Primary Unannounced Care Inspection

Name of Establishment:	**Prospects Beacon Centre**
Establishment ID No:	**11060**
Date of Inspection:	**16 March 2015**
Inspector's Name:	**Dermott Knox**
Inspection No:	**IN020062**

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

Name of centre:	Prospects Beacon Centre
Address:	River Suite 5-7 Parkview Road Castlederg BT81 7AH
Telephone number:	028 8167 0600
E mail address:	prospects@beaconwellbeing.org
Registered organisation/ Registered provider:	NI Association for Mental Health Miss Rose Anne Reynolds
Registered manager:	Ms Ciara Collins
Person in Charge of the centre at the time of inspection:	Mrs Martina McLoughlin, Project Worker
Categories of care:	DCS-MP, DCS-LD
Number of registered places:	26
Number of service users accommodated on day of inspection:	11
Date and type of previous inspection:	12 March 2013 Primary Unannounced
Date and time of inspection:	16 March 2015: 12:00 noon – 5:45pm.
Name of inspector:	Dermott Knox

Introduction

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

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

Purpose of the Inspection

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

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

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

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

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

Methods/Process

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

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

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

- Analysis of pre-inspection information
- Discussion with the registered manager
- Examination of records
- Consultation with stakeholders
- File audit
- Tour of the premises
- Evaluation and feedback.

Any other information received by RQIA about this registered provider and its service delivery has also been considered by the inspector in preparing for this inspection.

Consultation Process

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

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

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

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

Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to establish the level of compliance achieved with respect to the following DHSSPS Day Care Settings Minimum Standards and theme:

- **Standard 7 - Individual service user records and reporting arrangements:**

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

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

- **Theme 2 - Management and control of operations:**

  Management systems and arrangements are in place that support and promote the delivery of quality care services.

The registered provider and the inspector have rated the centre's compliance level against each criterion and also against each standard and theme.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance Statements		
Compliance statement	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

Profile of Service

Prospects Day Centre occupies the River Suite of Derg Valley Care Complex, located close to the centre of Castlederg.

The Day Centre is operated and run by Northern Ireland Association for Mental Health (NIAMH) a charitable organisation.

The centre currently provides care and therapeutic intervention for up to 26 adults, 18 years and older in the Castlederg area who have an enduring mental health illness and for up to eight adults with a learning disability in the same age category.

The centre is open four days a week from 9:30am to 4:30pm. A maximum of 10 individuals attend on designated days.

Prospects have established links with local statutory services such as the local Community Mental Health Services and Learning Disability Services.

Links have been establishes with other community groups in the Castlederg area such as Derg Valley Care, Churchtown Community Group, Mournederg Community Crae and in other areas such as South West College, Omagh Volunteer Bureau and Citizens Advice Bureau.

Summary of Inspection

A primary announced inspection was undertaken in Prospects Beacon Day Centre on Monday 16 March 2015 from 12:00 noon until 5:45pm. Following the inspection, the service provider submitted a self-assessment of the centre's performance in the one standard and two themes forming the focus of the inspection.

The inspector was introduced to many of the service users attending the centre and met for informal discussions with eight people in a group setting. Individual discussions were held with the team leader, who has day to day responsibility for the centre's operations and one other staff member. Discussions focussed mainly on activities, the standards, staff and management support and the overall quality of the service provided.

Discussions with all contributors elicited a very positive view of the service provided in the centre and indicated a strong commitment by the manager and the staff team to comply with the minimum standards for day care settings. Service users spoke highly of the staff and of the service they provided. There was evidence from discussions and in written records to indicate a high level of involvement of service users in discussions regarding their care plans and the activities in which they participated. These included a range of cultural, leisure and entertainment activities.

Overall there was wide-ranging evidence to confirm that the Prospects Beacon Day Centre provides a valuable, high quality service to those who attend. There is one requirement and three recommendations arising from this inspection, each addressing a detail of one of the centre's records.

Thanks are due to service users who welcomed the inspector to the centre and contributed to the evaluation by sharing their experiences. The inspector also wishes to acknowledge the open and helpful approach of the staff who were present throughout the inspection process.

Standard 7 - Individual service user records and reporting arrangements:

Service users' files were found to be very well organised and to contain almost all of the information required by this standard. Daily notes of each service user's involvement and progress were of a high standard with good detail regarding each person's needs and activities. Notifiable events and the reporting of these is included in the induction and training of staff members and the records of events were up to date.

