Unannounced Care Inspection Report
11 May 2017

The Croft Community

Type of service: Residential care home
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 took place on 11 May 2017 from 09:55 to 16:00. The Croft Community has two units on the same site – Mayne House, which accommodates nine permanent residents and Croft Lodge which provides short term respite care to a maximum of seven residents.

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

Is care safe?

There were examples of good practice found throughout the inspection in relation to staff induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment.

Two recommendations were made in regard to fire safety and to the Residents' Guide.

Is care effective?

There were examples of good practice found throughout the inspection in relation to care records and to communication between residents, staff and other key stakeholders.

No requirements or recommendations were made in relation to this domain.

Is care compassionate?

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 taking account of the views of residents.

No requirements or recommendations were made in relation to this domain.

Is the service well led?

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

One requirement was made in regard to visitors books in Mayne House and Croft Lodge.

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	1	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Alan Hutchinson, registered manager by telephone, 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 inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 22 November 2016.

2.0 Service details

Registered organisation/registered person: The Croft Community Ltd	**Registered manager:** Alan Hutchinson
Person in charge of the home at the time of inspection: Roberta George, senior support worker	**Date manager registered:** 4 January 2016
Categories of care: LD - Learning Disability LD (E) – Learning disability – over 65 years The home is also approved to provide care on a day basis only to 15 persons	**Number of registered places:** 16

3.0 Methods/processes

Prior to inspection we analysed the following records: the report and QIP from the last care inspection and notifications of accidents and incidents.

During the inspection the inspector met with five residents, four care staff and the person in charge. No visiting professionals and no residents' visitors/representatives were present.

The following records were examined during the inspection:

- Staff duty rota
- Induction programme for new staff
- Staff supervision and annual appraisal schedules
- Sample of competency and capability assessments
- Staff training schedule/records
- Care records of two residents
- The home's Residents' Guide for Croft Lodge
- Minutes of recent staff meetings

- Complaints and compliments records
- Equipment maintenance records
- Annual Quality Review report
- Minutes of recent residents' meetings
- Evaluation report from annual service user quality assurance survey
- Monthly monitoring report
- Fire safety risk assessments
- Fire drill records
- Maintenance of fire-fighting equipment, alarm system, emergency lighting, fire doors, etc.
- Programme of activities
- Policies and procedures manual

A total of 30 questionnaires were provided for distribution to residents, their representatives and staff for completion and return to RQIA. Seven questionnaires were returned within the requested timescale.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 10 January 2017

The most recent inspection of the home was an announced premises inspection. The completed QIP was returned and approved by the estates inspector. This QIP will be validated by the estates inspector at the next premises inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 22 November 2016

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 23.3 **Stated:** Second time **To be completed by:** 28 February 2017	The registered provider should ensure that mandatory staff training in managing residents' finances is provided. **Action taken as confirmed during the inspection**: Inspection of the staff training records confirmed that mandatory staff training in managing residents' finances was provided.	**Met**
Recommendation 2 **Ref**: Standard 17.3 **Stated:** Second time	The registered provider should ensure that a more user friendly version of the information for residents on how to make a complaint is developed.	**Met**

To be completed by: 28 February 2017	**Action taken as confirmed during the inspection**: Inspection of documentation confirmed that a more user friendly version of the information for residents on how to make a complaint was developed.	
Recommendation 3 **Ref**: Standard 21.1 **Stated:** First time **To be completed by:** 28 February 2017	The registered provider should ensure that a suitable policy for the management of records is developed.	**Met**
	Action taken as confirmed during the inspection: Inspection of documentation confirmed that a suitable policy for the management of records was developed.	

4.3 Is care safe?

The person in charge 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 and staff. A review of the duty roster confirmed that it accurately reflected the staff working within the home.

Review of completed induction records and discussion with the person in charge and staff evidenced that an induction programme was in place for all staff, relevant to their specific roles and responsibilities.

Discussion with staff and a review of returned staff views questionnaires confirmed that mandatory training, supervision and appraisal of staff was regularly provided. A schedule for mandatory training, annual staff appraisals and staff supervision was maintained and was reviewed during the inspection.

