PRIMARY INSPECTION

Name of Agency:	**The Croft Community**
Agency ID No:	**11045**
Date of Inspection:	**14 March 2014**
Inspector's Name:	**Michele Kelly**
Inspection No:	**15957**

The Regulation And Quality Improvement Authority
9th floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501

General Information

Name of agency:	The Croft Community
Address:	71 Bloomfield Road Bangor BT20 4UR
Telephone Number:	0289145 9784
E mail Address:	kate@croftcommunity.com
Registered Organisation / Registered Provider:	Miss Patricia Wilson
Registered Manager:	Miss Patricia Wilson
Person in Charge of the agency at the time of inspection:	Mrs Yvonne McCaughren
Number of service users:	12
Date and type of previous inspection:	Primary Announced Inspection 13 January 2013
Date and time of inspection:	Primary Announced Inspection 14 March 2014 9.45 am - 4.15 pm
Name of inspector:	Michele Kelly

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 supported living type domiciliary care agencies. 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, minimum standards and other good practice indicators 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 domiciliary care, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Domiciliary Care Agencies Regulations (Northern Ireland) 2007
- The Department of Health, Social Services and Public Safety's (DHSSPS) Domiciliary Care Agencies Minimum Standards (2011)

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
- 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	3
Staff	4
Relatives	0
Other 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	15	5

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 quality themes:

The following four quality themes were assessed at this inspection:

- **Theme 1: Service Users receive care in their own home**
- **Theme 2: Assessments, care plans, reviews and care practices reflect consideration of the service users' human rights**
- **Theme 3: Assessment and monitoring of quality of services**
- **Theme 4: Adult protection concerns are identified by the agency and followed through**

Review of action plans/progress to address outcomes from the previous inspection

There was one requirement stated at the last inspection on 10 January 2013. This requirement is partially met and will be restated in the quality improvement plan for this inspection. Three recommendations made have been fully met.

The registered provider and the inspector have rated the service's compliance level against each good practice indicator and also against each quality 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 Croft Community is a charitable organisation based on the Bloomfield Road Bangor. The domiciliary care agency supported living scheme commenced in 2000. Under the direction of the manager Ms.Pat Wilson a staff of 18 provide support to 12 adults with learning disabilities. The service users live in a shared bungalow and terraced accommodation, with some service users living in two houses nearby. Service users receive a range of assistance and support such as personal care, social support, and guidance on domestic tasks, to enable them to live independent lives. The South Eastern HSC Trust commissions their services. The agency receives funding from the Northern Ireland Housing Executive's Supporting People programme for the housing support provided to service users.

Summary of Inspection

The announced inspection was undertaken at the agency's registered office on 14 March 2014 from 9:45 am – 4:15 pm.

The inspector was provided with an opportunity to meet with three service users and four staff during the inspection visit.

Prior to the inspection, agency staff were invited to return to RQIA a completed questionnaire in relation to their views on the quality of service provision. Five agency staff returned a questionnaire and feedback from the inspection visit and from the questionnaires was provided to Mrs Yvonne Mc Caughren at the end of the inspection visit. Mrs Mc Caughren was in charge of the service while Ms Wilson the registered manager was on leave and Mrs Mary Russell who co-ordinates supported living services within The Croft Community was also in attendance throughout the inspection.

The inspector would like to thank the service users and agency staff for their warm welcome and full cooperation throughout the inspection process.

Detail of inspection process:

Theme 1: Service Users receive care in their own home

There were some arrangements in place to ensure that the service users supported by The Croft Community are receiving a service which promotes their independence, autonomy and control. Service users have tenancy agreements and separate care / support agreements which set out the individuals' rights and expectations in relation to their specific needs. Service users who participated in the inspection provided very positive feedback to the inspector in relation to their experience of receiving care in their own home. Service users also referred to a range of rights they enjoy as tenants including being able to choose who they live with and how they are supported.

Four service user files were examined by the inspector. The format for recording risk assessment did not provide the assessor with sufficient guidance or prompts to ensure a comprehensive, consistent approach was the result of the process.

A recommendation is made to review this template to improve the quality and rigor of risk assessments.

As discussed within additional matters in this report this inspection uncovered evidence of staff who were involved in the direct care of service users eating food which had been bought by tenants.

The agency was assessed as “Not compliant” for this theme.

Theme 2: Assessments, care plans, reviews and care practices reflect consideration of the service users’ human rights

Agency staff have undertaken training in human rights within Safeguarding Vulnerable Adult training and demonstrated their understanding of how care practices can impact on the rights of service users.

The manager and staff interviewed demonstrated an understanding and commitment to human rights and the principles of independence and autonomy within the group living model. Evidence was provided which showed that human rights issues were discussed at staff and tenant meetings on 20 January and 21 January 2014.

It is recommended that the policy in relation to restrictive practice referred to in the self-assessment is completed within the time frame specified in the quality improvement plan.

