Primary Unannounced Care Inspection

Name of Establishment:	**George Sloane Centre**
Establishment ID No:	**11193**
Date of Inspection:	**28 January 2015**
Inspector's Name:	**Louise McCabe**
Inspection No:	**20312**

The Regulation And Quality Improvement Authority
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Registered organisation/ Registered provider:	Dr Anthony Baxter Stevens
Registered manager:	Mrs Dorothy Robinson
Person in Charge of the centre at the time of inspection:	Mrs Dorothy Robinson
Categories of care:	DCS-MAX, MAX, DCS-PH,
Number of registered places:	95
Number of service users accommodated on day of inspection:	62 in George Sloane Centre 10 in SCOPE satellite unit
Date and type of previous inspection:	21 January 2014 Primary Announced Inspection
Date and time of inspection:	28 January 2015 9.15am–4.30pm
Name of inspector:	Louise McCabe

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	16
Staff	6
Relatives	0
Visiting Professionals	1

Questionnaires were provided, prior to the inspection, to staff to find out their views regarding the service. Matters raised from the questionnaires were addressed by the inspector in the course of this inspection.

Issued To	Number issued	Number returned
Staff	18	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

The George Sloane Centre is situated in an industrial estate on the outskirts of Ballymena, where it has been operational for over thirty years. The premises were not originally purpose built and comprise of two buildings adjacent to one another, one of which is used mainly for workshop activities. The main building, housing most of the group activity rooms, dining room and offices, was redesigned and refurbished several years ago to make it more suitable for its varied purposes.

The Centre provides day care for up to eighty eight service users with daily attendance averaging around eighty people. Each service user has a care plan, designed to support his or her development of life skills, socialisation, positive wellbeing and independence.

There is a wide of range of activities currently on offer within the centre e.g. literacy/numeracy: skills group; art/craft; communication skills development; current affairs discussions; personal development; personal care; health promotion activities; physiotherapy programmes; recreational activities and games; boccia; indoor bowling armchair aerobics; walking groups; bingo, arts and crafts; social skills outings. There are good links with the local community and council and funding was secured for service users to participate in the following groups and activities: Sensory Kids; Streetwise Circus Skills; KASK Percussion workshops; NI Special Pool league; Beyond Skin, an interactive music and movement experience and a Music Therapy Workshop 'Rhythm and Movement.'

The service has a satellite unit which commenced in July 2013 called S.C.O.P.E. (**S**kills, **C**hoice, **O**pportunities, **P**ursuits, **E**mpowerment). It is based in Broughshane and provides a five day week community-based service experience for a maximum of fourteen service users on a daily basis. Contribution to the local community forms a considerable part of each day and includes the following activities: litter patrol; recycling projects; Helping Hands (assisting in local community groups with laying and clearing tables and serving dinners to the elderly) and the Broughshane Buddies (music group) which visit local residential care homes.

Summary of Inspection

9:15am–4:30pm=7 hours 15 minutes

A primary unannounced care inspection was undertaken in George Sloane Centre on 28 January 2015. On this occasion, due to adverse weather conditions, the inspector did not visit the Scope satellite service in Broughshane, however spoke with four service users and a staff member by telephone to obtain their views and opinions of their day service. The satellite unit celebrated their first anniversary in July 2014. The service user's comments were very positive and a sample of these are reflected below.

The focus of the inspection was to assess the centre's compliance with the one standard and two themes chosen from the Day Care Settings minimum standards 2012; The Day Care Settings Regulations (Northern Ireland) 2007. Post inspection the provider submitted a self-assessment of the one standard and two themes inspected, this report compares the provider's statements with the findings of the inspection. During the inspection the inspector used the following evidence sources:

- Analysis of post-inspection information and questionnaires
- Discussion with the registered manager, locality manager and acting learning disability day services manager (buildings based); one professional; staff and service users

- Examination of a sample of service user individual file records including evidence of review and safeguarding information; the complaints record; staff training record; incidents and accidents recording; evidence of service user consultation, monthly monitoring records; the centres statement of purpose; service users guide and policies & procedures
- Tour of the premises.

An inspector spoke with six staff regarding the standards inspected and their views about working in the centre. This generated positive feedback regarding the management of records and reporting arrangements including recording and the management arrangements in the centre. Staff demonstrated their knowledge and experience regarding responding to behaviours which may challenge in the context of respecting service user's human rights. A recommendation is made in the quality improvement plan for staff to receive awareness training on Human Rights and the Deprivation of Liberty Safeguards (DoLS).

Staff seemed unsure of the Trust's process should a service user or their representative request to see their care file. A recommendation is made for staff to receive awareness training in this area and data protection.

Communication between management and staff is effective and no concerns were raised. Discussions with staff conclude there are aware the senior day care worker is in charge/responsible for the centre in the absence of the manager. It was evident via discussions with staff of their dedication, commitment and enjoyment of their work in the George Sloane Centre.

At the time of completing this inspection report, there were no completed RQIA questionnaires returned by staff members in the George Sloane Centre.

The review of four staff files showed formal supervision is taking place with staff in the George Sloane Centre, however the frequency of these for some staff is not in accordance with minimum standard 22.2. Assurances were given by the manager that a supervision matrix would be devised which will clearly highlight dates of when formal supervision is due. Approximately two thirds of the staff have received an annual appraisal in the previous year and plans are in place for remaining staff to have this before 30 April 2015. Both of these areas are restated in the quality improvement plan.

