The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Croft Communities Supported Living

Provider: The Cedar Foundation

Date of Inspection: 31 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/Responsible Person:	Mrs Mary Elaine Armstrong
Registered Manager:	Mrs Kirsty Spencer
Service Profile: Croft Communities Supported Living is a domiciliary care agency, supported living type which provides 24-hour care and support to service users that have a learning disability and complex needs. Service users live within a number of shared dwellings at the same location as the office and one off-site property.	

2.0 Inspection summary

An unannounced inspection was conducted 31 March 2026, between 10:30 am and 4.40 pm by a care Inspector.

The last care inspection of the service was undertaken on 16 July 2024 by a care Inspector. No areas for improvement were identified. This inspection was undertaken to evidence how the service is performing in relation to the regulations and standards; and to determine if the service is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that care delivery was safe and that effective and compassionate care was delivered to service users. However, improvements were required to ensure the effectiveness and oversight of certain aspects of the agency, such as complaints management, quality monitoring reports, staff supervision and appraisal.

It was evident that staff promoted the dignity and well-being of service users and that staff were knowledgeable and well trained to deliver safe and effective care.

Service users said that the care and support provided by Croft Communities Supported Living was a good experience. Refer to Section 3.2 for more details.

Full details, including 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 Croft Communities Supported Living 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 service. This included, registration information, and any other written or verbal information received from service users, service user representatives, staff or the commissioning trust.

Throughout the inspection process inspectors seek the views of those being supported by and working for the agency; and examine a sample of records to evidence how the service is performing in relation to the regulations and standards.

Information was provided to service users, relatives, staff and other stakeholders on how they could provide feedback on the quality of services. This included telephone, questionnaires and an electronic survey.

3.2 What people told us about the service

Through active listening, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

Service users spoken with told us that they were happy with the care and support that they receive from staff within Croft Communities Supported Living. One service user told us "the staff treat me well" whilst another service user advised "the staff are good". It was also positive to hear service users had regular interactions with the manager who they described as "nice". It was reassuring that service users felt there was good consistency with regards to staffing.

We were told about weekly meetings held that offers opportunity for service users to discuss any issues or matters directly with staff. Although those service users consulted did not feel any service improvement was currently required it was positive that service users were knowledgeable as to how to raise a complaint and expressed comfort in approaching staff to address any issues that may arise.

Service users felt actively involved in the service with one advising on their participation in interview panels which they told us was "very interesting" and a "very good" experience. Service user explained how staff assisted them day to day task such as completing shopping, preparing meals as well as supporting engagement within their local communities. A service user explained how one of their favourite things was to go walking with staff, advising of a new garden that service users can avail of within the service. Service users explained how they had been supported in achieving goals such as going on foreign holidays which they told us they had enjoyed.

Feedback regarding the environment was positive with one service user when referencing their home stating “I love it”. Another service user described their home as “comfortable”.

One service user representative who provided feedback stated that they are very satisfied with the care and support for which Croft Communities Supported Living provide to their loved one. Their feedback indicated that they felt care and support offered was safe, effective and compassionate and that the agency was well led.

Staff told us that us that the manager is “very approachable”. It was positive that staff felt confident in the leadership of the manager, feeling that the service is well led. One staff member told us that Croft Communities Supported Living “is a lovely place to work”.

Staff feedback indicated that staffing levels within the service were sufficient to meet the needs of service users. Staff told us that they were very satisfied in that the service users were treated with kindness, dignity and respect. Staff told us that they felt “service users are well cared for and happy”. In relation to service user homes a staff member advised that the environments in which service users are supported are “lovely”.

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 service users. There was evidence of robust systems in place to manage staffing. As noted, staff told us that they felt staffing levels were appropriate to enable them to provide the necessary care and support to service users.

A review of the agency’s staff recruitment records confirmed that all pre-employment checks, including criminal record checks (AccessNI), were completed and verified before staff members commenced employment and had direct engagement with service users. Checks were made to ensure that staff were appropriately registered with Northern Ireland Social Care Council (NISCC); there was a system in place for professional registrations to be monitored by the manager.

There was evidence that all newly appointed staff had completed a structured orientation and induction, having regard to the Northern Ireland Social Care Council’s (NISCC) Induction Standards for new workers in social care, to ensure they were competent to carry out the duties of their job in line with the agency’s policies and procedures. Written records were retained by the agency of the person’s capability and competency in relation to their job role. It was also positive to note that during employees probationary periods they received monthly supervisions, with performance review twice during the first five months of employment.

Records of all staff training were retained and the manager maintained oversight of the training matrix to ensure compliance. This training included Deprivation of Liberties Safeguards (DoLS), adult safeguarding and Dysphagia, at a level appropriate to their job roles. An area of good practice was identified with regards to training needs of staff being considered prior to admission to the service. For example, all staff had received epilepsy management training to ensure they could safely and appropriately care for service users with this diagnosis.

It was positive to find that a number of additional training had been undertaken by staff such as Physical and Learning Disability Awareness, Mental Health First Aid and Incident Management.

With regards to medications, all staffs competency in the safe handling and administration of medications had been assessed and staff practice in this area was reviewed on a regular basis.

It was identified that staff had not received supervision in line with the organisations policy and procedure. It was also noted that the system to monitor compliance in this area was insufficient, not readily identifying where action is needed nor providing overall compliance rates per individual employee. An area for improvement was identified.

Similar issues were also identified with respects to appraisals with all employees not having participated in an appraisal in the year previous. This was again discussed with the Registered Manager. An area for improvement was identified.

3.3.2 Care Delivery

The agency had a handover process in place, which included information about any changes to the service users' care that the staff needed to assist them in their roles.