The agency was assessed as “Substantially Compliant” for this theme.

Theme 3: Assessment and monitoring of quality of services

The agency has in place a range of methods for the assessment and monitoring of the quality of the services provided. A member of the House committee of The Croft Community visits monthly to meet with staff and service users and monitor complaints and incidents. This visit is recorded and outcomes reported to the management committee. The agency also has a policy and procedure where a member of the management committee conducts monthly monitoring visits in accordance with Regulation 23.

On the day of inspection monthly monitoring reports from visits conducted in response to Regulation 23 could not be located. In discussions with the registered manager after the inspection it became evident that monthly monitoring visits had not been undertaken consistently since September 2013.

A requirement was made to address this theme and improve standards.

The agency was assessed as “Not compliant” for this theme.

Theme 4: Adult protection concerns are identified by the agency and followed through

The deputy manager confirmed that one case had been referred as a Vulnerable Adult to the trust designated officer. The inspector requested the paper work associated with the referral. There were no records to evidence that procedures had been followed. Staff discussed the measures taken at a local level to by the service user's representative to ensure the service users safety which had been maintained since the original referral.

Training records confirmed that one member of staff required training in relation to Safeguarding Vulnerable adults.

This inspection identified that service users had experienced disadvantage as a consequence of The Croft community staff meals arrangements. This matter is discussed in Additional Matters in this report. Referrals have since been made to SEHSCT and an RQIA finance inspection of The Croft Community occurred on 7 May 2014.

A requirement is made to address this theme and improve standards.

The agency was assessed as "Not compliant" for this theme

Additional matters examined

Financial Matters

During discussions with staff it became clear that staff were consuming food purchased with service user funds. It was verified that this was customary practice for those staff engaged in direct support with the tenants. It was evident that there was no policy in relation to this practice which after consultation with senior staff in RQIA and the finance inspector has now ceased. The registered manager confirmed in an email to the inspector on the 27 March 2014 that staff no longer consume tenants' food.

It was unclear if service users had financial agreements and staff could not clarify this during the inspection. A residential service on site has documents on file referring to "Scale of charges and contract" but none could be found for the supported living service.

The inspector expressed concerns about the practice regarding staff meals and a finance inspection took place on 7 May 2014; the outcome of this inspection has been reported on separately. Representatives of The Croft Community were invited to attend a meeting in RQIA on 21 May 2014following the finance inspection of the service to explore matters further and clarify arrangements for charging service users and the reimbursement of monies owed.

Training Issues

Examination of training records confirmed that the requirement in relation to medication management had not been fully met. These records also verified that one staff member requires mandatory training in Safeguarding Vulnerable Adults. There was also one member of staff who required training in infection control.

A requirement is made in relation to this matter.

Follow-Up on Previous Issues

No.	Regulation Ref.	Requirements	Action Taken - As Confirmed During This Inspection	Number of Times Stated	Inspector's Validation of Compliance
1.	16 (2)	The registered person must ensure that staff receive medication training at least every three years and an annual competency assessment. A competency assessment must also be completed after a medication error. The medication policy must be updated to reflect this procedure.	The medication policy had been updated (8/3/13) to reflect the need for staff to have mandatory training and an annual competency assessment. This process had begun but was not complete for all staff on the day of inspection and therefore this requirement will be restated.	One	Partially met.

No.	Minimum Standard Ref.	Recommendations	Action Taken - As Confirmed During This Inspection	Number of Times Stated	Inspector's Validation Of Compliance
1.	7.14	It is recommended that the registered person ensures that a checklist template is devised and implemented to evidence the weekly medication audits.	This checklist has been developed and is in use.	One	Fully Met
2.	1.1, 2.1, 2.2, 4.1, 4.2, 8.6 - 8.9 9.1 - 9.5 Appendix 1	It is recommended that the registered person ensures that the agency's organisational policies, procedures, processes, and service user guide are further developed to underpin the principles of service users being able to choose who they share their accommodation with. The agency needs to clearly demonstrate how they discuss and consult with tenants about who they share their accommodation with.	The organisational policies procedures and service user guide have been reviewed to include the principles of service users being able to choose who they share accommodation with. Discussions regarding sharing arrangements are facilitated at house meetings.	One	Fully met

3.	2.1 – 2.3 4.1 – 4.5 8.6 - 8.9 9.1 - 9.5 Appendix 1	It is recommended that the registered person ensures that the agency's organisational policies, procedures, processes, and service user guide clearly show how they underpin the principles of tenants choosing who supports them, and that tenants are aware that they can remain in their accommodation even if the provision of care is no longer required or no longer meets their needs.	The organisational policies, procedures, processes and the service user guide include information underpinning the principles of tenants choosing who supports them, and that they can remain in their accommodation even if the provision of care is no longer required or no longer meets their needs	One	Fully met

