Unannounced Care Inspection Report
17 August 2016

Rathmoyle Resource Centre incorporating 'Sheskburn

Type of Service: Day Care Settings
Address: 6 Mary Street, Ballycastle, BT54 6QH
Tel No: 02820762713
Inspector: Priscilla Clayton.

1.0 Summary

An unannounced inspection of Rathmoyle Resource Centre took place on 17 August 2016 from 10.00 to 17.00 hours. Sheskburn House, the satellite unit has been temporarily closed from June 2016 by the Northern Health and Social Care Trust (NHSCT) until further notice. RQIA is to be notified of the date on which Sheskburn centre is to open.

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

Is care safe?

There was good supporting evidence that the centre was providing safe care through appropriate staffing levels, staff induction, staff training, supervision and appraisal, infection and prevention, competency and capability assessments, risk management systems and processes and positive feedback from staff and service users.

One area identified for improvement from the assessment of the “is care safe” domain related to the development of a staff duty roster.

Is care effective?

There was supporting evidence that the care provided was effective with positive feedback from service users and staff. Needs assessments were complemented with risk assessments and care plans reflected measures to minimise identified risks.

Three areas were identified for improvement from the assessment. These related to the retention of notes on internal care reviews, conducting audits on the effectiveness of working practices and staff to refrain from leaving spaces between dates when recording progress notes.

Is care compassionate?

There were several examples of good practice in relation to the culture and ethos of the day care centre, listening to and valuing service users and taking account of the views of service users and their relatives.

No requirements or recommendations were made in this domain.

Is the service well led?

There were several good examples of effective leadership from assessment of “is the service well led” domain. Staff gave positive feedback in respect of leadership and good team work with excellent support and encouragement provided by the manager though effective communication, supervision, staff meetings and the open door approach provided by the manager. Seeking of service user views on the day to day running of the centre is given a high priority with regular service user meetings held and pictorial satisfaction survey planned for 2016.

One recommendation, restated from the previous care inspection, and four recommendations were identified for improvement:

- Retention of monthly monitoring visit reports made on behalf of the registered provider
- Cease to use service users' names in monthly monitoring reports without obtaining consent
- Cross reference hard copies of policies/procedures with those held electronically
- Ensure full details of complaints received and investigation conducted are recorded within the complaints record.
- One recommendation was restated from the previous care inspection dated 21 October 2015 related to the provision of effective telephone communication.

This inspection was underpinned by The Day Care Settings Regulations (Northern Ireland) 2007, the Day Care Setting Minimum Standards 2012 and previous inspection outcomes and any information we have received about the service since the previous inspection.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	8

Details of the Quality Improvement Plan (QIP) within this report were discussed with Patricia Brown, 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 type e.g. care inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last inspection.

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2.0 Service details

Registered organisation/registered provider: Northern Health and Social Care Trust/Dr Anthony Baxter Stevens	**Registered manager** Patricia Brown
Person in charge of the day care setting at the time of inspection: **Patricia Brown**	**Date manager registered:** 18 June 2013
Number of service users accommodated on day of Inspection: 42	**Number of registered places:** 55

3.0 Methods/processes

During the inspection the inspector met with nine service users individually and with others in small group format, four staff including the manager and one Occupational therapist.

A total of 15 satisfaction questionnaires were provided for distribution to service users, relatives/representatives and staff for completion and return to RQIA. Four questionnaires returned to RQIA within the timescale included three from staff and one relative.

An inspection of the internal environment was undertaken.

During the inspection the following records were examined:

- RQIA certificate of registration
- Staff duty record
- Induction programme for new staff
- Staff supervision and annual appraisal schedules
- Sample of competency and capability assessments
- Staff training records
- Three service user's care files
- Statement of purpose and service users guide
- Minutes of recent staff meetings
- Complaint records
- Equipment maintenance records
- Accident/incident/notifiable events records
- Annual summary report
- Minutes of recent service user'/representatives' meetings
- Monthly monitoring reports
- Fire safety risk assessment
- Maintenance of fire-fighting equipment, alarm system, emergency lighting, fire doors, etc.
- Policies and procedures.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 21 October 2016

