Primary Announced Care Inspection

Name of Establishment:	**Aspen Beacon Centre**
Establishment ID No:	**11063**
Date of Inspection:	**3 June 2014**
Inspector's Name:	**Dermott Knox**
Inspection No:	**17715**

The Regulation And Quality Improvement Authority
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Name of centre:	Aspen Beacon Centre
Address:	16 Finaghy Road South Belfast BT10 0DR
Telephone number:	(028) 9061 1513
E mail address:	aspen@beaconwellbeing.org
Registered organisation/ Registered provider:	Miss Rose Anne Reynolds NI Association for Mental Health
Registered manager:	Ms Karen McCorry
Person in Charge of the centre at the time of inspection:	Ms Karen McCorry
Categories of care:	DCS-MP, DCS-MP(E)
Number of registered places:	32
Number of service users accommodated on day of inspection:	21
Date and type of previous inspection:	20 June 2013 Primary Unannounced Inspection
Date and time of inspection:	3 June 2014 10:00am – 3:30pm
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	7
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	6	4

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

The Northern Ireland Association for Mental Health (Niamh) was founded by Lady Margaret Wakehurst in 1959. The original name 'Beacon House' is the name of the Niamh central office building in Belfast. Niamh works to promote the mental well-being of everyone in society.

Aspen Beacon Day Support, formerly known as the South Belfast Beacon centre, is one of fourteen day support services which Niamh operate throughout Northern Ireland. The original centre was opened in 1962 by Dame Margaret Wakehurst at 84 University Street, Belfast. This long established service aims to meet the changing needs of service users over 18 years of age, in the north, south and west of Belfast, who have enduring mental ill health.

Aspen Beacon Day Support was established in its current premises at Finaghy Road South in November 2004. The centre is a converted, semi-detached, two storey house and is close to shops, restaurants and public transport routes.

Ground floor accommodation includes a sitting room, kitchen, dining area, female, male and disabled WC's. The first floor has a 'quiet room', 'harmony room', two offices and a storage room.

Externally, there is a small parking area at the front and a large well maintained garden area to the rear. There is also a decked area and a number of smaller screened seating areas for discussions or relaxation, individually or in small groups, as required.

Aspen Beacon Centre provides day support for up to thirty two members per day.

The service is available:

Monday	9.00am - 5.00pm
Tuesday	9.00am - 5.00pm
Wednesday	9.00am - 5.00pm
Thursday	1.00pm - 8.30pm
Friday	9.00am - 4.00pm

The service also supports a "User Led" social group on Saturdays from 1.00pm to 4.00pm.

Aspen Beacon Centre also has an outreach programme which facilitates 12 members over the age of 65 years. This group meet every Tuesday afternoon at Morton Community Centre in, Lorne Street, Belfast, a Belfast City Council facility in which the Aspen members have access to a large meeting room and kitchen facilities.

Summary of Inspection

A primary announced inspection was undertaken in Aspen Beacon Day Support on Tuesday 3 June 2014 from 10:00am until 3:45pm. Prior to the inspection the service provider submitted a self-assessment of the day centre's performance in the one standard and two themes forming the focus of the inspection. Both of the recommendations from the previous inspection had been met.

The inspector was introduced to many of the members attending the centre and met for discussions with seven people, four of whom had requested individual meetings. Individual discussions were also held with the manager, three staff and the services manager, who was present during part of the inspection, regarding the standards, team working, management support, supervision and the overall quality of the service provided.

Four completed questionnaires were returned by staff members, who reported that satisfactory arrangements were in place regarding supervision; staff training; staffing and management arrangements; responding to members' behaviour; confidentiality and recording. Positive comments were made regarding the quality of care provided, including, "I believe the quality of care & day service in Aspen is excellent and person centred."

Overall, the discussions with members and with staff contributed a very positive view of the service provided in the centre and indicated a commitment by the manager and the staff team to exceed the minimum standards for day care settings and to pursue continuous improvement with the full inclusion and involvement of service users.

Discussions with members elicited positive comments regarding the support experienced and the care provided by the staff. Members were very complimentary about the overall quality of the service and its value to them. They confirmed their approval of records kept in the centre about them and their full involvement in the review process.

The management and staff are commended for the provision of a high quality service.

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 members, who warmly welcomed the inspector to the centre and contributed to the evaluation of the service provided.

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 centre has written policies and procedures pertaining to confidentiality, recording and reporting, data protection, consent, and, storage and destruction of closed files. The policies and procedures were available for staff reference. The registered person had arrangements in place to audit policies and procedures with regard to the requirements of the minimum standards, in order to ensure that they were up to date and accurate.

In the sample of four service user care records examined, there were several examples of members having written their own progress notes and, where these had been written by staff, the member signed to indicate their involvement and agreement with the content. A number of members had declined to have their photograph included in their file and this had been recorded and signed by both staff and the member. This sense of developing ownership of the records, in terms of regularly contributing to them and having some control over what is included, is commendable.

