Unannounced Care Inspection Report
7 June 2016

The Croft Community

Type of Service: Residential

Address: 71 Bloomfield Road
Bangor
BT20 4UR
Tel No: 028 9145 9784
Inspector: Alice McTavish

1.0 Summary

An unannounced inspection of The Croft Community, a residential care home for adults with a learning disability, took place on 7 June 2016 from 09.50 to 17.00. The Croft Community has two units on the same site – Mayne House, which accommodates nine permanent residents and Croft Lodge, a newly built facility which offers respite care to a maximum of seven residents.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

Three recommendations were made within the area of safe care. One recommendation was in regard to the need to clearly identify the person in charge of Mayne House and of Croft Lodge and to noting the hours worked by the registered manager on the staff duty rota. One recommendation was made to the need to address all outstanding areas of mandatory training. One recommendation, stated for the second time, related to the completion of competence and capability assessments for any person who was given the responsibility of being in charge of the home for any period in the absence of the manager. There were examples of good practice found throughout the inspection in relation to staff induction, supervision and appraisal, recruitment practice, adult safeguarding, risk management and the home's environment.

Is care effective?

No requirements or recommendations were stated in regard to the delivery of effective care. There were examples of good practice found throughout the inspection in relation to care records, audits and reviews, communication between residents, staff and other key stakeholders.

Is care compassionate?

No requirements or recommendations were stated in regard to the delivery of compassionate care. There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, listening to and valuing residents and to taking into account the views of residents.

Is the service well led?

Two recommendations were made within the area of well led care. One recommendation was made in regard to the development of a policy and procedures on infection prevention and control (IPC) and a review of the policy on consent. One recommendation was made in regard to the need to develop a more user friendly version to guide residents on how to make a complaint. There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents and to quality improvement and good working relationships.

This inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005 and DHSSPS Residential Care Homes Minimum Standards, August 2011.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**0**	**5**

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mr Alan Hutchinson, registered manager and Mr Clive Evans, Chief Executive Officer of The Croft Community, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent care inspections

An unannounced care inspection was undertaken on 12 November 2015 and a Pre-Registration Care Inspection was undertaken on 11 December 2015. Other than those actions detailed in the previous QIPs, there were no further actions required to be taken following the last inspections.

2.0 Service details

Registered organisation/registered provider: The Croft Community Ltd	**Registered manager:** Mr Alan Hutchinson
Person in charge of the home at the time of inspection: Mr Alan Hutchinson	**Date manager registered:** 4 January 2016
Categories of care: LD - Learning Disability LD (E) – Learning disability – over 65 years	**Number of registered places:** 16
Weekly tariffs at time of inspection: £564 - £831.75	**Number of residents accommodated at the time of inspection:** 14

3.0 Methods/processes

Prior to inspection the following records were analysed: the reports and QIPs from the last care inspections and notifications of accidents and incidents.

During the inspection the inspector met with six residents, three care staff, one domestic assistant, the registered manager and the chief executive officer for The Croft Community.

No resident's visitors/representatives and no visiting professionals were present. Six resident views, six resident representative views and six staff views questionnaires were left in the home for completion and return to RQIA. No completed questionnaires were returned to RQIA.

The following records were examined during the inspection:

- Staff duty rota
- Induction programme for new staff
- Staff supervision and annual appraisal schedules
- Staff training schedule
- Staff recruitment files
- Two resident's care files
- The home's Statement of Purpose and Residents' Guide
- Minutes of recent staff meetings
- Complaints and compliments records
- Audits of risk assessments, care plans, care reviews, accidents and incidents and complaints
- Equipment maintenance records
- Accident/incident/notifiable events register
- Annual Quality Review report
- Minutes of recent residents' meetings
- Evaluation report from annual service user quality assurance survey
- Monthly monitoring report
- Fire safety risk assessment
- Fire drill records
- Maintenance of fire-fighting equipment, alarm system, emergency lighting, fire doors, etc
- Programme of activities
- Policies and procedures manual

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 28 January 2016

The most recent inspection of the home was an unannounced medicines management. The completed QIP was returned and approved by the specialist inspector. This QIP will be validated by the specialist inspector at their next inspection.

