Primary Unannounced Care Inspection

Name of Establishment:	**Everton Day Centre**
Establishment ID No:	**11177**
Date of Inspection:	**12 December 2014**
Inspector's Name:	**Dermott Knox**
Inspection No:	**20308**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

Name of centre:	Everton Day Centre
Address:	589/593 Crumlin Road Belfast BT14 7GB
Telephone number:	(028) 9039 1172
E mail address:	mariaj.murray@belfasttrust.hscni.net
Registered organisation/ Registered provider:	Mr Colm Donaghy Belfast Health and Social Care Trust
Registered manager:	Post vacant and due to be filled by the end of February 2014
Person in Charge of the centre at the time of inspection:	Ms Pam Surgenor, Assistant Manager
Categories of care:	DCS-LD, DCS-LD (E)
Number of registered places:	125
Number of service users accommodated on day of inspection:	87
Date and type of previous inspection:	30 January 2014 Primary Announced Inspection
Date and time of inspection:	12 December 2014 10:15am–4:45pm
Name of inspector:	Dermott Knox

Introduction

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

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

Purpose of the Inspection

The purpose of this inspection was to ensure that the service is compliant with relevant regulations and minimum standards and themes and to consider whether the service provided to 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	4
Relatives	1
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	0	0

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

Everton Day Centre is a purpose built facility situated on the Crumlin Road in North Belfast. The Belfast Health and Social Care Trust is the managing organisation with the chief executive being the registered person in control.

The centre provides day care for a maximum of one hundred and twenty five adults who have learning disabilities. The aim of the centre is to provide a daytime support service to people with a learning disability and their families/carers.

There are three departments within the centre; Workskills, Multi-therapy and Intensive Support, each with a senior staff member in charge. Staffing ratios and activities vary within these departments and are dependent upon assessed needs. The centre is open five days a week and referrals and allocation of days are offered following an assessment of need and in accordance with Trust procedures.

The Workskills Department was extensively re-designed and refurbished within the past year. The division of one large space into several rooms now provides for better quality care through greater privacy for some service users and reduced noise disturbance and distraction throughout.

Transport to and from the centre, a lunchtime meal and other refreshments are provided.

Summary of Inspection

A primary unannounced inspection was undertaken in Everton Day Centre on Friday 12 December 2014 from 10:15am until 4:45pm. Following the inspection the service provider submitted a self-assessment of the centre's performance in the one standard and two themes forming the focus of the inspection. There was one requirement from the previous inspection.

The inspector was introduced to many of the service users attending the centre and met for discussions with seven people, either in their groups, or individually in informal settings. Individual discussions were held with the acting manager, an assistant manager, three staff and one relative regarding the standards, team working, management support, supervision and the overall quality of the service provided.

Discussions with all contributors elicited a positive view of the service provided in the centre and indicated a strong commitment by the manager and the staff team to comply with, or to exceed, the minimum standards for day care settings. Service users spoke highly of the staff and of the service they provided.

There was evidence from discussions and in written records to indicate a good level of involvement of service users in discussions with regard to their care plans and the activities in which they participated. These included a range of cultural and entertainment activities in the local community, including shopping trips.

Thanks are due to service users who welcomed the inspector to the centre and contributed to the evaluation by sharing their experiences. The inspector also wishes to acknowledge the open and helpful approach of the manager and staff throughout the inspection process.

There are two requirements arising from this inspection, one of which is repeated from the previous inspection.

Standard 7 - Individual service user records and reporting arrangements:

Service users' files were found to be well organised and to contain all of the information required by this standard. Many records made good use of Makaton symbols and pictures and each service user's weekly timetable was presented in clear and colourful pictorial format. A weekly synopsis of each service user's involvement and progress was kept in good detail.

The Trust's written policy and procedures for reporting events were available in the centre and accessible by staff. Notifiable events and the reporting of these are included in the induction programme for newly appointed staff members and there was evidence of reporting procedures having been followed appropriately. Staff also reported that they had ready access to senior staff when they felt it necessary to seek guidance.

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

When devising or reviewing a service user's individual behaviour management plan, guidance regarding behaviours and management techniques is provided by members of the Trust's Behaviour Support Service. Management of any individual's behaviour is reviewed and action plans are discussed to ensure that interventions remain necessary and proportionate and do not infringe service the user's human rights. The use of restrictive practice was for very specific behaviours and events and the duration and outcomes were carefully monitored.

