The Regulation and Quality Improvement Authority

Announced Premises Inspection Report
10 January 2017

The Croft Community

Residential Care Home
71 Bloomfield Road, Bangor, BT20 4UR
Tel No: 028 9145 9784
Inspector: Colin Muldoon

1.0 Summary

An announced premises inspection of The Croft Community took place on 10 January 2017 from 10.30 to 14.15.

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

Is care safe?

On the day of the inspection the premises supported the delivery of safe care. However some issues were identified for attention by the registered provider. Refer to section 4.3.

Is care effective?

On the day of the inspection the premises supported the delivery of effective care.

Is care compassionate?

On the day of the inspection the premises supported the delivery of compassionate care.

Is the service well led?

On the day of the inspection the management of the premises was considered to be well led.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	8	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Alan Hutchinson (Registered Manager), as part of the inspection process. The timescales for completion commence from the date of inspection.

1.2 Actions/enforcement taken following the most recent premises inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the most recent premises inspection dated 21 May 2013.

2.0 Service Details

Registered organisation/registered provider: The Croft Community Ltd Mrs Yvonne McCaughren	**Registered manager:** Mr Alan Hutchinson
Person in charge of the home at the time of inspection: Mr Alan Hutchinson	**Date manager registered:** 04/01/2016
Categories of care: RC-LD, RC-LD(E)	**Number of registered places:** 16

3.0 Methods/processes

Prior to inspection the following records were analysed: Previous premises inspection report, statutory notifications over the past 12 months, duty call log.

During the inspection the inspector met with Alan Hutchinson (Registered Manager).

The following records were examined during the inspection: Copies of service records and in-house log books relating to the maintenance and upkeep of the building and engineering services, legionellae risk assessment, fire risk assessment.

4.0 The Inspection

The most recent inspection of The Croft Community residential care home was an unannounced care inspection on 22 November 2016. The completed QIP will be assessed by the specialist inspector and validated at their next inspection.

4.1 Review of requirements and recommendations from the last premises inspection dated 21 May 2013

Last premises inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref**: Regulation 27.-(2)(c) **Stated:** First time	Someone on the Gas Safe register should certify that all the gas cylinders, regulators and pipework (including kitchen) and the barbecue appliances are in a safe and satisfactory condition. **Action taken as confirmed during the inspection**: Since the last premises inspection the number of residential places has decreased from 32 to 16. The sixteen places are in the new Croft Lodge building and Mayne House.	**Met**

	The inspector was informed that there is no gas installation in Mayne House. Croft Lodge, which was opened in December 2015, has a gas cooker and heating boiler. The Gas Safe certification for Croft Lodge now requires to be renewed. Refer to section 4.3 item 1 and requirement 1 in Quality Improvement Plan.	
Requirement 2 **Ref**: Regulation 14.-(2)(c) **Stated:** First time	The reason for the temperature of the hot water at the calorifiers being lower than expected for the effective control of legionella should be investigated and rectified. The scheme of control in the legionella risk assessment should be revisited to ensure that all recommended actions are being implemented.	**Partially Met**
	Action taken as confirmed during the inspection: The response to the previous premises inspection Quality Improvement Plan confirms that the reason for the calorifier temperatures being low was identified and addressed. The registered residential places are now in the two modern buildings of Croft Lodge and Mayne House. A legionella risk assessment dated January 2016 for Croft Lodge was presented on the day of inspection. A legionella risk assessment dated 23 September 2015 for Mayne House was forwarded to the inspector on 11 January 2017. Refer also to section 4.3 item 2 and requirement 2 in Quality Improvement Plan.	
Requirement 3 **Ref**: Regulation 27.-(4)(a) **Stated:** First time	The fire risk assessments should be reviewed and include the social activity buildings. Reference should be made to NIHTM84.	**Partially Met**
	Action taken as confirmed during the inspection: A fire risk assessment for Croft Lodge was presented. It was dated 4 January 2017 and had been carried out by an accredited fire risk assessor. The current fire risk assessment for Mayne House was not available on the day of inspection but was forwarded to the inspector on 11 January 2017. It was dated April 2016 and had been carried out by an accredited fire risk assessor.	

