Inspection Report

7 December 2023

Croft Communities Limited
Residential Care Home

Type of service: Residential
Address: 71 Bloomfield Road, Bangor, BT20 4UR
Telephone number: 028 9145 9784

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Croft Communities Limited **Registered Person** Mrs Mary Elaine Armstrong	**Registered Manager:** Miss Caroline Barr – not registered
Person in charge at the time of inspection: Heather Law, Deputy Manager	**Number of registered places:** 16 The home is also approved to provide care on a day basis only to 15 persons
Categories of care: Residential Care (RC) LD – Learning disability. LD(E) – Learning disability – over 65 years.	**Number of residents accommodated in thw residential care home on the day of this inspection:** 14
Brief description of the accommodation/how the service operates: This home is a registered residential care home which provides health and social care for up to 16 residents. The home has two units, Mayne House, which accommodates nine permanent residents and Croft Lodge, which provides short term respite care for up to a maximum of seven residents. Day care is also provided for up to 15 persons in The Barn which is on the same site. In both Mayne House and Croft Lodge residents, have access to their own bedrooms with ensuites, communal dining and lounge areas.	

2.0 Inspection summary

An unannounced inspection took place on 7 December 2023, from 9.30 am to 5.00 pm by a care inspector.

The inspection assessed progress with all areas for improvement identified in the home during the last care inspection and sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

The home was warm,clean and had a homely, relaxed atmosphere. It was evident that staff promoted the dignity and well-being of residents; staff were observed spending time with residents, chatting to them in a respectful and pleasant manner throughout the day.

Residents confirmed that they would have no issue with raising any concerns or complaints to staff. Specific comments received from residents are included in the main body of this report.

Staff were knowledgeable with regards to the residents' needs and preferences and were well trained to deliver safe and effective care.

Evidence of good practice was found in relation to care delivery and maintaining good working relationships with the wider Multi-Disciplinary Team (MDT).

Six new areas for improvement was identified regarding the duty rota, Mental Capacity Act (MCA) training, staff supervision, care plans, storage of personal protective equipment and the reporting of incident and accidents.

RQIA found that there was safe, effective and compassionate care delivered in the home and the home was well led. Addressing the area for improvement will further enhance the quality of care and services in Croft Communities Residential Home.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

In preparation for this inspection, a range of information about the service was reviewed to help us plan the inspection.

Throughout the inspection RQIA will seek to speak with residents, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires were provided to give residents and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with the management team at the conclusion of the inspection.

4.0 What people told us about the service

On the day of inspection there was evidence that residents were happy and content in their surroundings. Some residents were unable to verbally communicate their wishes however, this was evidenced through non-verbal cues such as smiling, a thumbs up and nodding when asked if they were happy.

Residents who were able to make their wishes known spoke very positively about all aspects of life in the home. They said “I love it here,” “It is all good” and “The staff are taking us to a family night tonight, I can’t wait.”

Staff told us, “The residents are well looked after,” “I love working here,” and “There is brilliant team work here, we all work together.”

A record of compliments received about the home was kept and shared with the staff team, this is good practice. One compliment wrote “we trust in the staff, in Croft Lodge.”

No additional feedback was provided by residents, relatives or staff following the inspection.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 7 November 2022		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 27 (4) (a) (d) (i) **Stated:** First time	The registered person shall ensure that doors in the home are not wedged open. Staff should be aware of their responsibilities around fire safety. If it is necessary to keep doors open for monitoring or other purposes safe and appropriate systems should be in place. All units of the home should have a current fire risk assessment and management plan in place in order that any required actions are identified and undertaken in a timely manner.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

Area for Improvement 2 **Ref:** Regulation 14 (2) (a) **Stated:** First time	The registered person shall ensure that substances, such as cleaning products, which could potentially be hazardous to the heath of residents are not accessible and are stored safely and securely at all times.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for Improvement 3 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure that all staff adheres to current guidance regarding the use of PPE, hand hygiene and being bare below the elbow. Staffs' use of PPE and hand hygiene should continue to be monitored. If necessary staff should be provided with appropriate training to ensure that they understand their responsibilities in this area and embed their training into practice.	**Not met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was not met and is stated for a second time. Please refer to section 5.2.3 for details	
Action required to ensure compliance with the Residential Care Homes Minimum Standards (December 2022) (Version 1:2)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 6 **Stated:** First time	The registered person shall ensure that care plans regarding personal care include details of the residents' preferred and/or usual time to get up, washed and dressed. The daily care records should include details of the time care was provided at and the reason for any changes in the planned care or routine should be clearly documented.	**Met**
	Action taken as confirmed during the inspection: As stated this area for improvement was met.	

Area for improvement 2 **Ref:** Standard 27 (1) **Stated:** First time	The registered person shall ensure that all ceiling extractor fans are effectively cleaned; a record of cleaning should be maintained.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence that a robust system was in place to ensure staff were recruited correctly to protect residents. Enhancement of the recruitment checklist with regards to previous employment was discussed with the management team and this will be further reviewed at the next inspection.

