The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Croft Communities Residential Care Home

Provider: The Cedar Foundation

Date of Inspection: 29 April 2025

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:	The Cedar Foundation
Responsible Individual:	Miss Kelly Devlin
Registered Manager:	Miss Anita Todd – not registered
Service Profile – This home is a registered residential care home which provides health and social care for up to 16 residents. Residents have a range of needs and the home provide care for people living with a learning disability under and over 65 years of age. There are a range of communal areas for social activities and all areas are on the ground floor. The home consists of Mayne House accommodating up to nine permanent residents and Croft Lodge which provides short term respite care for up to seven residents. The home is also approved to provide care on a day basis only to fifteen persons, provided in the Barn.	

2.0 Inspection summary

An unannounced inspection took place on 29 April 2025 between 9.30 am and 5 pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 26 September 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection found that person centred and compassionate care was delivered to residents. It was evident that staff promoted the dignity and well-being of residents and that staff were knowledgeable and well trained to deliver effective care.

Residents said that living in the home was a good experience. Residents unable to voice their opinions were observed to be relaxed and enjoying in their surroundings.

However; as a result of this inspection, RQIA required the provider to attend a meeting in line with RQIA's enforcement procedures. A Serious Concerns Meeting was held on 12 May 2025 to discuss concerns relating to the systems in place to ensure residents risk assessments and care plans remained accurate and up to date; the management arrangements of the Barn; and oversight of Deprivation of Liberty Safeguards (DoLS). Details can be found in the main body of this report. RQIA accepted the action plan completed by the provider, which detailed the

actions they had taken and intended to take to ensure the minimum improvements necessary to achieve compliance.

As a result of this inspection nine areas for improvement were assessed as having been addressed by the provider. Other areas for improvement have either been stated again or will be reviewed at the next inspection. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

3.0 The inspection

3.1 How we Inspect

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

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from resident's, relatives, staff or the commissioning Trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Residents said, "it's alright here, people are nice" and "things are good and the food's good". and some told us they felt safe living there and that they were helped by staff.

Residents spoke of enjoying the choice available for activities or meals and their choice in who is contacted with regards to their care. Those unable to verbally communicate their experience of living in the home were observed to be enjoying their activities and interactions with staff; laughing, smiling and joking. Residents also enjoyed spending time with others and reflected on the friendships they had there.

Some spoke of being thankful of the help given by staff in assisting them in daily activities as well as helping them to feel safe overnight.

Staff told us there was good teamwork. One new member of staff confirmed this saying the others had been helpful through their induction and that they felt their induction was comprehensive and of good quality, adding "I feel confident in my role now".

Resident questionnaires returned confirmed that staff are supportive, assisting them in daily activities and helping them to be independent where possible. This positive feedback was shared with the manager.

Seven staff surveys were received offering positive feedback. Specific comments were shared with the manager for their review.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of residents. There was evidence of robust systems in place to manage staffing.

It was noted that there was enough staff in the home to respond to the needs of the residents in a timely way; and to provide residents with a choice on how they wished to spend their day. For example, whether residents wished to spend time outside or in the living area.

Staff said there was good team work and that they felt well supported in their role and that they were satisfied with the staffing levels. Staff were always available to facilitate activities; they knew what they were doing and residents expressed confidence in staffs' ability to provide good care.

There was a system in place to delegate tasks for the day in both Mayne House and Croft Lodge, and staff knew who to speak to in the absence of the manager. However, in the Barn there was limited evidence that the manager had a robust system in place to manage staffing arrangements. This is discussed in more detail in section 3.5.5.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss any changes in the needs of the residents. Staff were knowledgeable of individual residents' daily routine wishes and preferences.

Staff were skilled in communicating with residents; they were respectful, understanding and sensitive to residents' needs. For example, supporting residents by offering various levels of engagement with activities and making them laugh.

Residents told us they were offered choice throughout the day which included what clothes they wanted to wear, food and drink options, and what was shared with their family about their care. For example, which family member was contacted if they had a fall.

Where a resident was at risk of falling, measures to reduce this risk were put in place. For example, resident's walking aids were kept close by them to facilitate independence. If a resident had a fall, there were times where staff needed to closely monitor them to ascertain if medical attention was required. Discussion with the management team established that that staff were not completing these checks accurately or in a consistent manner. This was

being addressed with staff and a new management system of oversight was put in place from March 2025 to ensure improved adherence to this. This area for improvement was stated for a second time.

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 and their diet modified.

The dining experience was an opportunity for residents to socialise, and the residents enjoyed the company of others, chatting to one another and laughing. It was clear that staff had made an effort to ensure residents were comfortable, had a pleasant experience and had a meal that they enjoyed.

