# Unannounced Day Care Setting Inspection Report
# 05 August 2016

## Gloucester Park Day Centre

**Address: Gloucester Park, Larne, BT40 1PD**
**Tel No: 02828274311**
**Inspector: Priscilla Clayton**

## 1.0 Summary

An unannounced inspection of Gloucester Park Day Centre took place on 05 August 2016 from 10.00 to 15.30 hours.

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 which included appropriate staffing, 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.

No requirements or recommendations were made in this domain.

**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.

Four recommendations identified for improvement from the inspection of the “effective care” domain related to staff recording of notes within care records, provision of service user agreements and the submission of a report on the outcome of the service user satisfaction survey. One recommendation was reiterated from the previous inspection which included the repair/replacement of flooring in one toilet.

**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 examples of a well led service found throughout the inspection with systems and process in place for the effective day to day management of the centre. 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.

Two recommendations made related to audit of care records and provision of a complaint template.

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 |
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| **Total number of requirements and recommendations made at this inspection** | 0 | 6 |

Details of the QIP within this report were discussed with Catherine Kerr, "acting" 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 taken following the most recent care inspection

One recommendation from the previous care inspection has been restated for a second time. This recommendation related to the flooring in one toilet area of the centre.

## 2.0 Service details

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| **Registered organization/registered person:**<br>Northern HSC Trust/Dr Anthony Baxter Stevens | **Registered manager:**<br>Catherine Kerr |
| **Person in charge of the day care setting at the time of inspection:**<br>Catherine Kerr | **Date manager registered:**<br>Catherine Kerr- application received at RQIA - "registration as registered manager is pending".<br>. |
| **Number of service users accommodated on day of Inspection:**<br>45 | **Number of registered places:**<br>65 |

## 3.0 Methods/processes

Prior to inspection the following records were inspected:

- RQIA Certificate of registration
- Staff duty rota
- 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
- Audits
- Equipment maintenance records
- Accident/incident/notifiable events records(7)
- 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.

During the inspection the inspector met with 9 service users individually and with others in small group format, four staff including the manager. No relatives/representatives or professional staff visited the centre during the inspection.

A total of 15 satisfaction questionnaires were provided for distribution to service users, relatives/representatives and staff for completion and return to RQIA. No questionnaires were returned to RQIA within the timescale.

An inspection of the internal environment was undertaken.

## 4.0 The inspection

### 4.1 Review of requirements and recommendations from the most recent inspection dated 27 May 2015

The most recent inspection of the day care centre 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 27 May 2015

| Last care inspection statutory requirements | | Validation of compliance |
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| **Requirement 1**<br><br>**Ref**: Regulation 26(2)(c)<br><br>**Stated:** First time | The registered persons must ensure:<br><br>(a) The identified damaged pedestal of the toilet in the male WC must be replaced<br><br>(b) The lock is replaced on the male WC door (room 113).<br><br>The completed returned quality improvement plan must state the date these matters were actioned. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Work in regard to replacement of the pedestal and toilet door lock was completed as required. | |
| **Requirement 2**<br><br>**Ref**: Regulation 26(2)(c)<br><br>**Stated:** First time | The registered persons are asked to review the arrangements for responding to service users using the call bell in the toilets.<br>The completed returned QIP must state the outcome of this review and the actions to be taken (with timeframes) to ensure staff are able to hear and immediately respond to the call bell system. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The call bell panel has been moved from the office into the main reception area so that all staff is aware of calls for assistance. | |

| Last care inspection recommendations | | Validation of compliance |
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| **Recommendation 1**<br><br>**Ref**: Standard 5.3 and 5.6<br><br>**Stated:** First time | The manager must ensure all care plans are signed and dated by the service user, the member of staff completing it and the manager. Where the service user is unable to or chooses not to sign any document, this should be recorded and the basis of his or her agreement to participate noted.<br><br>When changes are made to the service user's care plan, the manager must ensure these are signed and dated by the service user, the member of staff completing it and the manager. The identified care plans are to be dated and signed by relevant parties. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Care plans signed in keeping with good practice. Audit of care file records has been established by the manager with a record of the outcome retained in each file. | |
| **Recommendation 2**<br><br>**Ref**: Standard 21.4<br><br>**Stated:** First time | The manager should make appropriate arrangements to further improve staff awareness in continence care and promotion of same with service users. The returned QIP must detail arrangements in place to address this improvement. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>Staff training was undertaken on 12 October 2015 by two staff who then provided training for the remaining care staff. Records were retained. | |

