Primary Unannounced Care Inspection

Name of Establishment:	**The Omagh Centre**
Establishment ID No:	**11313**
Date of Inspection:	**16 September 2014**
Inspector's Name:	**Margaret Coary**
Inspection No:	**IN020051**

The Regulation And Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544

Name of centre:	The Omagh Centre
Address:	4a Deverney Road Omagh Co Tyrone BT79 0JJ
Telephone number:	028 8224 4001
E mail address:	eddie.mccrystal@westerntrust.hscni.net
Registered organisation/ Registered provider:	Western Health and Social Care Trust
Registered manager:	Mr Edmund McCrystal
Person in Charge of the centre at the time of inspection:	Mr Niall Campbell
Categories of care:	DCS-LD
Number of registered places:	50
Number of service users accommodated on day of inspection:	40
Date and type of previous inspection:	22 January 2014 Primary Unannounced
Date and time of inspection:	16 September 2014: 11am to 3.30pm
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	**2**
Staff	**3**
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	**8**	**8**

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

Omagh Day Care centre is a WHSC Trust facility for people with a learning disability and can accommodate up to a maximum of 50 service users each day. The centre has recently been refurbished following a fire in 2008 when services were provided over two sites.

The overall aim of the service is to provide service users, where possible, with on-going educational opportunities and support which is underpinned by personal, social and vocational training, for example: sports and leisure, social and life skills, self-advocacy and development of new interests.

There are four units in which service users are accommodated according to the level of care and supervision required.

The centre is open from 08.45 hours until 16.45 hours each weekday and closes on public holidays, two weeks in July and periodic closure for staff training and development purposes.

Summary of Inspection

This is the report for the primary unannounced inspection of The Omagh Centre.

This unannounced inspection was carried out on 16 September 2014 from 11am to 3.30pm. 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 main focus of this unannounced inspection was to look at how the centre managed the use of restrictive practise and consequently the inspector looked at working practises within Units 1, 2 and 3.

The inspector was made welcome by Mr Niall Campbell, Acting Manager.

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 Campbell.

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.
Observation of practise within Units 1, 2 and three.
Examination of three files.
Discussion with three staff members.
Eight completed staff questionnaires.
Verbal contribution from the acting manager 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: Criterion inspected; 7.4, 7.5, 7.6 and 7.7.**

Records are kept on each service user's situation, actions taken by staff and reports made to others.

The inspector confirmed that the centre have appropriate policies and procedures in place which are accessible and available to staff.

The inspector talked with three staff members about their practise and opinions regarding confidentiality and the management of members' personal information. The inspector found that the staff were fully informed and aware of their roles and responsibilities in relation to those in their care.

The inspector examined one service users' file from each of the three units. The inspector found that information was person centre, detailed and informative incorporating advice from other professionals and good evidence of appropriate communications with relatives and carers.

Clear and detailed records were included in relation to restraint and all information was reviewed and signed in accordance with guidance.

The inspector noted that the centre has currently systems in place for reporting; discussion with staff verified that they were familiar with the reporting policy.

The inspector noted that a number of accidents / incidents had not been reported to RQIA as per regulations and whilst this is now current practise the inspector has made a requirement to ensure that this is established and ongoing.

The centre has achieved a substantially compliant level of achievement for the criterion inspected from Standard 7.

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

The day centre had relevant policies and procedures regarding restrictive practice and these were reflective of current national, regional and locally agreed protocols and guidance.

The inspector had discussion with the acting manager and three staff in relation to the deprivation of liberty and the consequence for those service users for whom restrictive practise is used. The inspector was satisfied that the acting manager and staff were acutely aware of the impact for service users and their human rights.

The centre were found to be diligent in relation to the management of restrictive practise and ongoing monitoring arrangements of risk assessments and care-plans were in place and on record. Relevant professionals were involved throughout the process to ensure that practise was necessary and safe for service users.

The inspector found that appropriate training was in place and continuing information was included in staff meetings to ensure that staff were cognisant of on-going good practise.

A review of the written records verified that in the event of any additional restrictive practices staff were fully aware of the procedures and protocols to follow. Systems were in place to ensure risk assessments pertaining to lap belts on wheelchairs were up to date and reviewed regularly.

The inspector noted that staff had a good rapport with service users and whilst they were unable to communicate with the inspector they appeared to be relaxed and content in their environment.

Based on the evidence reviewed the inspector agreed with the provider's self-assessment and has assessed the centre as substantially compliant in this theme.

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 was good evidence to demonstrate that the acting manager was experienced and qualified for his current role. Staff working in the centre had received appropriate training and observation of the rolling training programme confirmed that staff training was satisfactory ensuring that their day to day skills were enhanced to provide best outcomes for service users.

The organisational structure was clearly set out in the statement of purpose and is due to be updated to include the recent management arrangements.

