Inspection Report

7 & 8 December 2021

Camphill Community Glencraig

Type of Service: Residential Care Home
Address: 4 Seahill Road, Craigavad,
Holywood, BT18 0DB
Tel no: 028 9042 3396

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Camphill Community Glencraig **Responsible Individual** Dr Elizabeth Mitchell	**Registered Manager:** Mrs Ellen Majella McVeigh **Date registered:** 14 September 2021
Person in charge at the time of inspection: Mrs Ellen Majella McVeigh	**Number of registered places:** 55 The maximum number of residents to be accommodated within individual houses is as follows: Bethany (7), Craigowen (7), Comgall (3), Dell O'Grace (4), Emmaus House (7), Hermitage (3), Kintyre (7), Novalis (6), Parsifal (2), Pestalozzi (1), Samaria (4), Ceridwen (1), Columbanus (3). RQIA should be notified in advance of any changes in the occupancy of Columbanus House (3) and Ceridwen (1).
Categories of care: Residential Care Home (RC) LD – Learning disability. LD(E) – Learning disability – over 65 years.	**Number of residents accommodated in the home on the day of this inspection:** 47
Brief description of the accommodation/how the service operates: This home is a registered Residential Care Home which provides health and social care for up to 55 residents, many of whom have complex learning disabilities and may present with behaviours which challenge. The residential home is made up of 13 houses of various size and occupancy across a large site. The home is managed by a board of Trustees from Camphill Community and beds are commissioned by a number of trusts on a regional basis.	

2.0 Inspection summary

An unannounced inspection took place on 7 December 2021, from 10.10am to 5.10pm and on 8 December 2021, from 10.35am to 5.20pm by two care inspectors.

The inspection assessed progress with all areas for improvement identified in the home since the last care and estates inspections and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

We found that there was effective and compassionate care delivered in the home. Staff promoted the dignity and well-being of residents and it was evident that staff were knowledgeable about resident's individual needs, wishes and preferences.

Residents were relaxed and comfortable in their surroundings and in their interactions with staff.

Areas requiring improvement were identified in relation to staff training, staffing arrangements, the maintenance and management of the home's environment, infection prevention and control, and management and governance systems. Addressing the areas for improvement will further enhance the quality of care and services in Camphill Community Glencraig.

The findings of this report will provide the management team with the necessary information to improve staff practice and the residents' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

In preparation for this inspection, a range of information about the service was reviewed to help us plan the inspection.

Throughout the inspection RQIA will seek to speak with residents, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires and 'Tell Us' cards were provided to give residents and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with the management team at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection, the inspectors met with 17 residents and 23 staff.

Residents said that staff were nice and that they liked how they spend their days, such as going to the training college, going for a walk, pottery classes, or doing arts and crafts. Several

residents talked excitedly about their plans for Christmas, and were enjoying shopping for and wrapping Christmas presents.

Residents who were unable to express their opinions verbally looked relaxed and indicated through non-verbal cues that they were comfortable, such as smiling, waving, nodding or 'thumbs up' gestures.

Staff were positive about the lived experience of residents in the home, describing a loving, homely and family style atmosphere, where residents were provided with respect, dignity and choice. It was clear from speaking with staff that they knew the residents well. Staff did highlight that working in the home could be challenging and pressured at times. Feedback on staffing levels was mixed and is discussed in more detail in section 5.2.1.

No additional feedback was received from residents or their relatives following the inspection.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last care inspection on 13 and 14 August 2020 and the last estates inspection on 7 January 2021		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 15 (2) **Stated:** Second time	The registered person shall make arrangements for residents unnecessary risks to the health, welfare or safety of residents are identified and so far as possible eliminated; and (2) The registered person shall ensure that the assessment of the resident's needs is – (a) kept under review; and (b) revised at any time when it is necessary to do so having regard to any change of circumstances and in any case not less than annually. Some reviews for the residents had not taken place on time. The home should ensure that if a trust does not undertake the review this should be recorded in the file.	**Met**
	Action taken as confirmed during the inspection:	

	There was evidence that this area for improvement was met.	

