Primary Unannounced Care Inspection

Name of Establishment:	**Larne Adult Centre**
Establishment ID No:	**11300**
Date of Inspection:	**6 January 2015**
Inspector's Name:	**Louise McCabe**
Inspection No:	**20320**

The Regulation And Quality Improvement Authority
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Name of centre:	Larne Adult Centre
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Registered organisation/ Registered provider:	Dr Anthony Baxter Stevens
Registered manager:	Mrs Linda Montgomery
Person in Charge of the centre at the time of inspection:	Mrs Linda Montgomery (Acting Manager) Mrs Natalie Jackson (Registered Manager)
Categories of care:	DCS-MAX, MAX, DCS-PH(E), DCS-PH, DCS-LD(E), DCS-LD
Number of registered places:	84
Number of service users accommodated on day of inspection:	58
Date and type of previous inspection:	27 November 2013 Primary Announced Inspection
Date and time of inspection:	6 January 2015 9.30am–5.00pm
Name of inspector:	Louise McCabe

Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect day care settings. A minimum of one inspection per year is required.

This is a report of a primary inspection to assess the quality of services being provided. The report details the extent to which the standards measured during the inspection were met.

Purpose of the Inspection

The purpose of this inspection was to ensure that the service is compliant with relevant regulations and minimum standards and themes and to consider whether the service provided to service users was in accordance with their assessed needs and preferences. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, procedures, practices and monitoring arrangements for the provision of day care settings, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Day Care Settings Regulations (Northern Ireland) 2007
- The Department of Health, Social Services and Public Safety's (DHSSPS) Day Care Settings Minimum Standards (January 2012)

Other published standards which guide best practice may also be referenced during the inspection process.

Methods/Process

Committed to a culture of learning, RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the minimum standards.

The inspection process has three key parts; self-assessment, pre-inspection analysis and the visit undertaken by the inspector.

Specific methods/processes used in this inspection include the following:

- Analysis of pre-inspection information
- Discussion with the acting manager and 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	23
Staff	10
Relatives	0
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	20	9

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

Larne Adult Centre is situated about one mile from the town of Larne, on a sloping site close to the main Larne to Belfast road. The accommodation was originally a hotel and has two floors, the ground floor and lower ground floor. The lower part of the outdoor site has recently been developed as an easily accessible garden area, with smooth paths and raised beds, so that members can take part in the gardening activities.

The centre provides a day service to adults aged nineteen and over, who have a learning disability and/or associated physical or sensory disability. There are a number of service users (members) with complex health or behavioural needs, including individuals with mental ill health, dementia or autistic spectrum disorders. Some of the members require one to one or more staff attention, supervision and assistance. Drug administration, tracheostomy suction, or enteral/peg tube feeding are required by a small number of members.

There are currently seven established groups within the centre, each of which provides a varied and structured programme of care for service users. One group provides for members who may present challenging behaviours and some of whom require intensive assistance. Several TEEACH work stations are in place in this group. There is also a special needs group, whose service users may have a physical disability and other complex needs.

Service users are encouraged to develop their social, educational, vocational, recreational and work related skills and strong emphasis is placed on community as well as centre based activities. The principles of Person Centred Planning form the basis for the centre's current approaches to assessment, care planning and review.

Lunch is provided to members in the adult centre and is prepared in the centre's kitchen by dedicated catering staff.

Summary of Inspection

9:30am–5:00pm = 7 hours 30 minutes

A primary unannounced care inspection was undertaken in Larne Adult Centre on 6 January 2015.

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

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

An inspector spoke with ten staff regarding the standards inspected and their views about working in the centre. This generated positive feedback regarding the management of records and reporting arrangements including recording and the management arrangements in the centre. Staff demonstrated their knowledge and experience regarding responding to behaviours which may challenge in the context of respecting service user's human rights and have attended training on Human Rights. Staff stated they are aware of the process to follow should a service user or their representative request to see their care file. Communication between management and staff is effective and no concerns were raised. Discussions with staff conclude there are aware of who is in charge/responsible for the centre in the absence of the acting manager. It was evident via discussions with staff of their dedication, commitment and enjoyment of their work in Larne Adult Centre.