Staff were aware of their roles and responsibilities and there was evidence that the current management arrangements are suitable with appropriate policies in place for the operation of the day care centre.

There was evidence from discussions with staff to confirm that members of the team work supportively and well with one another.

The registered manager had arrangements in place for the supervision and performance appraisal of the staff team.

There was evidence of monitoring arrangements that included monthly unannounced monitoring visits.

The inspector has made one recommendation pertaining to the completion of unit health checks.

Based on the evidence reviewed the inspector has assessed the centre as substantially compliant in this theme.

Environment

The inspector found the premises 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.

There were 40 service users present on the day of inspection with 21 service users present in Units one, two and three.

The inspector discreetly observed that staff had a good rapport with the service users and were very aware of their individual needs caring for them in a gentle and kind manner.

There was one requirement and one recommendation from this unannounced inspection.

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

Follow-Up on Previous Issues

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	15.5	The monitoring visit should include audit of all reviews held and any follow-up action completed.	The monitoring visits now include an audit of reviews held and follow up actions.	Compliant
2	28.4	The centre should ensure that a policy and procedure in relation to monitoring visits is completed.	A policy and procedure in relation to monitoring visits has been compiled and was available for inspection.	Compliant
3	17.10	Working practises to be audited in the monitoring report.	Working practises are now audited as part of the monitoring visit.	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 Omagh 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**
Not Inspected on this occasion.	Not Applicable
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 Omagh Centre service users have access to their case notes/records as and when required, through advocacy meetings and at Person Centred 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**
Not inspected on this occasion.	Not Applicable

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 Omagh Centre are maintained for each service user. Notes contain information/documentation as per standard 7.4	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The inspector examined a selection of three files, the inspector found that the records were person centred; detailed and informative incorporating communications and advice from allied health professionals, risk assessments and care plans were regularly updated and appropriately signed off. There was also documented evidence of good communications with relatives and carers. The inspector found that reviews were held in accordance with guidance and information was person centred and focused on achieving best possible outcomes for service users. The inspector looked at a selection of monitoring inspection records and found that working practises were reviewed in accordance with the standard.	Substantially Compliant

The inspector noted that the centre have currently good reporting systems in place, however, found that since the last inspection there were instances where accidents /incidents had been passed to the Trust but had not been reported to RQIA. The inspector has made a requirement to ensure that this is on-going practise.	
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 was satisfied that regular entries were made for service users and that information was informative and relevant.	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 disiciplinary 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 found that there were appropriate policies and procedures pertaining to communication, confidentiality,	Compliant

consent, management of records, monitoring of records, recording and reporting care practices and assessment, care planning and review. The inspector talked with three staff members and confirmed that these were accessible for consultation. The inspector found that staff were knowledgeable and informed about proper reporting. The inspector has made a previous requirement to ensure that reporting is carried out as per regulations. The inspector noted that staff were diligent and conscientious regarding ensuring best outcomes for this vulnerable group through appropriate referral to behaviour support and clinical psychologist and other relevant professionals and this was well evidenced in the three files examined. The inspector talked with three staff members all of whom confirmed that there was excellent communication within the centre and that they were informed at all times. The acting manager advised that there were regular staff meetings held for each unit and the agenda was determined by those in attendance, this was verified by staff and evidenced.	
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 the records demonstrated that staff were conscientious and diligent in relation to good recording and information was reviewed and signed off in accordance with legislation. As stated in the self-assessment regular monthly health checks are completed to ensure that information is updated and appropriate to the needs of the service user. 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 Omagh Centre physical restraint is used MAPA all relevant staff trained. 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 noted that the centre had relevant policies in place in relation to this theme. These included; Policy for the Use of Restrictive Interventions, Definition of Restrictive Interventions incorporating Human Rights, Risk Assessment and Care-Planning for Restrictive Interventions, Deprivation of Liberty Safeguards, Behaviour Management and Management of Aggression. The policies and procedures are readily available for staff consultation and staff sign of to denote that they have been read and understood. The inspector viewed the training record and confirmed that staff had received appropriate training in the use of restrictive practise and the Management of Behaviours. The centre are fortunate in that the acting manager is one of the Trust trainers in the use of Mappa and consequently staff are well informed and advised as was evidenced in training records and in discussion with three staff members. The inspector looked closely at a selection of three files from units one, two and three. The records were detailed and person focused with good inter agency communications and advice recorded. The inspector and noted that information regarding Management of Behaviours and Restrictive Practise was recorded	Compliant

