The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Croft Communities Residential Care Home

Provider: The Cedar Foundation

Date of Inspection: 5 August 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 5 August 2026, from 9.30 am and 6.15 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 19 March 2026; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

As a result of this inspection significant concerns were identified in relation to the governance arrangements in the home and the lack of progress with the areas for improvement identified during previous care inspections conducted on 29 April 2025, 8 October 2025 and 19 March 2026.

Given the seriousness of the concerns raised, a meeting was held on 17 August 2026 with the intention of issuing one Failure to Comply (FTC) notice under The Residential Care Homes Regulations (Northern Ireland) 2005.

Based on the information provided to RQIA, during this meeting, RQIA were not satisfied that robust management and governance arrangements were in place to ensure the findings were fully addressed and improvements sustained. The decision was made to issue one Failure to Comply notice (FTC) in relation to the governance and management arrangements for the home, reference: FTC000262. Details of the FTC notices can be viewed on our website.

Details of our enforcement procedures and the notices issued can be found on our website www.rqia.org.uk

As a result of this inspection six 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 a future medicines management 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 resident's, 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 spoken with said that they were happy living in Croft Communities Residential Care Home. One resident said that the staff were "Amazing."

Residents who could not verbally communicate were well presented in their appearance and appeared to be comfortable and settled in their surroundings.

Staff said there was good teamwork within the home. A number of staff commented on the new respite manager, describing her as "An asset to the team."

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. There was evidence of robust systems in place to manage staffing.

Residents said that there was enough staff on duty to help them. Staff said there was good teamwork 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. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

The home was using a dual system with regards to their duty rota, one system was a paper copy and one on computer. Inconsistencies were noted between the two systems. It was observed that the paper copy did not reflect the staff that was on duty in the home on the day of the inspection. An area for improvement was identified.

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 made available for staff to review at the changeover of shift. However, there was no evidence that the manager had reviewed or signed these records. An area for improvement was stated for a second time.

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

Staff had a good rapport with residents and a sound knowledge of communication styles which were personalised for individual residents. Staff showed compassion and empathy when supporting residents throughout the day.

Discussion with residents confirmed that they were able to choose how they spent their day. For example, residents could have a lie in or stay up late to watch TV.

Residents also told us that staff offered them choices throughout the day which included food and drink options and where and how they wished to spend their time.

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.

Observation of the lunchtime meal, review of records and discussion with residents, staff and the manager indicated that there were robust systems in place to manage residents' nutrition and mealtime experience.

Staff understood that meaningful activity was not isolated to the planned social events or games.

Arrangements were in place to meet residents' social, religious and spiritual needs within the home.

RQIA were concerned with regards to the appropriateness of staff attire and the ability of residents and their visitors to identify who the staff members were. One staff member, who was providing one to one care to one resident, was observed wearing a 'hoodie' with the hood up; a second staff member was observed serving the residents' their lunchtime meal while wearing a bomber jacket. This would not be conducive to providing person centred care which treats residents with respect and dignity and is not in keeping with best practice on infection prevention and control. A number of staff were observed working directly with residents while not being bare below the elbow, wearing nail polish and long sleeves. There was no evidence that this had been identified or was being addressed by management. Details were discussed during the FTC meeting and actions required are included within the FTC notice issued.

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.

Care records were person centred, mostly well maintained, regularly reviewed and updated to ensure they continued to meet the residents' needs. It was positive to see improvements in care plans in relation to those residents who require one to one support; however, more detail was required. For example, there was limited evidence in the care plans reviewed of the allocated times for support or of the reasons why one to one support was in place. An area for improvement was identified.

Some residents may require special attention to their skin care. These residents were assisted by staff to change their position and to have skin checks carried out on a regular basis. However, supplementary documentation did not provide adequate assurance that care was being provided in line with resident's needs. For instance, records had not been signed by both staff involved in support a resident with repositioning, to ensure this was done safely. Details were discussed during the FTC meeting and actions required are included within the FTC notice issued.

Care staff recorded regular evaluations about the delivery of care. 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.

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.

Review of records confirmed that environmental and safety checks were carried out, as required on a regular basis. However, environmental audits where found to be inconsistent, containing contradictory information which indicated that audit systems were not robust. In addition, completed audits provided limited assurance of clear managerial oversight. This is discussed further in section 3.3.5.

Fire doors throughout the home were found to be propped open and prevented from closure in the event of a fire bell sounding; 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.

Concerns were identified in relation to a lack of managerial oversight in the home. A review of the auditing systems identified that while audits took place regularly, improvement was required including detail in some of the action plans. Completed audits provided conflicting information. For example; environmental audits where inconsistent with previous audits within the different units in the home. Audits of bedrails, agency staff inductions and the weekly health and safety checks contained gaps, such as dates and signatures and lacked managerial sign off. In addition to this, where actions were identified on audits there was no clear evidence that these actions had been completed. There was a lack of clarity and duplication regarding managerial review of the most recent quality improvement plan (QIP) from the inspection on 19 March 2026. Review of reports of the quality monitoring visits undertaken in accordance with Regulation 29 and on behalf of the responsible individual, indicated that the quality improvement plan (QIP) from 8 October 2025 was being reviewed. This is not the most recent version and some of the previous areas for improvement had been met. A dual process was in place for reviewing the QIP as the manager had a system online to review the most up to date QIP from the inspection on 19 March 2026 which was not the version used for the monthly monitoring.

Details were discussed during the FTC meeting and actions required are included within the FTC notice issued.

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	1	5*

* the total number of areas for improvement includes one standard that has been stated for a second time and two standards which are carried forward for review at a future medicine's management inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with 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 27 (3) (b) **Stated:** First time **To be completed by:** 5 August 2026	The registered person shall ensure that the practice of propping open fire doors ceases immediately. Ref: 3.3.4
	Response by registered person detailing the actions taken: The registered person has communicated to all staff that the practice of propping open fire doors must stop with immediate effect. The management team is completing regular monitoring of the services to pro-actively escalate concerns with staff as required in line with policy to ensure sustained change in practice.
Action required to ensure compliance with the Residential Care Homes Minimum Standards (Dec 2022)	
Area for improvement 1 **Ref:** Standard 32 **Stated:** First time **To be completed by:** 6 February 2026	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
	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: 2.0
	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 20 **Stated:** Second time	The registered person will ensure that there are systems in place that support and promote the delivery of safe, quality care services. This area for improvement relates to managerial oversight of handover sheets. Ref: 3.3.2

To be completed by: 12 August 2026	
	Response by registered person detailing the actions taken: The registered person will ensure that there are robust processes in place for the completion, storage and managerial sign-off of handover documentation.
Area for improvement 4 **Ref:** Standard 25.6 **Stated:** First time **To be completed by:** 12 August 2026	The registered person shall ensure that an accurate record is kept of staff working over a 24-hour period and the capacity in which they worked. Ref: 3.3.1
	Response by registered person detailing the actions taken: New digital rota management system is in now fully in place, which accurately records staff on duty/shift each day and night. Transitioning paper copies are no longer in use. The registered person reviews rota coverage daily to ensure staff details are accurate.
Area for improvement 5 **Ref:** Standard 6.6 **Stated:** First time **To be completed by:** 12 August 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 the times and the reason for one-to-one support. Ref: 3.3.3
	Response by registered person detailing the actions taken: The registered person will ensure that each service user requiring 1:1 support has the times and reasons for level of assistance accurately and clearly documented in their individual Care Plan.

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

The Regulation and Quality Improvement Authority

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