A risk assessment had been completed for each service user, in addition to the more general assessment of needs which linked accurately with the care plan content. Care/Support plans were well structured and required that needs, actions and outcomes for a range of social, emotional, health and functional aspects of living should be addressed. Two of the files examined did not contain a photograph of the service user and this is a requirement.

The NIAMH policies and procedures were available to staff on the computer records system and staff presented as confident and competent in key areas of operations. Staff reported that they have ready access to senior staff when they feel it necessary to seek guidance.

Prospects Beacon Day Centre was judged to be substantially compliant with this standard.

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

There was no evidence to indicate the use of restrictive practice in Prospects Beacon Day centre. Staff were knowledgeable of the organisation's policy and procedures regarding such practices and confirmed that they were well trained in calming and diffusing techniques and were confident of managing all of the events that had arisen in the centre. When devising or reviewing a service user's individual care plan, the manager and staff discuss proposed action plans with the service user and his or her representative/s to ensure that interventions are necessary and proportionate and do not infringe service the user's human rights. Each service user's file contained written reference to safety and to risk and vulnerability assessments and provided evidence that such matters had been considered in agreeing the care plan.

Staff discussed the use of restraint or seclusion, including how each service user's human rights are protected. Service users, who spoke to the inspector, expressed complete satisfaction with the care and support they experienced in the Prospects Beacon Day Centre.

Prospects Beacon Day Centre was judged to be operating in compliance with the criteria in this theme.

Theme 2 – Management and Control of Operations

The registered manager had ensured that an experienced staff member was competent to take charge in her absence and there was evidence on file and from observation to confirm that the day to day leadership in the centre was well within this staff's capability.

There was both written and oral evidence of good formal supervision arrangements. A culture of self-evaluation and continuous improvement has been developed within the centre and the beneficial outcomes of this were notable in many aspects of the centre's operations.

Monitoring arrangements were good in terms of their regularity and the numbers of service users and staff members who were asked for their views. Four monitoring reports were examined and all were found to address the matters required by Regulation 28. Each

monitoring report concluded with a service improvement plan, with progress on the matters identified being checked at the subsequent monitoring visit. This is good practice.

Prospects Beacon Day centre was judged to be operating in compliance with the criteria in this theme.

Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
		No requirements were made as a result of this inspection.		

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
		No recommendations were made as a result of this inspection.		

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 users personal information is maintained in accordance with NIAMH policies and procedures covering Confidentiality(RP/07), Data Protection(CS/06), Storage and Destruction of Closed Files(MA/14) and Safeguarding Vulnerable Adults(BS/2). NIAMH Data Protection Policy gives individual service users the right to have access to personal information relating to themselves where this information is being held or processed by NIAMH as outlined in 5.02.. Confidentiality in respect of obtaining, handling, use of, storage and retention of service user information and documentation is detailed in Sections 2.0 to 2.4 of NIAMH Confidentiality Policy, RP/07(a). All service user personal information held at scheme is stored in individual files within a locked cabinet. These procedures are supported by Safeguarding Vulnerable Adults Policy, BS/2, Sections 5.3 and 5.4. Good practice in relation to the Storage and Destruction of Closed Files is described in NIAMH Policy MA/14. Staff understanding of their legal and ethical duty is assessed and evidenced in Section A of the Induction and Foundation Framework undertaken by all staff prior to being confirmed in post, and in the "New Employee Orientation & Induction" workbook completed by staff as part of their induction. The DHPSSPS Code of Practice on Protecting the Confidentiality of the Service User is available on scheme to provide additional practical guidance on decision-making regarding the disclosure of service user personal information.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The comprehensive and detailed self-assessment, completed by the provider, was verified through examination of a sample of the identified policies and procedures and from discussions with staff members and service users. Personal information on service users was accessed from secure file storage cabinets and service users confirmed their confidence in the staffs' management of such information.	Compliant