	Refer also to section 4.3 item 3 and requirement 3 in Quality Improvement Plan.	
Requirement 4 **Ref**: Regulation 27.-(4)(d)(ii) **Stated:** First time	Plans should be made to link the fire detection and alarm installations in the social activity buildings to the main system. **Action taken as confirmed during the inspection**: Since the last premises inspection Croft Lodge has been built and two original buildings are no longer used for registered residential care. Refer to section 4.3 item 4 and requirement 4 in Quality Improvement Plan.	
Requirement 5 **Ref**: Regulation 27.-(4)(a) **Stated:** First time	The Mayne House emergency plan should be reviewed. The plan should be based on the fire risk assessment and set out, among other things: - Details of action to be taken by staff in case of fire; - The procedure to be followed in the evacuation of the premises in case of fire; - The arrangements for calling the Northern Ireland Fire and Rescue Service The advice of the fire safety advisor should be sought and the procedures in the plan should be in line with current good practice and take account of the findings and recommendations arising from the Rosepark Inquiry. **Action taken as confirmed during the inspection**: The current fire risk assessment notes that the fire procedures in Mayne House require review. The risk assessment action plan has not been marked up to confirm this has been carried out. Refer also to section 4.3 item 3 and requirement 3 in Quality Improvement Plan.	**Not Met**
Requirement 6 **Ref**: Regulation 27.-(4)(d)(iv) and (v) **Stated:** First time	It should be confirmed that the fire detection and alarm systems and the emergency lights in the social activity buildings are being tested and maintained. **Action taken as confirmed during the inspection**: There were records dated February 2016 relating to the test and servicing of the fire alarm and emergency lighting installations in the social activity buildings.	**Partially Met**

	Refer also to section 4.3 item 5 and requirement 4 in Quality Improvement Plan.	
Requirement 7 **Ref**: Regulation 27.-(4)(e) **Stated:** First time	The team leaders in each residential unit should be provided with professionally led fire safety training to at least fire warden level. It is recommended that the training incorporates the learning and recommendations arising from the Rosepark inquiry. The advice of a competent fire safety advisor should be sought. Reference should be made to NIHTM84.	**Met**
	Action taken as confirmed during the inspection: It is understood that fire training is carried out by a specialist contractor. The manager confirmed that staff fire training is up to date.	

4.2 Is care safe?

A range of documentation in relation to the maintenance and upkeep of the premises was presented for review during this premises inspection. This documentation included inspection and test reports for various elements of the engineering services and risk assessments. Documentation relating to the safe operation of the premises, installations and engineering services was presented for review during this premises inspection.
A range of fire protection measures are in place for the premises. This includes a fire detection and alarm system, emergency lighting, first aid fire-fighting equipment, structural fire separation and protection to the means of escape.

The standard used by the registered person to determine the overall level of fire safety within the premises takes account of the interaction between the physical fire precautions, the fire hazards, the number of service users, the management policies and the availability of adequately trained staff. This standard has been referenced in the fire risk assessment which was carried out by a risk assessor holding professional body registration for fire risk assessors. This supports the delivery of safe care.

A number of issues were however identified for attention during this premises inspection. These are detailed in the 'areas for improvement' section below.

Areas for improvement

1. Valid Gas safe certification should be obtained for the installations in Croft Lodge and any other gas installations.
   Refer to requirement 1 in Quality Improvement Plan.

2. On the day of inspection it could not be confirmed that there are schemes in place for the effective control of legionella.
   Refer to requirement 2 in Quality Improvement Plan.

3. The action plans arising from the fire risk assessments have not been marked up to confirm the status of the issues identified. It could not be confirmed that the social activity buildings were included in the fire risk assessments.
   Refer to requirement 3 in Quality Improvement Plan.

4. On the day of inspection there were no valid records relating to the maintenance of the fire alarm and emergency lighting installations in Croft Lodge and Mayne House.
   The advice of the fire risk assessor should be sought and followed regarding linking the fire alarm system in the social activity buildings to the current residential accommodation.
   Refer to requirement 4 in Quality Improvement Plan.

5. It should be confirmed that the fire safety installations in the social activity buildings are being function tested in accordance with good practice and that the servicing is up to date.
   Refer to requirement 4 in Quality Improvement Plan.

6. No records were presented relating to the maintenance of the thermostatic mixing valves.
   Refer to requirement 5 in Quality Improvement Plan.

7. A label on hoisting equipment indicates that it is subject to periodic checks. However, no records were presented relating to the LOLER (Lifting Operations and Lifting Equipment Regulations (NI) 1999) thorough examination of lifting equipment.
   Refer to requirement 6 in Quality Improvement Plan.

8. Documentation presented relating to fire installations in Croft Lodge indicate that function tests and checks can be irregular.
   Refer to requirement 4 in Quality Improvement Plan.

9. On the day of inspection the doors to the two living rooms in Croft Lodge were wedged open.
   Refer to requirement 4 in Quality Improvement Plan.

10. Whilst site records indicate that practice fire drills are being carried out there was no detail as to who took part, the outcome, learning points etc.
    Refer to recommendation 1 in Quality Improvement Plan.

11. On the day of inspection there was no documentation relating to the electrical installation in Mayne House or the social activity buildings.
    Refer to requirement 7 in Quality Improvement Plan.

12. During the walk round it was observed that the window restrictors in Mayne could be disengaged and that a tall drawer unit in Croft was not secured to the wall.
    Refer to recommendation 2 in Quality Improvement Plan.