The inspector spoke with a total of twelve service users in the George Sloane Centre (and annexe) and four service users in the SCOPE satellite unit regarding the standard inspected; the two themes and their views on the quality of the day service. The service users communicated positive feedback regarding their attendance at the centre, the activities they participate in and the care provided by staff. Due to the various levels of understanding and communication of several service users in group one, the inspector was unable to ascertain if they understood their rights to access their personal information. Most of the service users meeting with the inspector stated they are aware there are records kept in the day care setting about them and that they can access this information by asking staff. These service users confirmed they see their care plan on a regular basis and at their annual review. They said they are encouraged to be involved in all aspects of the care planning process. The service users are aware of who the manager is and if they had a problem or wanted to discuss something they would talk to the staff or manager in the centre. Service users in the George Sloane Centre stated they enjoy coming to the centre and the following comments were made:

- *"I love it here, my favourite activity is shopping, I'm very busy here and have important jobs."*

- *"I come here every day, it's brilliant and I see my friends."*

- *"It's a good place and I love the staff and things I do, I work hard."*

- *"I help the staff and have lots of jobs I like. We do lots of things and staff listen to us."*

- *"It's great coming here, I've lots of friends and we do different things."*

The inspector spoke with four service users in the Scope satellite service, they were aware there is care information retained on them and several said they help with this. The following comments were made:

- *"It's great here, I love it and there's plenty to do. Scope has got everything and I like the Helping Hands and the wildlife. The staff are good."*

- *"It's very good here, we work hard and I prefer coming here. I like the staff."*

- *"It's fun here and I love it. I like the peace and quiet here and doing the music in the old folks home and art. The staff are great and we are busy."*

- "*This place is better than going to the centre, it's great. I like going out, the shopping and the music."*

No concerns were raised by service users.

The previous announced inspection of the George Sloane Centre undertaken on 21 January 2014 had resulted in two requirements and six recommendations regarding formal supervision; annual appraisals; mandatory training; transport, initial review format; referral forms; service's annual report and progress care notes. Review of the returned quality improvement plan for this inspection and discussions with management concluded five areas were assessed as compliant. The requirement and recommendation regarding the formal supervision and annual appraisals of staff were assessed as substantially compliant and the matter relating to the title of the centre's referral form was assessed by the inspector as not compliant because this has not changed.

Standard 7 - Individual service user records and reporting arrangements: Records are kept on each service user's situation, actions taken by staff and reports made to others.

The six criterion criteria within this standard were reviewed during this inspection. Based on the evidence reviewed by the inspector, two criteria were assessed as compliant by the inspector and four as substantially compliant. Three recommendations are made in the appended quality improvement plan regarding this standard which concern assessments, care plans, awareness raising training for staff and file audits.

Discussions with a total of 16 service users, six staff and review of three service users' individual files provided evidence that the centre is performing well in some of the criteria and improvements are needed in identified areas. Two recommendations are made in the appended quality improvement plan concerning assessments and care plans, these must fully and accurately reflect the service user's current needs and include relevant information from

other professional's assessments. Documentation must always be dated and signed by all parties. Positive comments were shared with management on the use of pictures and symbols in care plans and that these are person centred. Clear examples were provided of how staff encourage and assist service users to get the most from their day care experience. It was also clear this service was improving outcomes for the service users and their carers by providing respite and identifying changes in need. The inspector concluded the centre promotes service users social needs, stimulates intellectual activity and promotes independence.

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

Two criterion from regulation 14 were inspected in relation to the use of any restrictive practices in this day care setting within the context of human rights. Both criteria were assessed as compliant.

Discussions with the manager, staff and examination of records provided evidence that the centre was using clear operational systems and processes which promote the needs of the service users who attend the centre. The Trust has in place a 'Restrictive Practices Registration' form which must be completed when a restrictive practice is used with service users. There have been no recorded incidents of restrictive practices being used in the service since the previous inspection.

A recommendation is made for staff to receive awareness raising/training on the Deprivation of Liberty Safeguards (DoLS) and Human Rights. Provision of this training would be beneficial for staff and should further enhance their understanding of how not to infringe on service user's rights should restrictive practices be needed in either a proactive or reactive situation.

Staff stated they know the service user's well and are familiar with their needs. Examples were relayed to the inspector of difficult and challenging situations that have occurred in the centre which required sensitive and diplomatic handling whilst ensuring service user's were respected and their rights adhered to. Staff use effective communication, diversion and calming techniques when the need arises and respond appropriately to service user's needs. Staff believe this assists them in ensuring service user's behaviour does not escalate and in doing so they meet individual and group needs.

Based on the evidence reviewed during this inspection, the inspector assessed the centre as compliant in this theme. One recommendation was made concerning this theme.

Theme 2 - Management and control of operations: Management systems and arrangements are in place that support and promote the delivery of quality care services.

Two criteria from regulation 20 and one criterion from regulation 21 were inspected in relation to this theme. All three criteria were assessed as substantially compliant as improvements are needed. Two requirements and one recommendation are made in the quality improvement plan regarding the formal supervision of staff, annual appraisals and the induction and orientation documentation for newly appointed staff members.

Review of selected management records, monthly monitoring reports and discussions with the manager and six staff provided evidence that the centre has in place monitoring arrangements and effective communication systems. These enhance and promote the quality of day care experience for the service user, their relatives/representatives and the public and is indicative of the care provision in this centre.

Additional Areas Examined

The inspector undertook a tour of the premises, reviewed the complaints record, examined three service user's individual files and validated the manager's post inspection RQIA questionnaire.