Criterion Assessed: 7.2 A service user and, with his or her consent, another person acting on his or her behalf should normally expect to see his or her case records / notes. 7.3 A record of all requests for access to individual case records/notes and their outcomes should be maintained.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
7.2 Current information in R/R/101 is contained in Beacon Member Notes p.19. A new draft referral procedure expands on this in R/R/102 Sections 7 and 14. In both sections members are reminded that they have open access to their files; they are also encouraged to input to their files participatively and by writing their own notes for example. Section 14 of R/R/102 contains additional information for Beacon Members wishing to access their files following discharge from the service. The Beacon Members Guide also provides relevant information to all new members. Sections 1.3 and 1.5 outline both content and open access arrangements to members files. 7.3 Section 6.0 of Corporate Policy no. CS/06 on Data Protection covers the right of access to personal information in relation to Individual Subject Data Requests.	Moving towards compliance
Inspection Findings:	**COMPLIANCE LEVEL**
There was both written and oral evidence to verify that service users are encouraged to participate in the process of record keeping with regard to their individual personal information. This was particularly notable in review preparation reports. Service users confirmed that they had access to their personal records and enjoyed open and trusting working relationships with staff members.	Compliant
Criterion Assessed: 7.4 Individual case records/notes (from referral to closure) related to activity within the day service are maintained for each service user, to include: • Assessments of need (Standards 2 & 4); care plans (Standard 5) and care reviews (Standard 15); • All personal care and support provided; • Changes in the service user's needs or behaviour and any action taken by staff; • Changes in objectives, expected outcomes and associated timeframes where relevant; • Changes in the service user's usual programme; • Unusual or changed circumstances that affect the service user and any action taken by staff;	**COMPLIANCE LEVEL**

• 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 case records are contained in the Beacon Members Personal File in accordance with Beacon Policy Number R/R/101(p.7,8) and titled Policy and Procedure for Referral and Attendance in Beacon Day Support. Beacon Members, staff members and referral agents work together through the processes outlined above to ensure a meaningful and holistic intervention. An individuals recovery journey is about change and Beacon consider that it is essential to record information that chronicles this. R/R/101 contains guidance for staff on the information and recording required to assess, plan and review the delivery of care and support to all our members with relevant appendices designed to provide the information required in Appendix 1 of the Standards, Schedule 4 of the Regulations. A separate Serious Incident Reporting Policy CS/07 provides an Incident Form and Flow Chart with clear guidance for recording and reporting.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Three personal information files for service users were examined and were found to be well organised and largely complete in their content. However, some files did not contain a photograph of the service user, as is required by Regulation 19 (1) (a). The registered person must ensure compliance with this regulation.	Substantially compliant
Criterion Assessed: 7.5 When no recordable events occur, for example as outlined in Standard 7.4, there is an entry at least every five attendances for each service user to confirm that this is the case.	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
R/R/101 currently notes in 2 locations (p.17,19) that a note is to be recorded at least at every fifth visit. This is standard practice across all our day care provision.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Progress records for service users were being kept in compliance with this standard and staff are commended for	Compliant

maintaining good quality records in each of the files examined.	
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 relevant guidance is outlined in a number of documents with an introduction to relevant policies and procedures an important part of the Induction process for new staff and a key component of the Induction and Foundation Framework (Units B, C). In addition staff are introduced to key mechanisms for communication within the organisation and the scheme. These include the staff section of the organisations website, the policy and procedure manual and the emergency procedures file; included within the scheme are the communication book, scheme diary and phone book, minutes of staff meetings, staff files and member files. For ease of access a number of policy documents include lists of numbers and flow charts that may be displayed on office notice boards, for example BS/4 Protection of Children and Reporting of Suspected Abuse requires a list of relevant contacts for Gateway Teams and Designated Officers to be displayed. BS/2 Safeguarding Vulnerable Adults includes a Reporting Flowchart as does QG/4 Incident Reporting and Management Policy and Procedure. Personal information on members and their contacts is updated annually at review using Appendix 3, Beacon Member Information Record, of Policy RR/101 Beacon Referral and Attendance Policy. Other relevant policies include BS/1 Beacon Member Safety/Risk/Vulnerability, BS/14 Consent Policy, HS/13 RIDDOR Policy and QG/3 Complaints Procedure.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
NIAMH has excellent written guidance for staff on the matters set out in this criterion and the provider's self-assessment was verified through examination of a sample of the identified documents and from discussions with staff members regarding their confidence in reporting appropriately when required.	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:	
Relevant guidance is contained in the section on Beacon Member Notes of R/R/101 Policy and Procedure on the Referral and Attendance in Beacon Day Support p.19.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
With the exception of two files which did not contain a photograph of the service user, personal records were maintained to a high standard. A recommendation on this matter has been included in the Quality Improvement Plan.	Substantially compliant

