Primary Announced Care Inspection

Name of Establishment:	**Castlederg Outreach Centre**
Establishment ID No:	**11296**
Date of Inspection:	**11 June 2014**
Inspector's Name:	**Margaret Coary**
Inspection No:	**16580**

The Regulation And Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
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Name of centre:	Castlederg Outreach Centre
Address:	Castlederg District Enterprise Centre Drumquin Road Castlederg BT81 7PX
Telephone number:	028 8167 9828
E mail address:	eddie.mccrystal@westerntrust.hscni.net
Registered organisation/ Registered provider:	Western Health and Social Care Trust Ms Elaine Way CBE
Registered manager:	Mr Edmund McCrystal
Person in Charge of the centre at the time of inspection:	Mr Edmund McCrystal
Categories of care:	DCS-LD
Number of registered places:	18
Number of service users accommodated on day of inspection:	14
Date and type of previous inspection:	10 October 2013 Primary Announced
Date and time of inspection:	11 June 2014: 10.30 hours -16.45 hours
Name of inspector:	Margaret Coary

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	**8**
Staff	**3**
Relatives	**1**
Visiting Professionals	**0**

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

Issued To	**Number issued**	**Number returned**
Staff	**1**	**1**

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

Castlederg Outreach Centre is located in an Industrial Estate on the outskirts of Castlederg town; the facility is leased long term from the Enterprise Association and is managed by the Western Health and Social Care Trust.

The registered manager for the centre is Mr Edmund McCrystal. Mrs Lavinia Harpur, Day Care Worker is in charge on a day to day basis, with managerial and supervisory support available from a centre in Omagh.

The day centre provides a service to a maximum of 18 people per day who have a learning disability between the ages of 19 to over 65.

The primary focus of the centre is to promote independence through programmes of integration and interaction within the local community.

Service Users have dependency levels that span the Wessex Assessment Scale ranging from service users who are semi–independent to those requiring supervision and assistance to meet their care needs.

The centre operates from Monday to Friday, and the majority of service users avail of the Trust bus which is based at the centre and is a valued asset.

Referrals and allocation of days are through the Trust procedures with placements offered following an assessment of need.

Provision for the groups includes two activity areas, one of which contains a large pool table. There are several smaller spaces including a dining room, and a well-equipped poly tunnel which is used during the summer months. There are ample toilet and washing facilities and a small kitchen.

Service users' avail of a local restaurant for their lunch and beverages are provided within the centre.

There is ample parking available for visitors.

Summary of Inspection

This is the report for the primary announced inspection of Castlederg Outreach Day Centre.

This announced inspection was carried out on 14 May 2014 from 10.30 hours to 16.45 hours. The aim of the inspection was to consider whether the services provided to service users were in compliance with legislative requirements and day care minimum standards.

The inspector was made welcome by the Manager of the centre, Mr Edmund McCrystal and the Senior Carer, Mr Sean Gormley.

The inspector had a short meeting and agreed the inspection process; feedback was given at the end of the inspection.

A completed self-assessment document was submitted by Mr McCrystal.

Evidence was validated during the inspection by the following methods:

Review and scrutiny of a variety of records pertaining to each standard.
Discreet observation of staff/service user interaction throughout the inspection process.
Discussion/ interaction with eight service users and two groups of service users.
Discussion with three staff members.
One completed staff questionnaire.
Verbal contribution from the manager and senior day care worker in relation to any other requested information.

The inspection sought to assess progress with the issues discussed 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 themes:

- **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 inspector looked at policies and procedures, inspected staff records, met with three staff members and examined four service users' files to ascertain the centres performance against the criterion inspected. The inspector found that the centre have further work to do to ensure full compliance.

  The inspector has made two reiterated recommendations from standard 7.

  The centre have achieved a substantially compliant level of achievement for Standard 7.

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

  The centre do not use restrictive practise at present, however, policies and procedures are in place and are available for staff consultation should the need arise.

  The inspector found that the centre have relevant training in place and have established good communication systems with other professionals in relation to managing specific behaviours.

  The centre have achieved Substantially Compliant level of achievement for Theme 1.

- **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 inspector found that there were good arrangements in place to support and promote the delivery of quality care services; however, further work needs to be completed to ensure that all regulations and standards are met.

  The inspector has made three requirements and two recommendations from Theme 2.

  The centre have achieved a substantially compliant level of achievement for Theme 2.