Area for improvement 2 **Ref:** Regulation 27(1)(b) **Stated:** Second time	The registered person shall having regard to the size of the home and the number and needs of residents provide (b) the premises to be used as the home are of sound construction and kept in a good state of repair externally and internally Specifically but no solely - • Nouvalis garden requires some attention by grounds maintenance staff • Bethany floor, wall and ceiling finishes are deteriorating and would benefit from a building condition survey and subsequent refurbishment works project • Ceridwen accommodation finishes, fixtures and fittings are robust and assessed to meet the needs of the service user	**Met**
	Action taken as confirmed during the inspection: There was evidence that, as written, there had been adequate improvements made in Nouvalis, Bethany and Ceridwen, to meet this area for improvement.	
Area for improvement 3 **Ref:** Regulation 20 (1) (c) (i) **Stated:** First time	The registered person shall ensure that all mandatory staff training is kept up to date. This is in reference, but not limited, to fire training which is to be provided twice annually.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met following additional information provided by the manager following the inspection.	

Area for improvement 4 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall review the management of thickening agents and nutritional supplements to ensure that: • records of staff training are available	**Not met**

	• up to date speech and language recommendations and care plans which detail the recommended consistency level are available • records of administration are maintained	
	Action taken as confirmed during the inspection: There was evidence that this area for improvement had not been fully addressed or that improvements had been sustained. Inconsistencies were identified within some care records, and a small number of staff used incorrect terminology in relation to IDDSI (International Dysphagia Diet Standardisation Initiative). This area for improvement is therefore not met and is stated for a second time.	
Area for improvement 5 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall review the medication administration process to identify the reasons why medication doses may be omitted. A copy of the investigation and resultant action plan should be forwarded to RQIA.	**Met**
	Action taken as confirmed during the inspection: The investigation and action plan report was submitted to RQIA on 23 October 2020.	
Area for improvement 6 **Ref**: Regulation 30 (1)(d) **Stated:** First time	The registered person shall ensure that any estates issues which may adversely affect the care, health, safety or welfare of any resident, should be notified to RQIA through the web portal without delay.	**Not met**
	Action taken as confirmed during the inspection: One lift was not working, preventing one resident from freely moving around their home. Some AGA cookers had stopped working requiring evening meals to be prepared with a smaller table top cooker. While RQIA were assured that the home had taken steps to minimise the impact on residents, these incidents had not been notified to RQIA. Therefore this area for improvement was not met and is stated for a second time.	

Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2021		
Area for improvement 1 **Ref**: Standard 6.4 **Stated:** Second time	The registered person shall ensure that the resident or their representative is given written notice of all changes to the agreement and these are agreed in writing by the resident or their representative. Where the resident or their representative is unable to sign or chooses not to sign, this is recorded.	**Carried forward to the next care inspection**
	Action taken as confirmed during the inspection: Discussion with the manager and review of care records established that written notices of changes had been posted to residents' representatives, however signed copies had yet to be returned. It was therefore agreed that this area would be carried forward to the next inspection.	
Area for improvement 2 **Ref**: Standard 8.5 **Stated:** First time	The registered person shall ensure that all records of care are appropriately signed and dated.	**Met**
	Action taken as confirmed during the inspection: There was evidence that sufficient improvements had been made to address this area for improvement.	
Area for improvement 3 **Ref**: Standard 31 **Stated:** First time	The registered person shall ensure that: • entries on the personal medication records are verified and signed by two trained members of staff • obsolete personal medication records are cancelled and archived	**Carried forward to the next medicines management inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.	
Area for improvement 4 **Ref**: Standard 30 **Stated:** First time	The registered person shall ensure that written authorisation from the prescriber is available when medicines are administered outside the terms of their product licence.	**Carried forward to the next medicines management inspection**

	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence that a robust system was in place to ensure staff were recruited correctly to protect residents.