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

4.2 Review of requirements and recommendations from the last care inspection dated 21 October 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 29 **Stated:** First time	The registered manager must ensure all notifiable accidents and untoward incidents as per regulation 29 are reported to RQIA in compliance with this regulation and RQIA's revised provider guidance.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and inspection of accident/incident reports evidenced that notifiable accidents and untoward incidents were being notified to RQIA.	
Requirement 2 **Ref**: Regulation 13(7) **Stated:** First time	The manager must ensure a review of grab rails and equipment is undertaken. Any rusted aids or equipment are made good or are replaced.	**Met**
	Action taken as confirmed during the inspection. Discussion with the manager and inspection of grab rails and equipment evidenced that review has taken place and rusted equipment replaced.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 5 **Stated:** First time	With regards to service user's care plans; the manager should ensure: (a) The continence promotion information fully reflects the individuals needs and preferences including (where appropriate) the following: • How the service user is approached • The language used by staff • If a preferred bathroom is used • The name and size of continence product used and where this is stored • The name and type of equipment used and the type and size of sling • The number of staff needed to provide assistance • The level of staff support and assistance needed • If a change of clothes is available and where these are located.	**Met**

	(b) The identified service user's care plan is updated to accurately reflect his/her days of attendance in the satellite unit. (c) All relevant signatures are in place; i.e. the service user or their representative, the staff member completing the care plan and the manager. If the care plan is amended new signatures from all relevant individuals should be obtained. The other identified service user's care plan is reviewed. Systems should be in place for all care plans to be reviewed annually or sooner if the individual's needs change.	
	Action taken as confirmed during the inspection: a)Information recorded within care records examined reflected individual assessed needs and preferences in respect of measures in meeting continence needs of service users. b) The manager informed the inspector that the satellite unit (Sheskburn House) is temporarily closed. Attendance within the unit no longer applies until further notice. RQIA to be notified of the date when this unit is to be opened. c) Three care plans selected contained signatures as recommended. d) Discussion with the manager confirmed that the care plan referred to in this recommendation had been reviewed and that the service user no longer attends the centre. A system is in place (diary) for recording review dates.	
Recommendation 2 **Ref**: Standard 8.5 **Stated:** First time	The manager should ensure the minutes of service users' meetings include the details of any action points; who is responsible; timeframes for completion and the subsequent minutes should record what action was taken.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and review of minutes evidenced that information, as recommended, had been developed.	

Recommendation 3 **Ref**: Standard 14 and 17.2 **Stated:** First time	The manager should ensure: (a) The area of dissatisfaction raised by the service user in Sheskburn House is recorded in the centre's complaints record and is investigated in accordance with standard 14.10. (b) The manager should ensure attempts are made to address all of the issues raised by staff in completed RQIA questionnaires.	**Met**
	Action taken as confirmed during the inspection: Examination of the complaint records evidenced that the complaint referred to in this recommendation had been documented.	
Recommendation 4 **Ref**: Standard 17.9 **Stated:** First time	With regards to ease of communication; the registered person should review the following working practices: (a) telephone arrangements for carers to contact staff in Rathmoyle Resource Centre. (b) update RQIA on the Trust's progress of providing a computer for Sheskburn House satellite unit; preferably with internet access.	**Partially Met**
	Action taken as confirmed during the inspection: a)The manager confirmed that a requisition for telephone lines had been placed with the communication department and that plans to upgrade the internal external telephone lines was to take place. The manager indicated that she would like to transfer the use of the mobile from Sheskburn House for use in Rathmoyle. Request is to be made to her line manager for permission to do so. b) RQIA was notified that Sheskburn House was temporarily closed with no set date for reopening. **Section (a) of this recommendation is restated**.	

Recommendation 5 **Ref**: Standard 15.5 **Stated:** First time	With regards to service user's annual review reports, the manager should ensure improvements are made regarding the recording of the views and opinions of individuals who have a significant cognitive impairment. Staff should ensure the views and opinions of the service user's carer or representative is included.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and inspection of three care review notes confirmed that service user views and opinions were sought and recorded.	

4.3 Is care safe?

The manager confirmed that staffing levels are subject to regular review to ensure the assessed needs of the service users were met. Currently one vacant post is being worked by consistent agency staff who have had induction and were deemed competent to provide this cover. The manager is hoping to have a replacement staff member appointed within the near future.

Currently staff on duty each day is recorded within three separate records; bus rota log, diary with record of leave and a lunch rota. Recommendation was made in respect of the development of a central duty roster of persons working in the day care setting each day and the capacity in which they worked.

Review of completed staff induction records and discussion with the manager and staff evidenced that the programme was relevant to specific roles and responsibilities. Induction records viewed were signed by the staff member and mentor.

The manager and staff confirmed that staff supervision was provided on a three monthly basis and appraisal annually. Records of staff supervision and appraisal were retained on file.