THEME 1 - SERVICE USERS RECEIVE CARE IN THEIR OWN HOME	
Statement 1 Service users receive care in their own home • The service user has a valid occupancy agreement (tenancy, licence etc.) that offers security of tenure; • The service user has an agreement specifying the number of support hours available to them individually; • The service user is enabled to understand rights and responsibilities of tenancy in a format suitable to their individual needs; • The landlord has no control over the care/support staff, the care/support staff have no control over housing; • The service user's home looks like his/her home and does not look like a workplace for care/support staff.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Each tenant has an individual tenancy agreement from the Landlord which offers security of tenure. Each tenant has an individual support and care plan which identifies support/ care hours. The tenancy agreement in is in a form which is appropriate for each individual. As part of Tenants meetings the tenancy agreement has been discussed, to ensure everyone understands their rights and responsibilities as tenants. The Croft Community are committed to ensuring tenants are supported to understand their rights and responsibilities as tenants. Monthly monitoring takes place when members of the Management Committee visit and talk with various tenants. Management committee send out questionnaires to next of kin regarding service provided. The current questionnaires are with Management committee. Tenants are regularly consulted through weekly House meetings or monthly Tenants meetings regarding the service provided. These meetings are minuted and the registered manager is informed about issues arising The manager is responsible for signing off tenant meeting minutes. Each tenant has been issued with a tenant`s guide which explains rights and responsibilities.	Compliant

The Land lord has no control over the care/support staff, and the care/support staff have no control over housing. The tenant`s home looks like a home, The staff office is in a separate building. Staff ring the doorbell and wait for tenants to let them in. Each tenant has their own front door key.	
Inspection Findings:	
Each of the service users has been issued with a support agreement which clearly highlights the service user' rights in relation to remaining in their own home. The support agreements also outlined in detail the support hours allocated to each individual supported and the times that staff would be available to provide support. Service users who participated in the inspection indicated that their home is comfortable and that staff do not treat their home as an office or workplace. Service users reported that there is a staff sleep over bedroom in their home and that this room is used by staff for storing files etc. The service users' homes were noted to be homely and comfortable and reflected the service users' preferences and tastes.	Compliant

THEME 1 - SERVICE USERS RECEIVE CARE IN THEIR OWN HOME	
Statement 2 Services users exercise control over who they live with and who enters their home: • The service user is in control of who enters their home and no-one else has keys to the accommodation without the permission of the service user; • The service user is consulted about who the accommodation is shared with; • The service user is not denied or restricted access to any part of their home that they have a right to as stated in their tenancy agreement; • The service user has exclusive possession of their own private accommodation.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
All visitors to the home ring the doorbell to ask permission to enter the house. No unnecessary people have keys to the door and due to the needs of the tenants a procedure is in place for key holding and access to keys. There is a policy in place regarding consulting with tenants about new tenants moving in, which is inclusive of a compatibility process and working with local Trust around this, ensuring tenants are consulted regarding who they share their home with. Tenants have full access to all areas of their home, with the exception of accessing co-tenants bedrooms without permission. Tenants have exclusive possession of their own bedroom areas, staff knock and await tenants permission to enter.	Compliant
Inspection Findings:	
The service users who participated in the inspection expressed a high level of satisfaction in relation to their relationships with agency staff who provide their care and support. Service users stated that they welcome the staff into their home and enjoyed having staff visit them and	Compliant

providing a presence in their home. Service users also reported that they had been sharing their homes with the other service users for several years and were continuing to make the choice to live with their fellow tenants. Service users also indicated that agency staff provided them with regular house meetings to comment on how the support could be improved and support to resolve any difficulties or issues arising from sharing with others. Service users who met with the inspector provided positive feedback in relation to their experience of receiving care and support from agency staff in their own home; service users also confirmed that they are free to come and go from their own home and can access all areas of their home without restriction. There is a policy specifying that staff can only access tenants' properties without permission in the case of emergency.	

THEME 1 - SERVICE USERS RECEIVE CARE IN THEIR OWN HOME	
Statement 3 Service users receive a service designed around their individually assessed needs that enables autonomy and independence: • Care and support needs have been individually assessed by a multidisciplinary team, agreed with the service user and/or their representative; • Risks and risk taking have been formally considered and balanced with positive risk taking that enables autonomy and independence; • The level of staff presence for care/support in a service user's home has been assessed by a multi-disciplinary team, agreed with the service user and/or their representative, reflected in person-centred care plans and regularly reviewed at pre-determined intervals; • The service user has been consulted about who provides care and support.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
All tenants have been residing at their current address for several years. Their care & support needs are assessed at least yearly at Care Management reviews with tenants encouraged to attend with their next of kin. The tenants are at the centre of all care and support provided and decisions regarding their care and support. Each tenant has an up to date care & support plan with risk assessments. These are very much person centred. Risk taking is very much part of the service and a document called "balancing safety with happiness "is in place. Tenants are fully involved in developing this document to ensure the risk assessments are in place in order help tenants increase their skills and independence as valued citizens. Risk assessments are in place in order to develop opportunities for social inclusion. The level of staff support has been developed by the assessment of need, it is under review throughout the year. This can be changed as needs change. The level of staff support is reviewed at yearly Care Management meetings with tenant involvement. The tenant has opportunity at Care Management reviews to discuss who provides care and support and to raise concerns. The tenants have been informed of the roles of the keyworker at House meetings and at reviews.	**compliant**