The inspector was accompanied by the Locality Manager on a tour of the environment. Positive comments were shared with management with regards to the spacious, bright and well decorated group rooms and dining room. Areas used by service users' were warm, tidy and fit for purpose. Group rooms and corridors displayed service users art work, photographs and murals.

The double exit doors of room 2 leading to an enclosed paved area are leaking in rain and the inspector observed rolled up towels had been placed along the bottom of the doors. The area of the roof above the entrance doors is also leaking rain water through the ceiling. A requirement is made in the quality improvement plan that these identified areas are made good.

The flooring in room 5 of the annexe is very worn in places, discoloured and has various paint stains from the days it was used as a workshop. A table in room 5 needs to be replaced as bare wood was observed and part of the edging is missing. The pitched external wood panelling of room 1 needs to be sanded and repainted. The Trust should consider adding George Sloane Centre signage to this area. A recommendation was made in the quality improvement plan about these areas.

The inspector wishes to acknowledge the work undertaken by the manager and staff in preparation for this inspection and their open and constructive approach throughout the inspection process. Gratitude is also extended to the service users who welcomed the inspector to their centre and engaged with her during the inspection. Overall the inspector commends the proactive approach to day care that is delivered in this centre that presents as in tune with the needs of the service users for support, stimulation and which meets their rehabilitation, social and other needs.

As a result of the inspection three requirements and eight recommendations have been made in the quality improvement plan. These concern the environment, annual appraisals, formal supervision; service user file audits; assessments, care plans; annual review preparation reports; provision of awareness training for staff; orientation and induction documentation for newly appointed staff and records of staff meetings. Progress in these areas will be monitored via completion of the returned quality improvement plan.

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 formal supervision of staff is carried out as required by this regulation and by Standard 22 of The Minimum Standards.	Discussions with the manager concluded two thirds of staff receive formal supervision in accordance with standard 22. Review of four staff files and discussions with six care staff during this inspection verified this. There was evidence several staff have not received formal supervision in approximately a year. Since this inspection the manager has devised a formal supervision template which highlights when staff will receive formal supervision. This requirement is restated in the appended quality improvement plan.	Substantially compliant
2	Regulation 20(1)(c)	The registered person must ensure that safeguarding training, and other mandatory training, is provided for all staff within the required timescales.	Safeguarding vulnerable adult training was provided to staff in March 2014 and other mandatory training has been delivered to staff. First aid training is due to be provided before October 2015.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	Standard 12.4	The Trust's Transport Department was reported to be reviewing transport arrangements for service users. The registered person should report the findings of this review in the Quality Improvement Plan response.	This was reviewed by the Trust's Transport Department and management of George Sloane Centre. After discussions with service users and their carers additional bus runs were added to transport drivers to ensure identified service users' journeys were shortened. Where a service user is collected first in the morning, they are returned home first in the afternoon or management has ensured alternative transport is provided. Three service users' journeys are longer than 45 minutes due to the rural location in which they live. Management and staff said the journey does not have a detrimental affect on them as they enjoy it. Management continue to monitor this on an ongoing basis.	Compliant
2	Standard 22.5	The registered person should make arrangements to complete performance appraisals annually with all staff members.	Discussions with the manager, six care staff and review of four staff files conclude two thirds of staff have received an annual appraisal in the previous year. Arrangements are in place by the Trust for an identified person to	Substantially compliant

			complete these with staff in George Sloane Centre and written assurances were received on 6 February 2015 stating outstanding annual appraisals would be completed by 30 April 2015. This requirement is restated in the appended quality improvement plan.	
3	Standard 15.3	The initial review should be formalised so that the suitability of a new service user's placement is discussed and a decision taken and recorded. This review should be completed as soon as the service user's on-going needs have been understood by the staff team.	The initial review form of a service user recently attending the George Sloane Centre was examined. This meets minimum standards.	Compliant
4	Standard 2.4	Referral forms in some service users' files were headed, "Buildings Based Provision". This impersonal term is unnecessary as a heading and should be revised to be in keeping with the Person Centred approach to service provision.	Management in George Sloane Centre are unable to revise this as the form is distributed by senior managers within the Trust prior to admission panel meetings where new potential service users to the centre are discussed. The chairperson of this panel should consider amending this title to one that is more person centred.	Not compliant

5	Standard 17.11	A quality of service evaluation and report should be completed annually and action should be taken to carry out any necessary improvements.	A 2013-2014 annual report of the George Sloane Centre has been completed and a copy of the service's most recent annual report was forwarded to RQIA on 6 February 2015. The content of this is informative and qualitative.	Compliant
6	Standard 7.5	The manager should ensure that all key workers meet or exceed the minimum standard of record keeping with regard to each service user's attendance, wellbeing and progress.	Three service users care files were randomly selected during this inspection. There was evidence the progress care notes are being completed in accordance with this standard. Care staff completing these on computer are reminded to regularly print these and insert into the service user's care file.	Compliant