Discussion with staff confirmed that mandatory training, supervision and appraisal of staff were regularly provided. Schedules for these activities were maintained and available for inspection.

Discussion with the manager confirmed that staff were recruited in line with Regulation 21 (1) (b), Schedule 2 of The Day Care Setting Care Homes Regulations (Northern Ireland) 2007 and that records were retained at the organisation's personnel department. Review of the NHSC Trust recruitment and selection policy and procedure confirmed compliance with current legislation.

Discussion with staff confirmed that they were aware of the new regional policy entitled, Adult Safeguarding Prevention and Protection in Partnership (July 2015) and that the NHSC Trust has adopted this policy. A copy of the policy was available for staff in the centre. Staff demonstrated knowledge and understanding of adult safeguarding principles and were also aware of their obligations in relation to raising concerns about poor practice and whistleblowing. No live safeguarding or disciplinary staffing issues has arisen since the previous inspection.

A review of staff training records confirmed that mandatory adult safeguarding training was provided for all staff on 30 March 2016. The manager confirmed that the Trust has planned to identify "champions" for adult safeguarding.

The manager confirmed that risk management procedures were in place relating to the safety of individual service users. These were observed within care records examined, for example, moving and handling, swallowing and falls risk assessments. Measures in place to minimise identified risks were reflected within care plans inspected.

Discussion with the manager identified that the centre did not accommodate any service users whose assessed needs could not be met. Care needs assessments and risk assessments reviewed were updated on a regular basis or as changes occurred.

A review of policy and procedure on restrictive practice/behaviours which challenge confirmed that this was in keeping with DHSSPS Guidance on Restraint and Seclusion in Health and Personal Social Services (2005) and the Human Rights Act (1998). It also reflected current best practice guidance including Deprivation of Liberties Safeguards (DoLS).

The manager confirmed that restrictive practice was not used or necessary within the centre. Appropriate documented assessment and review involving specialist multi-professional Trust personnel would be sought and records retained if restriction was to be used for the safety of the service user. Staff training in managing challenging behaviour was provided on 30 November 2015. Records of training provided were retained.

Inspection of three care records confirmed there was a system of timely referral to the multi-disciplinary team when required.

Review of the policy and procedures relating to safe and healthy working practices confirmed that these were reviewed. Policies included, for example; COSHH, fire safety and manual handling. A user friendly Health and Safety Law poster was displayed within the hallway of the centre.

Notifications of accidents/incidents were being submitted to RQIA as required. Five notifications received were discussed with the manager. Appropriate action was taken and recorded to minimise risks identified. Ensuring the correct section of the notification is entered was highlighted as the record made in one notification received was incorrect.

The manager confirmed that equipment and medical devices in use was well maintained and regularly serviced.

Examination of staff training records and discussion with the manager confirmed that all staff had received training in infection prevention and control (IPC) on 26 January 2016 and 01 June 2016. Inspection of the centre confirmed that there were wash hand basins, adequate supplies of liquid soap, alcohol hand gels and disposable towels and aprons wherever care was delivered. Observation of staff practice identified that staff adhered to IPC procedures. Review (IPC) policy and procedure confirmed that the policy was in line with regional guidelines. Staff demonstrated good knowledge and understanding of infection, prevention and control measures

Hand hygiene was a priority for the centre and efforts were applied to promoting good standards of hand hygiene among service users, staff and visitors. Notices promoting good hand hygiene were displayed throughout the centre in both written and pictorial formats.

Inspection of the internal and external environment identified that the centre and grounds were kept tidy, safe, suitable for and accessible to service users, staff and visitors. There were no visible hazards observed which may impact on health and safety.

The centre had a current fire risk assessment which was dated 27 May 2016. No recommendations for improvement were made. Fire drill was provided during August 2016. Fire safety awareness was last provided on 01 June 2015 with refresher training scheduled for 31 August 2016. Personal emergency evacuation plans (PEEPS) were undertaken on service users with mobility needs. Records were retained.

Three care staff spoken with during the inspection gave positive feedback in regard to care provided. No issues or concerns were raised or indicated.

Service users who spoke with the inspector indicated they were very satisfied with the care provided. No issues or concerns were expressed or indicated.

Three staff questionnaires and one from a relative were completed and returned to RQIA. Overall responses indicated positive.

Areas for improvement

One area identified for improvement from the assessment of the “is care safe” domain related to the development of a staff duty roster.

4.4 Is care effective?

Discussion with the manager established that staff responded appropriately to and met the assessed needs of the service users in attendance.