Nine questionnaires were returned by staff members who reported satisfactory arrangements were in place with regard to NISCC registration; staff training; staffing and management arrangements; responding to service user's behaviour; confidentiality and recording. The staff member's praised the quality of care provided within the returned questionnaires and the following comments were made:

- *"the quality of care in this unit is high and the clients are offered a wide range of activities."*
- *"the quality of care is excellent and most if not all of the clients' needs are met."*
- *"high standards on a daily basis."*
- *"I think the quality of care provision is excellent. I think all staff do a brilliant job and we are an excellent team."*
- *"All staff work well together to provide the best care possible."*
- *"All staff work well together as a team to provide an excellent environmentfor the day care of our clients."*
- *"The quality of staff within Larne Adult Centre is excellent, all staff work hard together as a team to provide the quality of care needed for the clients."*
- *"I feel the centre offers a high quality of care and each service user receives a varied person centred range of activities."*

One staff questionnaire stated that when they are undertaking bus escort duties, there are insufficient staff in rooms with service users. The manager is asked to respond to this. Several staff questionnaires stated supervision in Larne Adult Centre is mostly informal and one stated they do not receive formal supervision. The review of three staff files showed evidence of formal supervision taking place in accordance with minimum standard 22.2 for two staff. The third staff file showed gaps, these were discussed with the registered manager who explained she combined formal supervision with induction. A recommendation is made in the quality improvement plan stating all care staff must receive regular systematic formal supervision as separate to induction and annual appraisal and the records of same retained in their personal staff file.

The inspector spoke with a total of twenty three service users regarding the standard inspected; the two themes and their views on Larne Adult Centre. The service users communicated positive feedback regarding attending the centre, the activities they participate in and the care provided by the staff. Due to the various levels of understanding and communication of several service users the inspector was unable to ascertain if they understood their rights to access their personal information. Most of the service users meeting with the inspector stated they are aware there are records kept in the day care setting about them and that they can access the information by asking staff. These service users confirmed

they see their care plan on a regular basis and at their review. They said they are encouraged to be involved in all aspects of the care planning process. The service users are aware of who the manager and if they had a problem or wanted to discuss something about the day care setting they said they could talk to the staff or manager in the centre. Service users stated they enjoy coming to the centre and the following comments were made:

- *"I'm happy here."*
- *"I love coming to the centre and like the things I do."*
- *"I've made lots of friends and like the things I do here."*
- *"The staff are good to me, they are kind."*
- *"The staff listen to me about what I like and don't like. They help me."*
- *"I love it here."*

No concerns were raised.

The previous announced inspection carried out on 27 November 2013 had resulted in two recommendations regarding service users' annual quality assurance questionnaires and transport. Review of the returned quality improvement plan for this inspection and discussions with management concluded user friendly questionnaires had been devised and distributed in November 2014 and were more diverse regarding the topics they covered. The acting manager is in the process of collating the results and will be compiling a summary report which will be shared with service users; their carers and staff. The inspector noted questions concerning the service users satisfaction with their environment was not included. This was discussed with the acting manager who agreed to include the environment on the next quality assurance questionnaire. The recommendation regarding transport is assessed as substantially compliant as there continue to be service users on transport for longer than 45 minutes, this is due to the geographical location of their home and is not causing any negative affect on the service users.

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

The six criterion criteria within this standard were reviewed during this inspection. Based on the evidence reviewed by the inspector, all of the criteria were assessed as compliant by the inspector, no requirements or recommendations were made.

Discussions with twenty three service users, ten staff and review of seven service users' individual files provided evidence that the centre is performing well regarding standard 7. The care files were comprehensive in content and person centred. Each contained a service user consent form to photographs, publicity etc. Clear examples were provided of how staff encourage and assist service users to get the most from their day care experience. It was also clear this service was improving outcomes for the service users and their carers by providing respite and identifying changes in need and promoting any additional services that can improve outcomes for service users. The inspector concluded the centre promotes service users social needs, stimulates intellectual activity and promotes independence.

No requirements or recommendations have been made regarding the examination of this standard. This is commendable.

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

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

Discussions with the manager, staff and examination of records provided evidence that the centre was using clear operational systems and processes which promote the needs of the service users who attend the centre. The Trust has in place a 'Restrictive Practices Registration' form which must be completed when a restrictive practice is used with service users. There have been two recorded incidents of a mechanical physical restraint being used with a service user in Larne Adult Centre since the previous inspection. Discussions took place regarding these incidents, they concerned a service user releasing his/her seatbelt on transport and it was assessed that a recommended safety device was needed which attaches to a seatbelt. A written risk assessment was completed and involved the Trust's Behaviour Support Team, the service user, carer/s and staff and the device is used to ensure the safety of the service user on transport.

