Primary Announced Care Inspection

Name of Establishment:	**Foyle Disability Resource Centre**
Establishment ID No:	**11227**
Date of Inspection:	**10 March 2015**
Inspector's Name:	**Priscilla Clayton**
Inspection No:	**IN020056**

The Regulation And Quality Improvement Authority
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Name of centre:	Foyle Disability Resource Centre
Address:	Glen Road Londonderry BT48 0BX
Telephone number:	028 7126 6593
E mail address:	cathal.macelhatton@westerntrust.hscni.net
Registered organisation/ Registered provider:	Western Health and Social Care Trust Ms Elaine Way CBE
Registered manager:	Cathal MacElhatton
Person in Charge of the centre at the time of inspection:	Cathal MacElhatton
Categories of care:	DCS-PH, DCS-SI
Number of registered places:	89
Number of service users accommodated on day of inspection:	35
Date and type of previous inspection:	26 February 2014 Primary Announced
Date and time of inspection:	10 March 2015: 10.30am – 4pm
Name of inspector:	Priscilla Clayton

1.0 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.

2.0 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.

3.0 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.

4.0 Consultation Process

During the course of the inspection, the inspector spoke to the following:

Service users	**24**
Staff	**5 including the manager**
Relatives	**1**
Visiting Professionals	**nil**

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	**11**	**8**

5.0 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.

6.0 Profile of Service

Foyle Disability Resource Day Centre is owned and managed by the Western Health and Social Care Trust and is located in a residential area of Londonderry in close proximity to the city centre. The centre shares the building with the Community Brain Injury Support Team.

The centre can accommodate up to 35 persons each day who have physical disabilities, sensory disabilities, or an acquired brain injury with associated disabilities.

The focus of the centre is to maximise service user independence through programmes of therapeutic, social, recreational and educational activities.

The service is delivered on five days per week from 9.00am to 5.00pm with service users attending on designated days.

7.0 Summary of Inspection

The primary announced inspection of Foyle Disability Resource Centre took place on 10 March 2015 between the hours of 10.30am and 4 pm. The registered manager, Cathal MacElhatton and a team of six mixed skill care staff were on duty.

Five requirements and nine recommendations were made at the previous inspection conducted on 26 February 2014.Following discussion with the registered manager one recommendation relating to complaints' recording was reiterated for a second time.

Prior to the inspection, the registered manager completed a self -assessment of the standard criteria outlined in the standard and two themes to be inspected.

The inspector met with service users and staff, discussed the day to day arrangements in relation to the conduct of the day centre and standard of care provided to service users, observed care practice, examined a selection of records and carried out a general inspection of the day care environment.

Throughout the inspection service users were observed participating in various planned therapeutic activities. Service users were enabled to participate in activities of their choice by the provision of equipment, aids and support from staff.

7.0 Inspection findings

Standard 7 – Individual service user records and reporting arrangements.

Policies and procedures on Confidentiality, Data Protection and Management of Records were in place and available to staff who demonstrated knowledge and understanding of good professional practice in regard to recording and record keeping including assessment, care planning and review. Care records examined reflected user / representative consultation in regard to assessment, care planning, care reviews.

Care records examined were legible, current, dated / signed and securely stored.

The supporting evidence gathered through the inspection process concluded that Foyle Disability Resource Centre was compliant with Standard 7. This is to be commended.

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

Review of the arrangements in place for responding to service user's behaviour was undertaken.

The centre had a policy and procedure which reflected best practice guidance in relation to management of actual and potential aggression, restraint, seclusion and human rights.

Staff training in management of actual and potential aggression (MAPA) was being provided annually. Staff who spoke with the inspector demonstrated knowledge of the policy and procedure to follow should challenging behaviour ever arise

Through observation, review of documentation and discussion with staff and service users, confirmation was obtained that restraint would only ever be used as a last resort and that no form of restrictive practice or challenging behaviour had occurred.

The supporting evidence gathered through the inspection process concluded that Foyle Disability Resource Centre was compliant with Theme 1. This is to be commended.