There were systems in place to ensure staff were trained and supported to do their job. Initial review of governance records during the inspection identified that some staff had not completed their required mandatory training. Following the inspection, the manager provided RQIA with written assurances that mandatory training requirements had been met, and that management maintained robust oversight of this. Deficits were identified however, in relation to home's care quality staff training which included communication, management of complex behaviours, autism awareness and epilepsy awareness. An area for improvement was identified.

Staff told us that the residents' needs and wishes were very important to them. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner. Staff said there was good team work within individual homes and that they felt well supported by members of the management team.

The staff duty rota accurately reflected the staff working in the home on a daily basis, and an on call management duty rota was in place.

Care delivery was observed to be prompt, timely and compassionate during the inspection. There was enough staff in the majority of the home to provide residents with a choice on how they wished to spend their day. For example, many residents enjoyed attending the college on site, but had the option of staying at home or returning home early if they preferred. It was established that one home was not adequately staffed to provide supervision, support or flexibility to all residents in the home. This was highlighted to the manager for urgent action and adequate arrangements were in place at the conclusion of the inspection.

Feedback on staffing levels was mixed. Some staff were very positive about current staffing levels in the home, including ongoing recruitment of additional bank staff. However; some staff raised concerns regarding staffing arrangements to maintain individual 1-1 supervision of residents. Staff highlighted the range of duties to be completed in the home, including cleaning, cooking and laundry, which they felt reduced or prevented them from fulfilling their caring duties to a high standard. A number of homes did not have a member of staff awake during the night shift.

Staffing arrangements were discussed with the management team during and after the inspection. It was acknowledged that there are occasions, such as short notice staff sick leave, where temporary short staffing cannot be avoided. The management team also highlighted that

several residents are awaiting a formal reassessment of their needs and dependencies, which may require funding for additional staff. The manager also agreed to consider reviewing ancillary staff requirements. However; it remains the responsibility of the service to ensure minimum staffing requirements are in place, in line with the home's registration as a residential service. This includes adequate night time 'wake in' staff in each of the individual houses to ensure the potential needs of residents can be met in a timely manner. An area for improvement was identified.

5.2.2 Care Delivery and Record Keeping

Staff were knowledgeable of individual residents' needs, their daily routine wishes and preferences. Staff reported there was good communication and handover within individual houses.

Staff were observed to be prompt in recognising residents' needs and any early signs of distress or illness, including those residents who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with residents; they were respectful, understanding and sensitive to residents' needs, and able to comfort, reassure and redirect residents if they became agitated or distressed.

It was observed that staff respected residents' privacy by their actions such as knocking on doors before entering, discussing residents' care in a confidential manner, and by offering personal care to residents discreetly.

Examination of records and discussion with staff confirmed that the risk of falling and falls were well managed. There was evidence of appropriate onward referral as a result of the post falls review. For example, residents were referred to the Trust's Specialist Falls Service, their GP, or for physiotherapy.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Residents may need a range of support with meals; this may include simple encouragement through to full assistance from staff. There was evidence that residents' needs in relation to nutrition and the dining experience were being met. Residents' weights were checked at least monthly to monitor weight loss or gain. If required, records were kept of what residents had to eat and drink daily; however, some of these records contained inconsistent information and a small number of staff used incorrect dysphagia terminology. As discussed in section 5.1, an area for improvement identified at the last care inspection regarding the management of thickening agents and nutritional supplements was therefore not met and is stated for a second time.

Residents' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet residents' needs; and included any advice or recommendations made by other healthcare professionals. Residents care records were held confidentially.

Care records were adequately maintained and reviewed to ensure they continued to meet the residents' needs. Residents, where possible, were involved in planning their own care and the details of care plans were shared with residents' relatives, if this was appropriate.

Residents' individual likes and preferences were reflected throughout the records. Care plans were detailed and contained specific information on each residents' care needs and what or who was important to them.