Standard 7 - Individual service user records and reporting arrangements: **Records are kept on each service user's situation, actions taken by staff and reports made to others.**	
Criterion Assessed: 7.1 The legal and an ethical duty of confidentiality in respect of service users' personal information is maintained, where this does not infringe the rights of other people.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
The Trust has policies and procedures in place in relation to confidentiality and any records held by the organisation. These include; Records Management Policy and Processing of Personal Information (POPI). The purpose of these policies are to support staff and enable them to work within the law and within good practice guidelines. The policy covers retaining personal information, Records and Record keeping, Safe Storage of personal information, Access and Sharing of information and Retention and Disposal of Confidential Information.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
A sample of the records in respect of each service user, as described in Schedule 4; and those detailed in Schedule 5 are in place in George Sloane Centre. Discussions with staff conclude there are effective arrangements in place regarding confidentiality and all relevant policies and procedures pertaining to the access to records, storage of service user's information; communication, confidentiality, consent, management of records, monitoring of records, recording and reporting care practices are in place and readily available for example 'Accessing your personal information', 'Subject Access Request Form' etc. This information is reflective of current national, regional and locally agreed protocols concerning confidentiality and adheres to DHSSPS guidance, regional protocols, local procedures issued by the HSC Board and Trusts and current legislation. The centre's current service user agreement is also compliant with this criterion. Discussions with staff also validate they are knowledgeable about the duty of confidentiality and their role and responsibility regarding the need to record, the quality of recording and management of service users personal information. This is commensurate with staff role and responsibilities.	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:	
Service users and their representitives are permitted to have access to their own personal records/case notes. Requests for information are processed in line with Trust Procedure/Policy and documents maintained where this takes place. Within the Adult Centre, service users are actively involved in their care planning/review process and, where appropriate/when possible, will also contribute to completing records for this process.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Policies and procedures are in place and accessible in the centre pertaining to: the access to records; consent; management of records and service user's agreement. Discussions with the manager and receipt of her completed RQIA manager questionnaire showed there have been no requests to date whereby a service user or their representative have requested access to their care file. Discussions with staff conclude the policies and procedures are put into practice for example with reference to records being completed and maintained in the centre. It is evident from discussions with staff and the inspector's review of three service user's care files how they ensure a person centred approach to their recording. The inspector examined three service user's care files, there was no evidence stating they are aware they can request access to care information completed about them. Discussions with service users conclude they are aware of their care plan and many have seen this. There are adequate arrangements in place in the Trust regarding who takes responsibility for issues and queries of freedom of information, confidentiality, consent and access to records and arrangements. Discussions with staff conclude they are not familiar with the Trust's process should a service user or their representative request access to their care information. A recommendation is made in the appended quality improvement plan for awareness raising training to be delivered to staff on the process of requesting access to files,	Substantially compliant

data protection and confidentiality. Written assurances were given by the manager on 6 February 2015 training would be delivered to staff in these identified areas.	
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:	
Each service user has an individual case record. These are completed and maintained in line with Trust/RQIA requirements. These records include; referral information, carer/multi-disciplinary contacts, assessments and reviews, care plans, contacts and details of activities. Any changes to circumstances, significant incidents/near misses are recorded along with details of actions taken/further work to be done. All records are stored securely in line with Information Governance requirements.	Substantially compliant

Inspection Findings:	**COMPLIANCE LEVEL**
With regards to the management of records, the examination of a sample of three service user individual records evidenced improvements are needed in the areas of assessments, care plans and the need for systematic audits of service user care files. There was evidence care information is person centred and incorporated service user views and recorded information that can be used to review individual service user's outcomes. Care reviews are taking place as described in standard 15. Two recommendations were made relating to this criterion and concerned the review and updating of one identified service user's care plan so that it fully and accurately reflects his/her current needs and include a summary of the recommendations made in the Speech and Language Therapist's recent assessment. The registered manager must also ensure all assessments and care plans are up to date, signed and dated by the person completing them and periodically reviewed and signed off by her. The registered manager must also ensure service user annual review preparation reports are completed prior to the service user's annual review and contain information as per minimum standard 15.5. A recommendation is made for monitoring and peer review systems to be established to ensure all service user care plans include information arising from assessments. All care plans must reflect details of the matters specified in minimum standard 5.2.	Substantially compliant
Criterion Assessed: 7.5 When no recordable events occur, for example as outlined in Standard 7.4, there is an entry at least every five attendances for each service user to confirm that this is the case.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
Staff ensure that records are maintained/updated with an entry regarding service users, at least every five attendances. This is done in line with Trust and RQIA requirements. These records are signed and dated.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector examined three service user care records and evidenced individual care records have a written entry at least once every five attendances for each individual service user. The quality of information recorded was viewed by the inspector as relevant to the plan and outcomes for individual service users.	Compliant

Criterion Assessed: 7.6 There is guidance for staff on matters that need to be reported or referrals made to: • The registered manager; • The service user's representative; • The referral agent; and • Other relevant health or social care professionals.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
The Northern Health and Social Care Trust has a comprehensive package of policies and procedures directing staff on matters pertaining to service user care and reporting procedures. Specific training is also provided on areas such as Safeguarding, Recording, Storage and Sharing of Records. A policy library is available to all staff, either via "hard copy", or via the Trust Intranet. Advice and direction is also available at all times from Line Managers and Multi Disciplinary Team.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The service user's files detail referrals made to other services and described their involvement in the decision if they want other professionals to be involved in their care plan. Three service user's care files were reviewed by the inspector during this inspection, this showed referral forms had been completed to other professionals, however two forms were not dated by the person completing them and all three had not been signed. This was discussed with the manager and senior day care worker and a recommendation is made in the appended quality improvement plan about this. The inspector's discussions with six staff generated positive feedback regarding the management of records; reporting arrangements including recording and the management arrangements in the centre. Staff demonstrated their knowledge and experience regarding the referral process and responding to service user's needs and behaviours. Staff felt communication between management and themselves is effective and no concerns were raised. When the manager is absent from the centre, the senior day care worker is the responsible person in charge. Discussions with staff reflect they very much work as a team. The manager's line manager is contactable by mobile phone when she is absent from the centre. The inspector confirmed Trust policies and procedures are in place and available with regards to communication, confidentiality, consent, management of records, monitoring of records and recording and reporting care practices.	Substantially 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:	
Records are maintained in line with Trust requirements. They should be legible. These should be signed and dated by the person making the entry and periodically reviewed by management, within supervision and when monitoring review records/audits.	Moving towards complian
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector examined a sample of three service user individual records which met this criterion. Consultation with six staff confirmed their understanding of this criterion and their role and responsibilities to address this fully when recording in individual files and additional **records**. Improvements are needed with regards to the dating and signing of assessments, care plans and referral forms, a recommendation is made in the appended quality improvement plan about this. A further recommendation is made for the manager to ensure systematic file audits of service users care files are carried out on a regular basis, copies of these should be retained in the respective service user's care file.	Substantially Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE DAY CARE SETTINGS COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	**COMPLIANCE LEVEL**
	Provider to complete

