

Inspection Report

Name of Service:	Croft Communities Limited Residential Care Home
Provider:	The Cedar Foundation
Date of Inspection:	8 October 2025

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:	The Cedar Foundation
Responsible Individual:	Miss Kelly Louise Devlin
Registered Manager:	Miss Laura Overton – not registered
<p>Service Profile – This home is a registered residential care home which provides health and social care for up to 16 residents living with a learning disability, under and over 65 years. There are shared dining areas and lounge areas in the home. Permanent residents reside in 'Mayne House' and 'Croft Lodge' is utilised for respite.</p> <p>The home is also approved to provide care on a day basis for up to 15 persons in 'Barn'.</p>	

2.0 Inspection summary

An unannounced inspection took place on 8 October 2025, between 9.40 am and 5.30 pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to assess progress with the areas for improvement identified, by RQIA, during the last care inspection 29 April 2025; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

There was a calm atmosphere in the home. Residents were well presented and observed to be relaxed in their environment and in their interactions with staff.

Enforcement action resulted from the findings of this inspection as RQIA had concerns regarding the effectiveness and oversight of delivery of care and the management systems within the home.

A meeting with the intention to serve two Failure to Comply (FTC) notices in respect of The Residential Care Homes Regulations (Northern Ireland) 2005, Regulation 13 (1) (a) and (b) and 10 (1) was held with the senior management team on 22 October 2025.

At this meeting, the management team presented an action plan which was accepted by RQIA and the notices were not served. It was agreed that the home would continue to liaise with the South Eastern Health and Social Care Trust (SEHSCT) for further support in addressing the areas for improvement identified at this inspection.

As a result of this inspection two areas for improvement were assessed as having been addressed by the provider. One area for improvement has been stated for a third time. Nine areas for improvement have been stated for a second time. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

3.0 The inspection

3.1 How we Inspect

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

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from residents, relatives, staff or the commissioning Trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards. Inspectors will also observe care delivery and may conduct a formal structured observation during the inspection.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Comments from residents included: "it's great here", "I like that all my friends are here", "it's very good", "I like all the kind staff", "the food's good and you get good coffee".

Residents spoke positively of choosing which T.V programme they wanted to watch and that they liked having fun with staff.

Residents who benefited from assistance in articulating their opinions spoke positively of their time in this service and confirmed this in use of positive body language such as smiling and nodding.

A small number of relative questionnaires were received expressing that their loved ones were happy with the services in this home. Thanks were expressed regarding the care delivered and the caring and positive interactions from staff.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of residents.

Staff said there was good team work and that they felt well supported in their role and that they were satisfied with the staffing levels.

Review of the staff duty rota and staff training records identified that one staff member designated as person in charge of the home in the absence of the manager required updated fire training. One other staff member who was also designated as person in charge did not demonstrate adequate knowledge of the residents who were subject to restrictive practices. This was highlighted to the management team who agreed to take immediate action to address this.

3.3.2 Quality of Life

Staff met at the beginning of each shift to discuss any changes in the needs of the residents. However, discussion with staff and review of care records identified that the system was not robust as key information regarding residents' care had not been handed over. An area for improvement was identified.

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. Staff offered residents choice in how and where they spent their day or how they wanted to engage socially with others.

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 and their diet modified. It was positive to see staff were present and available for assistance if required.

The importance of engaging with residents was well understood by the manager and staff. Residents told us that staff understood their preferences and wishes and helped them to participate in activities they enjoyed such as watching their preferred programmes on T.V, completing jigsaws or facilitating outings. The weekly programme of social events was displayed on the noticeboard.

3.3.3 Care Delivery and Management of Care Records

Residents' needs were assessed by a suitably qualified member of staff at the time of their admission to the home. Following this initial assessment, a number of care plans were developed to direct staff on how to meet residents' needs and included any advice or recommendations made by other healthcare professionals.

However; care records provided no evidence of a clear and timely response to changes in residents' physical health needs; specifically, in relation to choking, mobility, Personal Emergency Evacuation plans (PEEPs) in the event of a fire, and skin care including the monitoring and prevention of pressure damage and falls.