PROVIDER'S OVERALL ASSESSMENT OF THE DAY CARE SETTINGS COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	**COMPLIANCE LEVEL**
	Substantially 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:	
NIAMH's policy on the use of restraint is set out in BS/2 Guidance on Restrictive Practice. This policy states clearly that staff are not to use "physical restraint" or "physical intervention" to restrain service users in any situation. Any physical intervention should only be the minimum used as a last resort to enable staff to get away for their own or others safety. If a situation is deemed serious enough to require physical intervention the police must be called. This guidance is reinforced by BS/16 Policy and Procedures for Dealing With Violence at Work, Section 6.2, g, which states that "the staff member should never attempt to restrain the service user". This guidance is explained in Section 6.3,a&b, of the policy, " The legal position on physical restraint", which states that "NIAMH staff are not trained in restraint techniques and therefore to ensure their own safety and that of the service user should not attempt to restrain the service user in any circumstances". In incidences where physical support is required to manage an incident of violence at work the staff member will summon the police. (6.2,f). All staff receive training on Personal Safety/ Calming and Diffusing. This training focuses on skilling staff to prevent work related violence rather than on how to use/apply restraint techniques.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
The NIAMH policy on restraint is very clear and unambiguous and staff were in no doubt about this aspect of their work. Support plans were written from the service user's perspective and identified objectives and expectations for the individual's participation in the centre's programmes. The high level of involvement of service users in their own programmes and progress was demonstrated in the samples of progress notes written by the relevant service user. There were no records of any restrictive practices having been used in the centre and service users confirmed that they were always treated with respect and kindness by staff members.	Compliant

Regulation 14 (5) which states: **On any occasions on which a service user is subject to restraint, the registered person shall record the circumstances, including the nature of the restraint. These details should also be reported to the Regulation and Quality Improvement Authority as soon as is practicable.**	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
BS/16, Policy and Procedures for Dealing with Violence at Work, states clearly that staff sholud never attempt to restrain a service user (6.2,g). In incidences where restraint would be required, police assistance would be called to do so (6.2,f). In such circumstances staff would follow the investigation and recording requirements detailed in 6.4 of the Policy and record details in accordance with QC/4, Incident Reporting and Management Policy and Procedure. RQIA would be notified of all incidents requiring the involvement of the police in the use of restraint (QC/4, Appendix 4).	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
There was no evidence to indicate the use of restraint in the centre. Other notifiable events had been reported appropriately.	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:	
Niamh's Recruitment Policy and Procedure R/P/04 uses a competency based selection process to recruit individuals with the qualifications, experience and character requirements that accord with Schedule 2 of The Day Care Setting Regulations (NI) 2007, and Part III Section 21 Fitness of Workers. In addition they meet the requirements of current employment legislation and good employment practice (as outlined in RP/07/1.3). Ongoing competence of staff is monitored and enabled via Supervision (R/P/39) and the group competency based Performance Management System (PMS). Twice a year managers and their direct reports complete a performance and development review that is linked to an competence profile and agree objectives and actions that are designed to enhance each staff members personal development in the context of their personal aspirations, the nature of the service they are delivering, and the overall organisational strategy. The management structure of each scheme is outlined in the Statement of Purpose. Section 2.0 identifies the number and qualifications of staff, Section 5.0 outlines the structure of the facility. Each facility will employ different grades of staff including Scheme Managers, Project Workers, Support Workers, Clerical Staff and Peripatetic Staff. Job descriptions detail the specifics of each role, lines of accountability and areas of activity. Scheme specific areas of activity will be reflected in Centre Programmes and Activity Schedules.	Compliant