There was a system in place to monitor staffs' registration status with the Northern Ireland Social Care Council (NISCC). Records in the home confirmed that staff who were required to be registered with NISCC had this in place.

The staff duty rota in all three units accurately reflected the staff working on a daily basis. However the duty rotas in both Mayne and Croft Lodge did not always identify the person in charge when the manager was not on duty. This was discussed with the management team during feedback for action. An area for improvement was identified.

There were systems in place to ensure staff were trained and supported to do their job. An overview of staff training was maintained. However, it was noted that staff had not completed training in the Deprivation of liberty safeguards (DoLS). This had been highlighted at a previous inspection on 27 September 2022. This was discussed with the management team during feedback for action, an area for improvement was identified.

In the Mayne unit a number of staff had not recievied formal supervision within the required timeframe. The importance of staff supervision was discussed with the management team. An area for improvement was identified.

Staff said that the residents' needs and wishes were very important to them. Staff responded to requests for assistance promptly in a caring and compassionate manner. Through observation of the interactions between the residents and staff, it was clear that the staff knew the residents well. For example, in the Mayne unit one resident told staff that they were unhappy, staff spent time with this resident providing reassurance.

Staff said there was good teamwork and that they felt well supported in their role, were satisfied with the training arrangements and with the level of communication between staff and management. Staff told us that there was enough staff on duty to meet the needs of the residents.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the residents. Observation of practice, review of care records and discussion with staff and residents established that staff were knowledgeable of individual residents' needs, their daily routine, wishes and preferences.

Staff were observed to be prompt in recognising residents' needs and any early signs of distress or illness, including those residents who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with residents; they were respectful, understanding and sensitive to residents' needs. For example in all three units staff were observed adapting their communication style to the needs of each individual.

Staff respected residents' privacy by their actions such as knocking on doors before entering, discussing residents' care in a confidential manner, and by offering personal care to residents discreetly.

Examination of records and discussion with staff confirmed that the risk of falling and falls were well managed.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Residents may need a range of support with meals; this may include simple encouragement through to full assistance from staff.

There was evidence that residents' needs in relation to nutrition and the dining experience were being met. Staff told us how they were made aware of residents' nutritional needs and confirmed that residents care records were important to ensure residents received the right diet. A review of care records confirmed that they were up to date with regards to speech and language therapy (SALT) recommendations.

Lunch was a pleasant and unhurried experience for the residents. It was observed that residents were enjoying their meal and their dining experience. Staff had made an effort to ensure residents were comfortable, had a pleasant experience and had a meal that they enjoyed. There was a variety of drinks available.

There was choice of meals offered, the food was attractively presented and smelled appetising, and portions were generous. There was a variety of drinks available. The menu for the day was on display. Residents spoke positively in relation to the quality of the meals provided and the choice available. One resident said "I love the food, it is very nice."

Residents' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet residents' needs; and included any advice or recommendations made by other healthcare professionals. Residents care records were held confidentially.

Care plans had not been regularly reviewed or updated to ensure that they continued to meet the residents' needs. For example; one care plan stated that a resident needed staff assistance but did not indicate the level of assistance required. Three different epilepsy management plans were found for one resident in the same file. This was discussed with the management team for action during feedback. An area for improvement was identified.

Daily records were kept of how each resident spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

Each resident had an annual review of their care, arranged by their care manager. A record of the meeting, including any actions required, was provided to the home.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was clean, tidy and well maintained. Residents' bedrooms in the Mayne unit were personalised with photographs, posters and other items or memorabilia. Bedrooms and communal areas in other units were well decorated, suitably furnished, and comfortable. The barn day care unit was clean,tidy and decorated with art work which had been completed by the service users.

Both Mayne House and Croft Lodge had been decorated for the Christmas holidays and residents' commented on how lovely the trees looked.

There was evidence that the environment was well maintained and a review of records confirmed that the required safety checks and measures were in place and regularly monitored in all three units. Corridors were clean and free from clutter or hazards. Fire doors were unobstructed and areas containing items with potential to cause harm such as the cleaning stores were appropriately secured.

Fire safety measures were in place and well managed to ensure residents, staff and visitors to the home were safe. Staff were aware of their training in these areas and how to respond to any concerns or risks. The Fire risk assessment was completed for all three units and was up to date. There was evidence that the actions outlined by the fire risk assessor were complete or were in the process of being completed.

There was evidence that systems were in place to manage infectious diseases. For example, there was ample supply of PPE with in the home. It was noted that PPE was being stored inappropriately, for example aprons were draped over handrails, creating a potential infection control risk. This was discussed with the management team and an area for improvement was identified.

Staff were observed using PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept. Staff were observed to carry out hand hygiene at appropriate times, however staff were noted to be wearing gel nail polish. This was discussed with the management team for action and an area for improvement was stated for a second time.