4.2 Review of requirements and recommendations from the last care inspections dated 12 November 2015 and 11 December 2015

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 3.2 **Stated:** First time	The residential services manager should ensure that a separate residents' guide is developed specific to the respite care service offered within Croft Lodge.	Met
	Action taken as confirmed during the inspection: Discussion with the registered manager and inspection of the residents guide confirmed that this was developed specific to the respite care service offered within Croft Lodge.	
Recommendation 2 **Ref**: Standard 24.5 **Stated:** First time	The residential services manager should ensure that a competence and capability assessment is undertaken of any person who is given the responsibility of being in charge of the residential home for any period in the absence of the residential services manager.	Partially Met
	Action taken as confirmed during the inspection: Discussion with the registered manager identified that a new competency and capability form had been devised and was to be introduced in the near future; staff competency and capability was currently established through the existing process of staff supervision and appraisal and had been completed for the majority of staff who were given the responsibility of being in charge of the residential home for any period in the absence of the residential services manager. It was identified that a small number of support staff were not included in this. This recommendation was therefore stated for a second time.	

Recommendation 3 **Ref**: Standard 1.6 **Stated:** First time	The manager should ensure that satisfaction surveys are undertaken annually, that the information obtained is used to identify areas for improvement and that these areas are addressed.	Met
	Action taken as confirmed during the inspection: Discussion with the registered manager and inspection of the summary report confirmed that a satisfaction survey was undertaken, that the information obtained was used to identify areas for improvement and that these areas were addressed.	
Recommendation 4 **Ref**: Standard 17.10 **Stated:** First time	The manager should ensure that the complaints register is revised to more fully reflect the process of managing complaints.	Met
	Action taken as confirmed during the inspection: Discussion with the registered manager and inspection of documentation confirmed that the complaints register was revised to more fully reflect the process of managing complaints.	

4.3 Is care safe?

The registered manager confirmed the staffing levels for the home and that these were subject to regular review to ensure the assessed needs of the residents were met. No concerns were raised regarding staffing levels during discussion with residents, residents' representatives and staff. The registered manager advised that, so far, only residents who had full mobility had used the newly built respite facility; when residents who use wheelchairs begin to use the respite service, additional staffing will be made available.

On the day of inspection, when many of the residents were away from the home and involved in day opportunities, the following staff were on duty –

- 1 x registered manager
- 1 x senior support worker
- 5 x support workers
- 3 x domestics
- 1 x cook

Two senior support workers and four support workers were due to be on duty later in the day. Two support workers were scheduled to be on overnight duty.

A review of the staff duty rota established that the person in charge of Mayne House and of Croft Lodge was not clearly identified, also that the hours worked by the registered manager was not noted on the staff duty rota. A recommendation was made in regard to these points.

A review of completed induction records and discussion with the registered manager and staff evidenced that an induction programme was in place for all staff, relevant to their specific roles and responsibilities. The registered manager advised that all new staff were provided with an induction booklet which contained further areas of staff development. New staff completed the booklet over the first six months of employment. New staff were also supported during this period through monthly supervision.

Discussion with staff confirmed that mandatory training, supervision and appraisal of staff was regularly provided. A schedule for staff training was available for inspection; examination of the schedule established that some areas of mandatory training (COSHH, fire safety) were recently out of date and that some staff who may be in charge of the home had not received training in managing residents' money. The registered manager advised that a training manager had commenced employment and was tasked with ensuring that these areas, already identified by senior management within The Croft Community, would be addressed at the earliest opportunity. A recommendation was made that all outstanding areas of mandatory training should be addressed.

A schedule for annual staff appraisals and staff supervision was maintained and was available for inspection. The registered manager confirmed that staff supervision and annual appraisals were up to date and the frequency of sessions met the minimum standard. In discussion with the registered manager it was suggested that a matrix could be developed for these areas which will provide ease of audit.

The registered manager confirmed that there was a system in place for the completion of competency and capability assessments for any person who was given the responsibility of being in charge of the home for any period in the absence of the manager. The registered manager advised that a new competency and capability form had been devised and was to be introduced in the near future; competency and capability was currently established through the existing process of staff supervision and appraisal. The new competency and capability form was found to structured and comprehensive.