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| **Recommendation 3**<br><br>**Ref**: Standard 5.2<br><br>**Stated:** First time | With regards to continence promotion with service users and where staff support and assistance is needed, the manager must ensure:<br><br>(a) Where appropriate service user's care plans detail:<br>• if staff prompting is needed and describe the language or signs used<br>• if the service user has a preferred bathroom or WC<br>• the type of support and staff assistance needed<br>• the name and type of continence product used<br><br>(b) Where the continence product is stored. Individual service user's continence products are not visible in the closed storage boxes.<br><br>(c) In order to protect service user's confidentiality and preserve their dignity and privacy; staff should ensure the names of service users are not displayed on the box containing their continence products. This is so other service users using the bathroom cannot identify who uses the products. Consideration should be given to other appropriate methods of identifying service user's boxes of continence products. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>a) Care plans examined reflected information as recommended.<br>b & c) Incontinence garments were being stored appropriately within a cupboard with garments named accordingly. | |

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| **Recommendation 4**<br><br>**Ref**: Standard 14.10<br><br>**Stated:** First time | The manager must ensure all areas of dissatisfaction, concern and complaints, formal or otherwise or recorded in the centre's complaints record. The area of concern identified during this inspection is to be retrospectively recorded in the complaints book. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>The manager confirmed that all concerns expressed were now recorded within the complaints record file. One complaint, as reflected within this recommendation has been recorded. | |
| **Recommendation 5**<br><br>**Ref**: Standard 8.3<br><br>**Stated:** First time | The manager should ensure the minutes of service user's meetings contain:<br><br>• An agenda<br>• The names of those attending;<br>• A summary of the matters discussed<br>• Any actions agreed with who is responsible for completing them with time frames<br>• Minutes of the next meeting must detail if the actions from the previous meeting were completed. | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>Notes of meetings held contained information as recommended. | |
| **Recommendation 6**<br><br>**Ref**: Standard 15.3<br><br>**Stated:** First time | The manager must ensure:<br><br>(a) the two identified service user's annual reviews of their day care placements are held as soon as possible and where possible with the referral agent.<br><br>(b) Service user's annual review reports contain information on all relevant areas specified in standard 15.5 | **Met** |
| | **Action taken as confirmed during the inspection**:<br><br>The two reviews referred to in this recommendation had been addressed as recommended. Dates of reviews are recorded within the centre's diary which is held in the office.<br>Annual review reports contained relevant information. | |

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| **Recommendation 7**<br><br>**Ref**: Standard 25.3<br><br>**Stated:** First time | The registered persons are asked to state on the completed returned QIP the action to be taken with timescales to replace the fluorescent strip lighting lengthways on the ceiling concerning the recommendation made as a result of the visually impaired audit of Gloucester Park Day Centre. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Florescence light has been replaced as recommended. | |
| **Recommendation 8**<br><br>**Ref**: Standard 25.1<br><br>**Stated:** Second time | The registered persons must ensure the works request (Job number 379590) is actioned so that the stained flooring in the identified WCs is replaced. The completed returned QIP must state the date the flooring will be replaced. | **Not Met** |
| | **Action taken as confirmed during the inspection**:<br>The flooring has not been replaced. Following the inspection the manager submitted a written response to RQIA confirming that this work would be completed by 31 August 2016.<br><br>The completed returned QIP must confirm the action taken including date of completion. | |
| **Recommendation 9**<br><br>**Ref**: Standard 21.4<br><br>**Stated:** First time | The manager must ensure the training and equipment issues identified by staff in completed RQIA questionnaires are addressed. The training areas concern:<br><br>• Whistleblowing<br>• How to report poor staff practice<br>• Core values<br>• Communication methods<br><br>The completed returned QIP must specify the action taken with timescales of when the above training is provided to staff. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Training as listed was provided on 15 November 2015. Equipment issues identified has been addressed as recommended. | |

## 4.3 Is care safe?

The manager confirmed that staffing levels were satisfactory and explained that three staff on long term leave was returning to work soon. Cover was provided on most days as reflected within the staff duty roster. A newly appointed day care worker is to commence on 22 August 2016. The manager confirmed that staffing levels are subject to regular review to ensure the assessed needs of the service users were met.

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. A schedule for mandatory training, annual staff appraisals and staff supervision was maintained and was available for inspection.

The manager and staff confirmed that competency and capability assessments were undertaken for any person who is given the responsibility of being in charge of the home for any period in the absence of the manager. A review of a sample of staff competency and capability assessments were found to satisfactory.