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

Based on the evidence reviewed during this inspection, the inspector assessed the centre as compliant in this theme. No requirements or recommendations were made concerning this theme.

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

Two criteria from regulation 20 and one criterion from regulation 21 were inspected in relation to this theme. One criteria were assessed as compliant and two as substantially compliant. One requirement and one recommendation are made regarding this theme; these regard the service's annual report and monthly monitoring visits.

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

Additional Areas Examined

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

A tour of the environment generated two requirements and three recommendations. These matters concern fire safety, infection control; replacing windows and/or seals; redecoration, replacing blinds; tidying the environment and storage.

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

As a result of the inspection three requirements and five recommendations have been made in the quality improvement plan. These concern fire safety; infection control; environment, care plans; service's annual quality review report; monthly monitoring visits and the review of an identified care plan. Progress in these areas will be monitored via completion of the returned quality improvement plan.

Follow-Up on Previous Issues

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	Standard 8.2	While the frequency of satisfaction surveys in the centre is good, it is recommended that the topics being evaluated should be more diverse.	Management had reviewed the centre's annual quality assurance questionnaires to service users. These encompassed the following quality areas: transport, activities, meals, their views on attendance and how they are treated by staff. Positive comments were shared with management about the questionnaires. The manager is in the process of collating the results and agreed to share a summary report of these with service users; their carers and staff. A discussion took place for the next quality assurance questionnaires to include questions about the environment.	Substantially compliant
2	Standard 12.4	The Registered Manager and the Transport Manager should continue to seek to reduce journey times for those service users whose journeys exceed 45 minutes.	Management and staff reviewed the journey times for service users at each service user's annual review of their day care placement. This showed there continue to be service users whose journey exceeds 45 minutes due to the rural area in which they live, however the duration of the journey does not adversely affect	Substantially compliant

			them. Most service users enjoy travelling on the bus. Carers were offered the choice of providing transport if they wanted their relative to have a shorter travel time to and from the centre and a longer day. Management agreed to continue monitoring this and to take appropriate action should the journey have any negative affects on the service user.	

Standard 7 - Individual service user records and reporting arrangements: **Records are kept on each service user's situation, actions taken by staff and reports made to others.**	
Criterion Assessed: 7.1 The legal and an ethical duty of confidentiality in respect of service users' personal information is maintained, where this does not infringe the rights of other people.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
The Trust has policies and procedures in place in relation to confidentiality and any records held by the organisation. These include; Records Management Policy and Processing of Personal Information (POPI). The purpose of these policies are to support staff and enable them to work within the law and within good practice guidelines. The policy covers retaining personal information, Records and Record keeping, Safe Storage of personal information, Access and Sharing of information and Retention and Disposal of Confidential Information.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
A sample of the records in respect of each service user, as described in Schedule 4; and those detailed in Schedule 5 are in place in Larne Adult Centre. Discussions with staff conclude there are effective arrangements in place regarding confidentiality and all relevant policies and procedures pertaining to the access to records, storage of service user's information; communication, confidentiality, consent, management of records, monitoring of records, recording and reporting care practices are in place and readily available for example 'Accessing your personal information', 'Subject Access Request Form' etc. This information is reflective of current national, regional and locally agreed protocols concerning confidentiality and adheres to DHSSPS guidance, regional protocols, local procedures issued by the HSC Board and Trusts and current legislation. The centre's current service user agreement is also compliant with this criterion. Discussions with staff also validate they are knowledgeable about the duty of confidentiality and their role and responsibility regarding the need to record, the quality of recording and management of service users personal information. This is commensurate with staff role and responsibilities.	Compliant