Individual care records were retained for each service user. Three care records examined contained assessment of needs which were complemented with risk assessments, life history, associated person centres care plans and daily/regular statement of health and well-being of the service user. Care records also reflected timely multi-professional input into the service users’ health and social care needs and were found to be updated regularly to reflect the changing needs of the service user. One recommendation made related to ensuring the notes of internal reviews held were retained within care records.

There was recorded evidence that service users and/or their representatives were encouraged and enabled to be involved in the assessment, care planning and review process, where appropriate. Discussion with staff confirmed that a person centred approach underpinned practice and that update training in person centre care planning was provided on 18 May 2016. Three care records examined showed that service users were consulted with their choice, views and preference reflected within person centred care plans. Regular notes were recorded within five days of attendance. One recommendation made related to ensuring staff cease to leave gaps between dated recordings.

Care records were being stored safely and securely in line with data protection.

The manager confirmed that a service user/representative satisfaction survey was undertaken during 2015 with no issues or concerns raised. A report was not developed. Pictorial service

user satisfaction is currently being developed for distribution this year to all service users. When completed and responses analysed a report is to be established which incorporates comments, views and opinions of service users/representatives, issues raised and any actions taken in response. The manager confirmed that the outcome of the survey would be shared with service users/representatives and staff. It is recommended that a copy of the report is submitted to RQIA.

Discussion was held with the manager in respect of the internal arrangements to monitor, audit and review the effectiveness and quality of care. It was recommended that audits for example; accident/incidents, complaints, supervision, environmental cleanliness and care records should be established in order to ensure that working practices are consistent with the day care setting's Minimum Standards and NHSC Trust policies and procedures.

The manager confirmed that systems were in place to ensure effective communication with service users, their representatives and other key stakeholders. These included for example; pre-admission information gathering, multi-professional collaboration and team reviews, service user' meetings, staff meetings and staff briefing meetings held each am. The manager and staff confirmed that the "open door" approach to the manager was available so that anyone can speak directly with her or the person in charge.

Service users meetings were being held on a quarterly basis with minutes recorded.

Service users spoken with during the inspection alongside observation of practice evidenced that staff communicated effectively with service users.

Service users provided the following comments:

"There is always staff around to assist us if we need anything".
"We have meeting and can raise any issues or talk about activities".
"I noticed staff wash their hands very often".
"If we were unhappy about something would say to the staff and they would fix whatever it was".
"Staff always asks if we would like to do and we are not forced to do anything we don't want to do".
"The centre is always kept clean and well heated during the winter".

Three staff questionnaires were completed and returned to RQIA. Overall responses indicated the care was excellent or good. One questionnaire returned from a relative indicated that care was excellent.

Areas for improvement

Three areas were identified for improvement in the "effective care" domain. These related to the following;

- Retention of notes on internal care reviews
- Submission of a report on the outcome of the service user satisfaction survey to RQIA and the undertaking of audits on the effectiveness of working practices including, for example; accident/incidents, complaints, supervision, environmental cleanliness, and care records
- Staff to cease leaving gaps in between dates when recording progress notes.

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.

There were a range of policies and procedures in place which supported the delivery of compassionate care. Discussion with staff and service users confirmed that service users' needs were being met.

The manager, staff and service users, who were able to communicate, confirmed that consent was sought in relation to care and treatment. Discussion with service users and staff along with observation of practice and interactions demonstrated that service users were treated with dignity and respect. Staff confirmed their awareness of promoting residents' rights, independence and dignity. Staff were also able to demonstrate how service' confidentiality was protected. For example any discussions held with service users regarding personal matters would be undertaken in private; care records are only shared with consent and those who need to know.

The manager and staff confirmed that service users were always listened to, valued and communicated with in an appropriate manner. Discussion with staff, service users, one representative and observation of practice confirmed that service users' needs were recognised and responded to in a prompt and courteous manner by staff.

Service users were provided with information, in a format that they could understand. For example, pictorial timetables, service user guide, displayed information leaflets/signage and annual report which enabled them to make informed decisions regarding their life, care and treatment.

The speech and language therapist gave positive feedback on the care provided and explained how effective the sensory approach to communication had been established and was ongoing. Service user training in music therapy, touch and smell was proving to be very effective for those with sensory needs. Makaton training is scheduled for 31 August 2016.

Three staff questionnaires and one from a relative completed and returned to RQIA. Responses in respect of the "is care compassionate" were positive. No issues or concerns.

