Unannounced Care Inspection Report
29 September 2020

The Croft Community

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

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.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards. August 2011.

1.0 What we look for

2.0 Profile of service

This is a residential care home which provides care for up to 16 residents. The home has two units, Mayne House, which accommodates up to nine permanent residents, and Croft Lodge, which accommodates short term respite care for up to seven residents. Day care is also provided for up to 15 persons.

3.0 Service details

Organisation/Registered Provider: The Croft Community Ltd **Responsible Individual(s):** Ms Linda May Wray	**Registered Manager and date registered:** Mr Alan Hutchinson 4 January 2016
Person in charge at the time of inspection: April Smyth Deputy manager	**Number of registered places:** 16
Categories of care: Residential Care (RC) RC-LD, RC-LD(E) LD – Learning disability. LD(E) – Learning disability – over 65 years.	**Number of residents accommodated in the residential home on the day of this inspection:** 13

4.0 Inspection summary

An unannounced care inspection took place on 29 September 2020 from 09.30 hours to 17.55 hours.

Due to the coronavirus (COVID-19) pandemic the Department of Health (DOH) directed RQIA to continue to respond to ongoing areas of risk identified in homes.

The following areas were examined during the inspection:

- staffing
- personal protective equipment (PPE)
- the environment
- care delivery
- care records
- governance and management arrangements.

Residents spoken with commented positively about living in the home.

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	*1	1

*The total number of areas for improvement includes one under the regulations which has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with April Smyth, 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.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report.

During the inspection the inspector met with 10 residents and seven staff. Questionnaires were also left in the home to obtain feedback from residents and residents' relatives. A poster was displayed for staff inviting them to provide feedback to RQIA on-line. The inspector provided staff with 'Tell us' cards which were then placed in a prominent position to allow residents and their relatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision. No completed questionnaires or responses to the staff survey were returned within the indicated timeframe.

The following records were examined during the inspection:

- duty rota from 21 September to 4 October 2020
- staff training records
- staff supervision schedule
- incident/accident reports
- monthly monitoring reports
- a sample of governance audits/records
- complaints/compliments records
- records confirming registration of staff with the Northern Ireland Social Care Council (NISCC)
- two staff recruitment files
- four residents' care records
- COVID-19 information file
- the home's statement of purpose
- recruitment policy
- RQIA registration certificate.

Areas for improvement 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

The most recent inspection of the home was an unannounced care inspection undertaken on 27 June 2019.

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 21 4 (b) (i) **Stated:** First time	The registered person shall ensure that Enhanced Access NI checks are made for all staff who change their roles within the organisation.	**Met**
	Action taken as confirmed during the inspection: No staff had changed their role within the organisation since the last inspection. However, review of the recruitment policy evidenced that this had been revised to state that staff changing their role within the organisation must have an Enhanced Access NI check completed.	
Area for improvement 2 **Ref:** Regulation 29 (4) **Stated:** First time	The registered person shall ensure that the visit by the registered provider covers Mayne House, Croft Lodge and the day services on each occasion.	**Not met**
	Action taken as confirmed during the inspection: Review of a selection of monthly monitoring reports completed evidenced that these did not cover all three services. See section 6.2.6 for more information.	

Area for improvement 3 **Ref:** Regulation 3 1 **Stated:** First time	The registered person shall ensure that a separate Statement of Purpose is developed for the residential care home.	**Met**
	Action taken as confirmed during the inspection: A separate Statement of Purpose had been developed for the residential care home and was available for review during the inspection.	

6.2 Inspection findings

6.2.1 Staffing

During the inspection we observed that residents' needs were met promptly by the number and skill mix of staff on duty. No concerns regarding staffing levels were raised by residents or staff during the inspection. Staff told us that teamwork was good and that the management team was supportive and approachable.

Review of two staff recruitment files confirmed that the necessary pre-employment checks were made prior to staff commencing work in the home. A supervision schedule was in place and staff confirmed that they received supervision. There was a system in place to ensure that staff were appropriately registered with NISCC.