Tenants are informed of staff changes, eg staff member leaving, staff off on long term sick and recruitment and appointment of new staff. Pictures of staff providing services are available to all tenants, these are displayed in the Common room.	
Inspection Findings:	
It was evident from speaking with the service users and the staff that service users are happy with the levels of care and support they receive and that the correct balance has been struck between promoting independence and autonomy and providing support, security and a welcome presence in the homes of service users. Four service user files were examined by the inspector. The format for recording risk assessment did not provide the assessor with sufficient guidance or prompts to ensure a comprehensive, consistent approach was the result of the process. A recommendation is made to review this template.	Substantially compliant

THEME 1 - SERVICE USERS RECEIVE CARE IN THEIR OWN HOME	
Statement 4 The model of service provision is consistent with the ethos of a supported living service: • There is evidence available to demonstrate that the service user and/or their representative is at the centre of service provision and all decision making processes; • If living in shared accommodation, the service user can "opt in or out of" additional services, such as household contribution to groceries, meals provision; • Any routine has been individually devised by the service user to facilitate his/her preferred service provision.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
The tenants are at the centre of the service provision which is very much person centred. There is a person centred care and support file in place for every individual tenant. We support tenants on the areas of – promoting independence, safety & security. Accessing community resources (health professionals, etc), daily living skills, health and well- being, enjoying and achieving new experiences (the feel good factor) in their lives. The ethos of supported living is in line with the philosophy of the organisation (helping each person reach their full potential) and the person centred support is reviewed at annual review with MDT. Tenants can opt out of services if they choose. Where there is substitute decision making the tenants representatives have the option to opt in or out on their behalf. All tenants have up to date schedules in place which are centred around the needs of the tenants and preferred interests. Tenants are fully involved in all decision making. We support tenants to have new experiences and offer alternatives to expand the tenants interests where appropriate, with the tenant always in control of the decision making.	Compliant
Inspection Findings:	
It was evident from discussions with service users that they were choosing to undertake a number of their support tasks in the company of other tenants, for example, completing shopping. Service users also described the arrangements in place to ensure that they could choose to opt out of aspects of the routines of	Not compliant

the household. As discussed within additional matters in this report this inspection uncovered evidence of staff who were involved in the direct care of service users eating food which had been bought with tenants' funds. The inspector expressed concerns about the practice regarding staff meals and a finance inspection took place on 7 May 2014; the outcomes of the finance inspection have been reported on separately. Representatives of The Croft Community were invited to attend a meeting in RQIA on 21 May 2014 following the finance inspection of the service to explore matters further and clarify arrangements for charging service users and the reimbursement of monies owed. Service users have individual person centred files. It was evident that service users are at the centre of service provision and decision making processes and that service users were experiencing significant levels of control, choice and independence. Agency staff who met with the inspector outlined their commitment to ensuring that service users' routines reflect their choices and preferences and that service users receive individualised care and support. As outlined in the self-assessment, service users can opt in or out of additional services and staff explained how one service user chose not to participate in pooled mobility costs. The agency's transport arrangements were also explored in depth by during the finance inspection.	

PROVIDER'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Compliant

INSPECTOR'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Not compliant

THEME 2 - ASSESSMENTS, CARE PLANS, REVIEWS AND CARE PRACTICES REFLECT CONSIDERATION OF THE SERVICE USERS' HUMAN RIGHTS	
Statement 1 Service users participate in their needs assessment, care planning and reviews • Service users with communication needs have their communication needs assessed and there is a plan in place to promote the service user's ability to meaningfully engage in the assessment of their needs and care planning, and in the review of their needs and services; • Where there are communication needs identified, there are appropriate arrangements in place to promote effective communication; • Service users with significant communication needs are supported by non-agency representatives in the assessment and review of their needs and in care planning; • Service users are provided with information in an accessible format in relation to their human rights.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
The communication needs of each tenant has been assessed this is highlighted in the annual Care Management review each year. The care and support plan includes a section regarding communication. We record daily notes for tenants and any communication issues are recorded and followed up. All tenants can have access to speech and language therapy or other relevant services, staff can help tenants access these services if required. Additional services required are always part of the care Management review and the Care Manager will also help tenants access additional services by making the appropriate referral. Tenants are provided with information in relation to their Human Rights. It has been discussed at a tenants meeting. There is a document in the tenants guide which is in a simple easy read format.	Compliant
Inspection Findings:	
Staff who participated in the inspection indicated that all service users have regular input from their HSC Trust representatives who are invited to care reviews along with day care staff. The HSC sensory support team have provided an input to assessment and care plans for some service users. Service users have been issued with human rights information in an accessible format.	Compliant