Theme 2 - Management and control of operations.

The defined management structure of the centre was reflected within the centre's Statement of Purpose (dated 2009). It was recommended that this document is reviewed and revised to include the change of named senior managers.

The registered manager, who has been in post since 2000, is supported in his role at senior management level by the Head of Service, Cathy Downey, who meets with the registered manager on a regular basis. At operational level support is provided by a mixed skill team of care staff.

Supporting evidence of the level of compliance with this theme was obtained from associated policies / procedures, examination of a sample of records maintained including for example; staff induction records, staff appraisal and supervision, staff meetings and mandatory training. In addition discussion was held with staff, service users and one visitor.

Examination of records and discussion with staff, service users and one visitor evidenced that the centre was compliant with Theme 2. This is to be commended.

Conclusion

The registered manager and staff are to be commended with the outcome of this inspection with compliance achieved in Standard 7, Theme 1 and 2.

Two requirements and three recommendations were made as a result of this inspection; these are contained within the appended Quality Improvement Plan.

The inspector wishes to thank the service users, staff and the registered manager for their assistance and co-operation throughout the inspection.

8.0 Follow-Up on previous inspection conducted on 26 February 2014

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	Regulation 28 (5)	Copies of the regular qualitative reports by the Assistant Director for the service should be kept in the centre.	All copies of the monthly visits are retained in the centre and were available on the day of inspection.	Compliant
2	Regulation 28 (3) Ref: 17.10	Monitoring visits to be carried out on a monthly basis.	Discussion and examination of monthly monitoring visits were in place.	Compliant
3	Regulation16 (1) Ref: 6.1	The registered person shall ensure that a written care plan is prepared in consultation with the service user or the service user's representative as to how the service user's needs in respect of the day centre are to be met.	Care plans randomly selected and reviewed evidenced that these were signed by service user / representative.	Compliant
4	13.5 Ref: Regulation 29 (d)	The centre should report any incident in day care which adversely affects the service user.	The manager reported that no accidents which adversely affected any service user had occurred. Should d there be any incidents in this regard the manager would notify RQIA.	Compliant
5	Schedule 1	Information on the review process to be developed and information pertaining to the role and function of the RQIA to be included in the management of complaints.	Details as recommended were included within the policy and a notice displayed to this effect.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	15.1	The centre should invite a member of an advocacy group to visit the centre and meet with service users and their relatives to explain the role of an advocate.	Invitation to the local advocacy group had been made by the manager. Minutes of meetings held were in place.	Compliant
2	15.2	Staff to receive training on the review process.	The manager and staff confirmed that training in person centred planning, which included review process, had been provided.	Compliant
3	15.2	Information relating to review should be signed and dated with the designation of those involved also recorded.	Review records retained were dated and signed.	Compliant
4	15.3	A review should be held following a change of circumstances.	The manager confirmed that review would always be requested and held when there is a change in a service user's circumstances. This was shown in two care records examined.	Compliant
5	15.4	Information for review should be further developed to include all aspects of care.	Review templates had been further developed to include details as recommended..	Compliant
6	15.6	The Regulation 28 monitoring should include audit of reviews held during the month and follow-up action to ensure that all recommendations from review are completed.	Monthly monitoring visits examined included review and action as recommended.	Compliant

7	14.10	The centre should maintain a complaints record in accordance with standard 14.10.	The manager confirmed that the Trust template for recording complaints had not been used for informal complaints and that details would be recorded within a book held at reception. However details within this book fell short of the minimum standard. This recommendation is reiterated. The NHSC Trust templates for recording informal / formal complaints was recommended.	Not compliant
8	28.4	The centre should have a policy and procedure in relation to monthly monitoring visits.	A policy on monthly monitoring visits had been developed and was available.	Compliant
9	28.4	The template for monitoring should be further developed to ensure full compliance with the stated criteria.	The RQIA template is used for recording monthly monitoring visits.	Compliant
10	28.5	The manager should advise service users and their relatives of the monitoring visit records and the accessibility of these should they wish to read them.	The manager confirmed that service users had been informed during meetings. This was also confirmed by service users who spoke with the inspector.	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:	
IThe Data Protection Act (DPA) and the Access to Health Records (ACR) Order 1993 give individuals the right of access subject to certain exemptions to personal information held by the Trust, including both paper and computer based records.. In FDRC confidentiality is covered in WHSCT's staff induction programme. Job description and contract, Policies ,guidelines and standards, Supervision process used to reinforce importance of confidentiality All meetings held in private. Files locked in secure filing cabinets Designated key holders Computers locked with secure passwords	Moving towards compliance
Inspection Findings:	**COMPLIANCE LEVEL**
Information as illustrated by the registered manager was verified through discussion with staff and review of associated policies / procedures. Care records were being securely stored.	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	**COMPLIANCE LEVEL**