Criterion Assessed: 7.2 A service user and, with his or her consent, another person acting on his or her behalf should normally expect to see his or her case records / notes. 7.3 A record of all requests for access to individual case records/notes and their outcomes should be maintained.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
Service users and their representitives are permitted to have access to their own personal records/case notes. Requests for information are processed in line with Trust Procedure/Policy and documents maintained where this takes place. Within the Adult Centre, service users are actively involved in their care planning/review process and, where appropriate/when possible, will also contribute to completing records for this process.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Policies and procedures are in place and accessible in the centre pertaining to: the access to records; consent; management of records and service user's agreement. Discussions with staff conclude the policies and procedures are put into practice for example with reference to records being completed and maintained in the centre. The inspector examined seven service user's care files which validated they know they can request access to information completed about them. Discussions with service users conclude they are aware a service user record is kept and have been informed how they can access the records. There are adequate arrangements in place regarding who takes responsibility for issues and queries of freedom of information, confidentiality, consent and access to records and arrangements. Discussions with staff validate their knowledge concerning this criterion which is commensurate with their role and responsibilities. It is evident from discussions with staff and the inspector's review of seven service user's care files how they ensure a person centred approach to their recording. Staff explained what they would do if a service user or their representative requested access to care records.	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:	
Each service user has an individual case record. These are completed and maintained in line with Trust/RQIA requirements. These records include; referral information, carer/multi-disciplinary contacts, assessments and reviews, care plans, contacts and details of activities. Any changes to circumstances, significant incidents/near misses are recorded along with details of actions taken/further work to be done. All records are stored securely in line with Information Governance requirements.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
With regards to the management of records, the examination of a sample of seven service user individual records evidenced the above records and notes are available and maintained according to relevant policies and procedures. There was evidence of working practices being systematically audited in this regard. The case records and notes were updated as required, they were current, person centred; incorporated service user views and recorded information that	Compliant

can be used to review individual service user's outcomes. Care reviews were taking place as described in standard 15.	
Criterion Assessed: 7.5 When no recordable events occur, for example as outlined in Standard 7.4, there is an entry at least every five attendances for each service user to confirm that this is the case.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
Staff ensure that records are maintained/updated with an entry regarding service users, at least every five attendances. This is done in line with Trust and RQIA requirements. These records are signed and dated.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector examined seven service user care records and evidenced individual care records have a written entry at least once every five attendances for each individual service user. The quality of information recorded was viewed by the inspector as relevant to the plan and outcomes being worked in with individual service users.	Compliant

Criterion Assessed: 7.6 There is guidance for staff on matters that need to be reported or referrals made to: • The registered manager; • The service user's representative; • The referral agent; and • Other relevant health or social care professionals.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
The Northern Health and Social Care Trust has a comprehensive package of policies and procedures directing staff on matters pertaining to service user care and reporting procedures. Specific training is also provided on areas such as Safeguarding, Recording, Storage and Sharing of Records. A policy library is available to all staff, either via "hard copy", or via the Trust Intranet. Advice and direction is also available at all times from Line Managers and Multi Disciplinary Team.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The service user's files detail referrals made to other services and described their involvement in the decision if they want other professionals to be involved in their care plan. The inspector's discussions with ten staff generated positive feedback regarding the management of records; reporting arrangements including recording and the management arrangements in the centre. Staff demonstrated their knowledge and experience regarding the referral process and responding to service user's needs and behaviours. Staff felt communication between management and themselves is effective and no concerns were raised. When the manager is absent from the centre, several day care workers take it in turns to be the responsible person in charge, however staff informed the inspector they very much work as a team. The acting manager's line manager is contactable by mobile phone when she is absent from the centre. The inspector confirmed Trust policies and procedures are in place and available with regards to communication, confidentiality, consent, management of records, monitoring of records, recording and reporting care practices and service user agreement.	Compliant

Criterion Assessed: 7.7 All records are legible, accurate, up to date, signed and dated by the person making the entry and periodically reviewed and signed-off by the registered manager.	
Provider's Self-Assessment:	
Records are maintained in line with Trust requirements. They should be legible. These are signed and dated by the person making the entry and periodically reviewed by management, within supervision and when monitoring review records/audits.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector examined a sample of seven service user individual records which met this criterion. Consultation with ten staff working in the centre confirmed their understanding of this criterion and their role and responsibilities to address this fully when recording in individual files and additional records. RQIA received nine completed staff questionnaires which confirmed policies and procedures are in place and available in the centre.	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**
	Compliant