Daily records were kept of how each resident spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

Each resident had an annual review of their care, arranged by their care manager or Trust representative. This review should include the resident, the home staff and the resident's next of kin, if appropriate. A record of the meeting, including any actions required, was provided to the home. There were separate review arrangements for any resident whose placement was not arranged through a Health and Social Care Trust.

5.2.3 Management of the Environment and Infection Prevention and Control

Observation of the home's environment evidenced that, overall, the home was clean, tidy and had 'homely' touches such as being decorated for Christmas, magazines, snacks and drinks available, and art work undertaken by residents on display.

Residents' bedrooms were furnished depending on the resident's needs and preferences, and personalised with items important to the resident. Bedrooms and communal areas were furnished and comfortable. Residents could choose where to sit or where to take their meals and staff were observed supporting residents to make these choices.

Several deficits were identified in relation to the management of the home's environment, specifically in Bethany, Emmaus, Columbanus, Novalis, Dell O'Grace, Samaria, Craigowen and Kintryre. This included signs of wear and tear in fixtures and fittings, such as radiators, windows, soft furnishings, curtains, blinds and doors. Flooring and carpets in each individual home were showing signs of wear and tear. Ceiling and window repairs were required in Columbanus and Bethany. Discussion with the management team provided a level of assurance about how these issues would be addressed. It was also acknowledged that some works were delayed due to the ongoing impact of the Covid-19 pandemic. The inspection findings have been shared with the RQIA estates inspector and an area for improvement identified.

Discussion with staff and review of governance records confirmed that fire training had been arranged and was due to be completed with all staff by the end of December 2021. The fire exit in one home was partially obstructed with clutter. This was highlighted to the manager for immediate action and was rectified by the conclusion of the inspection. It was established that one bedroom fire door was routinely wedged open, at the request of a resident. This practice is to cease immediately and the home's management agreed to review the fire door closures/mechanisms as a matter of urgency. An area for improvement was identified.

Additional areas for improvement were identified in relation to improving the management of COSHH (Control of Substances Hazardous to Health) and infection prevention and control (IPC) measures. Thickening fluid, toiletries, and one medicine cupboard were inadequately secured and accessible to residents. Inadequate storage of continence pads, towels and wipes in communal bathrooms created a potential risk of cross contamination. Written information on display was not laminated and therefore could not be effectively cleaned. Review of records and discussion with staff confirmed that training on IPC measures and the use of PPE had been

provided, however; several staff were observed wearing fluid resistant surgical masks incorrectly. Staff were observed to carry out hand hygiene at appropriate times. However; some staff were not 'bare below the elbow' wearing long sleeve tops, painted and long nails and jewellery such as watches. Two areas for improvement were identified.

There was evidence that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. For example, the home participated in the regional testing arrangements for staff and any outbreak of infection was reported to the Public Health Authority (PHA). The manager was also overseeing arrangements for COVID-19 vaccine boosters for staff and residents.

Visiting arrangements were risk assessed and were in place with positive benefits to the physical and mental wellbeing of residents.

5.2.4 Quality of Life for Residents

There was a calm and homely atmosphere throughout the home during the inspection.

Residents looked well cared for; they were well groomed and nicely dressed. It was obvious that staff knew the residents well; residents interacted easily with staff, seeking support as required. Staff were attentive and spoke to residents in a kind and friendly way.

Observation of practice and discussion with staff confirmed that residents were able to choose how they spent their day. It was observed that staff offered choices to residents throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time. Staff facilitated both group and individual activities, depending on resident's needs or interests on the day. Several staff expressed how rewarding they found it working in the home, due to the culture and ethos of the service of supporting residents to live a full and meaningful life with as much independence as possible.