For example, there was no written evidence that care records had been updated and reviewed when a resident experienced changes to their ability to swallow; or that these changes had been escalated to relevant health care professionals such as Speech and Language Therapists to mitigate this risk.

It was also noted that records relating to residents' dietary requirements were not consistent with their care plan or with staff's description of residents' needs; nor were these records reviewed on a resident's admission to the home. This was despite staff explaining that reviewing these records was part of the admission process, which is particularly important given the number of residents staying for short breaks.

There was no evidence of review of PEEPs for those residents who had experienced changes to their mobility and required increased assistance from staff; nor if these changes had been considered in planning appropriate staffing levels.

Discussion with staff and review of care records raised concerns that staff were unaware of how to identify and escalate concerns regarding skin care and potential pressure damage. Related care records were either inaccurate, incomplete or not available. Discussion with staff established there was not a robust system in place to record and monitor skin changes and ensure such information was shared with relevant staff through their handover.

Post falls records were either inconsistent or not completed, despite formal notifications to RQIA regarding notifiable events, which stated all required monitoring had been completed and recorded.

Bed rails were in place for some residents; however, there was no corresponding risk assessment or care plan in place for their safe use.

Following the inspection, RQIA shared the specific findings relating to six individuals, with the SEHSCT, as care records did not provide sufficient assurance that residents' needs are being appropriately assessed, monitored and attended to within the home.

These concerns were discussed in detail at the meeting on 22 October 2025 where the home's management team provided a detailed action plan outlining what actions had been taken, and were planned to take, to address these issues. The home had met with SEHSCT representatives and additional meetings were planned to further review and respond to the inspection findings.

One area for improvement as stated for a third time, seven areas for improvement were stated for a second time and one new area for improvement was also identified.

3.3.4 Quality and Management of Residents' Environment

The home was clean, tidy and well maintained. For example, residents' bedrooms were personalised with items important to the resident. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable.

There were 'homely' touches such as photographs and ornaments personal to residents in the communal areas. There was also a display of art work undertaken by residents as part of the activity programme provided.

The medication trolley was left unsupervised and unlocked with medication accessible; and prescribed creams were found in resident bedrooms. An area for improvement was stated for a second time.

There were residents who had access to toiletries in their bedrooms. However, there was no record of an individual or environmental assessment to identify and manage any potential risks to residents. An area for improvement was identified.

3.3.5 Quality of Management Systems

There has been change in the management of the home since the last inspection. Miss Laura Overton has been the manager since 23 September 2025.

Significant concerns were identified regarding the lack of robust managerial oversight of the home, including the lack of progress with the areas for improvement identified at the last care inspection on 29 April 2025. RQIA acknowledges that there have been changes in management since the last care inspection and are concerned that these frequent changes in management personnel is contributing to the lack of clear and sustained improvements. RQIA are also aware of the recent resignation of the Responsible Individual and that acting arrangements are now in place.

The manager did not demonstrate a clear understanding of their responsibility to ensure oversight of all aspects of the home's current registration, which includes care on a day basis provided to 15 persons in the 'Barn' building. Governance records for the home were requested; however the records provided did not include reference to the 'Barn'. When this was raised with the manager, RQIA were advised that that these had been delegated to another manager.

There was some improvement noted in relation to the management of restrictive practices; for instance, a register was now in place for persons subject to Deprivation of Liberty Safeguards (DoLS). However, there was limited evidence of a robust system in place to monitor DoLS arrangements given that senior care staff were unaware of which residents were subject to these safeguards. Residents who were subject to DoLS had no care plan or risk assessment in place to direct staff as to the care required.

Further concerns regarding staffs' knowledge and understanding of DoLS and restrictive practices was identified within Croft Lodge, where 'blanket' restrictions were in place regarding exit from the home. There was no care plan in place for residents in receipt of 'one to one' care to direct staff on the care required. Discussion with staff established they were unclear on the purpose of this restrictive practice or of how to escalate any concerns about this arrangement.

There was also no clear evidence as to whether the resident had consented to these arrangements.