Environment

The inspector toured the premises and found the facility to be warm, clean and comfortable.

Staffing

There were sufficient staff on duty to meet the needs of service users and the duty rota reflected that staffing was satisfactory; however, the inspector did have some concerns regarding the staffing arrangements over the lunch period.

Staff use the Trust bus to transport service users to and from the local café for lunch, the bus does not accommodate all service user's therefore two runs to the café have to be completed. This means that staff numbers are split, one staff member remains with the first group of service users at the café and two staff return to the centre for the second group, after lunch this happens in reverse. The inspector was concerned regarding the management of challenging behaviour and the safety of the service users when left in the care of one member of staff.

The inspector also had concerns about the venue for lunch; this is discussed at the end of the report.

The inspector has made one requirement regarding staffing arrangements for lunch time and sent an urgent action requirement in relation to the venue for lunch.

There were 14 service users present on the day of inspection. Twelve of the service users' were out shopping at Asda on the morning of the inspection and two were at their "work experience".

The inspector met and chatted with two groups of service users in the afternoon of the inspection and noted that they were content and happy to be at the day centre.

The inspector discreetly observed that staff had a good rapport with the service users and knew them well.

A number of service users accompanied the inspector to the back of the building to show her the Tunnel which houses their gardening project. The service users grow flowers from seeds and plant them in boxes and hanging baskets.

The senior carer advised that the local council use these for displays throughout the town. The service users were keen to explain their different roles in the gardening project and were proud of their endeavours. The centre are to be commended for this positive initiative.

There were three requirements, (one of which was sent as urgent action); four reiterated recommendations and two further recommendations from this announced inspection.

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

Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1 a	Regulation 20 (1) (a)	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 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.	The staff duty rota reflected that staffing arrangements were satisfactory.	Compliant
2	Regulation 20 (2) Standard 13.4	Competency and capability assessment to be completed on staff who are responsible for the day to day running of the centre.	The inspector confirmed that a competency and capability assessment had been carried out with the staff member who has responsibility for the day to day running of the centre.	Compliant
3	28 (3)	Monitoring visits should take place once a month and may be unannounced.	Monitoring visits are now carried out on a monthly basis.	Compliant

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	17.15	Staff to receive training on DHSS Standards for Day Care.	Not completed. Reiterate	Not Compliant
2	15.1	All staff to receive training on the policy and procedure for reviews.	Not compliant. Reiterate	Not Compliant
3	15.1	Advocacy services to be invited to the centre to talk to service users and their relatives about the services that are available to them.	Not arranged. Reiterate	Not Compliant
4	15.3	A review should be held in response to a change of circumstances.	Not compliant. Reiterate	Not Compliant
5	15.3 28 (4)	Recorded information for review to be further developed.	This was evidenced in files examined.	Compliant
6	15.5	The monthly monitoring visit should reflect that reviews have been completed and follow up action has been taken when required.	This was evidenced in monitoring inspection records.	Compliant
7	15.6	All updates on care plans following review should be signed by the person drawing it up, the manager and the service user or next of kin as appropriate.	Information in care plans have been updated and appropriately signed-off.	Compliant
8	13.5	All follow up action in relation to a vulnerable adult to be clearly documented in the service user's file.	Follow-up actions in this case have been documented and appropriately signed.	Compliant
9	28 (4)	The monitoring visit should include details of numbers of reviews held and assessment of follow-up action completed.	Monitoring visits now include details of numbers of reviews held and details of follow-up action.	Compliant