THEME 2 - ASSESSMENTS, CARE PLANS, REVIEWS AND CARE PRACTICES REFLECT CONSIDERATION OF THE SERVICE USERS' HUMAN RIGHTS	
Statement 2 Agency staff can identify care practices which may impact on the human rights of service users • Agency staff have received training and or guidance on the Human Rights Act and how this impacts on service users; • The human rights of all service users are explicitly outlined in care records; • Care practices which impact on the human rights of service users are only undertaken if in accordance with a HSC Trust care plan; • The agency can provide evidence that there are no practices undertaken which impact on the service user's right to freedom from torture, inhuman and degrading treatment (Article 3, Human Rights Act); • There are arrangements in place to detect and raise with the relevant HSC Trust any concerns about potential or actual breaches of service users' Article 3 rights; • All service users have unrestricted access to fresh air, daylight, snacks, fresh water and toilets; • Service users can form and sustain personal relationships.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Staff follow the NISCC code of conduct and Croft policy and procedures which promote core values of dignity and respect for all tenants. Staff have an understanding of deprivation of liberty and restrictive practices. Staff are aware that any restrictive practice must be fully assessed and agreed with MDT and tenants` representatives and take into account impacts of restrictions on the human rights of all tenants. There are no practices in place which impact on the tenant's right to freedom from torture, inhuman or degrading treatment. Procedures such as Management committee monthly visits, tenants meetings and family consultations are used to gauge the views of tenants on how they are treated in their homes. Safeguarding Vulnerable adults, complaints and whistleblowing procedures are in place which can be used to raise any concerns that may arise in relation to breach of the tenants human rights. All tenants have unrestricted access to fresh air, daylight, snacks, fresh water and toilets. Tenants are supported to develop and maintain personal relationships with friends within the organisation	Compliant

and outside the organisation. However not all tenants have demonstrated an awareness of understanding or wanting personal relationships. If this interest arose, tenants would be supported to develop these relationships and this would be based on the best interest of the tenant and we would work with MDT and tenants representatives to support the tenant in this area	
Inspection Findings:	
The inspector was advised by agency staff of the arrangements in place to ensure that service users are free from inhuman and degrading treatment. The inspector was informed that all service users have unrestricted access to fresh air, toilets, water and daylight. Staff spoken to on the day of inspection and information from returned questionnaires demonstrated an understanding of human rights. Evidence was provided which showed that human rights issues were discussed at staff and tenant meetings on 20 January and 21 January 2014.	Compliant

THEME 2 - ASSESSMENTS, CARE PLANS, REVIEWS AND CARE PRACTICES REFLECT CONSIDERATION OF THE SERVICE USERS' HUMAN RIGHTS	
Statement 3 Care practices which are restrictive in nature are undertaken in accordance with the HSC Trust needs / risk assessment and care plan and are reviewed regularly • The agency has developed a working definition of 'restrictive practice' which includes the use of physical restraint • The agency undertakes audits of 'restrictive practices' and can demonstrate a commitment to reducing these, in particular the use of mechanical or other means to restrict the service user's ability to leave their home or areas within their home freely; • The agency can demonstrate compliance with DHSSPS guidance in relation to restrictive practices • The agency engages with the HSC Trust regularly to review any 'restrictive practices'; • The principles of necessity, proportionality and least restriction can be evidenced in practice; • Care practices which are restrictive in nature impact only those service users who have assessed needs; • Where there are a number of service users, there are arrangements in place to evaluate the impact of restrictive practices on those service users who do not require any such restrictions. •	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Policy is currently being developed with regard to "Restrictive Practice" We do not have any restrictive practices in place. Staff have access to Behaviour support team for advice and guidance within Croft. A member of the S.E.Trust Behaviour Support Team visits Croft every 2 months for an "open workshop" which is available for all staff to attend for advice and guidance. Member of BHT will advise if a referral to the service is required and staff can access these referral forms.	Substantially compliant

Inspection Findings:	
The inspector was advised that there are no restrictive practices in The Croft Community. As stated in the self –assessment staff are supported by the behaviour support team within the South Eastern Health and Social Care Trust for guidance and advice regarding care practices. It is recommended that the policy in relation to restrictive practice referred to in the self-assessment is completed within the time frame specified in the quality improvement plan.	Substantially Compliant

