The Regulation and Quality Improvement Authority

Unannounced Care Inspection Report
17 July 2018

The Croft Community

Type of Service: Residential Care Home
Address: 71 Bloomfield Road, Bangor, BT20 4UR
Tel No: 028 9145 9784
Inspector: Alice McTavish

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a residential care home with 16 beds that provides care to adults who have a learning disability. The home has two units – Mayne House, which accommodates nine permanent residents and Croft Lodge which provides short term respite care to a maximum of seven residents. Day care is also provided in two separate buildings on the same site, The Barn and The Coffee Shop.

3.0 Service details

Organisation/Registered Provider: The Croft Community Ltd **Responsible Individual:** Clive Evans	**Registered Manager:** Alan Hutchinson
Person in charge at the time of inspection: Alan Hutchinson	**Date manager registered:** 14 October 2015
Categories of care: Residential Care (RC) LD - Learning Disability LD (E) – Learning disability – over 65 years	**Number of registered places:** 16 The home is also approved to provide care on a day basis only to 15 persons

4.0 Inspection summary

An unannounced care inspection took place on 17 July 2018 from 10.15 to 17.20.

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

The inspection assessed progress with any areas for improvement identified during and since 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.

Evidence of good practice was found in relation to staff recruitment, induction, training, supervision and appraisal, adult safeguarding, care records, audits and reviews, the culture and ethos of the home, governance arrangements, quality improvement and maintaining good working relationships.

Areas requiring improvement were identified. These related to policies and procedures, safety alert checks and annual attendance of staff at fire drills.

Residents said that they liked coming to the home for respite care.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and resident experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	3

Details of the Quality Improvement Plan (QIP) were discussed with Alan Hutchinson, Registered Manager, 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.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 21 November 2017.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records: the previous inspection report, the returned QIP, notifiable events and any written and verbal communication received since the previous care inspection.

During the inspection the inspector met with the registered manager, ten residents, two care staff, the responsible individual, the administrator and the finance manager. No visiting professionals and no residents' representatives were present.

A total of ten questionnaires were provided for distribution to residents and/or their representatives to enable them to share their views with RQIA. A poster was provided for staff detailing how they could complete an electronic questionnaire. No questionnaires were returned by residents, residents' representatives and staff within the agreed timescale.

During the inspection a sample of records was examined which included:

- Staff duty rota
- Induction programme for new staff
- Staff supervision and annual appraisal schedules
- Staff competency and capability assessments
- Staff training schedule
- One staff file
- Care files of four residents
- Minutes of staff meetings
- Complaints and compliments records
- Audits of accidents and incidents (including falls, outbreaks), NISCC registrations
- Equipment maintenance records
- Accident, incident, notifiable event records
- Evaluation report from annual quality assurance survey
- Reports of visits by the registered provider
- Legionella risk assessment
- 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

Areas for improvements identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 21 November 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 21 November 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 29.4 **Stated:** First time	The registered person shall ensure that staff complete fire safety training twice annually. **Action taken as confirmed during the inspection**: Discussion with the registered manager and inspection of staff training records confirmed that suitable arrangements were in place to ensure that staff complete fire safety training twice annually.	**Met**
Area for improvement 2 **Ref**: Standard 8.2 **Stated:** First time	The registered person shall ensure that all care records are fully and accurately recorded. **Action taken as confirmed during the inspection**: Discussion with the registered manager and inspection of care records confirmed that all care records were fully and accurately recorded.	**Met**

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager advised that the staffing levels for the home were subject to regular review to ensure the assessed needs of the residents were met. The registered manager advised that some temporary staff were used in the home and that agency staff had not been used within the past year; the use of temporary staff did not prevent residents from receiving continuity of care. Any turnover of staff was kept to minimum, where possible, and was monitored by the management of the home.

No concerns were raised regarding staffing levels during discussion with residents and staff; staff advised that the staffing levels in the home were very good and that there was stability in the staff team. A review of the duty rota confirmed that it accurately reflected the staff working within the home.

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 finance manager described how all new staff were provided with a corporate induction. The registered manager advised that the organisation’s structured induction programme had been replaced by the induction programme devised by the Northern Ireland Social Care Council (NISCC). This represents good practice.

Discussion with staff confirmed that mandatory training, supervision and annual appraisal of staff was regularly provided. Schedules of training, staff appraisals and supervision were reviewed during the inspection. The registered manager described how records of training, supervisions and appraisals were maintained electronically and how these areas were audited monthly by the responsible individual.

Discussion with the registered manager 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. The registered manager advised that the template used for the assessment had been revised to include a wider range of areas. Staff competency and capability assessments were reviewed and found to be satisfactory. The registered manager also advised that the assessments were reviewed with each relevant staff member on an annual basis. This represented good practice.