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

Theme 1: The use of restrictive practice within the context of protecting service user's human rights **Theme of "overall human rights" assessment to include:**	
Regulation 14 (4) which states: **The registered person shall ensure that no service user is subject to restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other service user and there are exceptional circumstances.**	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
In line with Trust Policy, restraint is only used when no other option is available to ensure the safety of service users. This is a practice standard emphasised in RESPECT training. Staff endeavour to ensure that prevention and early intervention measures are employed before restraint is considered. If physical intervention measures are not part of a service users plan, then the Positve Behaviour Support team/RQIA will be notified and the situation will be considered and assessed. It may be then appropraiate to include additional measures in the persons care plan to help manage any future incidents. Incidents are recorded and reported in line with requirements of the Northern Trust and RQIA.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector examined a selection of records including a sample of three individual service user records which revealed staff have comprehensive plans in place that clearly describe the day care service user's receive, their likes and dislikes. The manager informed the inspector there have been no occasions since the service's previous inspection where restrictive practices or interventions have been used with service users. Care is focused on meeting individual need, clear communication strategies, diversion, distraction and calming techniques. Service user information is written in the context of staff being able to facilitate positive outcomes in day care and avoid any negative experiences. There is a clear focus on identifying and understanding if service users are not happy; how to manage this sensitively and proactively. Overall the approaches referred to present as sound plans	Compliant

to avoid escalation of behaviour or concerns whilst respecting each individual service user's methods of communicating, their views, choices and needs. Staff attend Respect refresher training once a year as part of the mandatory training programme, this had taken place on 14 January 2015. Consultation with staff revealed their knowledge, skill and competence concerning this which is commensurate with their role and responsibilities. Staff access policies and procedures pertaining to: the assessment, care planning and review; managing aggression and challenging behaviours; recording and reporting care practices; reporting adverse incidents; responding to service users behaviour; restraint and seclusion; and untoward incidents which provide guidance for staff. Discussions with staff validate management and staff member's knowledge about when and why restraint is used including their understanding of exceptional circumstances. Staff working in the centre are aware of the exceptional circumstances when restraint or seclusion should be used. The inspector felt staff were unsure of the Deprivation of Liberty Safeguards (DoLS) and how service user's human rights can be protected if restraint or seclusion is planned for or when it is used reactively. A recommendation is made in the quality improvement plan for management to arrange for staff to receive awareness raising/training concerning these areas.	
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:	
Whatever the situation, all uses of restraint are recorded on the appropriate documentation and sent to the Positive Behaviour Support team/RQIA. Incidents, reports and records are also completed in line with requirements and recorded in the persons care notes and personal file.	Compliant

Inspection Findings:	COMPLIANCE LEVEL
Refer to the inspection findings above for information. Staff are currently using approaches such as sound planning, understanding the service user's needs, clear communication, diversion, one to one time, distraction and activities to avoid any escalation of behaviours. This approach is consistent with the settings ethos, statement of purpose and aims of the service. Guidance on Restraint and Seclusion in Health and Personal Social Services, Department of Health, Social Services and Public Safety, Human Rights Working Group, August 2005 is available. A selection of records in respect of each service user as described in schedule 4 and other records to be kept in a day care setting as per schedule 5 were reviewed by the inspector during this inspection. Several recommendations are made in the quality improvement plan as improvements are needed in the dating and signing of assessments, care plans and referral forms and an identified service user's care plan requires updating so that it fully and accurately reflects the speech and language therapist's recommendations.	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 Northern Trust have developed a dependancy tool to assess client need and calculate the number of staff required to meet service user needs, and this tool has been endorsed by the Northern Board. Where vacancies arise, or cover is required eg. for maternity leave, requests to ensure that appropriate staffing needs are met are submitted promptly to minimise any potential shortfall in provision of care. Where needed, suitably experienced "as and when" or agency staff are utilised to uplift staffing levels. These are staff used on a consistent basis and are familiar with service users, their needs and programmes of care. A flow chart outlining staff roles and lines of accountability is available in the unit. All staff have clear job descriptions, outlining roles, responsabilities and areas of accountability.	Moving towards complian