Staff discussed the use of restraint or seclusion, including how service users' human rights are protected and they demonstrated an understanding of the Deprivation of Liberty Safeguards. (DOLS) – Interim Guidance.

Theme 2 – Management and Control of Operations

Acting-up arrangements have been in place to cover the manager's role and responsibilities in the centre, since June 2013. In early 2014, the Trust had progressed selection procedures for the post of manager to the point where an interview date had been set. However, the procedures were terminated and the post was neither offered nor filled. Three senior staff, all acting-up in turn, on a monthly basis, have continued to manage the centre for this lengthy period. While there was evidence of many aspects of the centre's operations continuing satisfactorily, there were also aspects, such as formal supervision, which had fallen behind schedule for approximately 18 months.

The current management arrangements do not present a clear and satisfactory model for the management of the centre and do not meet the requirements of Regulation 9 of The Day Care Setting Regulations (NI) 2007.

Monitoring arrangements put in place by the Trust were satisfactory in terms of their regularity and the numbers of service users and staff members who were asked for their views. It is regrettable that a stronger case for resolving the registered manager vacancy was not made by monitoring officers.

Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	Regulation 20(2)	The registered person must ensure that staff working in the centre are appropriately supervised. (Ref. Standard 22.2)	While the planning and organisation of formal, individual supervision had improved since the previous inspection, some staff still did not have supervision provided as frequently as is required by the minimum standards.	Moving toward compliance

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:	
All service users have an individual file where personal information is held, this is stored in a locked filing cabinet. A signed permission statement is held in every file which explains that files may be audited by members of staff. The Trust has a Confidentiality Policy and Procedure to which all staff adhere. All staff have awareness and access to Trust Policies on ICT Security, Print Policy, Records Management, Fax Policy and Records Retention and Transportation of Records. Local policies and protocols are also in place. Staff receive training in 'My Data, Your Business' and follow the guidelines of the Data Protection and Protection of Personal Information Policy. Staff also receive mandatory training in the 'Safeguarding of Vulnurable Adults' so understand their remit and duty to share details of personal information where necessary for safety and wellbeing.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
There was evidence in written records and from discussions with staff members to verify that the legal and ethical duty of confidentiality in respect of service users' personal information was maintained in Everton Day Centre. Records were kept securely and staff demonstrated an acute awareness of the need to maintain confidentiality with respect to each service user's personal information. Training records showed that staffs' training was up to date regarding the relevant policies, procedures and practices. Each service user's permission was sought when anyone outside of the staff team wished to have access to personal records and this was demonstrated during the inspection, when one service user stated that he did not want the inspector to look at his file.	Compliant

Criterion Assessed: 7.2 A service user and, with his or her consent, another person acting on his or her behalf should normally expect to see his or her case records / notes. 7.3 A record of all requests for access to individual case records/notes and their outcomes should be maintained.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
Within Everton Day Centre all service users and carers are involved in the assessment, care planning and review process and all have access to their records, and will be aware that these records are kept in the day centre. This information is included in the Service User Guide. To date no service user or carer has requested access to their records, however in the event of such a request staff follow the Trust guidelines for processing requests for access to patient and client records.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
In each of the four service user's files examined there were examples of the service user, or a representative, having signed to indicate agreement with the content of that record. There was written evidence of good preparation for reviews, for which the individual service user and the keyworker had been involved.	Compliant