13. In relation to safety alerts published by the Department of Health the inspector advised that a formal system should be established to regularly check for the issue of relevant alerts on the DoH Northern Ireland Adverse Incident Centre website.
    Refer to requirement 8 in Quality Improvement Plan.

14. It is recommended that a system be established to carry out and record regular function tests of the nurse call system.
    Refer to recommendation 3 in Quality Improvement Plan.

Number of requirements	8	Number of recommendations:	3

4.3 Is care effective?

There are arrangements in place for routine premises management and upkeep as well as timely breakdown/repair maintenance. Service users are involved where appropriate in decisions around the upkeep of the premises.
This supports the delivery of effective care.

Number of requirements	0	Number of recommendations:	0

4.4 Is care compassionate?

The areas of the premises reviewed during this premises inspection were well presented, comfortable, clean, free from malodours and adequately lit.
Service users are consulted about decisions around décor and the private accommodation where appropriate.

This supports the delivery of compassionate care.

Number of requirements	0	Number of recommendations:	0

4.5 Is the service well led?

Premises related policies and documentation are retained in a manner which is accessible to relevant people.

The registered person has dealt appropriately with previous RQIA QIP items and other relevant issues relating to the premises and has been adequately supported and resourced by the registered responsible person.

There are appropriate relationships with maintenance personnel, specialist contractors and other statutory regulators where appropriate.
This supports a well led service.

Number of requirements	0	Number of recommendations:	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Alan Hutchinson (Registered Manager) as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the residential care home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises, RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/manager meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Residential Care Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions taken by the Registered Provider

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

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

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Statutory requirements</td></tr>
<tr><td rowspan="2">Requirement 1

Ref: Regulation 27.-(2)(c) and (q)

Stated: First time

To be completed by:
10 February 2017</td><td>Valid and satisfactory Gas Safe certificates should be obtained for the installations in Croft Lodge and any other gas installations.</td></tr>
<tr><td>Response by registered provider detailing the actions taken:
Commissioning certificates and current gas safe certificates have now been sourced from contractors and will be retained on site. The CEO, Service Manager and Maintenance Officer have met with Choice Housing and raised the issues of information processing and dissemination to relevant parties.</td></tr>
<tr><td rowspan="2">Requirement 2

Ref: Regulation
13.-(7)
14.-(2)(c)

Stated: Second time

To be completed by:
10 February 2017 and ongoing</td><td>The legionella risk assessments for both Croft Lodge and Mayne House should be revisited. It should be ensured that schemes, based on the risk assessments and good practice, are put in place for the effective control of legionella and that any necessary remedial works are addressed.
Records should be kept of all actions taken in relation to the control of legionella.
Reference should be made to the document HSG274 Part 2 which supports the code of practice for the control of legionella.</td></tr>
<tr><td>Response by registered provider detailing the actions taken:
We recognise in conjunction with Choice Housing that we have a joint repsonsibility to ensure LRA's are completed and that all necessary remedial work is identified and completed by target dates. In relation to Croft Lodge monthly checks are carried out by maintenance officer and delegated tasks completed by care staff in the unit and recorded appropriately. These records are retained on site at all times.
Mayne House LRA's are completed by Choice Housing which we have requested and are now on site, we are actively working on a solution to the transfer of information from Choice Housing including what remedial work has been completed, what is outstanding and what work orders have been raised. Work undertaken by contractors is then reported back to Choice Housing, we are therefore reliant on them to forward this information to us, as stated above we are currently working towards resolving this issue, but as an interim we are have asked for all records of work completed against current LRA to be forwarded to us.</td></tr>
<tr><td>Requirement 3

Ref: Regulation 27.-(4)(a)

Stated: Second time</td><td>The action plans arising from the fire risk assessments should be marked up to confirm that the issues identified have been addressed.
Arrangements should be made to address any issues that remain outstanding.
It should be confirmed that the social activity buildings used by the residents were included in the fire risk assessments.</td></tr>
</table>