Inspection Findings:	COMPLIANCE LEVEL
The registered manager and senior day care worker are both qualified and registered with the Northern Ireland Social Care Council (NISCC). All but four care staff are registered with the NISCC. The manager and senior day care worker have 34 years and 21 years' experience respectively in the care sector. In addition to this the manager has a National Vocational Qualification (NVQ) Level 4 in Management and both have NVQ Level 3 awards in Care. One band 5 staff member has successfully completed a QCF level 3. There is a defined management and staff structure in place in the centre. There are six day care workers (one of whom is a registered nurse); thirteen support workers, two catering staff; three domestic staff; four transport drivers and a part time administration worker. Based on the numbers and assessed needs of service users; there would be four day care workers and nine support workers in the main centre; two day care workers and three support workers in the annexe and one day care worker and support worker based in the SCOPE satellite unit. All staff are invited to attend daily meetings in the George Sloane Centre in order to ensure effective communication and to plan the events of the day and ensure staff ratios are adequate to meet the assessed needs of service users. A template for recording these meetings is currently in the process of being devised. There are up to four closure days per year for staff training. Records showed staff meetings are not taking place in accordance with minimum standard 23.8. The most recent full team meeting was held in October 2014, however improvements are needed in the recording of the minutes of staff meetings. It is recommended management ensure staff meetings take place on a regular basis and at least quarterly. Staff unable to attend must read these should evidence they have been informed of it's content. Records are kept of staff meetings which include the dates of meetings, the names of those attending, minutes of discussions and all actions agreed with responsibility for completion assigned and time frames for completion. Management plan to hold team meetings during closure days and will ensure that all meetings are documented. The service's annual report was forwarded to RQIA following this inspection, this was comprehensive, informative and contained information in accordance with Schedule 3. Four monthly monitoring reports were reviewed by the inspector during this inspection. These were qualitative and comprehensive in content. The person undertaking the monthly monitoring visits is advised to consistently record the	Substantially compliant

time of the visit; with regards to the total numbers of service users attending the George Sloane Centre, a proportionate number of service user's views and opinions should be recorded. It is noted that carers or representatives views and opinions are missing from the monthly monitoring reports, the inspector advises the designated person to ensure systems are in place to obtain and record these e.g. telephone contact. This will be monitored at the next inspection.	
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:	
Prior to appointment all staff must demonstraite, via interview and evidence of qualification/experience, that they are suitable for the work that they will be asked to undertake. The Trust expects staff to be suitably qualified and to undertake training and qualifications approppriate to their grade. A regular programme of mandatory and vocational training is provided to enable staff to continually develop their skills and knowledge.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
A requirement about formal supervision had been made as a result of the previous inspection of George Sloane Centre in January 2014. Discussions with the manager concluded two thirds of staff receive formal supervision in accordance with standard 22. Review of four staff files and discussions with six care staff verified this. There was evidence several staff have not received formal supervision in approximately a year. This requirement is therefore restated in the appended quality improvement plan and must be met. Assurances were given to the inspector that a formal supervision matrix would be devised which would clearly highlight when this is to be provided in accordance with minimum standard 22.2. Supervision records provided evidence of how the staff member's role improves outcomes for the service users who attend the day care setting. A previous recommendation had been made about ensuring staff receive annual appraisals from the last inspection. Discussions with the manager, six care staff and review of four staff files conclude two thirds of staff have received an annual appraisal in the previous year. Arrangements are in place by the Trust for an identified person to complete these with staff in George Sloane Centre. A requirement is made about annual appraisals in the appended quality improvement plan.	Substantially compliant

Regulation 21 (3) (b) which states: • **(3) For the purposes of paragraphs (1) and (2), a person is not fit to work at a day care setting unless –** • **(b) he has qualifications or training suitable to the work that he is to perform, and the skills and experience necessary for such work**	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
Prior to appointment all staff must demonstraite, via interview and evidence of qualification/experience, that they are suitable for the work that they will be asked to undertake. The Trust expects staff to be suitably qualified and to undertake training and qualifications approppriate to their grade. A regular programme of mandatory and vocational training is provided to enable staff to continually develop their skills and knowledge.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The Trust's Human Resources Department are responsible for ensuring compliance with regulation 21(3)(b) and as such retain evidence and carry out all relevant checks concerning this. Since the service's previous inspection, three new staff have been employed in the George Sloane Centre. One new staff member's file was reviewed by the inspector. This did not contain a completed induction and orientation checklist in accordance with good practice and the Northern Ireland Social Care Council's (NISCC) Induction guidelines. Management gave assurances a full and detailed induction and orientation of the George Sloane Centre did take place but acknowledge the lack of evidence regarding this. In addition to the Trust's Corporate Induction training for new staff, the manager must ensure orientation and induction documentation for newly appointed staff (including agency staff and students) concerning the George Sloane Centre is retained in the respective staff files. This should incorporate and reflect NISCC Induction guidelines. A recommendation has been made in the appended quality improvement plan about this.	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
	Substantially compliant

Additional Areas Examined

Complaints

The complaints record was reviewed as part of this inspection and did not reveal any concerns.

Compliments

Positive comments were shared with management regarding the many compliments recorded about the quality of care provision in the George Sloane Centre.

Incidents/Accidents

The inspector randomly sampled the centre's accident and incident records. An accident had occurred in the grounds of the George Sloane Centre involving a service user which resulted in him/her being assessed by a nurse. This was not recorded in the centre's accident/incident records. The manager was advised to retrospectively record this and to notify RQIA of this in accordance with regulation 29. The manager agreed.

Service User Care Files

The inspector reviewed three service user's care files during this inspection. These were comprehensive and reflected person centred care plans completed in user friendly language, however as specified in standard 7; improvements are needed in assessments and care plans.