Criterion Assessed: 7.4 Individual case records/notes (from referral to closure) related to activity within the day service are maintained for each service user, to include: • Assessments of need (Standards 2 & 4); care plans (Standard 5) and care reviews (Standard 15); • All personal care and support provided; • Changes in the service user's needs or behaviour and any action taken by staff; • Changes in objectives, expected outcomes and associated timeframes where relevant; • Changes in the service user's usual programme; • Unusual or changed circumstances that affect the service user and any action taken by staff; • Contact with the service user's representative about matters or concerns regarding the health and well-being of the service user; • Contact between the staff and primary health and social care services regarding the service user; • Records of medicines; • Incidents, accidents, or near misses occurring and action taken; and • The information, documents and other records set out in Appendix 1.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
Service user individual files follow a structured format to include: person centred plans, personal placemats, communication passports, care review, weekly timetable, weekly synopsis, personal information sheet including photographic identification and guidelines and support plans, contact sheets, medical information, incidents, accidents and near misses.and behaviour support plans.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Service users' files were found to be well organised and to contain all of the information required by this standard. The records of bruises and scratches for one service user who frequently falls, or otherwise accidently injures himself, were carefully written and drawn, with excellent detail. Many records made good use of Makaton symbols and pictures and each service user's weekly timetable was presented in clear and colourful pictorial format. A weekly synopsis of each service user's involvement and progress was kept in good detail.	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:	
Withtin Everton even if there are no recordable events, an entry is recorded every five attendances to confirm this is the case.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
A weekly synopsis of each service user's involvement and progress was kept in good detail.	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:	
Upon commencent of employent to the Belfast Trust all staff must undertake a full corporate and local induction. Staff adhere to all BHSCT Policies and Procedures and Local Procedures when referring to relevant professionals in the multidisciplinary teams.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The Trust's written policy and procedures for reporting events were available in the centre and accessible by staff. Notifiable events and the reporting of these is included in the induction programme for newly appointed staff members. Staff also reported that they had ready access to senior staff when they felt it necessary to seek guidance.	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:	
All records are legible, accurate and up to date and signed and dated by the person making the entry. These are reviewed during supervision.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Service users' records were maintained to a high standard and were legible, accurate and up to date. Records had been signed by the person making the entry and there was evidence of regular auditing, by senior staff, of the quality of 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**
	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:	
All staff are trained in Proact SCIP-r which provides a sound theory base regarding restrictive practice and where it is used in a planned or adhoc/emergency way. Restraint is only ever used as a last resort. Trust policy around restrictive practice states four grounds for physical intervention: 1. Self harm 2.Harm to others 3. Destructive behaviour 4. Reckless behaviour. The policy states physical intervention can only be used in an emergency when planned and when all other options have been tried. If a physical intervention is used, staff will inform the line manager and complete a physical intervention form. This form is sent to the Operations Manager and forwarded to the Clinical Psychologist and to the behaviour team. This information is recorded on a data base. The behaviour support team will contact the staff responsible to discuss any learning outcomes or if consultancy is required. A quarterly report of all interventions are presented at Managers meetings. A Trust policy is available on Physical interventions. Restrictive practices are developed by the Behaviour Support Service and Best Interests/Multidisciplinary panel. These are regularly reviewed a copy of which is available in their individual files.	Substantially compliant

Inspection Findings:	**COMPLIANCE LEVEL**
As part of the Trust's procedures for the management of behaviours that challenge others, the centre follows a 'Pathway for the use of Restrictive Practice'. Guidance regarding behaviours and management techniques is provided by members of the Trust's Behaviour Support Service, when devising or reviewing a service user's individual behaviour management plan. Management of any individual's behaviour is reviewed and action plans are discussed to ensure that interventions remain necessary and proportionate and do not infringe service the user's human rights. An example was discussed with a senior staff member, of the use of the 'Pathway', in relation to the provision of behaviour management clothing for one person. The use of restrictive practice was for a specific event and duration and was carefully monitored. Staff discussed the use of restraint or seclusion, including how service users' human rights are protected and they demonstrated an understanding of the Deprivation of Liberty Safeguards– Interim Guidance.	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:	
The policy states physical intervention can only be used in an emergency when planned and when all other options have been tried. If a physical intervention is used, staff will inform the line manager and complete a physical intervention form. This form is sent to the Operations Manager and forwarded to the Clinical Psychologist and to the behaviour team. This information is recorded on a data base. The behaviour support team will contact the staff responsible to discuss any learning outcomes or if consultancy is required. A quarterly report of all interventions are presented at Managers meetings. A Trust policy is available on Physical interventions RQIA are notified of any occasion interventions are used..	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Quarterly reports of events, where any degree of physical intervention was used, were available for inspection and had all been discussed at managers' meetings. Notifications had been sent, as necessary, to RQIA, in addition to the Trust personnel identified above. This level of monitoring of restrictive practices is commendable.	Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE DAY CARE SETTING COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Substantially 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:	
The Belfast Health and Social Care Learning Disability programme has a line management structure. Each level of management with defined roles and responsibilities.Each role has a job description detailing the extent of responsibilities.The Everton Centre statement of purpose contains an organisational structure. Within the centre the Registered Manager has ultimate responsibility for the management of the service. Responsibility and accountability is delegated to members of the team. Areas of responsibility include for example supervision, transport, training and management of annual leave and safe keeping of medication.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Acting-up arrangements have been in place to cover the manager's role and responsibilities in the centre, since June 2013. In early 2014, the Trust had progressed selection procedures for the post of manager to the point where an interview date had been set. However, the procedures were terminated and the post was neither offered nor filled. Three senior staff, all acting-up in turn, on a monthly basis, have continued to manage the centre for this lengthy	Moving toward compliance