The Aspen Beacon Service was judged to be operating in compliance with this standard.

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

The Northern Ireland Association for Mental Health (NIAMH) has a policy and clear guidelines on the use of restrictive practices, which states that staff are not to use physical restraint or physical intervention with service users. The evidence available from members, staff and the written records, verified that there had not been any instances of such practices in the centre. Staff discussed the use of good communication, calming and diffusing techniques, for which training is provided, and the importance of developing good understanding of their members' needs and preferences. They expressed the view that the development of trusting working relationships with members and between members has led to a positive working climate in which any member requiring help and support can access this easily. NIAMH also has a written policy and procedures for 'Dealing with Violence at Work', and staff confirmed their understanding of the procedures.

The centre was judged to be operating in compliance with 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.

Staff records showed that the registered manager and the support workers are appropriately qualified and experienced to take charge of the centre. Training for key aspects of this role had been provided. NIAMH has developed an 'Employee Competency Framework' against which each staff member's competence is assessed. This is a well-constructed framework and a useful staff development tool. NIAMH has supported experienced staff to undertake QCF Level 5, before they are in a position of full management responsibility for a service and this is commendable.

There was evidence from discussions with staff to confirm that members of the staff team work supportively and well with one another. The manager demonstrated a good understanding of the developmental needs of each staff member and had systems in place for supervision, appraisal and promoting staffs' learning. Records of staff training and supervision were well-presented and up to date, with formal supervision sessions being provided every 6 to 8 weeks.

The staffing structure and reporting arrangements were clearly set out in writing in the statement of purpose, for reference by all stakeholders. Staff presented as being knowledgeable, competent and confident in their roles and responsibilities.
Monitoring arrangements are standardised across NIAMH services and the four monitoring reports examined, addressed all of the required matters.

In recent years, Niamh had commissioned an independent review of Beacon Day Services and a comprehensive report of the findings was available. This, and other evaluative exercises, provided evidence of an organisational commitment to continuous improvement and this is commendable.

There was strong evidence to indicate compliance with the criteria in this theme.

Follow-Up on Previous Issues

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Inspector's Validation Of Compliance
1	15	**Review of Service Users' Placements** With regards to the review of service users' day care placements, the registered manager must ensure: (a) The Aspen Beacon Centre review procedures are revised to include when the service user's placement is initially reviewed so that this is in accordance with criterion 15.3; (b) Written records are made of when the initial review of the service user's placement took place; (c) The service user's annual review report contains all of the relevant information specified in criterion 15.5 (standard 15 refers).	The centre's referral and review procedures had been revised and were found to meet the criteria identified in this recommendation.	Compliant
2	17.10	**Monthly Monitoring Reports** The designated person's monthly monitoring reports for Aspen Beacon Centre must state the following: (a) Whether the visit is announced or unannounced; (b) Ensure the numbers of staff interviewed are recorded as well as a sample of their qualitative comments;	Four monthly monitoring reports were examined during this inspection and were found to include the information stipulated in this recommendation. The pro-forma for the monthly reports had been revised to require its inclusion.	Compliant

		(c) Devise a system for ensuring the views of service user's representatives are included in the report; (d) Qualitative comments about the environment (standard 17.10 refers).		