Review of the home's recruitment and selection policy and procedure confirmed that it complied with current legislation and best practice. Discussion with the registered manager and review of staff personnel files confirmed that staff were recruited in line with Regulation 21 (1) (b), Schedule 2 of The Residential Care Homes Regulations (Northern Ireland) 2005.

The Croft Community did not have a human resources department and used an umbrella organisation to assist with staff recruitment. The registered manager confirmed that Enhanced AccessNI disclosures for all staff were viewed by the umbrella organisation and that written confirmation of this was received by the registered manager prior to the commencement of employment. Arrangements were in place to monitor the registration status of staff with their professional body (where applicable).

The adult safeguarding policies and procedures in place were consistent with current regional guidance and included definitions of abuse, types of abuse and indicators, onward referral arrangements, contact information and documentation to be completed. The home had established a safeguarding champion.

Discussion with staff confirmed that they were aware of the new regional adult safeguarding guidance (Adult Safeguarding Prevention and Protection in Partnership, July 2015) and a copy was available for staff within the home. Staff were knowledgeable and had a good understanding of adult safeguarding principles. They were also aware of their obligations in

relation to raising concerns about poor practice and to whistleblowing. A review of staff training records confirmed that mandatory adult safeguarding training was provided for all staff.

Discussion with the registered manager, review of accident and incidents notifications, review of care records and review of complaints confirmed that all suspected, alleged or actual incidents of abuse were fully and promptly referred to the relevant persons and agencies for investigation in accordance with procedures and legislation; written records were retained.

It was identified that the home did not have a policy and procedure on infection prevention and control (IPC). As this issue related to a managerial matter, a recommendation was made within section 4.6 of this report that a suitable policy and procedure on IPC should be developed in line with regional guidelines. Staff training records confirmed that all staff had received training in IPC in line with their roles and responsibilities. Discussion with staff established that they were knowledgeable and had understanding of IPC procedures.

Inspection of the premises confirmed that there were wash hand basins, adequate supplies of liquid soap, alcohol hand gels and disposable towels wherever care was delivered. Observation of staff practice identified that staff adhered to IPC procedures. Hand hygiene was a priority for the home and efforts were applied to promoting high standards of hand hygiene among residents, staff and visitors. Notices promoting good hand hygiene were displayed throughout the home.

The registered manager reported that there had been no recent outbreaks of infection. Any outbreak would be managed in accordance with established procedures and would be reported to the local Consultant in Communicable Disease Control and to RQIA. Records would be retained.

The registered manager confirmed that there were risk management procedures in place relating to the safety of individual residents. Discussion with the registered manager identified that the home did not accommodate any individuals whose needs could not be met. Review of care records identified that an individual care needs assessment and risk assessments were obtained prior to admission of residents to the home. Care needs assessment and risk assessments were reviewed and updated on a regular basis or as changes occurred.

A review of policy and procedure on restrictive practice/behaviours which challenge confirmed that this was in keeping with DHSSPS Guidance on Restraint and Seclusion in Health and Personal Social Services (2005) and the Human Rights Act (1998). It also reflected current best practice guidance including Deprivation of Liberties Safeguards (DoLS).

The registered manager confirmed that areas of restrictive practice were employed within the home, notably locked external doors and a keypad entry system on some internal doors. Discussion with the registered manager regarding such restrictions confirmed these were appropriately assessed, documented, minimised and reviewed with the involvement of the multi-professional team, as required. A review of the Statement of Purpose and Residents Guide identified that restrictions were adequately described.

Inspection of care records confirmed that there was a system of referral to the multi-disciplinary team when required. Discussion with the registered manager confirmed that if individual restraint was employed, the appropriate persons/bodies would be informed.

The registered manager confirmed that there were risk management policy and procedures relating to assessment of risks in the home. Discussion with the registered manager and review of the home's policy and procedures relating to safe and healthy working practices confirmed that were appropriately maintained and reviewed regularly e.g. COSHH, fire safety etc. The registered manager confirmed that equipment and medical devices in use in the home was well maintained and regularly serviced.

Inspection of the internal and external environment identified that the home and grounds were kept tidy, safe, suitable for and accessible to residents, staff and visitors. There were no obvious hazards to the health and safety of residents, visitors or staff. Discussion with the registered manager confirmed that action plans were in place to reduce the risk where possible.