period. While there was evidence of many aspects of the centre's operations continuing satisfactorily, there were also aspects, such as formal supervision, which had fallen behind schedule for approximately 18 months. The current management arrangements do not present a clear and satisfactory model for the management of the centre and do not meet the requirements of Regulation 9 of The Day Care Setting Regulations (NI) 2007, which states, "The registered person shall appoint an individual to manage the day care setting --------". It is now a matter of urgency that a manager be appointed to lead the large staff team in Everton Day Centre. Staffing numbers in other roles in the centre appeared to be satisfactory.	
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:	
The Belfast Health and Social Care Trust has a Supervision Policy, which identifies the core principles underpinning the supervisory process. All staff have attended training in supervision. Every member of staff has an identified line manager who will organise and facilitate a formal quarterly supervision session. In addition informal supervision takes place between staff on a daily basis.	Moving towards complian
Inspection Findings:	**COMPLIANCE LEVEL**
An examination of the training, supervision, appraisal and staff records of four staff led to the finding that formal, individual supervision has not been provided for all staff with the frequency required in minimum standards. There has been some improvement since the previous inspection, approximately one year ago, but current management arrangements for the centre are unsatisfactory and shortcomings in the supervision provision may be one consequence of this. A requirement in this regard is included in the Quality Improvement Plan accompanying this report.	Moving toward compliance

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:	
The Registered Manager and Assistant Managers are all registered with NISCC and their duties are carried out in line with the NISCC Code Of Practice. All staff within the Belfast Trust have been appointed through the Recruitment and Selection process. This includes providing documentation of qualifications and details of employment history. Two written references are sought by the Human Resource Department. Original copies are held within the Human Resources Department. A staff information file held in the Centre details: Name, photographic identification, employment history, qualifications, and registration with professional bodies.There is an ongoing schedule of training available to staff to update knowledge and skills.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The provider's self-assessment was verified through examination of one assistant manager's file and those of three other staff members. Qualifications and experience of staff were also verified from the centre's statement of purpose and from discussions with three staff members. The selection of "Substantially compliant" in almost all criteria in the provider's self-assessment is one indication of possible uncertainties in decision making under current management arrangements. (See 17.1 above).	Substantially compliant

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

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

Additional Areas Examined

Complaints

The record of complaints was satisfactory, with all three of the complaints, recorded in 2014, identifying the level of satisfaction of the complainant. The assistant manager receiving feedback was advised on the format of the complaints record which was a little unwieldy.

Premises

On a tour of the premises, most areas were found to be well maintained and in good decorative order. There had been water damage in the floor of the main entrance foyer area and the flooring had already been removed by the Trust in preparation for the laying of a new surface. The schedule for this work was in place.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Anna Dunlop, Assistant Manager, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

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

Enquiries relating to this report should be addressed to:

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

Quality Improvement Plan

Primary Unannounced Care Inspection

Everton Day Centre

12 December 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 Mrs Anna Dunlop, Assistant Manager 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
1	Regulation 20(2)	The registered person must ensure that staff working in the centre are appropriately supervised. (Ref. Standard 22.2)	Two	The Trust Supervision policy is fully implemented within the facility. All staff have been reminded (13/01/15) of their statutory obligation to participate and provide supervision both as a supervisor and supervisee. A process has been put in place whereby dates for supervision sessions are planned and these dates recorded for each quarter. Provision has been included that should sessions be cancelled alternative dates are made to ensure compliance within each quarter.	27 February 2015
2	Regulation 9	The current management arrangements do not present a clear and satisfactory model for the management of the centre and do not meet the requirements of Regulation 9 of The Day Care Setting Regulations (NI) 2007, which states, “The registered person shall appoint an individual to manage the day care setting --------“.	One	A process has commenced to ensure that an appropriate individual will be appointed to manage the day care setting in keeping with Regulation 9 of the Day Care Setting Regulations(NI)2007.	27 March 2015

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	pam surgenor
Name of Responsible Person / Identified Responsible Person Approving Qip	martin dillon

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	D Knox	05/02/15
Further information requested from provider			