Staff were knowledgeable about the needs of the residents in their care and obviously knew them well. Staff were seen to speak to residents kindly and with warmth; there was a pleasant and friendly atmosphere in the home. Staff spoken with commented positively about working in the home; comments included:

- "I love working here."
- "It's excellent here, best place I have worked."
- "The residents view us like their family, it's really important that we look after them well."
- "Taking time to ensure everyone is well presented and well looked after is the most important part of the day."
- "I absolutely love it here."
- "It's great the way the organisation continues to develop and change."

Staff confirmed they were provided with mandatory training which was mainly provided online at present due to the current COVID-19 restrictions.

6.2.2 Personal Protective Equipment (PPE)

We observed that staff in all units of the home used PPE according to the current regional guidance. Staff were observed to put on and take off their PPE correctly and to carry out hand hygiene at appropriate times.

There was a plentiful supply of PPE available; PPE stations were well stocked and signage providing useful information on PPE was placed in appropriate areas throughout the home. Staff told us that they had had sufficient supplies of PPE at all times.

Staff and residents had a twice daily temperature check; a record of this was maintained. On arrival at the home we also had a temperature check.

The manager confirmed that sufficient supplies of PPE were maintained, staff had received PPE awareness training and audits were completed regularly to monitor staff use of PPE.

6.2.3 The environment

We observed that the home was warm, clean, tidy and fresh smelling throughout. Residents' bedrooms were personalised and the home was tastefully decorated. Corridors and fire exits were clear of obstruction. Equipment was found to be maintained in a clean condition and to be stored appropriately in the home.

The manager told us that infection prevention and control (IPC) measures had been enhanced due to COVID-19; frequently touched points were cleaned at least three times daily and deep cleaning was carried out as necessary in addition to the normal cleaning schedule in the home.

Measures had been put in place to maintain social distancing for residents where possible. Seating in the lounges and dining rooms had been arranged in such a way as to allow adequate social distancing.

6.2.4 Care delivery

Residents in the home looked well cared for; they were observed to be well presented and settled in their surroundings. The atmosphere was relaxed; staff were seen to effectively communicate with residents and to offer them support as required.

We observed that staff offered the residents choice and took their preferences into account when providing care and assistance. Staff knowledgeably discussed individual resident's likes and dislikes, communication needs and the problems that staff wearing masks presented for residents with communication difficulties and how these were managed.

We found that residents who could speak to us were chatty and engaged. Residents who were not able to communicate were seen to be content in their surroundings. Residents spoke positively about life in the home, the staff and the food; they commented:

- "I love it here."
- "The staff take me out for a wee walk."
- "The food is good."
- "I had a baked potato with beans and cheese yesterday, it was lovely."
- "I get whatever I like to eat."
- "I like it here, it's okay."
- "The staff help me out whenever I need help."
- "I like coming here."
- "The staff are really good, they help me."

Staff spoke of the importance of maintaining effective communication with families. Due to limited visiting at present staff were helping residents to keep in touch with their relatives via alternative methods, such as Face Time and phone calls, they found that this was generally working well. When a resident goes home following respite staff send a written report to their family with an update on their stay.

Activities on offer were tailored to the needs and interests of the residents; staff assisted with these and ensured residents were offered a choice of what they would like to do. We observed that residents in the lounges were watching TV, knitting, reading or chatting to staff. The residents told us that they enjoyed country music, dancing, church services and coffee mornings; some residents were missing trips out and about but understood why they had to be very careful at present.

Respite services were running at a much reduced capacity as a result of COVID-19 restrictions. Discussion with staff evidenced that those residents coming in for respite had an understanding of the need for social distancing. A risk assessment and temperature check was completed prior to respite residents entering the home; however, a COVID-19 test was not routinely carried out before admission. We discussed this with the manager as the current guidance around admissions to care homes states that COVID-19 tests should be completed 48 hours prior to admission. The manager told us that direction in this area had been sought from the Public Health Agency (PHA) but agreed that the present respite pre-admission process did not reflect the current guidance on COVID-19 testing prior to admission. The manager assured us that she would immediately contact the PHA to discuss the matter and clarify the actions that should be taken prior to admission of respite residents.