THEME 2 - ASSESSMENTS, CARE PLANS, REVIEWS AND CARE PRACTICES REFLECT CONSIDERATION OF THE SERVICE USERS' HUMAN RIGHTS	
Statement 4 The capacity of service users to consent to or decline care practices is assessed, reviewed and documented • Service users who experience care practices which impact on their human rights have been given the opportunity to consent to or decline the proposed intervention; • Where there are concerns about the individual's capacity to meaningfully consent to care practices decision specific capacity assessment is undertaken in conjunction with the HSC Trust; • The agency participates in and informs 'best interests' decision meetings.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
If restrictive care practices are required these would be fully discussed at a MDT meeting which would be minuted. All decisions would be based on best interest of the tenant in full consultation with HSC Trust and family representatives.	Substantially compliant
Inspection Findings:	
The agency's care records also contained HSC Trust needs and risk assessments and review records. The inspector was advised that all service users have capacity to meaningfully consent to care practices. Individual care/support plans indicate that person centred care is central to all provision and care is provided in line with tenants wishes and needs, the rights of individuals is taken into consideration when developing care plans with tenants.	Compliant

PROVIDER'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Substantially compliant

INSPECTOR'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Substantially compliant

THEME 3 - ASSESSMENT AND MONITORING OF QUALITY OF SERVICES	
Statement 1 The registered person shall establish and maintain a system for evaluating the quality of the services which the agency arranges to be provided	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Member of the Management committee undertakes monthly unannounced visits. There is a different theme to the visit – Care/support, Finance, environment, management, medication & quality of life House Committee (sub-committee) visit monthly, meet with Manager & Deputy Manager, check & monitor complaints & incidents. Talk with tenants and staff on duty. Reports from both these visits are given at the monthly management committee meeting. These reports are recorded in the minutes. Care Management reviews involve MDT and the quality of the service is also discussed. The Care Manager visits on a regular basis and has requested to see files. Reports etc. The weekly tenants meetings are minuted and concerns raised at these are brought to the attention of the Manager. The 4-6 weekly tenants meetings are minuted and these are left for Manager to read and sign. Tenants are encouraged and supported to raise their concerns. Throughout the year the manager will sit in on the tenants meetings to allow tenants time and opportunity to raise concerns directly with Manager. One tenant has an advocate, with whom he meets on a regular basis. Advocacy services are available to all tenants, through Care Manager.	Substantially compliant
Inspection Findings:	
The registered person's system for evaluating the quality of the service provision was examined and includes monthly quality monitoring visits undertaken by a management committee member of The Croft Community as outlined in the self-assessment. On the day of inspection the monthly monitoring reports were unable to be located within the service. In a telephone call with Ms Pat Wilson on 25 March 2014 she confirmed that there had been inconsistent monthly monitoring visits since September 2013. A member of the House committee of The Croft Community also visits monthly to meet with staff and service users and monitor	Not compliant

complaints and incidents. This visit is also recorded and outcomes reported to the management committee. Subsequent to the inspection visit, the responsible person forwarded to RQIA, at the request of the inspector, the reports of monthly quality monitoring visits undertaken since the inspection. RQIA have written to the responsible person to request that these reports are submitted to RQIA until further notice.	

THEME 3 - ASSESSMENT AND MONITORING OF QUALITY OF SERVICES	
Statement 2 Assessment of the quality of services provided is undertaken on a monthly basis and a report is prepared which reflects the registered person's assessment of the: a) Quality of services provided b) the views of service users and their representatives c) the agency's response to areas of quality improvement identified by RQIA	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Monthly visits by Management Committee are reported to Management Committee each month and recorded in minutes of Committee Meeting. These visits are unannounced to staff and tenants. There are different themes to these inspections – Quality of Care/support, environment, management, quality of life, medication & finance. Management Committee will speak with tenants during their visits. Details are recorded. Documents used are in line with RQIA requirements. These documents are returned to Manager after they have been reported to the Management Committee The Chairman of the Management Committee meets with families at least once a year at our family night. Chairman will give a brief report reflecting over past year and share plans for the future. Families have opportunity to talk with him or with other members of Committee present. The House Committee and Management Committee are fully informed with regard to areas of quality improvement identified by RQIA.	Substantially compliant
Inspection Findings:	
As outlined in statement one, monthly monitoring visits have not taken place with the frequency outlined in the minimum standards.	Not compliant

THEME 3 - ASSESSMENT AND MONITORING OF QUALITY OF SERVICES	
Statement 3 Assessment and monitoring of quality of services is undertaken in accordance with RQIA published guidance 'Monthly Quality Monitoring by Registered Persons' (March 2012)	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
The monthly monitoring is carried out in accordance with RQIA published guidance.	Substantially compliant
Inspection Findings:	
The absence of the quality monitoring reports on the day of inspection indicates that assessment and monitoring of services is not undertaken in accordance with RQIA published guidance.	Not compliant

PROVIDER'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Substantially compliant