Discussion with the manager confirmed that staff were recruited in line with Regulation 21 (1) (b), Schedule 2 of The Day Care Setting 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 and best practice.

Discussion with staff confirmed that they were aware of the new regional policy entitled, Adult Safeguarding Prevention and Protection in Partnership (July 2015) and the NHSC Trust had 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. 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.

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 and recorded. Inspection of three care records confirmed there was a system of timely referral to the multi-disciplinary team when required. Trust specialist behaviour management teams were available if referral was necessary.

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.

Notifications of accidents/incidents were submitted as required. Seven notifications were discussed with the manager. Appropriate action was taken to minimise risks identified.

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

A user friendly Health and Safety Law poster was displayed within the hallway of the centre.

Review of the infection prevention and control (IPC) policy and procedure (2015) confirmed that the policy was in line with regional guidelines. Staff training records confirmed that all staff had received training in IPC (October 2015); which was in line with their roles and responsibilities. Inspection of the centre confirmed that there were wash hand basins, adequate supplies of liquid soap, alcohol hand gels and disposable towels wherever care was delivered. Observation of staff practice identified that staff adhered to IPC procedures.

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. Additional user friendly information leaflets displayed included topics on hearing loss, dementia, social care benefits, social care governance and alcohol abuse. One service user stated he had seen the leaflets and had brought a few home for the family.

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. No recommendations for action were made.

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 indicated they were very satisfied with the care provided. No issues or concerns were expressed or indicated.

**Areas for improvement**

No areas were identified for improvement in this domain.

| Number of requirements: | 0 | Number of recommendations: | 0 |
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## 4.4 Is care effective?

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

A review of three care records confirmed that these were maintained in line with the legislation and standards. Care records examined contained an up to date assessment of needs, life history, risk assessments, associated care plans and daily/regular statement of health and well-being of the service user. Care records also reflected the 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.

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. For example; care records showed that service users were consulted with 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 do not leave gaps between dated recordings.

The manager confirmed that arrangements are in place to monitor, audit and review the effectiveness and quality of care delivered to service users at appropriate intervals. Annual reviews are conducted and audit of finance, medications, environmental cleanliness and monthly monitoring visits undertaken. The manager is currently working on the development of a tool for audit of care record files which would include all fully completed documents required and standard of recording within each file. One recommendation was made regarding completion of this work. Care records were being securely stored.

The manager advised that written service user agreements setting out the terms and conditions of service for service users was work in progress. One recommendation was made on the availability of agreements.

The manager explained that a service user satisfaction survey was undertaken earlier this year. No recorded summary of outcome was available. The manager agreed to forward a summary report on the outcome to RQIA including action taken to address any issues and improvements made.

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

Service users spoken with during the inspection alongside observation of practice evidenced that staff were able to communicate effectively with service users.
Service users meetings were being held on a monthly basis with minutes recorded.

A review of care records along with accident and incident reports confirmed that referral to other healthcare professionals was timely and responsive to the needs of the service users.

Service users provided the following comments:

“There is always staff around to see to us”.
“We have meeting and can raise any issues or talk about activities”.
“I notice staff wash their hands very often”.
“If I wasn’t happy about something I would just say to the staff and they would be put it right”.

**Areas for improvement**

Three areas identified for improvement in the “effective care” domain related to recording of notes within care records, provision of service user agreements and the submission of a report on the outcome of the service user satisfaction survey.

| Number of requirements: | 0 | Number of recommendations: | 4 |
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## 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, service users and one representative 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.

**Areas for improvement**

There were no areas identified for improvement in this domain.

| Number of requirements: | 0 | Number of recommendations: | 0 |
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## 4.6 Is the service well led?

Catherine Kerr, the manager who was appointed in January 2016 has settled very well into her new post. The manager has many years of experience working in community settings and has reviewed most systems and processes in the management of the centre. Her application for registration as manager is being processed by RQIA.

There was a clear organisational structure and all staff 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 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

A range of policies and procedures were in place to guide and inform staff. Policies were centrally indexed and retained in a manner which was easily accessible by staff. Policies and procedures examined were systematically reviewed every three years or more frequently as changes occurred.

The centre had a complaints policy and procedure which was in accordance with the legislation and DHSPPS 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 records confirmed that arrangements were in place to effectively manage complaints from service users, their representatives or any other interested party. Records of complaints were discussed with the manager who agreed that the development of a template to record all complaints would help to ensure consistency in recording. Details include investigation undertaken, all communication with complainant, outcome and the complainant's level of satisfaction. One recommendation was made in this regard.