A review of the recruitment and selection policy and procedure confirmed that it complied with current legislation and best practice. Discussion with the registered manager and review of one staff file in detail, and of others on the administrator’s electronic record system, confirmed that staff were recruited in line with Regulation 21 (1) (b), Schedule 2 of The Residential Care Homes Regulations (Northern Ireland) 2005.

The administrator and the finance manager advised that AccessNI enhanced disclosures were undertaken for all staff prior to the commencement of employment. Staff files reviewed confirmed that AccessNI information was recorded and managed in line with best practice.

The registered manager advised that the registration status of staff with their professional body (where applicable) was managed by the home's administration team; this was because the organisation had introduced, as part of an incentive to retain staff, a scheme to pay for all care staff registrations with NISCC and the annual registration renewal fees. Care staff spoken with advised that they were registered with NISCC and that they appreciated the organisation's generosity in paying NISCC fees on their behalf. The registered manager described how all new staff, not previously registered with NISCC, were expected to begin the process of application to NISCC within one month of employment and to have the process completed within three months. The progress of such registrations was closely monitored through the system of governance within the organisation.

The adult safeguarding policy in place was reviewed during a previous care inspection and was consistent with the current regional policy and procedures. This 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. The role and function of the adult safeguarding champion (ASC) and the necessity to complete the annual ASC position report from 1 April 2018 to 31 March 2019 was discussed with the registered manager.

Staff were knowledgeable and had a good understanding of adult safeguarding principles and had an awareness of child protection issues. 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.

Discussion with the registered manager and a review of care records 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. Appropriate action plans, as agreed with the adult safeguarding team, were in place to address any identified safeguarding concerns.

The registered manager stated there were risk management procedures in place relating to the safety of individual residents and the home did not accommodate any individuals whose assessed needs could not be met. A review of care records identified that residents' care needs and risk assessments were obtained from the trust prior to admission.

The policy and procedure on restrictive practice/behaviours which challenge 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 advised there were restrictive practices within the home, notably the use of locked external doors with keypad entry systems and wheelchair lap belts, bed rails and sound/vision monitors and door alarms for some residents. A small number of respite care residents smoked, hence staff in the home managed the smoking materials of these residents.

In the care records examined the restrictions were appropriately assessed, documented, minimised and reviewed with the involvement of the multi-professional team, as required. A review of the home's current policy on smoking identified that this related only to staff who smoked. Action was required to ensure compliance with the standards in relation to a review of the home's policy on smoking to include current safety guidance for residents who smoke in care home settings. Advice was provided to the registered manager in relation to a

corresponding review of the description of restrictive practices within the home's statement of purpose, residents' guide and the policy on restrictive practice.

Systems were in place to make referrals to the multi-professional team in relation to behaviour management when required. Behaviour management plans were devised by specialist behaviour management teams from the trust and noted to be regularly updated and reviewed as necessary. The registered manager advised that it was the home's policy that individual restraint was not employed but was aware that should such a physical intervention be used, RQIA and appropriate persons/bodies must be informed.

There was an Infection Prevention and Control (IPC) policy and procedure in place which was in line with regional guidelines. This was reviewed during a previous care inspection and was not reviewed on this occasion as no changes had been made. Staff training records evidenced 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, alcohol hand gels and disposable towels wherever care was delivered. Personal Protective Equipment (PPE), e.g. disposable gloves and aprons, was available throughout the home. 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 registered manager 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. The registered manager advised that formal IPC compliance audits were not undertaken with action plans developed to address any deficits noted. Information was forwarded to the registered manager after the inspection in respect of relevant audit tools.

Audits of accidents/falls were undertaken on monthly basis and analysed for themes and trends; an action plan was developed to minimise the risk where possible. Referral was made to the trust falls team in line with best practice guidance. "The Falls Prevention Toolkit" was forwarded to the registered manager after the inspection.

A general inspection of the home was undertaken and the residents' bedrooms were found to be individualised 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. No malodours were detected in the home.

The registered manager advised that the home's policy, procedures and risk assessments relating to safe and healthy working practices were appropriately maintained and reviewed regularly e.g. Control of Substances Hazardous to Health (COSHH), fire safety etc.

The home had up to date Legionella risk assessments in place for Mayne House dated 19 September 2017, Croft lodge dated 23 February 2018 and for both The Barn and The Coffee Shop dated 7 August 2017. All recommendations had either been actioned or were being addressed.

The registered manager advised that equipment and medical devices in use in the home were well maintained and regularly serviced. The registered manager described the system in place to review and action those safety alerts sent to the organisation from external sources, for example, RQIA. There was no system, however, in place to regularly check the Northern Ireland Adverse Incident Centre (NIAIC) alerts on a weekly basis. Action was required to ensure compliance with the standards in relation to NIAIC checks and the maintenance of a weekly log of checks.