INSPECTOR'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Not compliant

THEME 4 - ADULT PROTECTION CONCERNS ARE IDENTIFIED BY THE AGENCY AND FOLLOWED THROUGH	
Statement 1 Agency staff can identify safeguarding concerns, record and report these in a timely manner to the agency manager • Staff have received training in types of abuse, symptoms of abuse and reporting procedures; • Records confirm that safeguarding concerns have been communicated to the agency manager; • Service users are free from risks posed by other service users and do not experience assaults from other service users or have their property damaged; • Staff can identify when service users are experiencing distress, mental / physical suffering and take appropriate action; • Staff intervene appropriately in the event of service users experiencing threats or assaults from other service users or damage to their property.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
All staff receive Safeguarding Children & Vulnerable Adults training, which includes types and symptoms of abuse and reporting procedures. All safeguarding concerns are reported to line management and necessary parties including HSC Trust and tenants families. Staff follow safeguarding procedures. Tenants are very aware of the reporting procedures if they have any concerns. This is discussed at tenants meetings. Staff support tenants to deal with concerns regarding other tenants when appropriate. Risk assessments are in place in order to protect each individual from various forms of abuse. Whistle blowing policy is in place in order for staff to have a means of reporting abuse. All staff during induction are provided with Vulnerable adults training. Updated training will take place during Jan 2014 as part of ongoing training. Vulnerable AdultsTraining takes place on a regular basis as part of training programme.	Compliant

Care/support plans identify behaviours that can impact on others and staff will use diversion and communication tactics in order to defuse situations.	
Inspection Findings:	
Staff spoken to on the day of inspection confirmed they had received training on Safeguarding Children and Vulnerable Adults. Examination of training records showed that this training is out of date for one member of staff who is currently working and a requirement is made to address staff training.	Moving towards compliance

THEME 4 - ADULT PROTECTION CONCERNS ARE IDENTIFIED BY THE AGENCY AND FOLLOWED THROUGH	
Statement 2 Systems are in place to ensure that safeguarding concerns are reported by the agency in accordance with policies and procedures • Safeguarding concerns are reported immediately to the HSC Trust designated person and other agencies as required (i.e. PSNI, Emergency Services, RQIA) and confirmed in writing within 2 working days. Service users' relatives / representatives should be informed when appropriate.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
Systems are in place to ensure that Safeguarding concerns are reported. Staff follow the Vulnerable adults policy. Staff also follow the Whistleblowing policy, and can use this to raise a concern. All vulnerable adult concerns are reported via incident reporting procedures to HSCT and tenants representatives.	Compliant
Inspection Findings:	
The agency has made one referral to HSC Trust in relation to safeguarding concerns. The agency's records were examined and evidenced that this referral had not been made in accordance with policies and procedures, in spite of a significant concern being identified. There was no written confirmation of referral or information pertaining to the trusts assessment of the situation or any protection plan in place. On receipt of the safeguarding report from the member of staff the agency put in place a number of arrangements to safeguard the service user and had liaised with the HSC Trust, however, it was not clear during the inspection what remedial action had been taken to address the failure to adhere to the agency's safeguarding procedures. A requirement has been made with regard to this theme.	Not compliant

THEME 4 - ADULT PROTECTION CONCERNS ARE IDENTIFIED BY THE AGENCY AND FOLLOWED THROUGH	
Statement 3 The agency ensures it records the outcome of the HSC Trust screening of the VA referral and any immediate protection plan agreed with the Trust to ensure the service user/s safety.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
If a Vulnerable adult referral takes place, all records of outcomes will be followed and recorded in order to ensure any protection plans agreed with the Trust are put in place to ensure tenants safety.	Compliant
Inspection Findings:	
As stated in the previous statement the agency did not record the outcome of the HSC Trust screening of the vulnerable adult referral.	Not compliant

THEME 4 - ADULT PROTECTION CONCERNS ARE IDENTIFIED BY THE AGENCY AND FOLLOWED THROUGH	
Statement 4 The agency is included in the VA case discussion convened by the Trust designated person and contributes to the protection plan as directed by the Trust	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
The Croft Community would be fully involved in all discussions regarding VA case as convened by the Trust Designated person and would be contributing to the protection plan as directed by the Trust.	Compliant
Inspection Findings:	
On the day of inspection there was no evidence to support the information in the self-assessment.	Not compliant

THEME 4 - ADULT PROTECTION CONCERNS ARE IDENTIFIED BY THE AGENCY AND FOLLOWED THROUGH	
Statement 5 The agency is included in the monitoring and review of the VA protection plan. The agency is informed when the VA concerns have been resolved and the VA case closed.	**COMPLIANCE LEVEL**
Provider's Self-Assessment	
If a Vulnerable adults referral takes place Croft would follow through current procedures to ensure VA concerns are fully resolved and the VA case is closed.	Compliant
Inspection Findings:	
On the day of inspection there was no evidence to confirm that the agency is included in the monitoring and review of vulnerable adult protection plans.	Not compliant

PROVIDER'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Compliant

INSPECTOR'S OVERALL ASSESSMENT OF THE AGENCY'S COMPLIANCE LEVEL AGAINST THE STANDARD ASSESSED	COMPLIANCE LEVEL
	Not compliant

Any other areas examined

Complaints

The registered manager confirmed that there had only been one complaint since the previous inspection of 10 January 2013. This matter has been fully resolved.

Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mrs Yvonne Mc Caughren and Mrs Mary Russell, 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:

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

The Regulation and Quality Improvement Authority

Quality Improvement Plan

Announced Primary Inspection

The Croft Community

14 March 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 Mrs Yvonne Mc Caughren and Mrs Mary Russell 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 Domiciliary Care Agencies Regulations (NI) 2007

No.	Regulation Reference	Requirements	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1.	Regulation 23 (1)	The registered person must make adequate arrangements to ensure that monitoring visits to The Croft Community are carried out in accordance with Regulation 23. The quality improvement plan must detail arrangements in place to ensure this achieved.	Once	The Croft Management Committee are aware of their responsibilities and reports are being completed and sent monthly to RQIA as requested	Immediate from the date of inspection. 14 March 2014
2.	Regulation 16 (2) (a)	The registered person shall ensure that each employee of the agency – (a) Receives training and appraisal which are appropriate to the work he is to perform. This requirement refers to mandatory training in Safeguarding Vulnerable Adults and Infection Control.	Once	All staff have now received training in Safeguarding Vulnerable Adults and Infection Control. The Manager has commenced staff Appraisals but unfortunately is now off work on long-term sick and this will be completed by the Deputy Manager over the next few weeks if the Manager has not returned from sick leave..	Within five months of the date of inspection 11 August 2014
3.	Regulation 15 (6) (a) (12) (a)	The registered person shall ensure that where the agency arranges the provision of prescribed services to a service user , the arrangements shall— (a) Specify the procedure to be followed after an allegation of abuse, neglect or other harm has been made. The procedure shall in particular provide for- (a) Written records to be kept of any	Once	The Croft Coimmunity has a Policy in place for the reporting of Accidents and Incidents including allegations of abuse, neglect or harm. Unfortunately during the inspection it was noted that our Policy had not been fully adhered to. Croft have taken this on board and further Training on the Policy	Immediate from the date of inspection 14 March 2014

		allegation of abuse, neglect or other harm and of the action taken in response.		will be given to Senior staff with follow-on to all staff. As per the Policy, all allegations of abuse, neglect or other harm will be reported to SETrust/RQIA for further investigation. A complete written record will be kept and the outcome and any action taken or procedures put in place to safeguard the client will be fully recorded and forwarded to RQIA as a follow-on from the Incident. All paperwork in relation to the allegation will be filed in the Incident file, this is kept in the Management offices for confidentiality reasons.	
4.	Regulation (16) (2)	The registered person must ensure that staff receive medication training at least every three years and an annual competency assessment. A competency assessment must also be completed after a medication error.	Twice	All staff have received medication training and this will be updated every three years. An annual competency assessment is already in place and has been completed on all staff. This will continue annually and when there has been a medication error this will be carried out again immediately.	Within five months of the date of inspection 11 August 2014

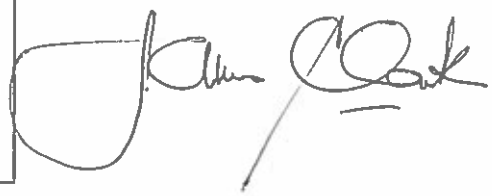
Recommendations

These recommendations are based on The Domiciliary Care Agencies Minimum Standards (2008), 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 6 .4	It is recommended that the registered manager ensures the template used for risk assessments is revised to ensure that there is a person –centred holistic assessment of need for each service user.	Once	In conjunction with the Care Managers at SETrust, Croft have reviewed their Risk Assessment template. Croft and the Care Managers feel that the template which is currently being used does have a centered holistic assessment of the needs of each service user. We have ammended the front page where it is applicable to our services and added some of the areas suggested by the Trust Care Managers. Croft are confident that this risk assessment is in the correct format and applicable specifically to our clients .	Within five months of the date of inspection. 11 August 2014
2.	Standard 9.1	It is recommended that the registered manager ensures that the policy in relation to Restraint and Restrictive Practice is developed.	Once	A Policy in relation to Restraint and Restrictive Practice has been in place since January 2014. At the time of the inspection the Policy was not immmediatley availabe, Management have now ensured that the policy has been placed in the correct file.	Within five months of the date of inspection. 11 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	Miss Patricia Wilson (on long term sick leave). This QIP has been completed by The Croft Deputy Manager - Yvonne McCaughren
NAME OF RESPONSIBLE PERSON / IDENTIFIED RESPONSIBLE PERSON APPROVING QIP	Mr J Clark MBE Chairman - Croft Management Committee



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	Michele Kelly	7/11/14
Further information requested from provider			