Arrangements were in place to share information about complaints and compliments with staff. Many complimentary letters and cards had been received from relatives/representatives.

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.

Regular audit of accidents and incidents was recommended so that any trends or patterns could be identified and action taken as necessary.

Reconciliations of financial and personal possessions held by the centre on behalf of service users 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 where necessary shared with staff at meetings held.

Discussion with the manager confirmed that information in regard to current best practice guidelines was made available to staff. Staff were provided with mandatory training and additional training opportunities relevant to any specific needs of the service users. For example: dysphasia and person centred planning.

A monthly monitoring visit was undertaken as required under Regulation 29 of The Residential Care Homes Regulations (Northern Ireland) 2005; a report was produced and made available for service users, their representatives, staff, trust representatives and RQIA to read.

Review of records and discussion with the manager and staff confirmed that any adult safeguarding issues were managed appropriately and that reflective learning had taken place. The registered 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. 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. There were also open and transparent methods of working and effective working relationships with internal and external stakeholders.

**Areas for improvement**

Two recommendations identified for improvement from the "is care compassionate" domain:

- Development of regular audits of accidents/incidents so that trends/patterns can be identified and action taken to address any issues identified.
- Development of a template for recording complaints would help to ensure consistency in recording.

| Number of requirements: | 0 | Number of recommendations: | 2 |
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## 5.0 Quality improvement plan

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

The registered person/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 person/manager 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 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.

## 5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s 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. They promote current good practice and if adopted by the registered person(s) may enhance service, quality and delivery.

## 5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to Day.Care@rqia.org.uk and assessed 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 person/manager 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 person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

## Quality Improvement Plan

| Recommendations | |
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| **Recommendation 1**<br><br>**Ref**: Standard 25.3<br><br>**Stated:** Third time<br><br>**To be completed by:**<br>31 August 2016 | The registered persons must ensure the works request (Job number 379590) is actioned so that the stained flooring in the identified WCs is replaced. The completed returned QIP must state the date the flooring will be replaced.<br><br>Following the inspection the manager provided written confirmation to RQIA that this work would be completed by 31 August 2016. The action taken by this date should be confirmed in the returned QIP. |
| | **Response by registered person detailing the actions taken:**<br>This work has now been completed. |
| **Recommendation 2**<br><br>**Ref**: Standard 19<br><br>**Stated:** First time<br><br>**To be completed by:**<br>31 August 2016 | The manager should ensure that staff does not leave gaps between dated recordings within care record notes. |
| | **Response by registered person detailing the actions taken:**<br>Staff are aware not to leave a line between recordings in care notes. |
| **Recommendation 3**<br><br>**Ref**: Standard 17.9<br><br>**Stated:** First time<br><br>**To be completed by:**<br>31 October 2016 | The manager should ensure audits of individual care record files are undertaken which includes documents required and standard of recording within each file.<br><br>(Further reference: DNSSPS guidelines for record management are available at: http://www.dhsspsni.gov.uk/index/gmgr.htm). |
| | **Response by registered person detailing the actions taken:**<br>A process of audit of individual care record files is now in place. |
| **Recommendation 4**<br><br>**Ref**: Standard 3<br><br>**Stated:** First time<br><br>**To be completed by:**<br><br>30 November 2016 | The manager should ensure that written service user individual agreements setting out the terms and conditions of service are available for each service user. |
| | **Response by registered person detailing the actions taken:**<br>A service user agreement form is currently being developed and will be made available once finalised. |

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| **Recommendation 5**<br><br>**Ref**: Standard 14.10<br><br>**Stated:** First time<br><br>**To be completed by:**<br>31 October 2016 | The manager should develop a template for the recording of complaints received to ensure consistency and that staff record full details and consistency of information is included by staff. |
| | **Response by registered person detailing the actions taken:**<br>A template for recording complaints is in place in our complaints book |
| **Recommendation 6**<br><br>**Ref**: Standard<br><br>**Stated:** First time<br><br>**To be completed by:**<br><br>31 September 2016 | The manager should ensure that a summary report on the outcome of the service user satisfaction survey is developed which includes for example any action taken to address improvements. A copy of this report should be forwarded to RQIA. |
| | **Response by registered person detailing the actions taken:**<br>The summary report from the service user survey has now been received and shared with RQIA. |

***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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