There was a range of activities provided for residents by staff in the home. Residents and their relatives had helped plan their activity programme. The range of activities included social, community, cultural, religious, spiritual and creative events. Staff discussed the impact of the ongoing pandemic, but expressed pride at how flexible and creative they had been to ensure that resident's social, emotional and therapeutic needs were still met through the activities provision in the home. Many staff highlighted the benefit of the large site the home was located on, providing ample space and opportunity for outdoor activities, including gardening, walks, horse riding and barbeques in the warmer weather.

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the COVID-19 pandemic. Visiting arrangements were in place with positive benefits to the physical and mental wellbeing of residents.

5.2.5 Management and Governance Arrangements

There has been a change in the management of the home since the last inspection. Mrs Ellen McVeigh has been the manager in this home since 28 June 2021. The manager is supported

by a governance lead, two deputy managers, and individual houses have team leaders, who act as the person in charge at each shift.

Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about residents, care practices or the environment.

There was a system in place to manage complaints.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The manager was identified as the appointed safeguarding champion for the home. It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults.

It was established that the manager had a system in place to monitor accidents and incident that happened in the home. Accidents and incidents were notified, if required, to residents' next of kin, their care manager and to RQIA.

The home was visited each month by a representative of the registered provider to consult with residents, their relatives and staff and to examine all areas of the running of the home. These visits reflected a sample of the home, with visits to one or two individual houses completed on a rotational basis. There was limited evidence that feedback from care and support staff, and from residents' relatives, was consistently sought or included in monthly visits. An area for improvement was identified.

Some improvements had been made to governance and management systems such as audits of accidents and incidents, staff training and care planning. There had also been an increase and improvement in communication between individual houses and management, including daily management handovers, weekly briefing meetings and staff meetings where issues and concerns could be raised. The manager outlined the current audit processes in the home; however, there was limited evidence that completed audits included adequate analysis and action plans, to address deficits and drive improvement in the home. Management conducted on-site visits to individual houses; however these visits are conducted on an 'ad hoc' basis and written records of these visits were not maintained. Regulation 29 monitoring reports contained action plans for improvement but there was no adequate follow up system to ensure that the actions were being reviewed and addressed. Given the areas for improvement identified during this inspection, RQIA were therefore not assured that the current governance and management oversight systems in place were sufficiently robust. An area for improvement was identified.

Following the inspection, the manager provided additional information on systems which had been reviewed and implemented to increase and improve direct management oversight in individual homes.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with **The Residential Care Homes Regulations (Northern Ireland) 2005 and/or the Residential Care Homes Minimum Standards (August 2021)**

	Regulations	Standards
Total number of Areas for Improvement	5*	8*

*The total number of areas for improvement includes two regulations that have been stated for a second time. One standard has been carried forward to the next care inspection. Two areas for improvement against the standards are carried forward to the next medicines management inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ellen McVeigh, manager and the management team as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** Second time **To be completed by:** 8 March 2022	The registered person shall review the management of thickening agents and nutritional supplements to ensure that: • records of staff training are available • up to date speech and language recommendations and care plans which detail the recommended consistency level are available • records of administration are maintained Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: There is currently one resident in the community assessed for thickening agents. The house has been provided with up to date IDDSI guidance. All staff are required to read, sign and be familiar with the terminolgy. The IDDSI chart is displayed in an area where the thickening agent is prepared and laminated to ensure it complies with IPC requirements. All staff are required to read and sign the SALT assessment and be familiar with the current level required for food and drinks. Formal training arranged for 11.2.22 to ensure staff are competent in dysphagia management.
Area for improvement 2 **Ref:** Regulation 30 (1) (d) **Stated:** Second time **To be completed by:** From the date of inspection	The registered person shall ensure that any estates issues which may adversely affect the care, health, safety or welfare of any resident, should be notified to RQIA through the web portal without delay. Ref: 5.1
	Response by registered person detailing the actions taken: All relevant estates issues will be reported through the designated portal in a timely manner.
Area for improvement 3 **Ref:** Regulation 20 (1) **Stated:** First time **To be completed by:** From the date of	The registered person shall, having regard to the size of the residential care home, statement of purpose and the number and needs of residents – (a) ensure that at all times suitably qualified, competent and experienced persons are working at the home in such numbers as are appropriate for the health and welfare of residents. This includes ensuring the presence of wake in staff at night.

