Unannounced Care Inspection Report
21 November 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

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 for adults who have a learning disability in 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, The Coffee House and The Barn.

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 21 November 2017 from 10:00 to 16:30.

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 induction, training, supervision and appraisal, adult safeguarding, the home's environment, audits and reviews, communication between residents, staff and other key stakeholders, the culture and ethos of the home, listening to and valuing residents, governance arrangements and quality improvement.

Areas requiring improvement were identified. These related to staff training and to care records.

Residents said that they liked living in the home or staying there for respite care and that staff were good to them.

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	2

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 11 May 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 and notifiable events received since the previous care inspection.

During the inspection the inspector met with three residents, three staff, the registered manager and the Chief Executive Officer of the Croft Community Ltd. No visiting professionals and no residents' representatives were present.

A total of 10 questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA. The registered manager was provided with details of how staff could submit questionnaires electronically. No questionnaires were returned within the requested timescale.

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 files of five residents
- The home's Residents' Guide
- Minutes of recent staff meetings
- Complaints and compliments records
- Audits of risk assessments, care plans, accidents and incidents
- Equipment maintenance records
- Accident/incident/notifiable events register
- Minutes of recent residents' meetings
- Evaluation report from annual service user quality assurance survey
- Monthly monitoring reports
- 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

Areas for improvements identified at the last care inspection were reviewed and assessment of compliance recorded as 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 25 July 2017

The most recent inspection of the home was an unannounced medicines management inspection. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 11 May 2017

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 19 (2) Schedule 4, 22 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Inspection of the premises confirmed that visitors' books were in place in both Mayne House and Croft Lodge to allow visitors to record when they enter or leave the buildings.	

Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011		Validation of compliance
Area for improvement 1 **Ref**: Standard 20.9 **Stated:** First time	The register provider should ensure that any restrictions used in Croft Lodge are adequately described within the Residents Guide.	**Met**
	Action taken as confirmed during the inspection: Inspection of the Residents Guide confirmed that any restrictions used in Croft Lodge were adequately described.	
Area for improvement 2 **Ref**: Standard 29.1 **Stated:** First time	The registered provider should ensure that all actions recommended in fire risk assessments are dated and signed when completed.	**Met**
	Action taken as confirmed during the inspection: Inspection of the fire risk assessments confirmed that all recommended actions were dated and signed when completed.	

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. 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.

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.

Discussion with staff 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. The registered manager advised that an improved system was to be introduced to ensure managerial oversight of supervision and appraisal for all staff. This will be inspected in detail at the next care inspection.

The registered manager advised 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 and found to be satisfactory. The registered manager advised that the assessment used was to be reviewed to take account of recent changes in adult safeguarding arrangements and in the method of notifying RQIA of accidents and incidents. This represented good practice.

The registered manager further advised that, due movement within the internal staff team, there were some staff who were now in the process of being trained to take responsibility of being in charge of the home in the absence of the manager; competency and capability assessments will be undertaken with all staff in these positions when training is completed. This area will be examined in more detail at the next care inspection.

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 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 registered manager advised that enhanced AccessNI disclosures were viewed by the registered manager for all staff prior to the commencement of employment. Staff personnel files were examined in detail during a previous care inspection and were not reviewed on this occasion.

The registered manager advised that arrangements were in place to monitor the registration status of staff with their professional body (where applicable). Staff confirmed that they were registered with the Northern Ireland Social Care Council (NISCC); it was also the organisation's policy that any member of staff whose registration lapsed, or who failed to pay annual registration fees, was not permitted to work in the home.

The adult safeguarding policy and procedure in place was examined during previous care 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. The registered manager advised that the home also had a policy in place in relation to child protection.

Discussion with staff confirmed that they were aware of the regional guidance (Adult Safeguarding Prevention and Protection in Partnership, July 2015) and the accompanying procedures 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 advised that no issues of adult safeguarding had arisen since that last care inspection. The registered manager remained aware that all suspected, alleged or actual incidents of abuse were to be fully and promptly referred to the relevant persons and agencies for investigation in accordance with procedures and legislation; written records were to be retained.

The registered manager advised 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 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 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 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 at night. For those residents who used wheelchairs, lap belts were used and for some residents, sound monitors were used at night. 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.

The registered manager advised there were risk management policy and procedures in place in relation to safety 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 these were appropriately maintained and reviewed regularly e.g. Control of Substances Hazardous to Health (COSHH), fire safety etc. The registered manager confirmed that equipment and medical devices in use in the home were well maintained and regularly serviced.

A review of the infection prevention and control (IPC) policy and procedure 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, alcohol hand gels 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 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.

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. Discussion with the registered manager confirmed that risk assessments and action plans were in place to reduce risk where possible.

The home had up to date fire risk assessments in place for all four the buildings and all recommendations were noted to be appropriately addressed.

Fire drills were completed regularly, the most recent being on 13 November 2017 for Mayne House. Records were retained of staff who participated and any learning outcomes. Fire safety records identified that, fire alarm systems, emergency lighting and means of escape were checked weekly and fire-fighting equipment was checked monthly. All systems and equipment was regularly maintained. Individual residents had a completed Personal Emergency Evacuation Plan (PEEPs) in place. A review of staff training records, however, identified that staff had not completed fire safety training twice annually. Action was required to ensure compliance with the standards in relation to the frequency of fire training for all staff.