The registered manager must ensure:

(a) all service user's assessments and care plans are up to date,

(b) assessments, care plans and referral forms are signed and dated by the person completing them;

(c) the identified service user's care plan is updated to fully and accurately reflect his/her current needs and the recommendations from the Speech and Language Therapist's recent assessment;

(d) care plans must reflect details of the matters specified in minimum standard 5.2;

(e) service user's annual review preparation reports contain information on each area specified in minimum standard 15.5.

Registered Manager Questionnaire

The manager submitted a questionnaire to RQIA following this inspection. The information provided confirmed that satisfactory arrangements are in place regarding governance and management, recruitment and induction of care staff, policies and procedures, responding to service user's behaviour and reporting of accidents and incidents. The information was verified during the inspection visit, from written records and from discussions with the manager and staff members.

Fire Safety

The centre's Fire Risk Assessment was reviewed on 5 November 2014. Fire training took place on three occasions in 2014, in January, June and July. The service's annual report completed on 6 February 2015 showed there has not been a fire drill in the George Sloane Centre since June 2013. Minimum standard 28.6 states:

"All staff attend a fire evacuation drill at least once per year."

The manager informed the inspector by email that a fire drill had taken place in the George Sloane Centre on 20 February 2015. Monitoring arrangements should be in place to ensure fire safety drills take place in accordance with minimum standards and safe working practices.

Discussions with Professionals/Visitors

During the inspection, the inspector met with a Consultant Psychiatrist who regularly uses a room in the George Sloane Centre to host clinics for service users' in the community. The professional's views were very positive with regards to effective communication with management of the centre and the staff team. She stated she felt it was a well run centre, a happy place with a great staff team. No concerns or issues were raised.

Environment

The inspector was accompanied by the locality manager on a tour of the environment. Positive comments were shared with management with regards to the spacious, bright and well decorated group rooms and dining room. Areas used by service users' were warm, tidy and fit for purpose. Group rooms and corridors displayed service users art work, photographs and murals. The George Sloane Centre won the Best Kept Adult Centre award in 2014 by the N.I. Amenity Council, Northern Region and the centre was awarded second place in 2013. Management, staff and service users are to be commended on this.

The double exit doors of room 2 leading to an enclosed paved area are leaking in rain and the inspector observed rolled up towels had been placed along the bottom of these doors. Staff informed the inspector drafts blow through the bottom of the doors. The area of the roof above the entrance doors is also leaking rain water through the ceiling and a requirement is made in the quality improvement plan that these identified areas are repaired / made good.

The flooring in room 5 of the annexe is very worn in places, discoloured and has various paint stains probably made when the room was a workshop. Bare wood was observed on areas of an old table in room 5 and part of the edging is missing, this table should be replaced so that it can be effectively cleaned. The pitched external wood panelling of room 1 needs to be sanded and repainted. The Trust should consider adding George Sloane Centre signage to this area. A recommendation was made in the quality improvement plan about these areas.

The Trust undertook a Regional Cleanliness Audit in April 2014, this was very comprehensive and contained action points for improvement which management are progressing with.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with the senior day care worker by telephone on 4 February 2015, 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:

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

Quality Improvement Plan

Primary Unannounced Care Inspection

George Sloane Centre

28 January 2015

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 Kelli Feeney Gordon, senior day worker (registered manager/ person receiving feedback) 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	26(2)(b)	**Environment** The registered person must ensure: (a) the double doors leading from room 2 to the outside paved area are fit for purpose; (b) The area of the roof above the entrance doors is made good so that it no longer leaks rain (additional information section refers).	Once	Referred again to estate services along with requirement date of 31.03.15 - Requests to repair and add a weather strip to doors also request to make good roof above entrance hall. Part now received (aluminium drip) – to be fitted and complete by 15th April 2015. Water leak repaired. Re-decoration works currently underway. To be completed by 24 April 2015.	By 31 March 2015
2	20(1)(c)(i)	**Annual Appraisals** The registered person must ensure all care staff employed in the George Sloane Centre receive an annual appraisal (Theme 2 refers).	Third	Attached matrix, to date all staff have received their PDP. The matrix includes dates of further KSF appraisals that are on-going.	Immediate and Ongoing with an update forwarded to RQIA Inspector by 1 April 2015
3	20(2)	**Formal Supervision** In accordance with minimum standard 22.2, the registered person must ensure all care staff receive formal written supervision at least every three months (Follow up on previous issues and Theme 2 refers).	Third	Management are currently working on bringing formal supervisions back in line.Formal supervision will be back on track by end of March, and will be 3 monthly thereafter as set out in contracts.	Immediate and Ongoing with an update forwarded to RQIA Inspector by 1 April 2015

Recommendations

These recommendations are based on The Day Care Settings Minimum Standards January 2012. This quality improvement plan may reiterate recommendations which were based on The Day Care Settings Minimum Standards (draft) and for information and continuity purposes, the draft standard reference is referred to in brackets. These recommendations are also based on research or recognised sources. They promote current good practice and if adopted by the Registered Person may enhance service, quality and delivery.