maintained.	
Provider's Self-Assessment:	
In FDRC care plans risk assessments,activity programmes are shared with service users as per person centred planning. if a situation arises in the centre where a service user or their representative wishes to see additional case notes. they have to make an application to the Central Information Governance Office. This process will be explained to the service user or representative. the process is outlined in the policy for the procedure for processing requests for access to patient or client records. Up to now there have been no requests for information. but we are aware of the need to record such requests and their outcomes.	Moving towards compliance
Inspection Findings:	**COMPLIANCE LEVEL**
Information as illustrated by the registered manager was verified through examination of four care records which evidenced consultation and through discussion with service users and staff. One visitor who spoke with the inspector confirmed they had good knowledge of the care plan and were continuously kept informed of their relative's progress.	Compliant
Criterion Assessed: 7.4 Individual case records/notes (from referral to closure) related to activity within the day service are maintained for each service user, to include: • Assessments of need (Standards 2 & 4); care plans (Standard 5) and care reviews (Standard 15); • All personal care and support provided; • Changes in the service user's needs or behaviour and any action taken by staff; • Changes in objectives, expected outcomes and associated timeframes where relevant; • Changes in the service user's usual programme; • Unusual or changed circumstances that affect the service user and any action taken by staff; • Contact with the service user's representative about matters or concerns regarding the health and well-being of the service user; • Contact between the staff and primary health and social care services regarding the service user; • Records of medicines;	**COMPLIANCE LEVEL**

• Incidents, accidents, or near misses occurring and action taken; and • The information, documents and other records set out in Appendix 1.	
Provider's Self-Assessment:	
The Social Worker makes a referral to FDRC by completing a referral form and also carries out a comprehensive assessment incorporating 17 Domains to ascertain the person's level of functioning. An admission Panel Meeting consisting of DCM, SDCW will meet to discuss. The key worker works closely with the service user in completing a care plan, and risk assessments.The care plan and risk assessments are reviewed every 3 months and sooner if necessary, The key worker also completes a Person Centred Plan report once a year and sooner if deemed necessary. Any service user who is Care Managed the key worker also prepares a Care Management Report once a year or sooner if necessary. Recommendations are recorded and time-frames set in place where relevant. Changes in in the service users needs or behaviour are recorded in their service user updates, care plan and risk assessments. If a service user has a behaviour modification programme change(s) in behaviour is recorded, and shared with all staff. Changes in service users programmes are recorded and amended in their Activity Programme and service user updates. Medicines administrated are recorded in the service users cardix. Incidents, accidents and near misses are recorded in the incident book and later recorded using the Datix to further investigate or close off incident.	Moving towards compliance
Inspection Findings:	**COMPLIANCE LEVEL**
Examination of four care records evidenced information as contained within this criterion were found to be comprehensive, individualised and person centred. Policies / procedures in place included Assessment, Care planning and Review. Staff training in person centred care / recording had been provided.	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:	
The current practice In FDRC is that each the key worker records weekly on all all their service users who they are key worker to.	Moving towards compliance