Areas of good practice

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.

Areas for improvement

One area for improvement was identified during the inspection. This related to the frequency of fire training for all staff.

	Regulations	Standards
Total number of areas for improvement	0	1

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 stored safely and securely in line with data protection. A review of the care records of five 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. nutrition, epilepsy, behaviours, where appropriate) were reviewed and updated on a regular basis or as changes occurred.

If marks, bruises or other injuries were observed on residents, these were recorded on body maps and in the daily notes of residents. It was identified, however, that selected body maps were not signed by the staff member who noted the injury and that some were not dated and timed. Action was required to ensure compliance with the standards in relation to the full and accurate completion of care records.

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 the individual choices and preferences of residents and how these were met within the home.

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, accidents and incidents were available for inspection and evidenced that any actions identified for improvement were incorporated into practice. Further evidence of audit was contained within the monthly monitoring visits reports.

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. The registered manager and 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 residents' meetings were reviewed during the inspection.

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 confirmed 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 key stakeholders.

Areas for improvement

One area for improvement was identified during the inspection. This related to the full and accurate completion of care records.

	Regulations	Standards
Total number of areas for improvement	0	1

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.

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.

A range of policies and procedures was in place which supported the delivery of compassionate care. Discussion with staff and residents confirmed that residents' spiritual and cultural needs, including preferences for end of life care, could be met within the home. Discussion with residents and staff confirmed that action was taken to manage any anxiety or distress 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, for example, easy read information on the Human rights Act was available for residents.

The registered manager, residents and staff 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 describe how residents' confidentiality was protected.

The registered manager and staff advised 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 and 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. 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 which 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. There were also arrangements in place for residents to maintain links with their friends, families and wider community, for example, the home was equipped with Wi-Fi which was available for the use of residents enabling them to communicate with family members who lived or worked abroad.

Residents spoken with during the inspection made the following comments:

- "All is good here. I'm enjoying my room - I got new flooring and I really like it. I'm getting on well here."
- "There is always lots of staff around and they are good to me and they take me out to do the things that I want to do. I like coming to (Croft lodge). The staff know me well and what I

like doing. They make me my favourite meals and I meet lots of my friends. I have a good time here."

Staff spoken with during the inspection made the following comments:

- "The staff put a lot of effort into planning the stays for the short break users and putting together a wide and varied range of activities. We get to know service users well and provide a high level of person centred support."

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. 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 available in easy read version. Discussion with staff confirmed that they had completed training in the management of complaints and were knowledgeable about how to receive and deal with complaints.

The registered manager advised that no complaints had been received since the last care inspection. A review of 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, should complaints be made, an audit of complaints would be used to identify trends and to enhance service provision.

There was 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. The registered manager advised that a regular audit of accidents and incidents was undertaken. Learning from accidents and incidents was disseminated to all relevant parties and action plans developed to improve practice.

There were quality assurance systems in place to drive continuous quality improvement which included regular audits and satisfaction surveys. There was a system to ensure medical device alerts, safety bulletins, serious adverse incident alerts and staffing alerts were appropriately reviewed and actioned.

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, dementia, epilepsy management and the emergency management of seizures.

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. Discussion with the registered provider identified that they had understanding of their role and responsibilities under the legislation. The registered manager confirmed that the Chief Executive Officer was based on site and was kept informed regarding the day to day running of the home.

The registered manager confirmed that the management and control of operations within the home was in accordance with the regulatory framework. Inspection of the premises identified that the RQIA certificate of registration and employers' liability insurance certificate were displayed in only one of the buildings. The registered manager agreed to have these certificates displayed in each of the four buildings and later provided written confirmation of this.

A review of governance arrangements within the home and the evidence provided within the returned QIP confirmed that the registered provider responded to regulatory matters in a timely manner.

A review of records and discussion with the registered manager and staff 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 and discussion with staff established that they were knowledgeable regarding this. The registered manager confirmed that staff could also access line management to raise concerns and that management would offer support to 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.

The registered manager confirmed that there were arrangements in place for managing identified lack of competency and poor performance for all staff.

A member of staff spoken with during the inspection made the following comments:

- "There are good systems in place in the home and all staff know their roles. I find that management does not interfere unnecessarily but are there if they are needed – they are very responsive, supportive and visible. We get very good training and we are made aware of all the key policies and procedures like adult safeguarding, whistleblowing and complaints."

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, 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 29.4 **Stated:** First time **To be completed by:** 28 February 2018	The registered person shall ensure that staff complete fire safety training twice annually. Ref: 6.4
	Response by registered person detailing the actions taken: Management have amended current training records to reflect this requirement, this will be monitored through supervision with senior staff on an monthly basis.
Area for improvement 2 **Ref**: Standard 8.2 **Stated:** First time **To be completed by:** 29 December 2017	The registered person shall ensure that all care records are fully and accurately recorded. Ref: 6.5
	Response by registered person detailing the actions taken: Records referred to in the inspection report have been updated and signed by appropriate staff. File audits are being completed from date of inspection to ensure ongoing compliance.

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

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