Staff confirmed that competency and capability assessments were undertaken for any person who is given the responsibility of being in charge of the home for any period in the absence of the manager; records of competency and capability assessments were retained. Samples of completed staff competency and capability assessments were reviewed during the last care inspection and found to be satisfactory. They were not reviewed on this occasion.

Recruitment and selection of staff was inspected in detail during previous care inspections and was not examined on this occasion.

Staff were able to describe the arrangements in place to monitor their registration status with their professional body (where applicable) and confirmed that staff were reminded of the importance of maintaining registration during regular staff meetings and at staff supervision.

The adult safeguarding policy and procedure in place was examined during previous inspections and was found to be consistent with the current regional guidance. It included the

name of the safeguarding champion, definitions of abuse, types of abuse and indicators, onward referral arrangements, contact information and documentation to be completed.

Discussion with staff confirmed that they were aware of the new regional 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 whistleblowing. A review of staff training records confirmed that mandatory adult safeguarding training was provided for all staff.

The registered manager confirmed after the inspection that no issues relating to adult safeguarding had arisen since the last care inspection. The registered manager remained aware of his obligations to fully and promptly refer all suspected, alleged or actual incidents of abuse to the relevant persons and agencies for investigation in accordance with procedures and legislation; written records would be retained.

The person in charge confirmed there were risk management procedures in place relating to the safety of individual residents. Discussion with the person in charge identified that the home did not accommodate any individuals whose assessed needs could not be met. Review of care records identified that individual care needs assessments and risk assessments were obtained prior to admission.

A review of policy and procedure on restrictive practice/behaviours which challenge during previous care inspections 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 policy and procedure remained unchanged.

The person in charge confirmed there were restrictive practices employed within the home, notably locked external doors and keypad entry systems on some internal doors. In Croft Lodge, alarms were used for some residents on bedroom doors at night. For those residents who used wheelchairs, a lap belt was used. For a small number of residents, a sound monitor was used at night. Discussion with the person in charge regarding such restrictions confirmed these were appropriately assessed, documented, minimised and reviewed with the involvement of the multi-professional team, as required. Review of the Residents' Guide for Mayne House during a previous care inspection identified that any restrictions were adequately described. A review of the Residents' Guide for Croft Lodge, however, identified that restrictions were not noted. A recommendation was made in this regard.

Discussion with the person in charge and review of the home's policy and procedures relating to safe and healthy working practices confirmed that these were appropriately maintained and reviewed regularly e.g. COSHH, fire safety etc. The person in charge confirmed that equipment and medical devices in use in the home were well maintained and regularly serviced.

Review of the infection prevention and control (IPC) policy and procedure during previous care inspection confirmed that this this was 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 policies and procedures. Inspection of the premises confirmed that there were wash hand basins, adequate supplies of liquid soap and disposable towels wherever care was delivered. Observation of staff practice identified that staff adhered to IPC procedures.

Good standards of hand hygiene were observed to be promoted within the home among residents, staff and visitors. Notices promoting good hand hygiene were displayed throughout the home in both written and pictorial formats.

The person in charge reported that there had been no outbreaks of infection within the last year. Any outbreak would be managed in accordance with home policy and procedures, reported to the Public Health Agency, the trust and RQIA with appropriate records retained.

A general inspection of the home was undertaken and the residents' bedrooms were found to be personalised with photographs, memorabilia and personal items. The home was fresh-smelling, clean and appropriately heated.

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.

The home had an up to date fire risk assessment in place for Croft Lodge dated 4 January 2017. Nine recommendations were made. In discussion with the registered manager after the inspection, it was agreed that documentation would be forwarded to RQIA to confirm progress with acting upon recommendations made within the fire risk assessments. The registered manager also agreed to forward the fire risk assessment for Mayne House as this was not reviewed on the day of inspection.

The information requested was forwarded via email. Written confirmation was provided that a number of recommendations within the fire risk assessments had been actioned. It was noted, however, that the progress with the actions recommended within both fire risk assessments were not signed as having been actioned. A recommendation was made that all actions recommended in fire risk assessments are dated and signed when completed.