Inspection Findings:	**COMPLIANCE LEVEL**
Examination of four service user care records evidenced that written evaluations had been made in accordance with this criterion.	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:	
All staff have completed Adult Safe Guarding Level 2 Training in 2014 and are aware of the Vulnerable Adult Process.	Moving towards compliance
Inspection Findings:	**COMPLIANCE LEVEL**
The centre had a range of policies / procedures which made reference to reporting / referral to the manager, service user / representative and other professional staff / agencies. Policies and procedures pertaining to safeguarding, communication, confidentiality, consent, management of records, accidents / incidents, monitoring of records and recording and reporting care practices were in place and were available for staff reference. Staff demonstrated awareness to report, refer, and record information on the outcomes achieved. Care records examined evidenced referral / collaboration with other professionals in planned care and review.	Compliant
Criterion Assessed: 7.7 All records are legible, accurate, up to date, signed and dated by the person making the entry and periodically reviewed and signed-off by the registered manager.	
Provider's Self-Assessment:	
All care plans and risk assessments are legible and accurate, signed and dated by the key worker and periodically signed of by the registered manager. All individual Care Plans and individulal risk assessments care plans are reviewed every 3 months and amended sooner if need be. All weekly service user updates are signed and dated by	Moving towards compliance

the key worker and are reviewed and signed off by the Day Care Manager/Senior Day Care Worker on a monthly basis. On appointment it is assumed that the Day Care Staff have knowledge and experience of keeping accurate records, as this is a requirement for the post, as per jop spec. Day Care Manager/Senior staff have responsibility to ensure competency of that person to complete task. If extra support is needed it is given. All staff have awareness of relevant Trust Policies.	
Inspection Findings:	**COMPLIANCE LEVEL**
Information as reflected by the registered manager in the self-assessment was verified through examination of four randomly selected care records. Records examined were found to be legible, up to date, signed by the staff member and periodically signed by the manager.	Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE DAY CARE SETTINGS COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	**COMPLIANCE LEVEL**
	Moving towards compliance

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

Theme 1: The use of restrictive practice within the context of protecting service user's human rights **Theme of "overall human rights" assessment to include:**	
Regulation 14 (4) which states: **The registered person shall ensure that no service user is subject to restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other service user and there are exceptional circumstances.**	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
The culture of the service is evidentally one in which the use of restrictive practices is discouraged and regarded as a last resort. We in FDRC have not had to use constraints on any occasion. Staff are aware that in such cases they have the knowledge and skils through their training to effectively deal with service users who display challenging/agresive, violent behaviour. Staff are trained to quickly assess the service user, the situation and the environment thus making it as safe as possible. By not raising your voice, try to remain calm, and give users personal space. Using other colleagues to remove other service users from the immediate area and at the same time not isolating yourself. Calmly negotiate with the service user and encourage him/her to go to a quiet room where we can speak without interruptions. Member of staff stays with the service user and encourages him/her to calm down Focus on their feelings rather than their behaviour. When you feel that the service user has calmed down he/she can leave the room but reassure them that if they feel the need to talk that you are only too willing to be there for them Staff training such as Promoting Positive Behaviour, Conflict Resolution, MAPA, Any service users who are at risk of needing restraint are identified through assessment.	Moving towards compliance
Inspection Findings:	**COMPLIANCE LEVEL**
Information as illustrated in the self-assessment was verified through discussion with the registered manager and staff. Examination of accident / incident records confirmed there has not been any recorded episodes of challenging behaviour and that no service user has been subjected to any form of restrictive practice or seclusion. Policies and procedures on Managing Challenging Behaviour and Restraint were in place and available to staff.	Compliant

Staff demonstrated knowledge of the procedure to follow should incidents in regard to challenging behaviour arise Records of staff training evidenced that training in managing challenging behaviour and restraint had been included and undertaken as reflected within the mandatory training programme retained in the centre. Resource information on Deprivation of Liberty Safeguards (DOLS) was available to staff who demonstrated awareness in this regard.	
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:	
In FDRC if there is a situation where restraint has had to be used an incident report will always be completed. In this report details such as circumstances and the nature of the restraint is recorded. As a result the services users care plans and risk assessment are updated. All staff are informed of changes. A copy of the incident is forwared to Risk Management, Assistant Director. Each incident based on risk assessed will be subject to investigation and review. Care plans and risk assessments are reviewed, updated and amended accordingly.	Moving towards compliance
Inspection Findings:	**COMPLIANCE LEVEL**
Information as illustrated in the self- assessment was verified through discussion with the registered manager and examination of policy / procedure on restraint and seclusion. The manager and staff demonstrated knowledge of the procedure to follow should restraint ever require to be used and the necessity to notify RQIA. The manager confirmed there were no service users presenting with behavioural problems and that restraint was not used in the centre.	Compliant