Theme 1: The use of restrictive practice within the context of protecting service user's human rights **Theme of "overall human rights" assessment to include:**	
Regulation 14 (4) which states: **The registered person shall ensure that no service user is subject to restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other service user and there are exceptional circumstances.**	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
In line with Trust Policy, restraint is only used when no other option is available to ensure the safety of service users. This is a practice standard emphasised in RESPECT training. Staff endeavour to ensure that prevention and early intervention measures are employed before restraint is considered. If physical intervention measures are not part of a service users plan then the Positive Behaviour Support team/RQIA will be notified and the situation will be considered and assessed. It may then be appropriate to include additional measures in the persons care plan to help manage any future incidents. Incidents are recorded and reported in line with requirements of the Northern Trust and RQIA.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector examined a selection of records including a sample of seven individual service user records which revealed staff have comprehensive plans in place that clearly describe the day care service user's receive, their likes and dislikes. Two examples of restrictive practices used with service users since the previous inspection were shared with the inspector. These involved the safety of service users on transport when the seat belt was unclipped by a service user. Staff responded quickly and appropriately following Respect guidelines to ensure the safety of the identified service user and others. A full risk assessment was subsequently undertaken which involved the Trust's Behaviour Support Team and as a result a mechanical safety device is now used on transport which attaches to the seat belt to ensure the safety of an identified service user. Written documentation concerning this is in place and viewed by the inspector. Care is focused on meeting individual need, clear communication strategies, diversion, distraction and calming	Compliant

techniques. Service user information is written in the context of staff being able to facilitate positive outcomes in day care and avoid any negative experiences. There is a clear focus on identifying and understanding if service users are not happy; how to manage this sensitively and proactively. Overall the approaches referred to present as sound plans to avoid escalation of behaviour or concerns whilst respecting each individual service user's methods of communicating, their views, choices and needs. Staff attend Respect refresher training once a year as part of the mandatory training programme, this had taken place in January and June 2014. Consultation with staff revealed their knowledge, skill and competence concerning this which is commensurate with their role and responsibilities. Staff access policies and procedures pertaining to: the assessment, care planning and review; managing aggression and challenging behaviours; recording and reporting care practices; reporting adverse incidents; responding to service users behaviour; restraint and seclusion; and untoward incidents which provide guidance for staff. Discussions with staff validate management and staff member's knowledge about when and why restraint is used including their understanding of exceptional circumstances. Staff working in the centre are aware of the exceptional circumstances when restraint or seclusion should be used, including how service users human rights are protected if restraint or seclusion is planned for or when it is used reactively. Staff are also aware of the Deprivation of Liberty Safeguards (DOLS) – Interim Guidance.	
Regulation 14 (5) which states: **On any occasions on which a service user is subject to restraint, the registered person shall record the circumstances, including the nature of the restraint. These details should also be reported to the Regulation and Quality Improvement Authority as soon as is practicable.**	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
Whatever the situation, all uses of restraint are recorded on the appropriate documentation and sent to the Positive Behaviour Support team/RQIA. Incidents, reports and records are also completed in line with requirements and recorded in the persons care notes and personal file.	Compliant

Inspection Findings:	COMPLIANCE LEVEL
Refer to the inspection findings above for information. Two incidents of restrictive practices have been recorded since the centre's previous inspection. All relevant documentation as specified by the Trust was appropriately completed on these occasions and the Trust's Behaviour Support Team involved. The Trust's governance systems also monitor this and receive copies of completed restrictive practices documentation. Staff are currently using approaches such as sound planning, understanding the service user's needs, clear communication, diversion, one to one time, distraction and activities to avoid any escalation of behaviours. This approach is consistent with the settings ethos, statement of purpose and aims of the service. Guidance on Restraint and Seclusion in Health and Personal Social Services, Department of Health, Social Services and Public Safety, Human Rights Working Group, August 2005 is available. A selection of records in respect of each service user as described in schedule 4 and other records to be kept in a day care setting as per schedule 5 were reviewed by the inspector during this inspection. These are being maintained in accordance with legislation and minimum standards.	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 Northern Trust have developed a dependancy tool to assess client need and calculate the number of staff required to meet service user needs, and this tool has been endorsed by the Northern Board. Where vacancies arise, or cover is required eg. for maternity leave, requests to ensure that appropriate staffing needs are met are submitted promptly to minimise any potential shortfall in provision of care. Where needed, suitably experienced "as and when" or agency staff are utilised to uplift staffing levels. These are staff used on a consistent basis and are familiar with service users, their needs and programmes of care. A flow chart outlining staff roles and lines of accountability is available in the unit. All staff have clear job descriptions, outlining roles, responsabilities and areas of accountability.	Compliant