10	17.10	A sample number of records should be examined as part of the monitoring process to ensure that the organisation is being managed in accordance with minimum standards.	There was evidence available for inspection that reflected that the monitoring visit included inspection of working practises.	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 legal and ethical duty of confidentiality, in respect of service user's personal information is maintained at Castlederg Outreach Centre by adhering to WHSCT Policy/Procedure in Confidentiality and abiding by the principals of Data Protection and DHSSPS code of practice 2009 on protecting the confidentiality of service users. Staff within the centre have attended training in the areas of Data Protection/Confidentiality and Information Governance and Records Management	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector looked at a selection of four files. The records reflected that information was recorded in line with guidance and all files conveyed a person centred ethos ensuring that individual circumstances were included and appropriate risk assessments and follow-up information in care plans dovetailed to meet assessed need. The inspector verified that each service user had a copy of the service users' guide; this was displayed in a user friendly format. The inspector viewed the policies and procedures and confirmed that the centre had appropriate policies in place, some of those included were; Records Management Policy, Data Protection policy and procedure, Assessment, Care planning and Review policy, Staff guidance on Confidentiality, Understanding Human Right and a Code of Practise in relation to Protecting the Confidentiality of service users and information pertaining to "Understanding your Human Rights". This information was accessible for staff consultation. The inspector found that recording practises and storage of information were reflective of current national guidelines. The inspector talked with three staff members and was satisfied that they were fully aware of the importance of ensuring confidentiality and their roles and responsibilities regarding quality recording and the management of service user information.	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:	
At Castlederg Outreach Centre service users have access to their case notes/records as and when required, through advocacy meetings and at Person Centered Planning Meetings. Service user or their representative consent has been obtained for access to case records/notes and a copy is held in service user file. A record of all requests for access to individual case notes/records is maintained detailing, date of access,by whom, reason and outcome of access. Service users and or representatives are made aware of access sought.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector examined five files and as stated in the self-assessment noted that each file included a form for completion in relation to consent to access. This is good practise and ensures that proper processes are followed in this regard. The inspector also looked at policies and procedures relating to access to records some of which included Media Communications Protocol, Staff Guidance on Confidentiality and Records Management and as stated these were available for staff consultation. The inspector met with three staff members and was satisfied that they were informed and aware of the proper processes and procedures to follow regarding access to records; all those spoken with had a good understanding of their roles and responsibilities in this regard. The inspector was satisfied that there was good communication between the centre and service users' relatives and the files examined evidenced that relatives were aware that records were maintained on all aspects of care.	Compliant

Criterion Assessed:	**COMPLIANCE LEVEL**
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.	
Provider's Self-Assessment:	
Individual person centered case notes from referral to closure, related to care and services provided within Castlederg Outreach Centre are maintained for each service user. Notes contain information/documentation as per standard 7.4	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector looked at a selection of four files, the inspector found that the records were detailed and informative meeting all stated criterion. All assessments were regularly updated and followed up in care plans and signed in accordance with guidance and all files evidenced that reviews were held, however, the inspector noted that there was one instance whereby there was a change of circumstances and a review was not held, this had major implications for the service user and his family. This was discussed with the manager and senior staff and will be followed up and a review held. There is a reiterated recommendation in relation to this. The inspector has also reiterated a recommendation that staff receive training on the policy and procedure for review so that this does not happen again. The inspector also looked at a selection of monitoring inspection records and noted that recording practises were	Substantially Compliant

regularly audited to ensure good practise, however, as previously stated a review following change of circumstances was not held and should have been identified as part of the monitoring inspection.	
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:	
A meaningful entry is made for each service user at least every five attendances when no recordable event has occurred. When a recordable event has occurred, this is documented on that day.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector confirmed that regular records were maintained for each service user and as previously stated, information was detailed and person centred.	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 are made aware of and adhere to Trust and centre Policy/Procedure pertaining to matters which need to be reported or referrals made. This is also discussed during staff meetings, supervision sessions as appropriate, person centered planning meetings, Multi didiplinary team meetings and core group meetings. Staff also receive training on a yearly basis relating to incident reporting, Safeguarding of Vulnerable Adult issues and Complaints management.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**

The inspector examined the policies and procedures manual and was satisfied that appropriate policies and procedures were in place in relation to communication, confidentiality, consent and reporting care practises and, as previously stated staff had access to all policies. The inspector found that the files examined reflected that appropriate referrals were made to other professionals and the advice recorded and followed up in assessments and care plans. The inspector looked at a number of monitoring inspection records and noted that the monitoring inspection included evidence of follow-up in relation to improved outcomes for service users. The inspector examined the Accidents and Incidents Records and found that these were maintained in accordance with guidance.	Compliant
Criterion Assessed: 7.7 All records are legible, accurate, up to date, signed and dated by the person making the entry and periodically reviewed and signed-off by the registered manager.	
Provider's Self-Assessment:	
All records are legable ,accurate,up to date, signed and dated by the staff member making the entry. All records are periodically reviewed/audited by centre manager and SDCW and signed off. Records will also be reviewed during monthly service health checks. Service health checks have been recently common practice within the facility. A selection of service user files are audited monthly	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector found that records inspected were legible, up to date signed and dated by the person making the entry and regularly reviewed and signed- off by the manager. The inspector also found that service health checks are carried out on a monthly basis. This is good practise.	Compliant