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

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:	
In the absence of the registered manager in FDRC the Senior Day Care Worker who is suitably qualified, competent and experienced would be designated as being in charge. The Senior Day Care Worker has a relevant professional qualification and as stated in the personal Specification one of the competences is that they have an ability to undertake line management duties. One of the major functions is to work as part of a team for the effective development and management of a Day Care Service for people with a disability. Currently the Senior Day Care Worker is in charge when the registered manager is on holiday or not in the building. Any absence of the registered manager of more than 28 days RQIA will be notified and arrangements for managing the day centre has to be approved by RQIA.	Moving towards compliance
Inspection Findings:	**COMPLIANCE LEVEL**
The organisational structure of the centre was reflected within the Statement of Purpose. As previously stated this requires to be reviewed and revised to include the names of senior management now in post.The registered manager is supported in his management role by the Head of Service.	Compliant

At operational level support is provided by a mixed skill team of care workers who had received on going mandatory training in accordance with RQIA recommendations. In accordance with the manager's completed questionnaire returned to RQIA, prior to the inspection appropriate policies and procedures were available in the centre. These included, for example; Operational policy, Absence of the Manager, Staff supervision and Appraisal and Management, Control of Operations and Staff Meetings. There was evidence of induction programme for all new staff which is signed by the employee when deemed competent in each of the activities / factors listed. The manager, staff and service users who spoke with the inspector confirmed that staffing levels were considered to be satisfactory in meeting the number and dependency levels of service users in attendance. Discussion and examination of the staff duty roster was undertaken. One requirement made related to ensuring that the daily duty hours worked by each staff member is recorded in accordance with Regulation 19 (2) Schedule 5. 7. Staff meetings were being held on a regular basis with minutes recorded and retained in the centre. Staff appraisal takes place on an annual basis with records retained by the manager.	
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:	
All staff in FDRC receive formal supervision every 3 months.	Moving towards compliance
Inspection Findings:	**COMPLIANCE LEVEL**
The registered manager confirmed that staff supervision is provided three monthly or more frequently if required. Records of staff supervision were being retained in the centre	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:	
All staff prior to interview have met all the essential criteria necessary to enable them to work in FDRC. All staff receive mandatory training which gives them the knowledge and the skills to effectively carry out their duties. Each staff member also have the opportunity through supervision and yearly appraisals to develop their Personal Development Plan by identifying their training and development needs for the coming year.	Moving towards compliance
Inspection Findings:	**COMPLIANCE LEVEL**
All care staff has various levels of care qualifications ranging from NVQ / QCF Levels 2 and 3, Certificate in social work and BSc degree. On- going mandatory and professional development training was being provided with records retained by the manager. Records of training provided were examined and discussed with the registered manager. One issue in regard to training was raised by two staff during the inspection and comments made by three staff in returned questionnaires to RQIA related to the identified need for training in Acquired Brain Injury in order to assist them to identify individualised needs and plan person centred care for the high number of service users with brain injury who attend day care. One recommendation was made in this regard. One staff member indicated in the returned questionnaire that the NISCC Codes of Practice were not used in the day to day practice in the centre. The manager agreed to follow this matter up at the arranged team meeting.	Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE DAY CARE SETTING COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Working towards compliance

INSPECTOR'S OVERALL ASSESSMENT OF THE DAY CARE SETTING COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Compliant

9.0 Additional Areas Examined

9.1 Complaints

The procedure and management of complaints was discussed with the manager. One informal complaint was recorded within a book which was retained at reception. The manager explained that this complaint had been investigated and was resolved to the complainants satisfaction. One recommendation made at the previous inspection related to maintaining a complaint's record in compliance with Standard 14.10. As discussed it was further recommended that this record is maintained in keeping with the NHSC Trust Complaints policy and that the template for informal / formal complaints recording is used.