Inspection Findings:	COMPLIANCE LEVEL
Larne Adult Centre's Statement of Purpose & Service User Guide were updated in July 2014. Information regarding the staffing structure and the acting manager's self-assessment in regulation 20(2) below differ. The manager is advised to review Larne Adult Centre's current statement of purpose to ensure the staffing structure and arrangements are accurate. The centre's annual report was dated September 2014, whilst this was informative; it did not contain all of the information in accordance with schedule 3 and action is required as per the appended quality improvement plan. Mrs Linda Montgomery became the acting manager of Larne Adult Centre earlier this year. She was previously a day care worker in the centre and a care assistant prior to this. It is intended Mrs Montgomery will commence Level 5 Leadership and Management qualification in February 2015. Mrs Montgomery is in the process of registering with the Northern Ireland Social Care Council (NISCC). The centre's current statement of purpose states following staff are employed in the centre: an acting manager; five day care workers; thirteen support workers (part time and full time); three catering staff; two part time domestic staff; three drivers and a part time clerical officer. In the manager's absence delegation of tasks to one of the day care workers was evidenced and clearly recorded in staff supervision records. The staffing compliment for the setting is appropriate in meeting the needs of the current service user group. Nine completed staff questionnaires were received by RQIA; one staff member stated he/she felt there were insufficient staff when support workers are needed to undertake bus escort duties. The manager is asked to investigate this. The manager has provided evidence of her NISCC registration and provided evidence of how she ensures her team are kept informed regarding key issues for this service user group such as empowering service users, improving outcomes, person centred practice, understanding how to protect service user's rights in the day care setting. The inspector sampled three staff files to review staff training, supervision and appraisal records. All three staff files validated annual performance appraisals are taking place. Two files showed formal supervision is taking place in accordance with minimum standard 22.2; one staff file showed a gap of formal supervision records and was discussed with the manager. Several completed staff questionnaires stated staff felt supervision was informal and one care staff said they did not receive formal supervision. This generated a recommendation in the quality improvement plan. Discussions with staff concluded they all receive regular formal supervision in accordance with minimum standard 22.2. Discussions with ten staff during this inspection validate their knowledge is commensurate with their roles and responsibilities regarding management arrangements of the day care setting. For example who they report to; who	Substantially compliant

they seek support or guidance from; who supervises them and the effectiveness of same. Staff are aware of their role and responsibilities to ensure management and control of operations tasks in the day care setting are competently completed, they also have contact mobile phone numbers of their manager and her line manager should the need arise. Regulation 28/monthly monitoring reports of Larne Adult Centre evidence the staffing arrangements in place for the month being inspected and form a view regarding: the effectiveness of staffing arrangements; and compliance with regulations and standards regarding same. The monthly monitoring reports for the months of July and December 2014 were not in place. A discussion took place about regulation 28 and that monitoring visits must occur every month. Larne Adult Centre's Annual Quality Review report of April 2013–2014, completed in September 2014 was in place and reviewed by the inspector during this inspection. Positive comments were shared with management and staff regarding the varied activities and outings that have taken place with service users throughout the year, however the inspector concluded the content of the report does not reflect all of the matters to be monitored by the registered person and therefore does not comply with Regulation 17(1), Schedule 3 (points 1-15). A requirement is made in the quality improvement plan for this to fully comply with the schedule 3.	
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:	
Supervision is undertaken on a cascading framework through grades of staff. Day Care Locality Manager to Registered Manager and Band 5 Day Care Workers, who in turn supervise Support Workers (Band 3). Day care Locality Manager, holds a professional Social Work qualification, Acting Registered Manager holds NVQ Level 3 and has registered for Level 5 Leadership & Management due to begin in February, 2015. We have seven Day Care Workers (Band 5), three of whom are part-time. All of our staff members have many years experience in Day Care settings. All Band 5 staff are well experienced and provide support staff with daily direction and guidance to ensure service users receive an effective and quality service. The staff team meet each morning informing staff of the daily rota and exchanging information, these meetings ensure that good communication is maintained and staff have a forum to voice feelings, ideas and concerns with managers	Compliant