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

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:	
Within Castlederg Outreach Centre physical restraint is not used. Measures are in place to ensure the safety and wellfare of each service user; eg Lap belts on wheelchairs and Seat belts while on buses. Staff have been apraised of the WHSCT policy on Restrictive Practice March 7th 2014. Restrictive intervention training is now planned for later part of 2014	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector confirmed that there were policies and procedures in place pertaining to; 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 available for staff reference. The centre also has information regarding "Understanding your Human Rights", all policies and procedures and information is accessible and available for staff reference. The inspector met with three staff members, all of whom stated that they had completed training on Challenging Behaviour and were aware that training on Restrictive Practise was planned later in the year. This was confirmed in training records. The inspector found that service users' files evidenced that good direction was in place from the behaviour support team to ensure that challenging behaviour was managed and was followed up in individual care plans.	Compliant

Regulation 14 (5) which states: **On any occasions on which a service user is subject to restraint, the registered person shall record the circumstances, including the nature of the restraint. These details should also be reported to the Regulation and Quality Improvement Authority as soon as is practicable.**	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
On any occasion on which a service user is subject to restraint, the registered person shall record the circumstances, including the nature of the restraint. The details will then be reported to RQIA as soon as is practicable through form 1a statuatory notificationof events form.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Restraint is not used in the centre. As stated previously the centre have good processes in place for managing challenging behaviours.	Substantially Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE DAY CARE SETTING COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	**COMPLIANCE LEVEL**
	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 registered manager ensures that at all times, taking into account the size of the day care setting, the statement of purpose and number and needs of service users, that there are suitably qualified ,competent and experienced persons working in the day care setting, in such numbers as are appropriate for the care of service users. In Castlederg Outreach Centre there is a defined management structure that clearly identifies lines of accountability, specifies roles and details responsibilities for areas of activity.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector examined the professional registration, qualifications, experience and evidence of competence of the registered manager and found that these reflected that he had the experience, training and skills to manage the centre effectively. The records of the staff member who manages the day care setting in his absence were also available to the inspector and these confirmed that the staff member had completed a competency and capability assessment which verified that she was qualified and capable of running the centre on a day to day basis. The inspector was satisfied that there were appropriate policies and procedures in place pertaining to the management	Moving towards compliance

of operations, a selection of policies and procedures included; Day Care Operational policy, Policy and Procedure for the Absence of the Manager, Incident Reporting, Supervision policy, Performance Appraisal Policy, and Safeguarding Vulnerable Adult policy. All policies and procedures are held in the office and are available for staff reference. The inspector talked with three staff members and was satisfied that they were aware of their roles and responsibilities in relation to the service users. The inspector also looked at supervision records and noted that one part time staff member did not receive supervision. There is a requirement in relation to this. The inspector examined the training records and found that recent training topics included; Autism, Risk Management, Behaviour Support and Dysphagia Awareness. The inspector has made a recommendation that all staff complete an evaluation of all training undertaken and that this be maintained in their personal files. The inspector looked at a number of copies of the staff duty rota and found that the rota was outlined in accordance with guidelines and there were sufficient staff on duty, however, the inspector did have some concerns regarding staffing arrangements at lunchtime, this was discussed earlier in the report and a requirement has been made in this regard. The inspector examined the statement of purpose and noted that there was information pertaining to the management structure and staffing arrangements and this was clear and informative. The inspector also examined a selection of monthly monitoring visits and verified that staffing levels are routinely inspected to ensure that there are adequate numbers of staff on duty to ensure that service users' needs are met.	
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:	
At Castlederg Outreach Centre the Senior Day Care Worker, Day Care Workes receive supervision on a monthly basis. Care assistant staff receive supervision every 3 mths. Staff appraisals take place yearly.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector examined supervision and appraisal records and confirmed that overall these were held in accordance	Substantially Compliant