Review of staff training records confirmed that staff completed fire safety training twice annually. Fire drills were completed regularly in Mayne House, most recently on 11 January 2017 and 6 March 2017. The most recent fire drill in Croft Lodge was confirmed in writing as having been completed on 18 April 2017. Records were retained of staff who participated and any learning outcomes. Fire safety records identified that fire alarm systems were tested weekly and that fire-fighting equipment, emergency lighting and means of escape were checked monthly and were regularly maintained. Individual residents had a completed Personal Emergency Evacuation Plan (PEEPs) in place.

Seven completed questionnaires were returned to RQIA from residents, residents' representatives and staff. Respondents described their level of satisfaction with this aspect of care as very satisfied.

Areas for improvement

Two areas for improvement were identified. One recommendation was made in relation to a description of any restrictions used in Croft Lodge within the Residents Guide. One recommendation was made in relation to ensuring that all actions recommended in fire risk assessments are dated and signed when completed.

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

4.4 Is care effective?

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

A review of the care records of two residents confirmed that these were maintained in line with the legislation and standards. The Croft Community was in the process of changing to an electronic system of recording. Staff in Mayne House were able to demonstrate the new system. Croft Lodge was to move to the new system in the near future. The records included an up to date assessment of needs, life history, risk assessments, care plans and daily statement of health and well-being of the resident. Care needs assessment and risk assessments were reviewed and updated on a regular basis or as changes occurred.

The care records also reflected the multi-professional input into the residents' health and social care needs and were found to be updated regularly to reflect the changing needs of the individual residents. Residents and/or their representatives were encouraged and enabled to be involved in the assessment, care planning and review process, where appropriate. Care records reviewed were observed to be signed by the resident and/or their representative. Discussion with staff confirmed that a person centred approach underpinned practice.

Records were stored safely and securely in line with data protection.

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

Residents spoken with and observation of practice evidenced that staff were able to communicate effectively with residents, their representatives and other key stakeholders. Minutes of resident meetings were reviewed during the inspection.

A review of care records confirmed that referral to other healthcare professionals was timely and responsive to the needs of the residents.

Seven completed questionnaires were returned to RQIA from residents, residents' representatives and staff. Respondents described their level of satisfaction with this aspect of care as very satisfied.

A comment received from a resident's representative was as follows:

- "I was impressed with how everyone co-ordinated for (my relative's) recent surgery, from Croft staff to the (medical facility) and with family members."

Areas for improvement

No areas for improvement were identified during the inspection in relation to this domain.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

The person in charge confirmed that staff in the home promoted a culture and ethos that supported the values of dignity and respect, independence, rights, equality and diversity, choice and consent of residents.

A range of policies and procedures was in place which supported the delivery of compassionate care. Discussion with staff confirmed that residents' spiritual and cultural needs, including preferences for end of life care, were met within the home. Discussion with staff confirmed that action was taken to manage any pain and discomfort in a timely and appropriate manner

Residents were provided with information, in a format that they could understand, which enabled them to make informed decisions regarding their life, care and treatment.

Staff and residents confirmed that consent was sought in relation to care and treatment. Discussion with residents and staff along with observation of care practice and social interactions demonstrated that residents were treated with dignity and respect. Staff confirmed their awareness of promoting residents' rights, independence and dignity; staff were also able to demonstrate how residents' confidentiality was protected.

Staff confirmed that residents were listened to, valued and communicated with in an appropriate manner. Residents confirmed that their views and opinions were taken into account in all matters affecting them. Discussion with staff and observation of practice confirmed that residents' needs were recognised and responded to in a prompt and courteous manner by staff.

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. For example, there were residents' meetings and residents were encouraged to participate in annual care reviews.

Residents are consulted with, at least annually, about the quality of care and environment. The findings from the consultation were collated into a summary report which was made available for residents and other interested parties to read. An action plan was developed and implemented to address any issues identified.

Discussion with staff and residents, observation of practice 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.

A staff member spoken with during the inspection made the following comment:

- "I believe the care team here tries so hard to give the residents the kind of care that we ourselves would wish to have."

Seven completed questionnaires were returned to RQIA from residents, residents' representatives and staff. Respondents described their level of satisfaction with this aspect of care as very satisfied.