The home’s management team were asked to liaise with SEHSCT urgently to ensure these safeguards and restrictions were reviewed in a timely manner; and if necessary, take immediate action to protect and promote the rights of the residents within the home.

Completed audits of care plans, the home’s environment and the DoLS Register, did not evidence that the manager maintained oversight of these. This was particularly concerning given the inspection findings.

These concerns were discussed in detail at the meeting on 22 October 2025. The management team provided an action plan and detailed how the home’s management and governance systems had been reviewed and improved since the inspection. Both the Responsible Individual and Manager had commenced their applications to register with RQIA and agreed to complete this without further delay.

Four areas for improvement were stated for a second time and two new areas for improvement were identified.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	9*	8*

* The total number of areas for improvement includes four Regulations that have been stated for a second time, one Standard which has been stated for a third time and five Standards which have been stated for a second time.

Findings of the inspection were discussed with the management team as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan	
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
<p>Area for improvement 1</p> <p>Ref: Regulation 15 (2) (a) (b)</p> <p>Stated: Second time</p> <p>To be completed by: 8 October 2025</p>	<p>The registered person shall ensure that the assessment of the resident's need is kept under review; revised at any change and reviewed no less than annually.</p> <p>Ref: 3.3.3</p> <p>Response by registered person detailing the actions taken: The registered person has devised and implemented a process within the service ensuring residents assessed needs are continually reviewed and identified changes in need incorporated within residents care and support plans . A Schedule also identified for annual care reviews.</p>
<p>Area for improvement 2</p> <p>Ref: Regulation 13 (4) (a)</p> <p>Stated: Second time</p> <p>To be completed by: 8 October 2025</p>	<p>The registered person shall ensure that all prescribed medication is securely stored.</p> <p>Ref: 3.3.4</p> <p>Response by registered person detailing the actions taken: The registered person has ensured all perscribed medication is securly stored. Regular spot audits completed by Registered manager at medication administration times within the service to monitor process. Staff have been reminded at Medication training, staff meetings and staff memos of this process.</p>
<p>Area for improvement 3</p> <p>Ref: Regulation 13 (1) (a) (b)</p> <p>Stated: Second time</p> <p>To be completed by: 8 October 2025</p>	<p>The registered person shall ensure that the manager maintains clear operational oversight and control of the services, treatment and supervision of residents provided in line with the home's current registration and Statement of Purpose.</p> <p>Ref: 3.3.5</p> <p>Response by registered person detailing the actions taken: The Registered Manager has clear operational oversight and control of all services within the registration of the service as outlined within Statement of purpose. The manager conducts daily visits to all services within the registration and completes audits regularly within the service providing assurance service users needs are met.</p>

<p>Area for improvement 4</p> <p>Ref: Regulation 13 (1) (a) (b)</p> <p>Stated: Second time</p> <p>To be completed by: 8 October 2025</p>	<p>The registered person shall ensure that there is a robust system in place to oversee and monitor the arrangements in place for those residents who may require Deprivation of Liberty Safeguards (DoLS).</p> <p>Ref: 3.3.5</p>
<p>Area for improvement 5</p> <p>Ref: Regulation 13 (1) (a) (b)</p> <p>Stated: First time</p> <p>To be completed by: 8 October 2025</p>	<p>Response by registered person detailing the actions taken: The Registered Manager has Implemented a robust system to review and monitor all residents/service users Deprivation of Liberty Safeguards (DoLS) on a regular basis. Meetings have been convened with commissioning trusts for review of DoL and Restrictive Practice reviews for all residents availing of the service.</p> <p>Further staff training completed with all staff sharing all DoL and restrictive practice information for all service users availing of the service.</p> <p>The registered person shall ensure that where a resident may be at risk of choking, the associated risk assessment and care plan are in place, and are reviewed and updated where necessary.</p> <p>Ref: 3.3.3</p> <p>Response by registered person detailing the actions taken: The registered manager has Implemented a robust system to update all risk assessments and care plans where necessary for residents at risk of choking.</p> <p>Information changes are communicated to staff at daily/nightly handover, accessing residents electronic care and support plans , staff memos and discussion at staff team meetings.</p>
<p>Area for improvement 6</p> <p>Ref: Regulation 13 (1) (a) (b)</p> <p>Stated: First time</p> <p>To be completed by: 8 October 2025</p>	<p>The registered person shall ensure that where a person requires their diet to be modified that the care plans accurately reflect the most recent assessment; and are updated following any review by specialist professionals.</p> <p>Ref: 3.3.3</p> <p>Response by registered person detailing the actions taken: The registered manager has implemented a robust process to ensure all care plans are updated and reflective of recent assessment/ review conducted by specialist professionals for residents who require support with modified diets.</p> <p>Information changes are communicated to staff at daily/nightly handover, accessing residents electronic care and support plans , staff memos and discussion at staff team meetings.</p>