To be completed by: **10 February 2017**	**Response by registered provider detailing the actions taken:** Croft Lodge - All remedial action taken and completed following last FRA. Mayne House - FRA's are undertaken by Choice Housing contractors, we have requested and received the last 2 FRA's and following up any work completed and / or outstanding with the housing association. We can confirm that social activity buildings are included in FRA's , we have requested an up to date FRA for both Social activity buildings from our partner housing association
Requirement 4 **Ref**: Regulation 27.-(4)(d)(iv) and (v) **Stated:** Second time **To be completed by:** **10 February 2017**	It should be confirmed that the fire alarm and emergency lighting installations throughout are being maintained in accordance with good practice. Arrangements should be made which will ensure that function tests and checks of fire safety installations, such as the fire alarm, emergency lighting, and extinguishers, are carried out in accordance with good practice. Reference should be made to BS5839 (Fire alarm) and BS5266 (Emergency lighting) The advice of the fire risk assessor should be sought and followed regarding linking the fire alarm system in the social activity buildings to the current residential accommodation buildings. The practice of using wedges to hold open fire doors should be discontinued. If fire doors are required to stand open for operational reasons they should be held back with devices which reliably release the door on activation of the fire alarm. The advice of the fire risk assessor should be sought.
	Response by registered provider detailing the actions taken: Maintenance schedules are being adhered to, however evidence was not available on the day of inspection as these records are held by the partner housing association. Staff conduct weekly checks of fire alarm system and lighting, house / unit recording form to be amended to highlight specific call points / lighting. Linking the alarm system has been discussed at meeting with housing association and will be included in next FRA, work orders if appropriate will be raised against these recommendations. This practice has been stopped, staff advised this is a fire risk. An assessment will be completed to ascertain if and why doors need to be held open, outcome will determine further action required. Any door holding devices will be compliant with current regulations.
Requirement 5 **Ref**: Regulation 14.-(2)(a) and (c) **Stated:** First time	As part of the legionella controls and to help ensure the delivery of safe hot water the thermostatic mixing valves should be maintained in accordance with the Health and Safety Executive document HSG274 Part 2. Included in the servicing should be the cleaning of any associated filters and a check of the fail safe arrangement. It is recommended that the temperature of the hot water at all outlets

To be completed by: 10 February 2017 and ongoing	with TMV's is regularly monitored to ensure the thermostatic mixing valves are working effectively and that the temperature of the hot water is in line with the Health Guidance Note '*Safe' hot water and surface temperatures.*
	Response by registered provider detailing the actions taken: Mayne House - housing association have responsibility for testing, maintaining and any work identified during testing. This is normally completed by the contractor of choice every 4 - 6 weeks, currently HBE. Croft are working with Choice to ensure certificates, work orders etc are on site and available for inspection. Croft Lodge - Our maintenance officer completes these checks / tests and recorded and stored in the unit at least monthly. If work is required the MO will arrange for this to be done and will maintain records on site.
Requirement 6 **Ref**: Regulation 27.-(2)(c) **Stated:** First time **To be completed by: 10 February 2017**	It should be confirmed that there are reports on valid LOLER thorough examinations which verify that all lifting equipment is safe to use.
	Response by registered provider detailing the actions taken: Maintenance and service reports have been received from suppliers after date of inspection, and now held on site.
Requirement 7 **Ref**: Regulation 27.-(2)(q) **Stated:** First time **To be completed by: 10 February 2017**	In relation to all the buildings used by service users it should be confirmed that there are valid condition reports which verify that the electrical installations are in satisfactory condition.
	Response by registered provider detailing the actions taken: Croft maintenance officer has raised a work order for the buildings which are due for the 5 year electrical inspection. Currently waiting on date/s to be confirmed by housing association.
Requirement 8 **Ref**: Regulation 14.-(2)(a) and (c) **Stated:** First time **To be completed by: Ongoing**	A system should be established to regular check the NIAIC website for relevant safety alerts. Records should be maintained of the date of the check, the alerts found to be relevant and the action taken. Guidance is available on the RQIA website.
	Response by registered provider detailing the actions taken: The Service Manager will do monthly checks via the NIAIC / RQIA link and record same, any relevant alerts will be forwarded to appropriate houses and discussed at Senior meetings. CEO and Management Committee will also informed if appropriate.
Recommendations	
Recommendation 1	A record should be maintained of each practice fire drill and include

Ref: Standard 29 **Stated:** First time **To be completed by:** Ongoing	details of the circumstances of the event, who took part, points learned in relation to compliance with the fire procedure etc. The records should be used to monitor and manage the participation of all staff. The advice of the fire risk assessor should be sought.
	Response by registered provider detailing the actions taken: Current recording pro forma will be replaced to include more details of staff / service user participation, this will be discussed with the fire risk assessor at next FRA.
Recommendation 2 **Ref**: Standard 27 **Stated:** First time **To be completed by:** 10 February 2017	The window restrictors in Mayne should be reviewed using HSE guidance document HSIS5 and any necessary action taken. The security of all tall furniture should be reviewed and any necessary action taken.
	Response by registered provider detailing the actions taken: Having considered this risk, and the fact that all windows are at ground level and no-one has attempted to open windows beyond restrictors and service users have mobility limiting conditions the risk remains very low. This will be reviewed if new services users are accommodated or needs change. All tall furniture has been inspected in all houses and secured where appropriate.

Recommendation 3 **Ref**: Standard 27 **Stated:** First time **To be completed by:** Ongoing	A system should be established to carry out and record regular function tests of the nurse call system. **Response by registered provider detailing the actions taken:** This will be done by staff when doing their fire alarm system checks and recorded on the new pro forma, including which call point was initiated.

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

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