Areas for improvement

No areas for improvement were identified during the inspection in relation to this domain.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

The person in charge outlined the management arrangements and governance systems in place within the home. These were found to be in line with good practice. The 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 with RQIA.

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 as changes occurred.

There was a complaints policy and procedure in place which was in accordance with the legislation and Department of Health (DoH) guidance on complaints handling. Residents and/or their representatives were made aware of how to make a complaint by way of the Residents Guide which was also provided in an easy read version. Discussion with staff confirmed that they had received training on complaints management and were knowledgeable about how to receive and deal with complaints.

Review of the complaints records confirmed that arrangements were in place to effectively manage complaints from residents, their representatives or any other interested party. Records of complaints included details of any investigation undertaken, all communication with complainants, the outcome of the complaint and the complainant's level of satisfaction. Arrangements were in place to share information about complaints and compliments with staff.

There was an accident/incident/notifiable events policy and procedure in place which included reporting arrangements to RQIA. The management of accidents and incidents was reviewed in detail during the last care inspection and was not reviewed on this occasion.

Staff confirmed that there was a system to ensure medical device alerts, safety bulletins, serious adverse incident alerts and staffing alerts were appropriately reviewed and actioned. Staff were provided with mandatory training and additional training opportunities relevant to any specific needs of the residents, for example, in epilepsy awareness and the administration of emergency epilepsy medication.

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 to read.

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

The person in charge confirmed that the management and control of operations within the home was in accordance with the regulatory framework. Inspection of the premises confirmed that the RQIA certificate of registration and employer's liability insurance certificate were displayed.

Review of governance arrangements within the home and the evidence provided within the returned RQIA Quality Improvement Plan (QIP) confirmed that the registered provider responded to regulatory matters in a timely manner.

Review of records and discussion with staff confirmed that any adult safeguarding issues were managed appropriately and that reflective learning had taken place. The person in charge confirmed that there were effective working relationships with internal and external stakeholders.

The home had a whistleblowing policy and procedure in place and discussion with staff established that they were knowledgeable regarding this. Staff confirmed that they could access line management to raise concerns and that management was supportive of staff.

Discussion with staff confirmed that there were good working relationships within the home and that management were responsive to suggestions and/or concerns raised.

It was noted that a visitor's book was not present in either Mayne House or Croft Lodge. Accurate records of visitors entering and leaving the home is essential for reasons of fire safety and of general security; a requirement was made in this regard.

Seven completed questionnaires were returned to RQIA from residents, residents' representatives and staff. Respondents described their level of satisfaction with this aspect of care as very satisfied.

Areas for improvement

One area for improvement was identified. This was in relation to visitors books in Mayne House and Croft Lodge.

Number of requirements	1	**Number of recommendations**	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Alan Hutchinson, registered manager, 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/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to care.team@rqia.org.uk for assessment 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

Statutory requirements	
Requirement 1 **Ref**: 19 (2) Schedule 4, 22 **Stated:** First time **To be completed by:** 7 June 2017	The registered provider must ensure, for reasons of fire safety and of general security, that visitors' books are placed in both Mayne House and Croft Lodge to allow visitors to record when they enter or leave the buildings.
	Response by registered provider detailing the actions taken: From 18th May 2017 visitors books are located in the foyer of each house, staff are encouraging visitors (relatives, staff or Trust workers etc) to sign on each visit and state reason.
Recommendations	
Recommendation 1 **Ref**: Standard 20.9 **Stated:** First time **To be completed by:** 14 July 2017	The registered provider should ensure that any restrictions used in Croft Lodge are adequately described within the Residents Guide.
	Response by registered provider detailing the actions taken: The updated residents guide will include reference to keypad entry on internal doors and door alarms on specific bedroom doors. In relation to door alarms this will also be agreed through MDT meetings and reflected in individual care plans.
Recommendation 2 **Ref**: Standard 29.1 **Stated:** First time **To be completed by:** 14 July 2017	The registered provider should ensure that all actions recommended in fire risk assessments are dated and signed when completed.
	Response by registered provider detailing the actions taken: Fire risk assessments for both residential units have been reviewed and where work has been actioned and completed has been signed off by provider (Croft Lodge). Any remedial work to be completed by housing partnership in respect of Mayne House has been identified and will be signed off on completion.

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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