The importance of engaging with residents was well understood by the manager and staff. Observation of a resident baking in the morning confirmed that staff knew and understood residents' preferences and helped residents to participate fully.

Life story work with residents and their families helped to increase staff knowledge of their residents' interests and enabled staff to engage with them in a more meaningful way throughout the day.

Arrangements were in place to meet residents' social, religious and spiritual needs within the home.

The weekly programme of social events was displayed on the noticeboard for residents and families using pictures, advising of future events such as bus trips, movie night, dinner party or a quiz. There were photographs of previous activities on display in communal areas.
Many residents spent much of the day at a day centre, returning later for their evening meal. The management team therefore planned these social activities with the residents for them to enjoy in the evening with one another.

3.3.3 Management of Care Records

Residents' needs were assessed by a suitably qualified member of staff 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 and there was evidence that residents had been involved in planning their care.

A dual system of electronic and paper records was in place. Management and staff were unclear which of these had the most up to date versions.

There was no evidence of a management system in place to ensure residents' risk assessments, such as assessments of potential risk of falls and choking, were accurate and up to date. There was limited assurance that assessments had been meaningfully reviewed or updated in the past year. This had previously been stated as an area for improvement under the standards and has now been subsumed under Regulation.

Care plans, including supplementary records, in relation to residents' mobility, Personal Emergency Evacuation Plans, Speech and Language Therapy (SALT) guidelines, skin care and repositioning needs, the provision of 1:1 care and Deprivation of Liberty Safeguards (DoLS) were either, not in place or lacked sufficient detail, to direct staff on the care to be provided. Management oversight and audits of care plans were not robust to ensure care plans remained accurate and up to date.

This was discussed during the Serious Concerns Meeting on 12 May 2025, where the management team provided an update on the actions taken and actions they planned to take, to address this. Six new areas for improvement were also identified.

3.3.4 Quality and Management of Residents' Environment

The home was clean, tidy and well maintained. Residents' bedrooms were personalised with items important to the resident such as art, photographs and ornaments. Bedrooms and communal areas were free from clutter, well decorated, suitably furnished, warm and comfortable.

Residents said they liked having access to the communal garden which was well maintained.

Effective systems and processes were in place regarding infection prevention and control measures. This included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

In a number of rooms across the home there were items such as batteries, razors, other personal care items, and prescribed creams which were not securely stored and accessible to residents. This was brought to the attention of the manager for immediate action. This area for improvement was stated for a second time and a new area for improvement was also identified.

Review of the Fire Risk Assessment found that where actions were identified, the necessary action was not fully addressed in the timeframe directed. This area for improvement was stated for a second time.

3.3.5 Quality of Management Systems

There has been a change in the management of the home since the last inspection. Miss Anita Todd has been the manager in this home since 9 April 2025 and is not yet registered with RQIA.

Residents and staff commented positively about the management team and described them as approachable and able to provide guidance.

It was positive to note that there has been improvement in the systems for reviewing the quality of care, other services and staff practices. However, concerns were identified regarding the lack of clear management, oversight and governance arrangements in the 'Barn' building. This was clarified at the meeting with the management team on 12 May 2025 and adequate assurances provided that this had been addressed with staff. An area for improvement was also identified.

Discussion with management and staff identified concerns regarding the overall management of DoLS as they could not clearly establish which residents may be subject to DoLS. There was no current information regarding this retained in care or management records. This was discussed during the Serious Concerns meeting on 12 May 2025 where the management team provided details on how this had been addressed, including escalation to the relevant HSC Trust. An area for improvement was also identified.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	5*	7*

* the total number of areas for improvement includes one Regulation which has been stated for a second time and two Standards which have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Anita Todd, Manager 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 14 (2) (c) **Stated:** Second time **To be completed by:** 29 April 2025	The registered person shall ensure as far as reasonably practicable that all parts of the home which residents have access to are free from hazards to their safety. Ref: 3.3.4
	Response by registered person detailing the actions taken: Full assessment of the Residential and Respite services for hazards took place and a visual check is completed daily by team leaders/managers. Care Plans and Risk assessments updated for residents to ensure safety regarding potential hazards.
Area for improvement 2 **Ref:** Regulation 15 (2) (a) (b) **Stated:** First time **To be completed by:** 6 June 2025	The registered person shall ensure that the assessment of the resident's need is kept under review; revised at any change and reviewed no less than annually. Ref: 3.3.3
	Response by registered person detailing the actions taken: Assessment of need is kept under review and any changes updated no less than annually
Area for improvement 3 **Ref:** Regulation 13 (4) (a) **Stated:** First time **To be completed by:** 29 April 2025	The registered person shall ensure that all prescribed medication is securely stored. Ref: 3.3.4
	Response by registered person detailing the actions taken: All medication is securely stored within the medication rooms. All staff made aware to ensure that medication is returned to the medication trolly/room after use.
Area for improvement 4 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure that the manager maintains clear operational oversight and control of the services, treatment and supervision of residents provided in line with the home's current registration and Statement of Purpose. Ref: 3.3.5