<p>Area for improvement 7</p> <p>Ref: Regulation 13 (1) (a) (b)</p> <p>Stated: First time</p> <p>To be completed by: 8 October 2025</p>	<p>The registered person shall ensure that where a resident has been assessed by an appropriate professional as suitable for bedrails, there is an associated risk assessment and care plan in place which is appropriately reviewed.</p> <p>Ref: 3.3.3</p>
<p>Area for improvement 8</p> <p>Ref: Regulation 15 (2) (a)</p> <p>Stated: First time</p> <p>To be completed by: 8 October 2025</p>	<p>Response by registered person detailing the actions taken: The registered person will conduct a regular audit of all residents assessments in relation to bedrails ensuring risk assessments and care plans accurately reflect regular review . Assessments will be reviewed annually or if any change is required.</p> <p>Information changes are communicated to staff at daily/nightly handover, accessing residents electronic care and support plans, staff memos and discussion at staff team meetings.</p> <p>The registered person will ensure that where there are toiletries accessible to residents that there is evidence of comprehensive assessment of risk.</p> <p>Ref: 3.3.4</p> <p>Response by registered person detailing the actions taken: The registered person has completed comprehensive risk assessments for all service users who have accessibility to their toiletries within their home.</p> <p>The registered person also conducts regular reviews of risk assessments and updates should any changes be required.</p> <p>Information changes are communicated to staff at daily/nightly handover, accessing residents electronic care and support plans , staff memos and discussion at staff team meetings.</p>
<p>Area for improvement 9</p> <p>Ref: Regulation 29 (5) (a)</p> <p>Stated: First time</p> <p>To be completed by: From 5 December 2025</p>	<p>The registered person shall ensure that completed Regulation 29 monthly monitoring reports are submitted to RQIA on or before the 5th of every month.</p> <p>Ref: 3.3.5</p> <p>Response by registered person detailing the actions taken: The registered person will ensure that Regulation 29 MMV reports will be sent to RQIA by 5th of every month.</p>
<p>Action required to ensure compliance with the Residential Care Homes Minimum Standards (version 1.2 Dec 2022)</p>	
<p>Area for improvement 1</p> <p>Ref: Standard 8.2</p> <p>Stated: Third time</p>	<p>The registered person will ensure records maintained for resident's detail accidents, incidents or near misses occurring and action taken. This is in relation specifically to post falls records being accurate and up to date.</p>

<p>To be completed by: 8 October 2025</p>	<p>Ref: 3.3.3</p> <p>Response by registered person detailing the actions taken: The registered person will ensure a regular review of residents records for accidents, incidents and near misses is complete. This review will incorporate of post falls documentation and Incident analysis.</p> <p>Information changes are communicated to staff at daily/nightly handover, accessing residents electronic care and support plans , staff memos and discussion at staff team meetings.</p>
<p>Area for improvement 2</p> <p>Ref: Standard 12.1</p> <p>Stated: Second time</p> <p>To be completed by: 8 October 2025</p>	<p>The registered person will ensure that there is a system in place to ensure that staff have access to the up-to-date assessment of resident's requirements for modified diets and levels of assistance.</p> <p>Ref: 3.3.3</p> <p>Response by registered person detailing the actions taken: The registered person has devised and implemented a process to ensure all staff have access to up to date assessment and requirements of residents modified diets and levels of assistance required.</p> <p>Kitchen and support staff are all informed via the handover and copies placed in the kitchen and available for everyone to read.</p> <p>Information changes are communicated to staff at daily/nightly handover, accessing residents electronic care and support plans , staff memos and discussion at staff team meetings.</p>
<p>Area for improvement 3</p> <p>Ref: Standard 6.2 and 6.6</p> <p>Stated: Second time</p> <p>To be completed by: 8 October 2025</p>	<p>The registered person shall ensure care plans regarding personal emergency evacuation plans (PEEP's) are kept up-to-date and reflects the residents' current needs.</p> <p>Ref: 3.3.3</p> <p>Response by registered person detailing the actions taken: The registered person has reviewed the process of care plan emergency evacuation plans (PEEPS) from annual to six monthly or before should change be required which accurately reflects up to date information with reference to residents current needs.</p> <p>Information changes are communicated to staff at daily/nightly handover, accessing residents electronic care and support plans , staff memos and discussion at staff team meetings.</p>

<p>Area for improvement 4</p> <p>Ref: Standard 8.2</p> <p>Stated: Second time</p> <p>To be completed by: 8 October 2025</p>	<p>The registered person will ensure that where a resident is supported with repositioning, this is recorded in care records.</p> <p>Ref: 3.3.3</p> <hr/> <p>Response by registered person detailing the actions taken: The registered person has reviewed all residents care plans and records to ensure residents requiring support with repositioning has an accurate record to include time and change of position left or right side.</p> <p>Information changes are communicated to staff at daily/nightly handover, accessing residents electronic care and support plans , staff memos and discussion at staff team meetings.</p>
<p>Area for improvement 5</p> <p>Ref: Standard 6.7</p> <p>Stated: Second time</p> <p>To be completed by: 8 October 2025</p>	<p>The registered person will ensure that care plans are kept up-to-date and reflect the residents' current needs. This is in relation to residents who are subject to Deprivation of Liberty.</p> <p>Ref: 3.3.5</p> <hr/> <p>Response by registered person detailing the actions taken: The registered person completes regular reviews of residents care plans ensuring recording of residents current needs in relation to Deprivation of Liberty.</p> <p>Information changes are communicated to staff at daily/nightly handover, accessing residents electronic care and support plans , staff memos and discussion at staff team meetings.</p>
<p>Area for improvement 6</p> <p>Ref: Standard 6.2 and 6.6</p> <p>Stated: Second time</p> <p>To be completed by: 8 October 2025</p>	<p>The registered person will ensure that care plans are kept up-to-date and reflect the residents' current needs. This is in relation to residents who have one-to-one support in place.</p> <p>Ref: 3.3.5</p> <hr/> <p>Response by registered person detailing the actions taken: The registered person has conducted a review of residents who receive one to one support ensuring this information is reflective within their care plans.</p> <p>Information changes are communicated to staff at daily/nightly handover, accessing residents electronic care and support plans , staff memos and discussion at staff team meetings.</p>
<p>Area for improvement 7</p> <p>Ref: Standard 9.3</p> <p>Stated: First time</p> <p>To be completed by: 8 October 2025</p>	<p>The registered person will ensure that where a person has been identified at risk of pressure damage, there is evidence of monitoring and onward referral to the appropriate professionals.</p> <p>Ref: 3.3.3</p>

	<p>Response by registered person detailing the actions taken: The registered person has devised and implemented a document for staff to record and report any changes in residents skin presentation twice daily. All skin presentation changes are reported were required to appropriate professionals.</p> <p>Information changes are communicated to staff at daily/nightly handover, accessing residents electronic care and support plans , staff memos and discussion at staff team meetings.</p>
<p>Area for improvement 8</p> <p>Ref: Standard 35</p> <p>Stated: First time</p> <p>To be completed by: 8 December 2025</p>	<p>The registered person will ensure that where deficits are identified through audit processes, there is a time bound action plan to address these, with appropriate management oversight.</p> <p>Ref: 3.3.5</p> <p>Response by registered person detailing the actions taken: The registered person has ensured all actions identified within weekly/monthly/quaterly/annual audits are added to the Service Improvement plan which is updated regularly within the service. Actions are updated/actioned within a timely manner.</p>



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