inspection	Ref: 5.2.1
	Response by registered person detailing the actions taken: This period of time has been a challenging one for the care sector and it cannot go unmentioned the impact of COVID 19 on staffing, recruitment and retention. We endeavour to ensure at all times suitably qualified staff are available to meet the needs of the residents. Where there have been shortfalls we have enlisted block booked agency staff to provide consistency and continuity. This area of improvement for wake in night staff had never been raised in any prior inspection. Houses have always been staffed day and night based on the MDT assessed needs of the residents. We had five houses in the community which did not have wake in night staff. However we have embraced this area of improvement and can report three of these houses now have wake in staff and the remaining two have planned start dates for week commencing 14th February.
Area for improvement 4 **Ref:** Regulation 27(1)(b) & E13 **Stated:** First time **To be completed by:** 8 March 2022	The registered person shall ensure that a comprehensive refurbishment plan is developed, detailing specific and realistic timescales as to how the home will be kept in a good state of repair externally and internally. Floor coverings, wall finishes and soft furnishings should be reviewed and made good to ensure they remain suitable for the purpose of each room and meet health and safety and infection control requirements. Ref: 5.2.3
	Response by registered person detailing the actions taken: The facilities team are conducting an audit of all outstanding repairs to fittings and fixtures working alongside the housing associations. From this a detailed plan will be in place to address outstanding issues. Three houses have been identifed for installation of new kitchens. Two houses for new bathrooms. Three houses identified for sanding floors. It is anticipated this work will be completed by end of March. In addition each house has identified soft furnishings and have purchased and replaced tired materials. Weekly auditing and reporting procedures will support a timely response to each area. In addition monthly governance meetings of all facility issues will ensure repairs are timelined.

Area for improvement 5 **Ref:** Regulation 29 (4) (a) **Stated:** First time **To be completed by:** From the date of inspection and ongoing	The person carrying out the monthly Regulation 29 visit shall interview, with their consent and in private, such of the residents and their representatives and persons working at the home as appears necessary in order to form an opinion of the standard of provided in the home. Ref: 5.2.5
	Response by registered person detailing the actions taken: This area of improvement has been shared and discussed with the regulation 29 visitor who confirmed that as part of the visit relatives, carers and where appropriate residents comments are sought. The visitor will explore an improved means of evidencing this in the reports.
Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2021)	
Area for improvement 1 **Ref:** Standard 23.4 **Stated:** First time **To be completed by:** 8 March 2022	The registered person shall ensure that arrangements are in place for staff to complete the home's care quality staff training, in line with their roles and responsibilities. This includes, but is not limited to, training in relation to communication, management of complex behaviours, autism awareness and epilepsy awareness. Ref: 5.2.1
	Response by registered person detailing the actions taken: Every staff member completes their online training through Evolve which covers all mandatory requirements within the first six months of employment. All staff complete refreshers and full training in line with regulations. Managment of complex behaviours is explored with all staff completing foundation MAPA and PBS. Some staff complete advanced and emergency MAPA and some Group leaders have completed PBS coach training. Epilepsy specialist nurse provides training in Epilepsy awareness and Midazolam administration and Autism training is completed inhouse as required. Training is monitored from supervisioy position by group leader and manager. A monthly governance report is completed and shared with each area.
Area for improvement 2 **Ref:** Standard 29 **Stated:** First time	Corridors and fire exits must remain free from obstruction and the practice of wedging open fire doors must cease immediately. Ref: 5.2.3