and team. Occasionally these meetings will separate for Band 3 and Band 5 staff dependant on the need/agenda/discussion items. Staff also receive Supervision and annual appraisals and complete personal development plans to enable them to further develop their skills and knowledge. Staff are aware that they have daily access to line managers for any concerns or advice. Larne Adult Centre operates an "Open Door Policy" whenever possible.	
Inspection Findings:	**COMPLIANCE LEVEL**
A sample of three staff files were reviewed and confirmed staff have participated in the Trust's annual performance appraisal process (known as a Performance Development Plan). Discussions with care staff members concluded they receive regular informal and formal recorded supervision, however the inspector's review of one staff file showed gaps in formal supervision records, this was partly due to sick leave. The registered manager said she had combined induction and annual appraisal as formal supervision, the records did not reflect this. Review of nine completed staff questionnaires also reflected there are gaps in formal supervision, this is not in accordance with NISCC Codes of Practice and minimum standard 22.2. A recommendation is made in the quality improvement plan regarding formal supervision and associated records. Two of the three staff files reviewed by the inspector validated formal recorded supervision is taking place in accordance with standard 22.2. The setting has policies and procedures pertaining to the management and control of operations, for example: absence of the manager; staff records; staff supervision and appraisal; staffing arrangements. These are available for staff reference and reflect day to day practice.	Substantially compliant
Regulation 21 (3) (b) which states: • **(3) For the purposes of paragraphs (1) and (2), a person is not fit to work at a day care setting unless –** • **(b) he has qualifications or training suitable to the work that he is to perform, and the skills and experience necessary for such work**	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
Prior to appointment all staff must demonstraite, via interview and evidence of qualification/experience, that they are suitable for the work that they will be asked to undertake. The Trust expects staff to be suitably qualified and to undertake training and qualifications appropriate to their grade. A regular programme of mandatory and vocational training is provided to enable staff to continually develop their skills and knowledge.	Compliant

Inspection Findings:	COMPLIANCE LEVEL
There are no concerns regarding compliance with this criterion.	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
	Substantially compliant

Additional Areas Examined

Complaints

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

Compliments

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

Incidents/Accidents

The inspector randomly sampled Larne Adult Centre's accident and incident records. These meet minimum standards.

Service User Care Files

The inspector reviewed seven service user's care files during this inspection. These were comprehensive and reflected person centred care plans completed in user friendly language.

One identified service user's care plan needs to be reviewed and updated to fully and accurately reflect his/her current situation with regards to what had previously been an area of unmet need. It is positive to note action has been taken regarding this. The care plan had been devised by professionals not employed in Larne Adult Centre, however input from care staff in the centre had been sought. It contained an abbreviation which was not explained. Abbreviations should not be used in care plans. A recommendation is made in the quality improvement plan concerning the updating of this care plan.

Registered Manager Questionnaire

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

Environment

On a tour of the premises, the areas used by service users were found to be warm, well ventilated and in mostly good decorative order. Service users presented as being at ease in the environment of the adult centre and could access facilities which they needed.

Positive comments were shared with staff regarding Larne Adult Centre receiving a highly commended in the Best Kept Centre Awards 2014. Service users also won a Larne Musical Festival Association award.

The inspector observed two doors wedged open, one was the adjoining door between two rooms on the ground floor used by one group of service users and the other was a door in the same area leading to a small room used by an identified service user. In the interests of fire

safety, doors must never be wedged open. A requirement is made in the appended quality improvement plan about this. A WC on the lower ground floor was out of order and the flooring in the store room is very worn in one area and needs to be replaced.

The inspector identified several infection control issues which concerned the need to replace identified chairs and tables throughout group rooms in the centre. Most of this furniture was worn, there were missing or damaged drawers in several tables used by service users; the edging sealant strips of parts of tables was missing; material ripped/torn on the seat or arm pads of chairs and the paint work on the arms of chairs had worn off showing bare wood. The inspector observed significant gaps and holes in the plaster work around the door frame of the training flat and there were several holes in parts of the wall in the relaxation/snoozeleen room off one of the group rooms. A requirement is made in the quality improvement plan for the Trust to replace these items of furniture as soon as possible. Consideration should be given to the Trust replacing fabric chairs with chairs which have an easy to clean wipeable material. A recommendation is made for the Trust to make good the identified areas around the door frame of the training kitchen and redecorate the relaxation/snoozeleen room.