The registered manager and review of Lifting Operations and Lifting Equipment Regulations (LOLER) records confirmed that safety maintenance records were up to date.

The home had up to date fire risk assessments in place for Mayne House dated 26 February 2018, Croft Lodge dated 2 March 2018 and both The Barn and The Coffee Shop dated 7 August 2017. The recommendations arising from each of the fire risk assessments had been actioned.

A review of staff training records confirmed that staff completed fire safety training twice annually. A review of documentation identified that, whilst fire drills were completed on a regular basis with records which included the staff who participated and any learning outcomes, there was no robust system in place to demonstrate that each staff member attended a fire drill at least annually. Action was required to ensure compliance with the standards in this regard. Advice was provided to the responsible individual and the registered manager as to how this could be achieved, recorded and effectively audited.

Fire safety records identified that fire alarm systems were tested weekly and emergency lighting was checked monthly. All equipment and systems were regularly maintained. Individual residents had a completed Personal Emergency Evacuation Plan (PEEP) in place.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, supervision and appraisal, adult safeguarding and the home’s environment.

Areas for improvement

Three areas for improvement were identified during the inspection. These related to the home’s policy on smoking, weekly NIAIC alert checks and attendance of staff at fire drills at least annually.

	Regulations	Standards
Total number of areas for improvement	0	3

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome

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

Records were maintained electronically and in hard copy with plans in place to completely move to electronic recording in the near future. All records were stored safely and securely in line with General Data Protection Regulation (GDPR). A review of the care records of four residents confirmed that these were maintained in line with the legislation and standards. They 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 (e.g. bedrails, Speech and Language Therapy, epilepsy management, where appropriate) 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 they were familiar with person centred care and that a person centred approach underpinned practice. Staff were able to describe in detail how the needs, choices and preferences of individual residents were met within the home, for example, the permanent residents of Mayne House had a monthly residents meeting in which they chose which dishes should be added or removed from the proposed menu.

There are arrangements in place to refer residents to dieticians and speech and language therapists (SALT) as required. Guidance and recommendations provided by dieticians and SALT are reflected within the individual resident's care plans and associated risk assessments.

Discussion with staff confirmed that were able to recognise any pressure area damage to residents skin; referrals would be made in a timely manner to the multi-professional team to address any areas of concern identified.

The registered manager advised 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 accidents and incidents (including falls) were available for inspection and evidenced that any actions identified for improvement were incorporated into practice. Further evidence of audit was contained within the reports of the visits by the registered provider.

The registered manager advised 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 reported that they had received training in Makaton, a visual communication method using signs and symbols. Minutes of staff meetings were reviewed during the inspection.

Observation of practice evidenced that staff were able to communicate effectively with residents. Discussion with the registered manager and staff confirmed that management operated an open door policy in regard to communication within the home.

There were also systems in place to ensure openness and transparency of communication, for example, the organisation produced a quarterly staff newsletter to update staff about areas of interest within The Croft Community services.

A review of care records, along with accident and incident reports, confirmed that referral to other healthcare professionals was timely and responsive to the needs of the residents.

The registered manager reported that arrangements were in place, in line with the legislation, to support and advocate for residents.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to care records, audits and reviews, communication between residents, staff and other interested parties.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

A range of policies and procedures was in place which supported the delivery of compassionate care.

The registered manager advised 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.

The registered manager and staff advised that consent was sought in relation to care and treatment. Discussion and observation of care practice and social interactions demonstrated that residents were treated with dignity and respect. Staff described their awareness of promoting residents' rights, independence and dignity and demonstrated how confidentiality was protected, for example, knocking bedroom doors prior to entering and encouraging residents to discuss private matters with staff away from other residents.

Discussion with the registered manager confirmed that residents' spiritual and cultural needs, including preferences for end of life care, were met within the home. Action was taken to manage any pain and discomfort in a timely and appropriate manner. This was further

evidenced by the review of care records, for example, care plans were in place for the identification and management of pain or distressed reactions, where appropriate.

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. Care plans, menus, the activity programme and the staff on duty, for example, were written or displayed in a pictorial format and some policies were available in easy read versions.

Discussion with staff and residents and observation of practice confirmed that residents' needs were recognised and responded to in a prompt and courteous manner by staff; residents were listened to, valued and communicated with in an appropriate manner and their views and opinions were taken into account in all matters affecting them, for example, residents were encouraged and supported to actively participate in the annual reviews of their care. Other systems of communication included residents' meetings and visits by the registered provider.

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

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, for example, one resident's representative who lives abroad was enabled to actively contribute to the resident's annual care review by using Skype.

Residents spoken with during the inspection made the following comments:

- "I like it here. I come here for respite. They (staff) are very nice to me and they talk to me and make me laugh."
- "I like it here because the staff take me out to different places."
- "It's good here. I like living here…we have a good time. We are all going on holiday and I can't wait."