To be completed by: From the date of inspection	**Response by registered person detailing the actions taken:** This was actioned immediately and highlighted at adult weekly meeting with all houses. All fire door closures are being reviewed by facilities team, and magnetic door holders have been installed in relevant areas and will be connected by week commencing 7th February and commissioned by 11th.
Area for improvement 3 **Ref:** Standard 28.3 **Stated:** First time **To be completed by:** From the date of inspection	The registered person promotes safe and healthy working practices through the provision of information, training, supervision and monitoring of staff in Infection Prevention and Control measures and Control of Substances Hazardous to Health (COSHH). Ref: 5.2.3
	Response by registered person detailing the actions taken: Safe and healthy working is promoted in the homes in Glencraig. The houses are designed to be homely and residents encouraged to explore and add to their enviroment. The balance between safety and homely enviroment is discussed with all staff. Training is provided regarding management of COSHH materials, IPC measures,including the use of PPE, sanitisation, deep cleans and reducing exposure to any hazards. All staff are aware of the requirements and reminded verbally, electronically through formal training, team meetings and supervision about wearing masks, washing hands using sanitisers. Audits have been conducted to ensure proper hand hygiene is observed. All group leaders have been reminded that medication cupbords are locked when not in use, all hazardous materials are stored correctly, continence pads are safely stored to avoid risk of cross contamination.
Area for improvement 4 **Ref:** Standard 35.7 **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure that all staff employed in the home adheres to the guidance provided by the Northern Ireland Regional Infection Prevention and Control Manual (PHA) Specifically that staff are bare below the elbow and not wearing nail polish or jewellery when on duty. Please refer to the following link for details: https://www.niinfectioncontrolmanual.net/hand-hygiene Ref: 5.2.3
	Response by registered person detailing the actions taken: All staff have been made aware and advised in line with Glencraig policy that nail polish cannot be worn at work. In addition all jewellery apart from wedding bands must be

	removed. The use of watches is needed to follow some care plans and group leaders advised a designated person is in place to facilitate this. In some areas this may be more than one person. Bare below the elbow is not always a possiblity due to individual care plans and risk to staff, bite guards are worn and other clothing to ensure staff are not seriously hurt. Where possible and specifically during personal care, staff will remain bare below the elbow if it is safe to do so.
Area for improvement 5 **Ref:** Standard 20 **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure that robust governance arrangements are implemented and maintained which ensure consistent and effective oversight by the manager within all resident areas. Completed monitoring reports and audits contain clear, time limited action plans and a review of any actions taken to ensure that the organisation is being managed in accordance with minimum standards. Ref: 5.2.5
	Response by registered person detailing the actions taken: Written records are maintained following management visits in the homes. These purposeful visits are designed to support the Group leaders and assist in smooth running of the home. In addition it acts to enable any issues to be raised, addressed, recorded and monitored. Weekly adult house meetings are held and minuted. Any issues specifically for a house is adressed with expediency. Reg 29 actions are reviewed, discussed and updates provided to reg visitor. Monthly house reports are reviewed and reponses in place. In attempts to reduce footfall and cross contamination visits were reduced during COVID 19. We have reinstated managers visiting houses requlary, staying for longer periods observing practice, providing support, guidance and feedback when needed. In addition managers attend team meetings and build rapport with staff.
Area for improvement 6 **Ref:** Standard 6.4 **Stated:** Second time **To be completed by:** 15 June 2020	The registered person shall ensure that the resident or their representative is given written notice of all changes to the agreement and these are agreed in writing by the resident or their representative. Where the resident or their representative is unable to sign or chooses not to sign, this is recorded. Ref: 6.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next care inspection.

Area for improvement 7 **Ref:** Standard 31 **Stated:** First time **To be completed by:** From the date of inspection onwards	The registered person shall ensure that: • entries on the personal medication records are verified and signed by two trained members of staff • obsolete personal medication records are cancelled and archived Ref: 6.2.7.1
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next medicines management inspection.
Area for improvement 8 **Ref:** Standard 30 **Stated:** First time	The registered person shall ensure that written authorisation from the prescriber is available when medicines are administered outside the terms of their product licence. Ref: 6.2.7.3
To be completed by: 13 October 2020	**Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next medicines management inspection.**

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

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