To be completed by: 29 April 2025	**Response by registered person detailing the actions taken**: There is a clear management structure in place that ensures the registered manager has clear operational oversight and control of the services and this is detailed in the Statement of Purpose.
Area for improvement 5 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** 19 May 2025	The registered person shall ensure that there is a robust system in place to oversee and monitor the arrangements in place for those residents who may require Deprivation of Liberty Safeguards (DoLS). Ref: 3.3.5 **Response by registered person detailing the actions taken**: DoLs have been reviewed for all residents in conjunction with the SEHCHT and MCA Team as applicable. Restrictive Practice Register has been updated for all services users as applicable and there is supporting evidence and communication to from SEHSCT and MCA Team to support progress with this.
Action required to ensure compliance with the Residential Care Homes Minimum Standards (version 1.2 Dec 2022)	
Area for improvement 1 **Ref:** Standard 8.2 **Stated:** Second time **To be completed by:** 29 July 2025	The registered person will ensure records maintained for resident's detail accidents, incidents or near misses occurring and action taken. This is in relation specifically to post falls records being accurate and up to date. Ref: 3.3.3 **Response by registered person detailing the actions taken:** Records are being maintained for resident's accidents, incidents or near misses that occur. Any action taken is recorded and lessons learned competed as applicable. Post falls records are completed as required and are accurate and up to date.
Area for improvement 2 **Ref:** Standard 20.10 **Stated:** Second time **To be completed by:** 29 April 2025	The registered person will ensure that working practices are systematically audited and actions taken when required. The manager will have oversight of this specifically in relation to fire risk assessments. Ref: 3.3.4 **Response by registered person detailing the actions taken:** Fire Risk Assessment actions are all complete. All required audits are complete in the required timeframes.
Area for improvement 3 **Ref:** Standard 6.7 **Stated:** First time	The registered person will ensure that care plans are kept up-to-date and reflects the residents' current needs. This is specifically in relation to residents who are subject to Deprivation of Liberty. Ref: 3.3.3

To be completed by: 19 May 2025	**Response by registered person detailing the actions taken:** There is a current review of all residents care plans and needs to reflect if a resident is or is not subject to DoLs. Any DoLs in place are indicated in the residents care plan on iplanit. Restrictive Practices Register has also been updated to reflect same.
Area for improvement 4 **Ref:** Standard 6.2 and 6.6 **Stated:** First time **To be completed by:** 29 April 2025	The registered person shall ensure care plans regarding personal emergency evacuation plans (PEEP's) are kept up-to-date and reflects the resident's current needs. Ref: 3.3.3
	Response by registered person detailing the actions taken: All PEEPS have for each resident have been reviewed and reflect the residents current needs. (inc Day and Night). This is linked to the Care Plan on Iplanit
Area for improvement 5 **Ref:** Standard 12.1 **Stated:** First time **To be completed by:** 06 June 2025	The registered person will ensure that there is a system in place to ensure that staff have access to the up-to-date assessment of resident's requirements for modified diets and levels of assistance. Ref: 3.3.3
	Response by registered person detailing the actions taken: There is a system in place to ensure that staff have access to the up-to-date assessment of resident's requirements for modified diets and levels of assistance. All SALT new assessments are directed to the registered manager who will update care plans/risk assessments and disseminate any changes to all staff inc cook.
Area for improvement 6 **Ref:** Standard 8.2 **Stated:** First time **To be completed by:** 29 April 2025	The registered person will ensure that where a resident is supported with repositioning, this is recorded in care records. Ref: 3.3.3
	Response by registered person detailing the actions taken: The registered person will ensure that where a resident is supported with repositioning, this is recorded in care records.
Area for improvement 7 **Ref:** Standard 6.2 and 6.6 **Stated:** First time **To be completed by:** 6 June 2025	The registered person will ensure that care plans are kept up-to-date and reflects the residents' current needs. This is specifically in relation to residents who have one-to-one support in place. Ref: 3.3.3
	Response by registered person detailing the actions taken: Care plans are currently being reviewed to reflects the residents' current needs. One-to-one support documented on the Care Plan

	on Iplanit. All staff are fully aware of the one-to-one support requirements.

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

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