The registered manager confirmed that the home had an up to date fire risk assessment in place. A review of the fire safety risk assessment, dated 14 December 2015, identified that any recommendations arising had been addressed appropriately. Fire drills were completed monthly and records retained of staff who participated and any learning outcomes. Fire safety records identified that fire alarm systems were tested weekly and there were quarterly tests and inspections of the emergency lighting and fire alarm systems. Individual residents had a completed Personal Emergency Evacuation Plan (PEEPs) in place.

Areas for improvement

Three areas for improvement were identified during the inspection. One area related to the need to clearly identify the person in charge of Mayne House and of Croft Lodge and to noting the hours worked by the registered manager on the staff duty rota. One area related to the need to address all outstanding areas of mandatory training. One area related to the completion of competence and capability assessments for any person who was given the responsibility of being in charge of the home for any period in the absence of the manager.

Number of requirements	**0**	**Number of recommendations**:	**3**

4.4 Is care effective?

Discussion with the registered manager established that staff in the home responded appropriately to and met the assessed needs of the residents.

A review of two care records confirmed that these were maintained in line with the legislation and standards. They included up to date assessment of needs, life history, risk assessments, care plans and daily/regular statement of health and well-being of the resident. Care records were updated regularly to reflect the changing needs of the resident. Residents and / or their representatives were encouraged and enabled to be involved in the assessment and care planning and review process, where appropriate. Discussion with staff confirmed that they had an understanding of person centred care and that a person centred approach underpinned practice. The care records reflected multi-professional input into the service users' health and social care needs. The registered manager confirmed that records were stored safely and securely in line with data protection.

The registered manager confirmed that there were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to residents at appropriate intervals. Audits of risk assessments, care plans, care review, accidents and incidents (including falls, outbreaks) and complaints were available for inspection and evidenced that actions identified for improvement were incorporated into practice. An example of this was where an analysis of incidents identified that a resident had displayed instances of uncharacteristic behaviour and staff had observed a reduction in the resident's general wellbeing. A referral was made to the trust's psychology department and the resident was diagnosed with dementia. This led to a reassessment of the resident's needs and a review of the care plan and risk assessment in order to better meet the needs of the resident. Specialist training was identified as a need for the staff team. Further evidence of audits was contained within the monthly monitoring visits reports and the annual quality report.

The registered manager confirmed that systems were in place to ensure effective communication with residents, their representatives and key stakeholders. These included pre-admission information, multi-professional team reviews, residents meetings, staff meetings and staff shift handovers. Discussion with the registered manager and staff confirmed that management operated an open door policy in regard to communication within the home.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.5 Is care compassionate?

The registered manager confirmed that staff promoted a culture/ethos that supported the values of dignity and respect, independence, rights, equality and diversity, choice and consent of residents. The registered manager also confirmed that residents were listened to, valued and communicated with in an appropriate manner.

Review of the home's policies and procedures confirmed that appropriate policies were in place; it was noted, however, that the home's policy on consent was limited and would benefit from further development. A recommendation was made that this policy should be reviewed; as the issue related to a managerial matter, this recommendation was included in one made in section 4.6 relating to policies and procedures.

Discussion with staff confirmed that residents' spiritual and cultural needs were met within the home. Discussion with residents confirmed that action was taken to manage pain and discomfort in a timely and appropriate manner.

The registered manager and staff confirmed that consent was sought in relation to care and treatment. Residents and staff and observation of interactions demonstrated that residents were treated with dignity and respect; also that residents' needs were recognised and responded to in a prompt and courteous manner by staff. Staff confirmed their awareness of promoting residents' independence and of maintaining dignity. Staff were also able to demonstrate how residents' confidentiality was protected.

Discussion with staff and residents and review of care records confirmed that residents were enabled and supported to engage and participate in meaningful activities. Arrangements were in place for residents to maintain links with their friends, families and wider community.