New vertical blinds are required in two of the ground floor rooms as most of the blind slats are missing. The seals appear to be ineffective in two identified circular windows; French doors and the window in one group room on the ground floor. Two recommendations are made in the quality improvement plan concerning these matters.

The inspector noted there were numerous storage issues in specific areas throughout the centre where items had been placed on top of storage cupboards, partially filled black bin bags and clear bags were observed to be on the floor, behind doors and under the training flat's kitchen units. An opened box of washing powder was observed on a bench in the training flat. This could be a health and safety hazard if a service user ingested this. These areas were discussed with staff and the manager. A recommendation is made in the quality improvement plan for staff to prioritise the tidying up; removal and appropriate storage of identified items. If additional storage be required, this should be shared with the manager and appropriate action taken.

A total of two requirements and three recommendations were made regarding the environment.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Natalie Jackson, Registered Manager, as part of the inspection process.

The timescales for completion commence from the date of inspection.

The registered provider/manager is required to record comments on the Quality Improvement Plan.

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

Enquiries relating to this report should be addressed to:

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

Quality Improvement Plan

Primary Unannounced Care Inspection

Larne Adult Centre

6 January 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Natalie Jackson (registered manager/ person receiving feedback) either during or after the inspection visit.

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

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

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

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

Statutory Requirements

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

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	26(4)(b)	**Fire Safety** Fire doors must never be wedged open. The Trust should consider the use of magnetic devices where it is assessed doors can safely stay open (additional information section refers).	Once	Minor Works Request has been resubmitted for stand alone devices to be fitted to doors as needed. Doors will not be wedged open at any time.	Immediate and Ongoing
2	13(7)	**Infection Control** All identified chairs and tables must be replaced with appropriate furniture that can be effectively cleaned (additional information section refers).	Once	Staff are in the process of decluttering and collating a list of tables and chairs needing replaced in each activity room and throughout the centre. An order will be submitted by the end of February, 2015.	By 30 April 2015
3	17 (1) Schedule 3	**Annual Quality Review Report** The registered person must ensure Larne Adult Centre's Annual Quality Review report contains all of the qualitative information as specified in Schedule 3 (Theme 2 refers).	Once	Currently being amended to reflect specifications set out in Schedule 3, and will be completed before the 31st March, 2015.	By 31 March 2015

Recommendations

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

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details of Action Taken By Registered Person(S)	Timescale
1	25.1	**Environment** It is recommended the Trust: (a) redecorate the identified areas in Larne Adult Centre; (b) replace the vertical blinds on the windows in the two rooms used by one group of service users on the lower ground floor; (c) make good the identified areas of paintwork around the door frame of the training kitchen door and fill the small holes in the walls in the relaxation/snoozeleen room (additional information section refers).	Once	(a) Minor works has been resubmitted. (b) Waiting on quotation from supplier. (c) Requests submitted to Estates Department to action these issues asap.	By 31 March 2015 for all
2	25	**Windows** It is recommended the Trust replace the seals of the two identified round windows; French doors and window on the lower ground floor (additional information section refers).	Once	Request submitted to Estates Department to action asap.	By 30 May 2015

3	25	**Appropriate Storage** It is recommended staff: (a) remove all items stored on top of storage cupboards; (b) undertake a tidy up and clear out of all unwanted items and materials; (c) ensure there is sufficient storage throughout the centre (additional information section refers).	Once	(a) Actioned January, 2015 (b) Actioned January, 2015 (c) Staff collating list of what is needed.	By 21 January 2015 for (a) and (b) By 31 March 2015 for (c)
4	17.10	**Monthly Monitoring Reports** The registered person must ensure monthly monitoring visits must take place of Larne Adult Centre and records of same retained for inspection purposes (Theme 2 refers).	Once	Will be completed monthly as per regulations.	Immediate and Ongoing
5	5.6	**Care Plan** The identified service user's care plan must be updated to fully and accurately reflect his/her current situation and needs. Abbreviations must not be used in care plans (additional information section refers).	Once	Care Plan was updated immediately. Passed onto Named Worker of Care Plan in question as per inspector's recommendation re: abbreviations.	Immediate and 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	Linda Montgomery
Name of Responsible Person / Identified Responsible Person Approving Qip	Tony Stevens

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Louise McCabe	03 February 2015
Further information requested from provider			