One comment made from a relative included "we have no concerns what so ever. My daughter is treated with kindness, respect and dignity by wonderful staff at Rathmoyle"

Areas for improvement

There were no areas identified for improvement from assessment of the "is care compassionate" domain.

4.6 Is the service well led?

There was a clear organisational structure and all staff who spoke with the inspector demonstrated awareness of their roles, responsibility and accountability. This information was outlined in the centre's Statement of Purpose and Service User Guide. Discussion with the manager identified that she had good understanding of her role and responsibilities under the legislation. The manager confirmed that the registered provider was kept informed regarding the day to day running of the centre through line management and frequent contact with the locality manager who visited the centre on a regular basis to undertake unannounced monthly monitoring visits.

The manager should ensure that RQIA is informed when plans are in place to re-open Sheskburn House as an estates inspection may be necessary, depending on the closure timescale.

Competency and capability assessments of persons in charge of the centre when the manager is out of the centre were available. The manager reported that a new template has been developed and a copy is to be forwarded from her line manager.

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

The centre's certificate of registration with RQIA was displayed in a prominent position.

The manager explained that the seeking the views of service users on the day to day running of the centre is given a high priority through service user meetings and satisfaction survey conducted during 2015 and planned survey to be conducted. One planned improvement is the provision of service user health and safety training programme. First aid and safety in the sun has been provided with positive feedback received. Other training is planned in consultation with service users. This is to be commended.

A range of policies and procedures were in place to guide and inform staff. These were held in hard copy format and electronically. One recommendation made related to the undertaking of cross referencing of policies held in hard copy with those held electronically to ensure all hard copies are current and are systematically reviewed every three years.

The centre had a complaints policy and procedure which was in accordance with the legislation and DOH guidance on complaints handling. Service users and their representatives were made aware of how to make a complaint by way of the Service User Guide and NHSC Trust leaflets. Discussion with staff confirmed that they were knowledgeable about how to receive and deal with complaints.

Review of the complaints proforma forwarded to RQIA, dated 01 April to 31 March 3016, was discussed and records examined. The manager confirmed that complaints received had been investigated and resolved. One recommendation made related to ensuring that full details of complaints received and investigation conducted are recorded within the complaints record retained.

The centre had received many complementary cards and letters from service users/ representatives on the excellent care provided by staff. This is to be commended.

Arrangements were in place to share information about complaints and compliments with staff through meetings held and regular supervision.

A review of a selection of accidents/incidents/notifiable events confirmed that these were effectively documented and reported to RQIA and other relevant organisations in accordance with the legislation and procedures. The manager explained that learning from accidents and incidents was disseminated to the staff team through staff meetings and supervision. One recommendation was made regarding the undertaking of regular audits so that any trends or patterns could be identified and action taken as necessary. This recommendation alongside other audits is reflected under section 4.4 of this report.

Reconciliation records of service user financial transactions were in place. Transactions undertaken by staff on each service user's behalf were recorded and signed accordingly.

There was a system to ensure medical device alerts, safety bulletins, serious adverse incident alerts and staffing alerts were appropriately reviewed and actioned. Records were retained by the manager and when necessary shared with staff.

Discussion with the manager confirmed that information in regard to current best practice guidelines was made available to staff, for example, dysphasia and autism. Staff were provided with mandatory training and additional training opportunities relevant to any specific needs of the service users. For example: autism awareness,12 October 2015, and dysphasia awareness 30 September 2015.

Examination of monthly monitoring reports retained showed that the last report on file was dated 21 December 2015. The manager reported that visits had been undertaken but reports not received. One requirement was made in regard to the retention and availability of reports in the centre. The names of service users were noted to be recorded within reports retained. One recommendation was made in this regard as there was no evidence that consent was sought.

The manager confirmed that there were effective working relationships with internal and external stakeholders. The centre had a whistleblowing policy, dated 2014, and procedure in place. Discussion with staff established that they were knowledgeable regarding the policy and procedure. One recommendation was made in respect of policies and procedure cross referencing of hard copies with those held electronically is stated within section 4.4 of this report.

The manager confirmed that staff could access line management to raise concerns and to offer support. Discussion with staff confirmed that there were good working relationships and that management were responsive to suggestions and/or concerns raised.

The manager confirmed that there were arrangements in place for managing identified lack of competency and poor performance for all staff. This procedure was reflected within corporate policies retained.