Areas of good practice

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.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

The registered manager outlined the management arrangements and governance systems in place within the home and advised that 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. The registered manager stated that 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 Resident's Guide and information on display in the home. The policy was also available in an easy read version. Discussion with staff confirmed that they were knowledgeable about how to respond to complaints. RQIA's complaint poster was available and displayed in the home.

A 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. The registered manager advised that since no complaints had been made since the last care inspection, an audit of complaints was not used currently used; should complaints be more frequently received, and audit would be used to identify trends, drive quality improvement and to enhance service provision.

The home retained compliments received, e.g. thank you letters and cards and there are systems in place to share these with staff.

There was an accident, incident and notifiable events policy and procedure in place, reviewed during a previous care inspection, which included reporting arrangements to RQIA. A review of these 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 was reviewed as part of the inspection process. The registered manager advised that learning from accidents and incidents was disseminated to all relevant parties and action plans developed to improve practice.

There was evidence of managerial staff being provided with additional training in governance and leadership, for example, one staff member was in the process of completing the Qualifications and Credits Framework (QCF) level 5 award.

The registered manager advised that there was a system to share learning from a range of sources including complaints, incidents, training; feedback was integrated into practice and contributed to continuous quality improvement.

Discussion with the registered manager confirmed that staff were provided with mandatory training and additional training opportunities relevant to any specific needs of the residents for example, bespoke training in the use of hoists for individual residents, Visual Impairment awareness, Epilepsy management.

A visit by the registered provider 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, RQIA and any other interested parties to read. An action plan was developed to address any issues identified which include timescales and person responsible for completing the action.

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. Discussion with the registered provider identified that he had understanding of his role and responsibilities under the legislation. The responsible individual was based on site and was kept informed regarding the day to day running of the home through frequent visits to the home, face to face and email communication with the registered manager and with staff.

The registered manager reported that the management and control of operations within the home was in accordance with the regulatory framework. The returned QIP confirmed that the responsible individual responded to regulatory matters in a timely manner. Inspection of the premises confirmed that the RQIA certificate of registration and employer's liability insurance certificate were displayed.

The home had a whistleblowing policy and procedure in place and discussion with staff confirmed that they were knowledgeable regarding this. The registered manager advised that staff could also access line management to raise concerns and that staff would be offered support.

Discussion with staff confirmed that there were good working relationships within the home and that management were responsive to suggestions and/or concerns raised. There were open and transparent methods of working and effective working relationships with internal and external stakeholders.

The responsible individual described how he had introduced a system of one to one meetings between himself and individual staff members on an ad hoc basis each month. This was designed to support closer engagement with staff and to remove the barriers between staff and senior management. This had been a useful exercise as staff spoke openly about their observations of the organisation and made suggestions as to how improvements could be made, for example, staff indicated that they preferred face to face training in some areas and that more training in specialist communication would be beneficial. Both suggestions were positively received and the training was arranged.

In addition to the organisation paying for staff to be registered with NISCC, The Croft Community also listened to staff and have introduced a health care plan for staff.

The inspector discussed arrangements in place in relation to the equality of opportunity for residents and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of residents.

Some equality data was collected on residents. The registered manager was advised to contact the Equality Commission for Northern Ireland for guidance on best practice in relation to collecting and managing this type of data in line with best practice.

Areas of good practice

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.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement 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 if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011	
Area for improvement 1 **Ref**: Standard 21.1 **Stated:** First time **To be completed by:** 31 October 2018	The registered person shall ensure that the home's policy on smoking is reviewed to include current safety guidance for residents who smoke in care home settings. Ref: 6.4
	Response by registered person detailing the actions taken: The registered manager will review and update current Policy to reflect RQIA guidance (June 2017) and ensure reference to this guidance is included in the relevant service user guides.
Area for improvement 2 **Ref**: Standard 28.1 **Stated:** First time **To be completed by:** 31 August 2018	The registered person shall ensure that a system is put in place for the Northern Ireland Adverse Incident Centre (NIAIC) alerts to be checked on a weekly basis with records of such checks maintained. Ref: 6.4
	Response by registered person detailing the actions taken: The registered manager or a designated person in the absence of the registered manager will access NIAIC website weekly, record this and forward any relevant information to staff teams.
Area for improvement 3 **Ref**: Standard 29.6 **Stated:** First time **To be completed by:** 31 August 2018	The registered person shall ensure that a robust system is put in place to demonstrate that each staff member attends a fire drill at least annually. Ref: 6.4
	Response by registered person detailing the actions taken: A new sytem of recording attendance / completion of fire drills will be implemented utilising the current training database which will be reviewed on a monthly basis by management and any training needs will be discussed with team leaders for immediate attention. We will also utilise face to face fire training sessions to do fire drill / evacuation simulations if required.

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