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details of Action Taken By Registered Person(S)	Timescale
1	25.1	**Environment** The registered person must ensure: (a) New flooring is laid in group 5 in the annexe; (b) A new table is provided in group 5 and a review is undertaken of all tables and chairs in the annexe to ensure they are fit for purpose and are easily cleaned. (c) Make good the external wooden panelling above group 1 and consider adding signage to this (additional information section refers).	Once	Minor works completed for new flooring with dates for completion in accordance with QIP Member of staff allocated to carry out checks on all furniture needing replaced. New furniture ordered for room 5. Refferal to Estates for signage has been submitted, alongside the request to make good wooden panelling outside. Re. (a) Flooring being programmed for re-painting under routine estates maintenance. To be completed on or before 30 June 2015. Re. (c) Re-decoration works currently underway. To be completed by 24 April 2015 (weather permitting). New signage being ordered & fitted - completion by 29 May 2015.	By 30 June 2015

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details of Action Taken By Registered Person(s)	Timescale
2	17.9	**Service User file audit** It is recommended the manager ensures systematic file audits are carried out on a regular basis of service user's care files. Copies of the audits should be included in the service user's care file (standard 7 and Theme 2 refers).	Once	Files will continue to be audited during monotoring visits. An audit form has been devised for staff and management to ensure files are regularly checked. These will be kept in each clients personal file.	Immediate and on-going
3	7.7	**Service User's Care Information** The registered manager must ensure: (a) all service user's assessments and care plans are up to date, (b) Assessments, care plans and referral forms are signed and dated by the person completing them (standard 7 refers).	Once	The file audits will highlight any missing information, signatures and dates. This will remind staff to bring any amendments, etc to managers attention for signing this has been discussed with staff at team meeting.	Immediate and on-going

4	5.6	**Service User Care Plans** The registered manager must ensure: (a) the identified service user's care plan is updated to fully and accurately reflect his/her current needs and includes relevant information from the recommendations made in the Speech and Language Therapist's recent assessment. (b) Monitoring and peer review systems should be established to ensure all service user care plans include information arising from assessments. Care plans must reflect details of the matters specified in minimum standard 5.2 (standard 7 refers).	Once	Staff to ensure care plans are updated following reviews to include programmes / recommendations from the multi-disciplinary team, and signed off by manager. Member of staff tasked introducing the easy read versions of documentation throughout the files. This will commence the peer to peer review of files.	Immediate and on-going
5	15.5	**Service User Annual Review Preparation Report** The registered manager must ensure service user's annual review preparation reports contain information on each area specified in minimum standard 15.5 (additional information section refers).	Once	Easy read review reports have been amended to include information from standard 15.5.	Immediate and on-going

6	21	**<u>Training/Awareness Sessions</u>** It is recommended management arrange for staff to receive training / awareness raising of: (a) Deprivation of Liberty Safeguards (b) Confidentiality & Data Protection (c) Process of service user's or their representatives requesting access to their care information (standard 7 and theme one refers). (d)	Once	Training on Deprivation of Liverty Safeguards and information Governance has been organised for 23rd June 2015. Awareness training on access care file information, policy guidelines and flyers shared with staff. All other awareness training will be delivered to staff during full staff meetings. E-Learning will provide staff with the opportunity to complete awareness sessions relative to sharing of information and data protection.	By 31 March 2015

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details of Action Taken By Registered Person(s)	Timescale
7	21.1	**Orientation and Induction for New Staff** In addition to the Trust's Corporate Induction training for new staff, the manager must ensure there is evidence that newly appointed staff (including agency staff and students) have completed a structured orientation and induction to the centre. This should incorporate and reflect the Northern Ireland Social Care Council's (NISCC) Induction guidelines (Theme 2 refers).	Twice	Trust Induction Policy implemented for new staff and in-house inductin covering all areas within the centre including operational management to ensure staff are aware of the lines of communication.	Immediate and on-going
8	23.8	**Staff Meetings** It is recommended management ensure staff meetings take place on a regular basis and at least quarterly. Staff unable to attend must read these should evidence they have been informed of it's content. Records are kept of staff meetings which include: • Dates of meetings • Names of those attending • Minutes of discussions • All actions agreed with responsibility for completion assigned and time frames for completion (Theme 2 refers).	Once	A new template has been devised to record daily morning meetings and staff signatures. A staff member has been allociated to ensure all other staff read and sign the minutes if they are not present. Full staff meetings will continue to be incorporated into closure days. One has already taken place on 10th March 2015, next meeting due on 2nd April 2015.	Immediate and on-going

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes the responses are acceptable regarding requirements 2 and 3, recommendations 1(b) 2, 3, 4(b), 5, 6 and 8. No the responses are unacceptable regarding requirement 1, recommendations 1(a) and (c), 4(a) and 7. Further information and confirmation is requested in these areas.	Louise McCabe	By 15 June 2015

Further information requested from provider	Confirmation is required from the Trust that the Estates Department has completed works in the George Sloane Centre regarding requirement 1 as the timescale was by 31 March 2015: (a) the double doors leading from room 2 to the outside paved area are fit for purpose; (b) The area of the roof above the entrance doors is made good so that it no longer leaks rain. Confirmation is also required from the Trust that the Estates Department will have the following work completed by 30 June 2015: (a) New flooring is laid in group 5 in the annexe; (b) Make good the external wooden panelling above group 1 and consider adding signage to this. With regards to standard 5.6, the registered manager is asked to confirm the identified service user's care plan has been updated to fully and accurately reflect his/her current needs and includes relevant information from the recommendations made in the Speech and Language Therapist's recent assessment. The registered manager is asked to confirm written documentation / evidence is now in place showing all new staff have completed their orientation and induction.	Louise McCabe	Information to be received by 15 April 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	Dorothy Robinson/ Kelli Gordon
Name of Responsible Person / Identified Responsible Person Approving Qip	Dr Tony Stevens

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Second response assessed by inspector as acceptable	Yes	Louise McCabe	22 April 2015
Further information requested from provider			