with regulations; however, the inspector found that one staff member who works on a part time basis does not receive supervision. There is a previous requirement in relation to this. The inspector also noted that Regulation 28 visits reflected that staffing was inspected and recorded as part of the inspection.	
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:	
Staff at Castlederg Outreach Centre are suitably qualified or trained and have skills and experience necessary for such work Staffing at Castlederg is as follows. 1xBand 7 Day Service Manager 37.5 Hrs (Based in Omagh) 1xBand 5 SDCW 37.5 Hrs (Based in Omagh) 1xBand 5 DCW 37.5Hrs 2xBand 3 Care Assistants 37.5 Hrs	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector examined the professional registration, qualifications, experience and evidence of competence of the registered manager and the records of the staff member who manages the day care setting in his absence. The inspector was satisfied that these were in accordance with legislation and guidance and there was good evidence to verify that both the manager and the staff member who covers in his absence have the training and skills to manage the day centre effectively. The inspector verified that there were appropriate policies and procedures in place pertaining to the management of operations, a selection of policies and procedures included; Day Care Operational policy, Policy and Procedure for the Absence of the Manager, Incident Reporting, Supervision policy, Performance Appraisal Policy, and Safeguarding Vulnerable Adult policy. All policies and procedures are held in the office and are available for staff reference. The inspector has reiterated a previous recommendation that staff receive training on day care standards to help	Substantially Compliant

improve their skills in their day to day work.	

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

The inspector discussed arrangements for lunch in relation to service users with the manager and senior carer and was advised that the centre take the service users to a local café.

The inspector noted that a risk assessment had been completed which reflected concerns for the health and safety of service users in relation to fire safety, care and supervision. The inspector has made a requirement regarding a review of staffing arrangements, and completed an “urgent action” form which was sent to the centre following the inspection. This is to ensure that the lunch time arrangements can be considered in relation to both the appropriateness of the café in relation to health and safety and the supervision of service users whilst a second bus run is carried out.

The inspector also looked at a selection of staff meeting records and has made a recommendation that the content of these be further developed to include discussions on policies and procedures and training undertaken.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Manager of the centre, Mr Edmund McCrystal and the Senior Carer, Mr Sean Gormley, 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:

Margaret Coary
The Regulation and Quality Improvement Authority
Hilltop
Tyrone & Fermanagh Hospital
Omagh
BT79 0NS

The Regulation and Quality Improvement Authority

QUALITY IMPROVEMENT PLAN

PRIMARY ANNOUNCED INSPECTION

CASTLEDERG OUTREACH CENTRE

11 JUNE 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Manager of the centre, Mr Edmund Mc Crystal and the Senior Carer, Mr Sean Gormley 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

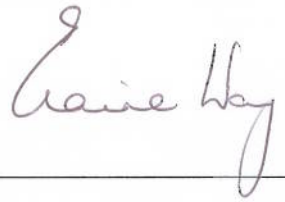
No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	20 (1) Ref; 13 (1) (b)	Arrangements for lunchtime arrangements to be reviewed in relation to staffing.	One Urgent action form sent to centre for follow-up in this regard	Action is being taken to ensure a review of lunchtime arrangements in relation to staffing.	Immediate
2	20 (2)	Supervision to be arranged for part time staff member.	One	Supervision dates have been arranged for part time staff member.	Immediate
3	13 (1)	Arrangements for lunch to be reviewed. (Urgent Action form sent to centre on 12 June 2014)	One	Arrangements are in place to review lunch provider.	Immediate

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	15.3 Ref; 7.4	Review to be held in change of circumstances.	Two	Where necessary reviews will be held in change of circumstances.	Immediate
2	17.15	Staff to receive training on DHSS Standards for Day Care.	Two	Staff will receive training on DHSS Standards for Day Care within the timescale stated.	Three months
3	15.1 Ref; 7.4	All staff to receive training on the policy and procedure for review.	Two	All staff will receive training on the policy and procedure for review within the timescale stated.	Three months
4	15.1	Advocacy services to be invited to the centre to talk to service users and their relatives about the services that are available to them.	Two	Service users and relatives will receive information informing them of advocacy services available to them.	Three months
5	21.9	Staff to complete an evaluation of all training undertaken and this to be maintained in staff files.	One	Staff will complete an evaluation of all training undertaken and copies of evaluations will be maintained in the staff training file.	Ongoing
6	23.8	Staff meetings to be further developed.	One	Plan in place to evidence development of staff meeting agenda.	Ongoing

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	Margaret Dolan Head of Service
Name of Responsible Person / Identified Responsible Person Approving Qip	

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable			
Further information requested from provider			

QIP Position Based on Comments from Registered Persons	Yes	Inspector	Date
Response assessed by inspector as acceptable	Yes	Maire Marley	16 January 2015
Further information requested from provider			