Numbers of staff reflect a balance between number of sessions, numbers of users and programme of delivery.	
Inspection Findings:	**COMPLIANCE LEVEL**
There was excellent evidence to verify the provider's self-assessment. The management structure and the lines of accountability for staff were set out in the statement of purpose. The manager was not in the centre during this inspection but the staff member in charge had access to all of the necessary records to provide evidence of compliance with this criterion.	Compliant
Regulation 20 (2) which states: • **The registered person shall ensure that persons working in the day care setting are appropriately supervised**	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
All staff supervision takes place in accordance with the Supervision Policy R/P/39. Staff are supervised at a frequency and duration commensurate with their position and levels of responsibility as outlined in section 1.3 of the policy, with every staff member having a supervision contract and a shared responsibility for the process. The supervision process is designed with links to the organisation's Performance Management System. All managers attend a full day's training on supervision. Staff Supervision Records form part of Monthly Monitoring.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Staff's accounts of supervision provided good evidence of a well-structured system in place, which exceeded the minimum requirement of the standards. Excellent records of staff meetings, staff training and monthly monitoring indicated a strong commitment to quality assurance in the centre.	Compliant
Regulation 21 (3) (b) which states: • **(3) For the purposes of paragraphs (1) and (2), a person is not fit to work at a day care setting unless –** • **(b) he has qualifications or training suitable to the work that he is to perform, and the skills and experience necessary for such work**	**COMPLIANCE LEVEL**
Provider's Self-Assessment:	
In the first instance Niamh recruits staff with the quailifications, skills and experience required by the Personnel Specification for the role. Niamh provide an Essential Regional Training Schedule designed to meet the mandatory training requirements of RQIA and essential sector specific content. To ensure timescales match RQIA requirements	Compliant

all staff are required to attend training on the dates allocated with attendance being monitored on the HR IT System(Cascade) and reviewed in supervision, to ensure compliance. All new staff are required to complete a New Employee Orientation and Induction Handbook that in particular introduces staff to those policies, procedures and systems, knowledge of which enables them to take charge in the absence of the manager. Staff also complete an Induction and Foundation Framework leading to an accredited qualification with the National Open College Network, that is either a level 2 or level 3 in Social Care and Mental Health (level is commensurate with grade). In addition and annually all grades of staff have access to opportunities for further development that include short courses with external providers and/or additional qualifications such as the Qualification Credit Framework (QCF) Level 3 in Health and Social Care, or QCF Level 5 in Leadership in Health and Social Care Services (Adults Management). The organisation is also currently developing 2 programmes to identify and develop future leadership talent through their 'Nurturing Talent' and 'Building Talent' Programmes for different grades of staff across the whole Niamh Group.	
Inspection Findings:	**COMPLIANCE LEVEL**
The provider's detailed self-assessment provides evidence of a well-integrated system, operated by NIAMH, to ensure that staff are trained and qualified for their roles and responsibilities. Staff confirmed in discussions that they were very well supported in their work, through relevant and timely training.	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

Additional Areas Examined

Complaints

The centre's record of complaints was found to be mostly satisfactory and had been audited by the monitoring officer in November 2014. In the new record format, the section on resolving the complainant's concerns had not been completed in one instance and the registered manager should ensure that this is completed.

Records of staff meetings

Records of staff meetings should include the names of all those attending, in keeping with Standard 23.8.

Records of activities

The record of activities should include information on the qualifications of any activity leader who is contracted in to lead or facilitate.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Martina McLoughlin, Senior Support Worker, as part of the inspection process and this was followed up by phone with the Registered Manager, Ms Ciara Collins.

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:

Dermott Knox
The Regulation and Quality Improvement Authority
Hilltop
Tyrone & Fermanagh Hospital
Omagh
BT79 0NS

Quality Improvement Plan

Primary Unannounced Care Inspection

Prospects Beacon Centre (11060)

16 March 2015

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

The specific actions set out in the Quality Improvement Plan were discussed with Mrs Martina McLaughlin, Project Worker 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	Requirement	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	Regulation 19 (1) (a) (See Schedule 4)	Service users' records should include a recent photograph of the person. If a service user objects to the inclusion of a photograph, this objection should be recorded and signed by them, or, if necessary, a representative.	One	Aprocess has been implemented to ensure all members either have a photograph with authorisation or a record of their objection if they chose not to.	30 April 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	Standard 14.10	While the pro-forma for complaints records was satisfactory, some records had not been fully completed and the registered manager should ensure that this standard is met.	One	signed off as complete on 20th March 2015	31 March 2015
2	Standard 23.8	Records of staff meetings should include the names of all those attending, in keeping with this standard.	One	implemented with immediate effect.	31 March 2015
3	Standard 9.6	The record of activities should include information on the qualifications of any activity leader who is contracted in to fulfil this function.	One	we source tutors through South West College who manage the recruitment process and provide a letter annually to confirm that tutors have appropriate qualifications and experience in their subject area.	31 March 2015

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	Ciara Collins
Name of Responsible Person / Identified Responsible Person Approving Qip	Billy Murphy

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	D Knox	11 May 2015
Further information requested from provider			