately reflect their continence support needs; or refers to the self-maintenance sheet.	
	Action taken as confirmed during the inspection: a) The manager confirmed that care plans were reviewed and where necessary signed in accordance with this recommendation. Care plans examined were noted to be signed/ dated by the service user, staff member and manager. b) The care plan had been reviewed and revised in accordance with this recommendation.	
Recommendation 3 **Ref**: Standard 8.5 **Stated:** First time	With regards to service users' views and opinions; the registered manager should ensure an evaluation report is completed regarding Pavestone Centre's annual service users survey. It should incorporate: • details of the action taken in response to issues raised by service users from the previous years' survey • qualitative comments made and issues raised by service users in the current survey • any actions to be taken in response; • a copy of this report is made available or shared with service users and records are made of when this occurred.	**Partially Met**
	Action taken as confirmed during the inspection: The analysis of the survey provided an overview of responses from service users with histograms developed. The manager advised that the full report could not be located at the time of inspection. The completed report was forwarded to RQIA following the inspection. Further work is necessary as the inclusion of details on the outcome of actual action taken to address some low responses and where applicable, improvements made should be included.	

	A copy of the final summary report should be made available to service users.	
Recommendation 4 **Ref**: Standard 15.4 and 15.5 **Stated:** First time	The registered manager must ensure a written review report is prepared by staff in consultation with the service user prior to the annual review of their day care placement. The review report must address, where relevant, the areas stated in minimum standard 15.5.	**Met**
	Action taken as confirmed during the inspection: The manager confirmed that reviews had been completed. Review reports were contained within four care records examined. .	
Recommendation 5 **Ref**: Standard 21 **Stated:** First time	The registered manager should ensure care staff receives awareness information or training in continence promotion and epilepsy. The returned QIP should state the action taken with training dates.	**Met**
	Action taken as confirmed during the inspection: Training records examined reflected staff training was provided on 5 September 2016.	

4.3 Is care safe?

Discussion with the manager confirmed that staff employed were sufficiently qualified, competent and experienced to meet the assessed needs of service users in attendance. The manager and staff explained that they can be short staffed by one care staff at times, particularly on Fridays, due to the necessity to provide transport escort duties with service users. The manager is seeking to appoint a permanent care assistant in order to address this deficit. Records of named staff working in the centre each day, alongside hours worked were recorded within the duty roster retained in the general office.

The manager explained that only experienced senior day care workers would ever be in charge at any time when the manager is out of the centre and that a competency and capability assessments were completed. Review of two assessments evidenced that these were completed and signed by the manager.

Employment records of staff were held within the Northern Health and Social Care Trust (NHSCT) human resource department. The manager confirmed that employment procedures were in keeping with the NHSCT policy/procedures and that the registered manager would be involved in the appointment of new staff and in the review of information including; staff application forms, references and ensuring Access NI checks were completed.

Induction records of two staff employed were reviewed and discussed with the manager. Records reviewed contained a comprehensive account of the standard to be achieved. Induction programmes were noted to be signed and dated by the staff member and mentor on the achievement of each standard. Electronic corporate policies and procedures on the employment and induction of new staff were available.

Mandatory staff training was discussed with the manager and staff. Training provided included adult safeguarding and whistleblowing. Staff confirmed that mandatory training was ongoing alongside other professional development opportunities.

The manager confirmed that no safeguarding allegations were currently active and should any arise that the correct procedure would be followed in accordance with the NHSCT policy and procedures. Staff training in the protection of vulnerable adults is provided on a two yearly basis. The manager explained that staff refresher training in adult safeguarding and the new DOH regional policy entitled "Prevention, Protection in Partnership" (April 2015) was planned for January 2017. The named safeguarding "champion" for the centre was to be decided by senior management. One recommendation made related to review and revision of the adult safeguarding policy/procedure to reflect the new regional policy including the named adult safeguarding "champion".

The manager and staff confirmed that no restrictive practice takes place in the centre. Some service users have lap straps in use when seated within wheelchairs. The manager confirmed that this practice was in use for health and safety reasons and that risk assessments had been completed with details reflected in care records. Electronic policies and procedures on restrictive practice were available to all staff.

Necessary infection protection and control measures were in place with a good standard of hygiene observed throughout the centre; "seven step" hand hygiene notices were positioned at all wash hand basins; availability of disposable gloves and aprons; provision of staff training in infection, prevention and control; and availability of electronic trust policies / procedures on infection prevention and control.

The centre had an identified fire safety resource person (senior day care worker) with responsibility to ensure that all aspects of fire safety were upheld and records maintained. Weekly and monthly checks of fire equipment were undertaken with associated records retained Fire doors were closed and exits unobstructed. Staff training records showed that fire safety training was provided twice yearly. The centre's current fire risk assessment, dated 19 January 2016, was considered to be in keeping with safe fire safety standards.