There were systems in place to ensure that the views and opinions of residents, and or their representatives, were sought and taken into account in all matters affecting them. Residents were consulted about the standard and quality of care and about the home environment. This consultation was carried out at least annually. The findings from the consultation were collated into a summary report which was made available for residents and other interested parties. An action plan was developed and implemented where improvements were required. An example of this is when a small number of residents' representatives indicated some dissatisfaction in the annual consultation about the standard and quality of care and about the home environment. Mr Evans, the C.E.O of The Croft Community, made arrangements to meet with each representative individually to discuss any issues. This approach was greatly appreciated by the representatives. It was raised that residents might be disadvantaged in participating in outings as the home did not have its own transport. In order to address this, the home engaged in some fundraising activities. Monies were made available to allow residents to avail of the services of a local taxi company and this allows residents to enjoy outings.

A resident offered the following comment about the care provided within the respite facility - "I like it here and the staff are kind, They took me to Ballywalter in the minibus and I really enjoyed it. The new house is lovely. I like my room and it's great that I have my own bathroom. I like the food. The staff make me all my favourite meals when I am here." Another resident said – "I'm really looking forward to going on my holiday to Portaferry. I like living in Mayne House."

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**:	**0**

4.6 Is the service well led?

The registered manager confirmed that there were management and governance systems in place to meet the needs of residents and that the health and social care needs of residents were met in accordance with the home's Statement of Purpose and the categories of care for which the home was registered. There were also quality assurance systems in place to drive quality improvement.

A range of policies and procedures was in place to guide and inform staff. Policies were centrally indexed and retained in a manner which was easily accessible by staff. Policies and procedures were systematically reviewed every three years or more frequently should changes occur. It was identified, however, that the home did not have a policy and procedure on infection prevention and control. A recommendation was made that a suitable policy and procedure should be developed in line with regional guidelines; the recommendation also included that the home's policy on consent should be reviewed (see section 4.5 of this report).

The home had a complaints policy and procedure in place. This was in accordance with the relevant legislation and DHSSPS guidance on complaints handling. Residents and their representatives were made aware of the process of how to make a complaint by way of the Residents Guide. A recommendation was made that a more user friendly version should be developed to guide residents on how to make a complaint. Discussion with staff confirmed that they were knowledgeable about how to receive and deal with complaints.

Review of the complaints records established that there were clear arrangements for the management of complaints from residents and any other interested parties. Records of complaints included details of the investigation undertaken, all communication with complainants, the result of any investigation, the outcome and the action taken to address the issues raised. Arrangements were in place to share information about complaints and compliments with staff. An audit of complaints was used to identify trends and to enhance service provision.

The registered manager confirmed the home had an accident/incident/notifiable events policy and procedure in place which included reporting arrangements to RQIA. A review of accidents/incidents/notifiable events confirmed that these were effectively documented and reported to RQIA and other relevant organisations in accordance with the legislation and procedures. A regular audit of accidents and incidents was undertaken and this was available for inspection. Learning from accidents and incidents was disseminated to all relevant parties and action plans developed to improve practice. There was also a system in place to ensure medical device alerts, safety bulletins, serious adverse incident alerts and staffing alerts were appropriately reviewed.

Discussion with the registered manager confirmed that information in regard to current best practice guidelines was made available to staff. Staff were provided with mandatory training and additional training opportunities relevant to any specific needs of the residents.

A monthly monitoring visit was undertaken as required under Regulation 29 of The Residential Care Homes Regulations (Northern Ireland) 2005; a report was produced and made available for residents, their representatives, staff, trust representatives and RQIA.

There was a clear organisational structure and all staff were aware of their roles, responsibility and accountability within the overall structure. This was outlined in the home's Statement of Purpose and Residents Guide. The registered manager confirmed that the registered provider was kept informed regarding the day to day running of the home.

Staff spoken with confirmed that they were familiar with organisational and management structure and with their lines of professional accountability. Staff were aware of their individual responsibility in relation to raising concerns. Residents were informed of the roles of staff within the home and who to speak with if they wanted advice or had any issues or concerns.

The registered manager confirmed that the home was operated in accordance with the regulatory framework. Inspection of the premises confirmed that the home's certificate of registration and employers' liability insurance certificate were displayed.