in detail, regularly reviewed and signed off by the appropriate people. The inspector was pleased to find that reviews were timely and looked at the continued use of restrictive practise to ensure that this was appropriate and necessary with recorded information and guidance from relevant professionals as part of the review. The inspector found that each service users' Human Rights were considered and every effort made to ensure that this remained a priority when restraint was necessary. The inspector discussed the use of restraint in the units with three staff members and found that they were well informed and aware of their responsibilities in ensuring that Human Rights were always respected and restrictive practise only used when absolutely necessary. Staff stated that they felt that their training was good and the acting manager was involved in training for MAPPA and as a consequence they were well informed and given on-going literature regarding restrictive practise. The acting manager advised that the Draft Mental Capacity Bill document has been given to all the day centres for discussion and is penned in to a staff meeting to ensure that staff have a good understanding and insight in to the repercussions and effects of this bill in relation to their service users. The inspector commends this pro-active work which encourages staff to be constantly aware of the human rights and dignity of those in their care.	
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**
The inspector verified that appropriate policies and procedures were in place and available for staff reference.	Compliant

The inspector examined a selection of three files and found that these were recorded in accordance with legislation and guidance. The files included detailed assessments, risk assessments and care plans and a Behaviour Response chart which was compiled from advice and support from the behaviour team. All information is reviewed monthly or more often as required and evaluated. The files also contain a restrictive intervention signature chart which parents/carers also sign along with all relevant professionals and acting manager. This is good practise and ensures that continued use of restrictive practise is closely monitored.	

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 Omagh 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 looked at the acting managers professional qualifications and noted that he had experience of working within the field of special needs extending over the past 24 years. This included working as a care assistant and then progressing to senior day care worker in 2003 and acting deputy manager in 2014 to his current role as acting manager. The acting manager has qualifications in supportive employment and has Levels 2 and 3 NVQ. He is currently completing Level 5 in management. As previously stated he completes MAPPA training with Trust staff which is a great advantage for practise within The	Substantially Compliant

Omagh Centre. The inspector confirmed that appropriate policies and procedures were in place pertaining to the management of operations some of which included; Operational policy, Staff supervision and appraisal and Protection of Vulnerable Adults. The inspector confirmed that the person who manages the centre in the absence of the acting manager has completed a competency and capability assessment. The inspector was satisfied that this person was suitably qualified to take on the role. The inspector noted that the management structure was detailed in the statement of purpose and information on staff within the centre was also detailed. The acting manager advised that the statement of purpose is due to be updated following his recent appointment as acting manager. The inspector also examined the staff duty rota and verified that this was maintained in accordance with guidance and there were sufficient staff on duty at all times. The inspector talked with three staff members all of whom confirmed that they receive regular supervision. Staff appraisals have been booked and will be completed within the next few months. The inspector also looked at a selection of monitoring inspection records and confirmed that staffing levels were inspected as part of the visit. The inspector also examined the Unit Health Management checks and found that these had not been completed from the month of November 2013 to July 2014. There is a recommendation in relation to this.	

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 Omagh Centre the Senior Day Care Worker, Day Care Workers 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**
As stated the inspector verified that staff receive regular supervision.	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:	
Staff at Omagh Centre are suitably qualified or trained and have skills and experience necessary for such work Staffing at Omagh is as follows. 1xBand 7 Day Service Manager 37.5 Hrs (Based in Omagh) 2xBand 5 SDCW 37.5 Hrs (Based in Omagh) 5xBand 5 DCW 37.5 Hrs 15xBand 3 C/Assistants and agency support workers	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The acting manager is based in The Omagh Centre and is available on a regular basis. Arrangements are in place for the senior day care worker to cover in his absence and a competency and capability assessment has been carried out and held on record. The inspector confirmed staffing qualifications as stated in the self-assessment.	Compliant

The inspector examined the policies and procedures manual and was satisfied that relevant policies and procedures were in place and readily available for staff reference. As previously stated staff "sign off" relevant policies to confirm that they have been read and understood. The inspector talked with three staff members and discussed their day to day work in the centre. The inspector was satisfied that staff were very aware of their roles and responsibilities and were keen to help this vulnerable group to get the utmost from their day care experience.	

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 looked at the complaints record and was satisfied that these were managed in accordance with guidance.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr Niall Campbell, Acting 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:

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 UNANNOUNCED INSPECTION

THE OMAGH CENTRE

16 SEPTEMBER 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 Mr Niall Campbell, Acting Manager during 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	Requirement	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	Schedule 5 (10) Ref; 7.6	All accidents and incidents should be reported to RQIA.	One	All incidents and accidents are reported to RQIA from the date of inspection 16/9/14	Ongoing

Recommendations

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

No.	Minimum Standard Reference	Recommendation	Number Of Times Stated	Details of Action Taken By Registered Person(S)	Timescale
1	17.1	Unit health management checks had not been completed from the month of November 2013 to July 2014; these should be completed in line with the centres policy.	One	All management health checks have been completed from September by acting day care manger and filed.	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	Niall Campbell
Name of Responsible Person / Identified Responsible Person Approving Qip	Elaine Way

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	17 December 2014
Further information requested from provider			