9.2 Registered Manager Questionnaire

The questionnaire was completed by the manager and returned to RQIA as requested. One section relating to provision of staff appraisal was not confirmed. The provision of annual appraisal was verified by the manager on the day of inspection. Other governance and management arrangements were confirmed within the questionnaire and were found to be operational within the centre. Policies / procedures and professional support staff to meet challenging behavioural needs of service users were in place. Additionally the registered manager confirmed that restraint was not used in the centre.

9.3 Statement of Purpose

The centre's Statement of Purpose, which was dated 1 May 2009, was examined. One requirement was made in regard to review and revision to include the change of the named senior management.

9.4 Accidents / Incidents

Accident / incident records were cross referenced with those notified to RQIA.

One requirement was made as all accidents / incidents must be notified to RQIA in accordance with Regulation 29 of The Day Care Setting Regulations (Northern Ireland) 2007.

Service users' views

The inspector met with several service users individually or in small group format. Service users who were able spoke freely and gave positive feedback in regard to staffing, the care they received and activities provided and confirmed they were always consulted by staff about their preferences and views on planned care. Service users spoke highly of the staff and care provided. No issues or concerns were raised.

Visitor views

One visitor afforded time to meet with the inspector. Very positive comment was made by the visitor who stated he would find it difficult continue to care if this support was not available. Positive comments were made on the overall day to day organisation, care provided by staff and the "open door" approach by the manager who was always visible in the centre. The visitor explained that" staff always made him feel welcome, afforded time to speak" and he greatly appreciated all their support. No issues or concerns were raised or indicated.

Environment

An inspection of the centre was undertaken. All areas of the centre were comfortably heated, clean, tidy, organised and fresh smelling throughout. New flooring in one communal room was work in progress. The manager confirmed that service users were not inconvenienced in any way by this work. Other lounges / activity areas were being utilised.

No visible hazards were observed.

Fire doors were closed and exits unobstructed.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Cathal MacElhatton, 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:

Priscilla Clayton
The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
Belfast
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The Regulation and Quality Improvement Authority

Quality Improvement Plan

Primary Announced Care Inspection

Foyle Disability Resource Centre

10 March 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 Cathal MacElhatton, registered manager on conclusion of the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers / managers should note that failure to comply with regulations may lead to further enforcement and/ or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider / manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan are addressed within the specified timescales.

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

Statutory Requirements

This section outlines the actions which must be taken so that the Registered Person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Day Care Settings Regulations (NI) 2007

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	Regulation 19 (2) Schedule 5. 7	**Staff duty roster** The daily duty hours worked by each staff member, including the manager within the staff duty roster.	One	In place within centre	13 March 2015
2	Regulation 29 (1) (2)	**Accidents / incidents** The registered manager must give notice to RQIA of the occurrence of any accidents / incidents within the three day working timescale. Ref: 9.4	One	New procedure put in place	Immediate and ongoing

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	Standard 17.6	**Statement of Purpose** It is recommended that this document is reviewed and revised to include the names of the senior managers now in post.	One	Statement of purpose updated	31 May 2015
2	Standard 14.10	**Complaints record** The centre should maintain a complaints record in accordance with standard 14.10 Ref; 9.1	Two	Complaints record book now in place	31 May 2015
3	Standard 21.4	**Staff training** It is recommended that the registered manager has discussion with his line manager regarding the expressed identified staff training need in Acquired Brain Injury. Ref: Theme 2	One	A.B.I. information and awareness sessions have taken place in May 2015 and training requirements are being discussed within Acquired Brain Injury working group .	31 May 3015

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	Cathal Mac Elhatton
Name of Responsible Person / Identified Responsible Person Approving Qip	Elaine Hay

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	[illegible]	11 June 2015
Further information requested from provider			