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:	
In Aspen Beacon Day service 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, 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 . 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/07and also in our S.O.P. 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 provider's comprehensive self-assessment was verified through examination of selected policies and procedures and from discussions with service users and with staff members.	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 In accordance with Niamh Referral and Review policy R/R/101and our Beacon Member Handbook members are encouraged to open access to their notes . Our 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 complian
Inspection Findings:	**COMPLIANCE LEVEL**
There was excellent evidence to verify that members who participate in the Beacon service were well involved in the record keeping process, with some members writing their own progress notes from time to time. Members confirmed that they felt very included in the care planning and review procedures. The manager had initiated a system for recording any requests for access to records, although access and involvement were generally indicated by the member's signature.	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:	
In accordance with Niamh Policy & Procedures and Day Care Standards,the Beacon member guide and Aspen statement of purpose - all individual Aspen members case records are contained in their own Beacon Members Personal File . Beacon Members, staff members and referral agents ,were applicable, work together through the processes outlined above to ensure a meaningful and holistic intervention is provided. An individuals recovery journey is about change and Beacon consider, as an area of good practice, that it is essential to record information that chronicles this-this includes,were possible, an Individuals self reflection on member notes and alsorecorded joint validation of key working sessions . Policy 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. A separate Serious Incident Reporting Policy Q&G/4 - CS/07 provides an Incident Form and Flow Chart with clear guidance for recording and reporting.	Substantially compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Four members' records were examined and were found to address all of the required matters. Individual notes were of a high standard, with several entries having been made by the members. Assessments were well detailed and comprehensive and most of the entries in the care plan and progress notes had been signed by the member.	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:	
In accordance with Niamh policy R/R/101and also the Daycare setting standards all Aspen staff are familiar with and follow outlined recording procedures that also outline that a note is to be recorded at least at every fifth visit. This is standard practice across all our day care provision.As an area of Good practice Aspen Staff meet with individual members on a regular basis to discuss and write up member notes that informs the individuals support plan and also adds information for individual review planning.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Progress notes included written verification by staff that the record was being kept on every fifth visit, at least. Staff confirmed that regular recording of the health, wellbeing and involvement of each member was an important part of the job.	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 relevant policy /procedures ,reporting and recording procedures right from their induction as new staff within Niamh. to ratify this further this area is a key component of the Induction and Foundation Framework (Units B, C)for new staff.. In addition staff are introduced to key mechanisms for communication within the organisation and Aspen. 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 , minutes of staff meetings,Centre meetings , New Member Pathyway , 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**
The provider's self-assessment was verified through examination of relevant policies, procedures and guidance. Staff confirmed that they had been given clear guidance on matters that should be reported and they felt confident in fulfilling the requirements in this regard.	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:	
As outlined in Niamh Referral and review policy all Aspen staff follow the relevant guidance contained on how to record all necessary recordable events.As outlined in our Draft revised poicy and also in line with RQIA Day Care setting standards the Manager periodically reviews Member notes , Support Plans ,Reviews and Signs these off to verify the following of procedures by Aspen Staff in a competant and effective manner.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Aspen Beacon service had excellent, up to date records, which had been regularly reviewed and signed off by the manager.	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:	
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 Aspen 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 written policy and guidance on restrictive practice was examined and the manager and staff confirmed that there has not been any need for, or use of restraint or seclusion in the service. Training records showed that staff had been trained in the use of calming and diffusing techniques and staff reported that their close working relationships with the members enabled them to diffuse tensions before they became unduly challenging.	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:	
Niamh Policy and Procedures for Dealing with Violence at Work,BS/16 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 QG/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 (QG/4, Appendix 4). To date no Aspen staff have been in incidences were restraint has been required.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
There was evidence from discussions with staff and members, to confirm that there has not been any use of restraint or other restrictive practices in the Aspen Beacon Centre.	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	Compliant

activity will be reflected in Centre Programmes and Activity Schedules. Numbers of staff reflect a balance between number of sessions, numbers of users and programme of delivery.	
Inspection Findings:	**COMPLIANCE LEVEL**
The provider's comprehensive self-assessment was verified through discussions with the services team manager, the centre manager and three staff members. Three staff files were examined during the inspection and provided evidence of a well organised staff selection process, good training support and regular supervision.	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 Aspen staff supervision takes place in accordance with Niamh Supervision Policy R/P/39.The Staff are individually formally 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. As an area of good practice we also have ongoing informal supervision on a regular basis through daily team meetings and formal Staff meetings.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 supervision records were detailed and comprehensive, indicating a rigorous and balanced supervision system, which staff reported as being supportive and developmental.	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 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.	Compliant
Inspection Findings:	**COMPLIANCE LEVEL**
Niamh has an excellent system in place for staff support and development and there was evidence to show that the organisation exceeds the minimum requirements for staffs' qualifications for their roles and responsibilities, striving to help staff members prepare for positions of greater responsibility, should those opportunities arise.	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 record of complaints was examined and was found to be satisfactory. One member had made a complaint since the previous inspection and this had been resolved to the satisfaction of the complainant.

Premises

Niamh has plans in place to remove the chimney and repair the roof of the building, during the summer months. Arrangements were already in place for the use of alternative accommodation during the period when this work is being carried out.

The smoking area at the rear of the building had been brightened with wall paintings, but the outdoor furniture was in poor condition and the area was not up to the high standard of the rest of the premises. Improvements in this area are recommended.

The art room was well used by members and there was evidence of creative work by a number of people. The décor of the room had become marked and worn and the room should be re-decorated.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Ms Karen McCorry, 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:

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

Quality Improvement Plan

Primary Announced Care Inspection

Aspen Beacon Day Support Service

3 June 2014

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

The specific actions set out in the Quality Improvement Plan were discussed with Ms Karen McCorry, Registered Manager, 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.

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 25.5	The smoking area at the rear of the building had been brightened with wall paintings, but the outdoor furniture was in poor condition. Improvements in this area are recommended.	One	Feedback and discussion has taken place with Members and the purchase of new seating has been agreed	29 August 2014
2	Standard 25.5	The art room was evidently well used and is now in need of some re-decoration.	One	Quotes for painting refurbishment have been obtained .Members are involved in creatively designing one wall to include a mural.	29 August 2014

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	Karen McCorry
Name of Responsible Person / Identified Responsible Person Approving Qip	Liam Quigley

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	yes	D Knox	16 July 2014
Further information requested from provider	No		