Some residents and service users attended day care in The Barn or The Coffee Shop on site. This was also operating at a much reduced capacity in order to ensure social distancing guidelines could be followed. Arrangements had been put in place to ensure that service users from the community and the home's permanent residents attended separate sessions. Activities were planned with COVID-19 restrictions in mind; each resident or service user attending day care had been provided with a washable plastic box to keep their own individual items in, for example, arts and crafts supplies, games and jigsaws.

6.2.5 Care records

We reviewed the online care records for four residents and found that these contained relevant risk assessments and care plans to ensure that residents' daily needs were met. A daily, up to date, record of care provided was maintained. We could see that some residents had had recent care reviews completed with their keyworkers and families in attendance via Zoom.

The care records were person centred and informative. However, we observed that when a resident had suffered an accident such as a fall, this was recorded in the daily record but the relevant risk assessments and care plans were not consistently updated to reflect any changes and/or actions required. An area for improvement was made.

There was evidence, in the records reviewed, of referral to other healthcare professionals such as the occupational therapist (OT), dietician or speech and language therapist (SALT) where required.

6.2.6 Governance and management arrangements

Discussion with the manager evidenced that there was a system in place to manage complaints. We noted that one complaint record needed to be updated with an outcome; the manager assured us that the complaint had been successfully resolved and that the record would be updated to reflect this.

A record of compliments received was also recorded; comments included:

- “What a pleasure it has been visiting Croft.”
- “To show you our huge appreciation, admiration and thanks.”

Review of accidents and incident records confirmed that there was a system in place to ensure these were managed appropriately and reported to RQIA and any other relevant bodies in a timely manner.

There was a system in place to monitor staff compliance with mandatory training and to indicate what training was due.

The manager showed us the most recent service development plan for the home; this was reviewed on a monthly basis and included a comprehensive action plan.

We also reviewed the monthly monitoring reports completed in respect of the home. The reports were comprehensive, included the views of residents, relatives and staff and contained an action plan. However, the reports did not cover Mayne House, Croft Lodge and the day services on each occasion; this area for improvement had not been met and will be stated for a second time.

Review of audits carried out evidenced that systems were in place to monitor and evaluate the quality of care and other services provided in the home; action plans were developed as required.

Areas of good practice

Areas of good practice were identified in relation to staffing, teamwork, use of PPE, the environment, care provided, treating residents with respect and kindness, communication, supporting staff and management arrangements.

Areas for improvement

An additional area for improvement was identified in relation to updating risk assessments and care plans in the event of a fall or accident.

	Regulations	Standards
Total number of areas for improvement	0	1

6.3 Conclusion

Following the inspection the manager informed RQIA that advice had been sought from the PHA and that with immediate effect all respite admissions would be subject to a COVID-19 test prior to planned admission as per the current guidance. The manager had updated the relevant trust keyworkers with this information in order to facilitate the arranging of tests to ascertain the COVID-19 status of potential respite admissions to the home.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with April Smyth, 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 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 Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 29 (4) **Stated:** Second time **To be completed by:** 29 October 2020	The registered person shall ensure that the visit by the registered provider covers Mayne House, Croft Lodge and the day services on each occasion. Ref: 6.1 and 6.2 **Response by registered person detailing the actions taken:** The monthly monitoring visit has been amended to cover Mayne House, Croft lodge and Day services on every occasion. We are currently in negotiation with RQIA to register day services as separate service. If granted thereafter a separate Monthly Monitoring Visit (MMV) and report will be completed for each separate service on a monthly basis. MMV's will be carred out by our Head of Service who will submit these to our Responsible Individual for auditing and monitoring purposes.
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011	
Area for improvement 1 **Ref**: Standard 8.2 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that when a resident has an accident or a fall the relevant risk assessments and care plans are updated to reflect and changes and/or actions required. Ref: 6.2 **Response by registered person detailing the actions taken:** The registered person will ensure that when a resident has an accident or fall the relevant risk assessments and care plans are updated to reflect any changes required and / or actions to be carried out. The registered manager will review current Policy & Procedure to ensure that reviews of accident & incident reports include updating of care plans or risk assessments where appropriate and will reflect current reporting procedures for relevant H&SC Trusts. Registered Managers will follow up on these through support meetings with relevant staff teams to ensure compliance.

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

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