Staff gave positive feedback in respect of leadership and good team working with excellent support and encouragement provided by the manager though effective communication, supervision, staff meetings and the open door approach provided by the manager. No issues or concerns were expressed or indicated.

Three staff questionnaires and one from a relative were completed and returned to RQIA. Overall responses indicated that staff felt the centre was well led and indicated this domain as excellent/good. One questionnaire returned from a relative indicated the well led domain as excellent.

Areas for improvement

One requirement and three recommendations were identified for improvement from assessment of the "is care well led" domain:

- Ensure monthly monitoring visit reports are retained within the centre
- Ensure that the names of service users are not reflected in monthly monitoring reports without obtaining consent.
- Cross referencing of hard copies of policies/procedures with those held electronically
- Ensure full details of complaints received and investigation conducted are recorded within the complaints record.

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Patricia Brown, 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 (Insert Service Type). 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 the Day Care Setting Minimum Standards 2012. They promote current good practice and if adopted by the registered provider may enhance service, quality and delivery.

5.3 Actions taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to day.care@rqia.org.uk 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:** 31 August 2016	The registered provider shall ensure that monthly monitoring reports made on behalf of the registered provider are retained in the day care setting. **Response by registered provider detailing the actions taken:** Line Manager advised of Requirement 1 regulation 28 and actioned accordingly

Recommendations	
Recommendation 1 **Ref**: Standard 17.9 **Stated:** Second time **To be completed by:** 31 October 2016	With regards to ease of communication the registered person should review the following working practice: a) Telephone arrangements for carers to contact staff in Rathmoyle Resource Centre. **Response by registered provider detailing the actions taken:** Service Users and their carers have been furnished wth a second contact Number Mobile - 07841495911 (Reabling works will enhance communication services to and from Rathmoyle Resource Centre)
Recommendation 2 **Ref**: Standard 23.7 **Stated:** First time **To be completed by:** 31 August 2016	The registered provider should develop a central duty roster of persons working in the day care setting each day and the capacity in which they work. **Response by registered provider detailing the actions taken:** A roster has been developed that reflects who is on-site and the capacity in which they work and is displayed on Staff Notice board
Recommendation 3 **Ref**: Standard 7.7 **Stated:** First time **To be completed by:** 31 August 2016	The registered provider should ensure that staff ceases to leave gaps between dated recordings in care records. **Response by registered provider detailing the actions taken:** Staff have been advised of this recommendation at staff meeting. Practice is in situ and reminder notices have been fixed to Filing Cabinets that contain service user files highlighting this recommendation

Recommendation 4 **Ref**: Standard 17.9 **Stated:** First time **To be completed by:** 31 September 2016	a) The registered provider is requested to submit a copy of the Service User survey outcome report to RQIA. b) The registered manager should ensure that arrangements are in place to monitor, audit and review the effectiveness and quality of care including for example;
	Response by registered provider detailing the actions taken: a) A copy of Service user survey submitted with QIP Action b) Service User Surveys are being developed in Partnership with Speech and Language Therapists to ensure Service users understand content and can complete a survey themselves or with the help and support of Carers or staff
Recommendation 5 **Ref**: Standard 15.4 **Stated:** First time **To be completed by:** 31 September 2016	The registered provider should ensure that the notes of internal reviews held are retained within care records.
	Response by registered provider detailing the actions taken: Internal Review records are now insit
Recommendation 6 **Ref**: Standard 18.5 **Stated:** First time **To be completed by:** 31 October 2016	The registered provider should ensure that policies held in hard copy format are cross referenced with those held electronically to ensure all hard copies are current and that policies are systematically reviewed every three years. (For complete list of recommended policies; ref Day Care Settings Minimum Standards Appendix 2)
	Response by registered provider detailing the actions taken: Policy Folders reviewed and will be reviewed three yearly as recommended
Recommendation 7 **Ref**: Standard 7.1 **Stated:** First time **To be completed by:** 31 October 2016	The registered provider should ensure that the names of service users are not reflected in monthly monitoring reports without obtaining retaining a record of consent.
	Response by registered provider detailing the actions taken: Line Manager advised of Recommendation and actioned accordingly

Recommendation 8 **Ref**: Standard **14.10** **Stated: First** time **To be completed by:** 31 September The registered provider should ensure 2016	The registered provider should ensure that full details of complaints received, investigation conducted and resolution are recorded within the complaints records.
	Response by registered provider detailing the actions taken: Complaints received, investigations conducted and resolutions will be recorded fully .

Please ensure this document is completed in full and returned to day.care@rqia.org.uk from the authorised email address

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