An inspection of the centre was undertaken. All areas were observed to be clean, tidy, organised and appropriately heated. COSHH substances were noted to be securely stored.

Four care staff who spoke with the inspector gave positive feedback in regard to the provision of safe care and confirmed that staff training, supervision, appraisal and staff meetings were provided. They also explained that there were good multi-professional working in the planning and monitoring of care.

Service users who met with the inspector indicated that the care was very good and that they enjoyed participating in the varied therapeutic workshops provided. One service user who spoke with the inspector stated that it would be good if he did not have to wait so long in the hallway until staff were available to open the dining room door and wondered if this could be addressed. The possibility of the installation of an automatic self -opening door device which

would allow independence was discussed with the manager who agreed to make referral for assessment to the trust estates officer and to meet with the service user and agree how best to address this matter while awaiting the assessment.

Externally the grounds were observed well maintained.

Areas for improvement:

Two recommendations were made**:**

- One recommendation made related to review and revision of the adult safeguarding policy/procedure to reflect the new regional policy including the named adult safeguarding "champion".
- One recommendation made related to requesting an assessment from the trust estates department regarding the suitability of installing an automatic door opening device to allow independence for one service user.

Number of requirements	0	**Number of recommendations**	2

4.4 Is care effective?

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Four service users care records were provided for review by the inspector. These were found to be in line with legislation and minimum care standards including, for example; holistic health and care needs assessments which were complemented with updated risk assessments; person centred care plans and regular records of the health and wellbeing of the service user. Records of reviews held were in place which included participation of the service user. There was recorded evidence of multi-professional collaboration in planned care.

Reviews of care were undertaken within the first four weeks of placement to ensure suitability of the placement with further regular reviews held with records retained as required.

There were effective systems in place to promote effective communication between service users, staff and other stakeholders. This was evidenced within a number of sources including: discussions with staff and service users, care records examined; minutes of three monthly service users' meetings and bi-monthly service user committee meetings, minutes of bi-monthly staff meetings, information notices displayed on health and social care and photographs of various activities and social events.

Staff and service users confirmed that the modes of communication in use between the staff team, with service users/representatives and other stakeholders were effective and that these were enhanced through the "open door" policy operated by the manager.

Service users confirmed they were aware of whom to contact if they had any issues or concerns about the service.

The manager explained that audits undertaken included selected areas within care records, fire safety, food provided, staffing and activities. In addition a suggestion box is situated within the hallway although some of the service users stated they were not aware of the purpose of this.

The manager explained that the responses from the service users' in the satisfaction survey regarding the effectiveness of care had been completed with histograms of responses developed and comments recorded. The annual quality report was not available during the inspection and the manager agreed to forward the report to RQIA following the inspection. This report was received at RQIA on 21 December 2016. The inclusion of further information is recommended. This relates to the inclusion of a summary on the outcome of the planned action taken, including where necessary, improvements made. This report should be shared with service users when fully completed.

Areas for improvement

One recommendation from the previous inspection which was partially met was restated for a second time. The inclusion of a summary on the outcome of the actual action taken, including where necessary, improvements made and the shearing of the report with service users.

Number of requirements	0	**Number of recommendations**	1

4.5 Is care compassionate?

The manager confirmed that there was a culture/ethos within the centre that supported the values of dignity and respect; independence; rights; equality and diversity; choice and consent of service users. This was reflected within the statement of purpose (dated 16 February 2015), service user guide, care records and minutes of service user meetings examined.

There was a range of policies and procedures in place which supported the delivery of compassionate care.

Discussions with service users confirmed that consent was sought in relation to their care. Observation of staff practice and their interactions with service users demonstrated that they were treated with dignity and respect. Staff confirmed their awareness of promoting service user rights, independence and dignity.

Discussions with staff, service users, review of care records and observation of staff practice and interactions confirmed that service users' needs were acknowledged and recorded.

There was evidence that service users were enabled and supported to engage and participate in a range of meaningful rehabilitation activity for those with physical disabilities, sensory or mental health needs. The manager explained that the pavestone model in use views service users as people having the same needs and desires as other people in the community whereby it promotes a natural balanced lifestyle for work and leisure. Occupational therapists are employed within the team to undertake assessment, monitor progress and give advice and support when required. A programme of outings and lunches was included within the programme.

Four workshops were available within the centre; woodwork room, clay room, fibre room, paper room/wax room. Service users, supported by staff are to be commended on the excellent manufactured items produced which are sold to provide further resources for the rehabilitation programmes within the centre.