Review of notifications of accidents and incidents and the returned RQIA Quality Improvement Plan (QIP) confirmed that the registered provider/s responded to regulatory matters in a timely manner. Review of records and discussion with the registered manager confirmed that any adult safeguarding issues were managed appropriately and that reflective learning had taken place.

The registered manager confirmed that there were effective working relationships with internal and external stakeholders. The home had a whistleblowing policy and procedure in place. Discussion with staff established that they were knowledgeable regarding the policy and procedure. The registered manager confirmed that staff could also access line management to raise concerns and to offer support to staff. Discussion with staff confirmed that there were good working relationships and that management were responsive to suggestions and/or concerns raised.

The registered manager confirmed that there were arrangements in place for managing identified lack of competency and poor performance for all staff. There were also open and transparent methods of working and effective working relationships with internal and external stakeholders.

Areas for improvement

Two areas for improvement were identified during the inspection. One area related to the development of a policy and procedures on IPC and to a review of the policy on consent. One area related to the need to review information for residents on making a complaint and the development of a more user friendly version.

Number of requirements	**0**	**Number of recommendations**:	**2**

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mr Alan Hutchinson, registered manager and Mr Clive Evans, Chief Executive Officer of The Croft Community, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP 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 the residential care home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises, RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Residential Care Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Residential Care Homes Minimum Standards, August 2011. They promote current good practice and if adopted by the registered provider may enhance service, quality and delivery.

5.3 Actions taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to *Care.Team@rqia.org.uk* by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 24.5 **Stated:** Second time **To be completed by:** 12 August 2016	The residential services manager should ensure that a competence and capability assessment is undertaken of any person who is given the responsibility of being in charge of the residential home for any period in the absence of the residential services manager.
	Response by registered provider detailing the actions taken: These assessments are ongoing and will be completed by the Service Manager. Any person who will have to take on this responsibility will also have the support of the Chief Executive on a daily basis to support them in the day to day management.
Recommendation 2 **Ref**: Standard 25.6 **Stated:** First time **To be completed by:** 12 August 2016	The registered provider should ensure that the staff duty rota clearly states the following:- • the person in charge of Mayne House and Croft Lodge • the hours worked by the registered manager
	Response by registered provider detailing the actions taken: The sevice manager has made all Senior Support Workers and Support Workers Level II aware of the fact that they need to designate a member of staff to take responsibility for the house/unit in their absence and this must be clearly marked on the staff rota and clearly stated during handovers. Senior or SWII should also put this note in the communication book. The hours worked by the registered manager will be included in a three week Senior on duty rota which is held in all houses.
Recommendation 3 **Ref**: Standard 23.3 **Stated:** First time **To be completed by:** 31 October 2016	The registered provider should ensure that all outstanding areas of mandatory training are addressed.
	Response by registered provider detailing the actions taken: The new training officer commenced post on 31st May 2016 as part of her job role she has identified the gaps in mandatory training and is currently sourcing appropriate providers to ensure compliance in these areas. As part of this process the Organisation have signed up to an e learning package which will be monitored by the training officer and facilitate easier access to training modules.
Recommendation 4 **Ref**: Standard 21.1 **Stated:** First time **To be completed by:**	The registered provider should ensure the following:- • a suitable policy and procedure on Infection Prevention and Control is developed in line with regional guidelines • the home's policy on consent is reviewed

31 October 2016	**Response by registered provider detailing the actions taken:** A new policy and procedure is currently in draft form reflecting the regional guidelines and will be discussed with all staff through senior and staff/team meetings when this is complete the finished Policy and procedure will be issued to all facilities. The consent Policy will be reviewed by the service manager and co-ordinator and will include consultation with our service users. This will facilitate updating current policy and presenting this in a more appropriate user friendly way to all our service users to aid their unserstanding.
Recommendation 5 **Ref**: Standard 17.3 **Stated:** First time **To be completed by:** 31 October 2016	The registered provider should ensure that the information for residents on how to make a complaint is reviewed and that a more user friendly version is developed.
	Response by registered provider detailing the actions taken: This will be done concurrently with the Consent Policy. The various forms of communication with and to our service users including Policies is something the Organisation wants to change in the future to facilitate an improved and more inclusive service to all.

Please ensure this document is completed in full and returned to Care.Team@rqia.org.uk from the authorised email address*

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