5.2.4 Quality of Life for Residents

Discussion with residents and staff confirmed that they were able to choose how they spent their day. For example, in both the Mayne unit and in Croft Lodge residents were observed to be having a lie in and a late breakfast, while in the Barn unit service users were observed choosing the activity that they wanted to do.

Residents' meetings were held in all three units on a regular basis and residents and service users had the opportunity to discuss upcoming activities, menu planning and any areas of concern.

Resides and staff said that they were all attending a 'family night' party and that they were looking forward to this.

Residents said that staff offered them choices throughout the day which included preferences on what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time.

Croft Communities has a bi-monthly newsletter which is used to keep residents and families upto date on events in the home.

The Barn was well equipped with a variety of games and art materials. Service users' artworks were on display in the Barn.

The atmosphere throughout all three units was warm, welcoming, relaxed and friendly.

5.2.5 Management and Governance Arrangements

There has been a change in the management of the home since the last inspection. Miss Caroline Barr has been the acting manager in this home since 9 January 2023. Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about residents, care practices or the environment.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. A director in the organisation was identified as the appointed safeguarding champion for the home. It was established that systems and processes were in place to manage the safeguarding and protection of adults at risk of harm.

Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about residents, care practices or the environment. Staff commented positively on the management team, and said, "The managers here are very good , they are very supportive."

It was established that the manager had a system in place to monitor accidents and incident that happened in the home. Accidents and incidents were notified, if required, to residents' next of kin and their care manager. However, there was evidence that not all incidents had been appropriately reported to RQIA. This was discussed with the management team and an area for improvement was identified.

There was evidence that complaints were managed correctly and that good records were maintained.

The home was visited each month by a representative of the registered provider to consult with residents, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. These are available for review by residents, their representatives, the Trust and RQIA.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with **The Residential Care Homes Regulations (Northern Ireland) 2005 and the Residential Care Homes' Minimum Standards (December 2022) (Version 1:2)**.

	Regulations	Standards
Total number of Areas for Improvement	2*	5

* the total number of areas for improvement includes one regulation that has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with the management team, as part of the inspection process.The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for Improvement 1 **Ref:** Regulation 13 (7) **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that all staff adheres to current guidance regarding the use of PPE, hand hygiene and being bare below the elbow. Staffs' use of PPE and hand hygiene should continue to be monitored. If necessary staff should be provided with appropriate training to ensure that they understand their responsibilities in this area and embed their training into practice. Ref: 5.1 & 5.2.3
	Response by registered person detailing the actions taken: The registered person will ensure that all staff adhere to current guidance regarding use of PPE. Discussed within staff meetings. The registered person has actioned PPE audits and Hand hygiene on SCTV added for all staff and will continue to monitor.
Area for Improvement 2 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** From date of inspection 7 December 2023	The registered person shall ensure that all notifiable events are reported promptly to the Regulation and Quality Improvement Authority (RQIA). Ref: 5.2.5
	Response by registered person detailing the actions taken: The registered person will ensure that all notifiable events are reported promptly to RQIA as appropriate.

Action required to ensure compliance with the Residential Care Homes Minimum Standards (December 2022) (Version 1:2)	
Area for improvement 1 **Ref:** Standard 25.6 **Stated:** First time **To be completed by:** From date of inspection 7 December 2023	The registered person shall ensure that the duty rota identifies the person in charge of the home when the manager is not on duty. Ref: 5.2.1
	Response by registered person detailing the actions taken: The duty rotas have been updated to identify clearly who the person in charge is when the manager is not on duty. This change has communicated to all staff within the service.
Area for improvement 2 **Ref:** Standard 23.3 **Stated:** First time **To be completed by:** 31 March 2024	The registered person shall ensure that staff receive Mental Capacity Act training, in line with their roles and responsibilities. Ref 5.2.1
	Response by registered person detailing the actions taken: This training has been allocated to all staff who require it, and the registered person is monitoring to ensure completion.
Area for improvement 3 **Ref:** Standard 24.2 **Stated:** First time **To be completed by:** 31 March 2024	The registered person shall ensure that all staff have recorded individual, formal supervision no less than every six months. Ref: 5.2.1
	Response by registered person detailing the actions taken: There is an updated supervision tracker in place which is audited by the registered person regularly. Supervision is provided to staff no less than every six months.
Area for improvement 4 **Ref:** Standard 6.6 **Stated:** First time **To be completed by:** From date of inspection 7 December 2023	The registered person shall ensure that all care plans are kept up-to-date and reflects the residents' current needs. Ref 5.2.2
	Response by registered person detailing the actions taken: The registered person completed an internal review of Care Plans and this will be monitored to ensure all care plans are kept up-to-date and reflects the residents current needs.

Area for improvement 5 **Ref:** Standard 35 **Stated:** First time **To be completed by:** From date of inspection 7 December 2023	The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. This area for improvement relates to: • the correct storage of personal protective equipment Ref: 5.2.3
	Response by registered person detailing the actions taken: Actioned and correct storage in use. Blue aprons on back order and to arrive next week comm 21st January.

Please ensure this document is completed in full and returned via Web Portal

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