Service users who participated in individual and group discussions confirmed that they were consulted and felt very much involved about arrangements within their centre. All comments

received from staff and service users were very positive. No issues or concerns were raised or indicated in this regard.

Reference to the service users' satisfaction report is made under section 4.4 of this report.

Areas for improvement

No areas for improvement were identified during within the "Is care compassionate" domain.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Rhonda Baxter, the Registered Manager is employed full time within the centre was on duty throughout the inspection. Ms Baxter who is a qualified occupational therapist has many years of experience working within the centre and is supported by a mixed skill team including occupational therapists and care staff.

The centre's current RQIA registration certificate was not displayed. The manager explained it had been removed due to recent redecoration of the hallway. The certificate was replaced by the manager in a prominent position during the inspection.

The manager confirmed that the centre operated in accordance with the regulatory framework and that the health and social care needs of service users were met in accordance with the centre's statement of purpose.

There was a range of electronic corporate policies and procedures to guide and inform staff. Several were also held in hard copy format. Staff demonstrated awareness of policies including the policy and procedure on whistle blowing and adult safeguarding.

The manager and staff confirmed that annual appraisal was provided. Individual staff supervision is provided every month for occupational therapists and three monthly for care assistants. Records of supervision and appraisal were retained.

Staff meetings were held on a three monthly basis with minutes recorded which included names of staff in attendance and discussions held. Staff confirmed that there was very good working relationships within the team and that the manager was responsive to suggestions/comments raised.

Records on complaints were reviewed and discussed with the manager. No complaints were received since the previous inspection. A notice on how to complain was displayed and information reflected within the statement of purpose and service user guide. Corporate policy/procedures on complaints management were available and known by staff who spoke with the inspector.

Records of accidents/incidents were discussed with the manager who was aware of procedure in regard to notification to RQIA. The manager explained that any issues arising from the investigation of accidents or incidents would be addressed, and where necessary risk assessments undertaken and recorded with measures in place to minimise the identified risk.

Examination of records showed that accidents/incidents were investigated, with reports forwarded by the manager to the trust governance department for monitoring and review purposes. Notifications of accidents/incidents were forwarded to RQIA as required.

Review of the monthly monitoring visits made on behalf of the registered provider was undertaken. The last report of a visit undertaken was dated 06 September 2016. This was in breach of regulation 28 of The Day Care Setting Regulations (Northern Ireland) 2007 as visits require to be undertaken monthly.

Areas for improvement

One requirement made within the "Is the service well led" domain relates to the undertaking of monthly monitoring visits and retention of written reports within the centre.

Number of requirements	1	**Number of recommendations**	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Rhonda Baxter, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP 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 the day care setting. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Day Care Settings Regulations (Northern Ireland) 2007.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and Day Care Settings Minimum Standards 2012. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to web portal for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 28 **Stated:** First time **To be completed by:** 30 December 2016	The registered person shall ensure that monthly monitoring visits are undertaken with a copy of the written report retained within the centre.
	Response by registered provider detailing the actions taken: Two monthly monitoring visits (Oct. 16 and Nov.16) were omitted due to the Line Manager being on sick leave. Dec. 17 was carried out. In the event of this happening again the Line Management will ensure that a substitute person will be assigned to undertake this duty.
Recommendations	
Recommendation 1 **Ref**: Standard 4 **Stated:** Second time **To be completed by:** 31 March 2017	With regards to service users' views and opinions; the registered manager should ensure an evaluation report is completed regarding Pavestone Centre's annual service users survey. It should incorporate: • details of the action taken in response to issues raised by service users from the previous years' survey • a copy of this report is made available or shared with service users and records are made of when this occurred.
	Response by registered provider detailing the actions taken: A report is completed and attached. It contains details of the action taken in response to the issues raised by service users. It was made available to service users on 06.02.17
Recommendation 2 **Ref**: Standard 13.1 **Stated:** First time **To be completed by:** 01 April 2017	The registered provider should ensure that review and revision of the adult safeguarding policy/procedure is undertaken to reflect the new DOH regional policy including the named adult safeguarding "champion".
	Response by registered provider detailing the actions taken: Review and revision of the new DOH regional policy/procedure will be carried out at the next Pavestone Staff Meeting including the named adult safeguarding "champion".
Recommendation 3 **Ref**: Standard 25.3 **Stated:** First time **To be completed by:** 31 January 2017	The registered provider should request an assessment from the NHSCT estates department regarding assessment of the suitability of installing an automatic door opening device to allow independence for one service user. Discussion with the service user regarding how best to meet the identified need for timely access to the dining room is recommended.
	Response by registered provider detailing the actions taken:

	An NHSCT Estates Works Request Form has been completed regarding the above and discussion with the service user has also taken place.

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

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews