The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Croft Communities Residential Care Home

Provider: The Cedar Foundation

Date of Inspection: 19 March 2026

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	Mrs Mary Elaine Armstrong
Registered Manager:	Miss Laura Overton
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. The home provides care on a day basis for up to 15 persons in 'Barn'.	

2.0 Inspection summary

An unannounced inspection took place on 19 March 2026, between 9.30 am and 6.00 pm by two care inspectors.

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 on 8 October 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, relaxed atmosphere in both the home and the day care setting. Residents were well presented and observed to be relaxed in their environment and in their interactions with staff.

Residents said that living in the home was a good experience. Service users in the day care area also commented positively about the service and the staff.

Residents unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

While we found care to be delivered in a compassionate manner, improvements were required to ensure the effectiveness and oversight of the care delivery. As a result of this inspection, twelve areas for improvement were assessed as having been addressed by the provider. Other areas for improvement have either been stated again or will be reviewed at the next inspection. 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

Residents described staff as "Very nice." Residents spoken with said that they were happy living in the home. Comments included, "I like it here."

Staff said that they enjoyed working in Croft Communities Residential Care Home. Staff comments included, "I enjoy working here," and "The staff are very friendly."

No additional feedback was received within the allocated timeframe for this inspection.

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 safe staffing levels. There was evidence of systems in place to manage staffing.

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

Observation of the delivery of care evidenced that residents' needs were met by the number and skills of the staff on duty.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss any changes in the needs of the residents. Handover sheets were available for staff to review at each changeover of shift. However; there was no evidence of managerial oversight of these records and in some cases, handover sheets were not signed or dated. An area for improvement was identified.

Staff were 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.

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. 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. The menu for the day was displayed and residents had been made aware of the choices.

Residents' needs were met through a range of individual and group activities such as music events, board games, arts and crafts and parties for special occasions. The weekly programme of social events displayed for residents and their visitors to view.

3.3.3 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 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.

It was positive to see improvement in the residents care records. However, gaps were identified in care plans for those residents who require 'one to one' care. An area for improvement was stated for a third time.

Bed rails were in place for some residents; however, for one identified resident there was no corresponding up to date risk assessment. An area for improvement was stated for a second time.

Care records in relation to skin care checks were either inaccurate or incomplete. An area for improvement was stated for a second time.

A review of supplementary documentation in the home, for example skin care checks and falls observation records were found to be incomplete, inaccurate. In addition a majority of these records had not been signed or dated by the person making the entry. An area for improvement was 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 artwork undertaken by residents as part of the activity programme provided.

In both Mayne and Croft Lodge, doors to the electricity switch rooms were found to be unlocked. An area for improvement was identified. Kitchen cupboards containing cleaning chemicals in the day centre were also found to be unlocked. An area for improvement was identified.

PPE stations were sufficiently stocked with aprons and gloves. However, Dani stations in 'Croft Lodge' were stocked with vinyl gloves. This was discussed with the manager who agreed to review the use of appropriate PPE depending on staff and resident allergies with in the home. This will be reviewed at the next inspection.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. However, some staff were observed wearing nail polish, watches and long sleeved clothing, which is not in accordance with good practice in infection prevention and control. An area for improvement was identified.

Catering uniforms were being inappropriately stored in a bathroom. This was discussed with the manager for immediate review and action as appropriate; an area for improvement was identified.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Miss Laura Overton has been the manager since 23 September 2025.

It was positive to see that the manager had made some progress with the areas for improvement identified at the last care inspection on 8 October 2025. However; there was no recorded evidence of managerial 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. There was no managerial oversight of the governance records concerning the 'Barn' day care building. An area for improvement was stated for a third time.

A review of records evidenced that there were some audits in place to review the services provided by the home, however these audits were not always robust in identifying deficits and no action plans to drive improvement had developed following the audits. There was no evidence of managerial oversight in relation to the audits carried out in the cay centre. An area for improvement was stated for a second time.

There was a lack of evidence of managerial oversight of supplementary documentation in the home. An area for improvement was 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	4*	10*

* the total number of areas for improvement includes one Regulation and one standard that have been stated for a third time; three standards that have been stated for a second time and two standards which are carried forward for review at a future medicines management inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Laura Overton, manager, 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 (1) (a) (b) **Stated:** Third time	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. Ref: 2.0 & 3.3.5
To be completed by: 19 March 2026	**Response by registered person detailing the actions taken:** The registered person will ensure that the manager will have operational oversight of the services, treatment and supervision of service users in line with the current registration and statement of purpose and regular review and audit of care plans.

Area for improvement 2 **Ref:** Regulation 13 (1) (a) (b) **Stated:** Second time	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. Ref: 2.0 & 3.3.3
To be completed by: 19 March 2026	**Response by registered person detailing the actions taken:** The registered person will continue to liaise with all professionals carrying out assessments of need in relation to bedrails, ensuring any changes are reflected in the individual's risk assessment and care plan, which is regularly reviewed.
Area for improvement 3 **Ref:** Regulation 14 (2) (c) **Stated:** First time **To be completed by:** 19 March 2026	The registered person shall ensure that any unnecessary risks to health, welfare, or safety of residents are identified and as far as possible eliminated. This area for improvement is in relation to access to the homes electricity switch rooms. Ref: 3.3.4
	Response by registered person detailing the actions taken: The registered person will ensure that service users do not have access to elctricity switch rooms .
Area for Improvement 4 **Ref:** Regulation 14 (2) (a) **Stated:** First time	The registered person shall ensure that residents to not have access to substances hazardous to their health such as cleaning products. Ref: 3.3.4
To be completed by: 19 March 2026	**Response by registered person detailing the actions taken:** The registered person will ensure that there is appropriate storage within locked cupboards to ensure service users do not have access to substances hazrardous to health.
Action required to ensure compliance with the Residential Care Homes Minimum Standards (version 1.2 Dec 2022)	
Area for improvement 1 **Ref:** Standard 32 **Stated:** First time	The registered person shall ensure that the room temperature of the medicine storage areas is monitored daily and maintained at or below 25ºC. Ref: 2.0
To be completed by: 6 February 2026	**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 2 **Ref:** Standard 32 **Stated:** First time **To be completed by:** 6 February 2026	The registered person shall ensure that the current, maximum and minimum temperatures of the medicines refrigerators are monitored and recorded each day and the thermometer is reset. Ref: 3.3.2 **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 3 **Ref:** Standard 6.2 and 6.6 **Stated:** Third time **To be completed by:** 19 March 2026	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. Ref: 2.0 &3.3.3 **Response by registered person detailing the actions taken:** The registered person will ensure that residents who have one to one support will be documented in care and support plans this will include the hours of support and what the support entails.
Area for improvement 4 **Ref:** Standard 9.3 **Stated:** Second time **To be completed by:** 19 March 2026	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. Ref: 2.0 & 3.3.3 **Response by registered person detailing the actions taken:** The registered person will ensure that residents who have an identified risk of pressure damage will be monitored and referrals made to the appropriate professionals when required.
Area for improvement 5 **Ref:** Standard 35 **Stated:** Second time **To be completed by:** 30 April 2026	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. Ref: 2.0 & 3.3.5 **Response by registered person detailing the actions taken:** The registered person will will ensure that any actions that are required after audits are identified and actioned in a timely manner and managerial oversight of these actions.
Area for improvement 6	The registered person will ensure that there are systems in place that support and promote the delivery of safe, quality care

Ref: Standard 20 **Stated:** First time **To be completed by:** 30 April 2026	services. This area for improvement relates to managerial oversight of handover sheets. Ref: 3.3.2
	Response by registered person detailing the actions taken: The registered Manager will ensure that managerial oversight of the handovers and that these are checked regularly and signed off by Registered manager.
Area for improvement 7 **Ref:** Standard 8.5 **Stated:** First time **To be completed by:** 30 April 2026	The registered person will ensure that all records are accurate, up to date, signed and dated by the person making the entry. Ref: 3.3.3
	Response by registered person detailing the actions taken: The registered person will ensure that all documentation will be completed accurately, up to date checked regularly and signed off by staff making the entry.
Area for improvement 8 **Ref:** Standard 35.7 **Stated:** First time **To be completed by:** 30 April 2026	The registered person shall ensure that all staff are aware of the importance of hand hygiene and that staff remain bare below the elbows at all times. Ref: 3.3.4
	Response by registered person detailing the actions taken: The registered person will ensure that staff remain bare below the elbows and practice good hand hygiene techniques.
Area for improvement 9 **Ref:** Standard 35.7 **Stated:** First time **To be completed by:** 30 April 2026	The registered person shall ensure catering uniforms are stored appropriately to minimise the risk of cross contamination. Ref: 3.3.4
	Response by registered person detailing the actions taken: The registered manager will ensure that catering uniforms are moved to an appropiate area to minimise the risk of cross contamination.
Area for improvement 10 **Ref:** Standard 8 **Stated:** First time **To be completed by:** 30 April 2026	The registered person shall ensure that records are kept in accordance with professional and legislative requirements on each resident's situation, actions taken by staff and reports made to others. This area for improvement is in reference to supplementary records in the home. Ref: 3.3.5

	Response by registered person detailing the actions taken: The registered person will ensure that she has oversight of all documentation within the service in accordance to legislative requirements.

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

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