An area of good practice was identified with regards to service user engagement, with service user meetings occurring on a monthly basis. It was positive to find that service user's communication needs had been considered to enable participation, for example pictorial agendas were made available to service users. Review of minutes also evidenced that service users added to items to the agenda for discussion.

An area of good practice was also identified in that sign language was utilised by staff. The manager advised that additional training had been offered to staff

In addition to the service organising events to encourage socialisation amongst service users, individual interests were recognised and actively encouraged, supporting service users to pursue activities that were meaningful to them. Service user who consented also saw their achievements celebrated through the agency's newsletter. This included photos and extracts detailing service user engagement in an array of activities such as horse riding, spa days, music concerts, barbeques, day trips as well as recent foreign holidays.

Review of service user documents evidenced that service agreements were in place. This document assured service users of their rights, made a commitment to providing person-centred care and clarified the responsibilities of both the individual and agency.

3.3.3 Management of Care Records

Service users care records were held confidentially in line with data protection regulations.

Service users' needs were assessed when they were first referred to the agency and before care delivery commenced. Following this initial assessment care plans were developed to direct staff on how to meet service users' needs and included any advice or recommendations made by other healthcare professionals.

There was evidence that service users had received a support agreement, which outlined conditions and expectations of the service relationship that was reviewed on a regular basis. Copies of the service users' tenancy agreements were also retained. There was evidence that service user consent had been sought in relation to use of their image in their documentation as well as social media posts or in any organisational promotional material.

Care records were person centred, well maintained, regularly reviewed, and updated to ensure they continued to meet the service users' needs. Within service user plans, readers were directed to refer to multidisciplinary assessments in place, ensuring staff had a comprehensive understanding of individuals' needs and the involvement of relevant professionals.

There was evidence that service users, where possible, were involved in planning their own care and efforts had been made to ascertain service user's preferences and choices around how their support was provided. Where a service user was unable to engage in care planning or review processes, the agency actively promoted the involvement of service user representatives who could advocate on behalf of their loved one.

There was evidence of multidisciplinary assessments which were used by the agency to devise plans to ensure care delivered to service users responsive and in keeping with their assessed needs. An example of this related to directions given to staff in assisting service users with meal preparation where a modified diet was required.

One service user's Positive Behaviour Support (PBS) Plan had been recently reviewed in conjunction with Trust representatives. This provided staff working with the individual clear and concise information regarding the purpose of behaviours displayed and prescribed personalised interventions and strategies to be utilised to reduce the experience of anxiety/distress. There was evidence that staff monitored the effectiveness of interventions and utilised the review process to examine if changes to current practice could bring about further improvement in the quality of life of the service user.

There were arrangements in place to ensure that service users who required high levels of supervision or monitoring and restriction had their capacity considered and, where appropriate, assessed. Where a service user was experiencing a deprivation of liberty, the care records contained details of assessments completed and agreed outcomes developed in conjunction with the HSC Trust representative. Any service user subject to authorised Deprivation of Liberty Safeguards (DoLS) had their care plan reviewed by an HSC professional annually to ensure that they were not used disproportionately or for longer than is necessary. Any changes to the DoLS were communicated to the manager and updated documents shared and stored within the service users care records. A central register was in place to enable tracking of any DoLS due for review.

There was a register in place to ensure effective monitoring of DoLs and restrictive practices in place. The restrictive practice register tracker was detailed and added further assurances to ensure interventions prescribed were absolutely necessary and proportionate; this was highlighted as an area of good practice.

3.3.4 Quality of Management Systems

There has been a change in the management of the service since the last inspection. Mrs Kirsty Spencer has been the Registered Manager in this service since 8 July 2025. Staff commented positively about her management style, describing her as supportive, approachable and able to provide guidance.

Review of incident records identified that they were managed appropriately. There was evidence that incidents were audited on a regular basis, to establish any patterns/trends.

Agencies are required to have a person known as the Adult Safeguarding Champion (ASC), who has responsibility for implementing the regional protocol and the agency's adult safeguarding policy. It was established that good systems and processes were in place to manage the safeguarding and protection of adults at risk of harm. The annual safeguarding position report had been completed.

Review of feedback received by the service, identified an issue that should have been managed through the organisation's complaints policy and procedure. As a result evidence was not readily available to illustrate actions taken and if a satisfactory resolution had been achieved. An area for improvement was identified.

Some quality monitoring reports reviewed contained feedback from service users and their representatives which expressed dissatisfaction with aspects of service delivery; these should have been managed in line with the organisation's complaints policy and procedure. Additionally, information contained within the quality monitoring report relating to complaints did not accurately reflect information retained by the service. 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 the Regulations and the Standards.

	Regulations	Standards
Total number of Areas for Improvement	2	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Kirsty Spencer 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 Domiciliary Care Agencies Regulations (Northern Ireland) 2007	
Area for improvement 1 **Ref:** Regulation 22 (8) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure that all complaints received are responded to according to the agency's policy and procedure and an appropriate record is retained to enable analysis of any developing patterns and/or trends. Ref: 3.3.4 **Response by registered person detailing the actions taken**: The Registered person shall ensure all complaints received are reponded to in line with the organisatioans Polices and Procedures. A Complaints Register is in place to document details on complaints and any action to be taken. This register will enable the Registered person to idenitfy any trends or patterns.
Area for improvement 2 **Ref:** Regulation 23 (2), (4) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure monitoring officers are aware of the organisation's complaints policy and procedure assuring that any complaint received during the assessment of the quality of the agency is processed appropriately. Ref: 3.3.4 **Response by registered person detailing the actions taken:** The Registered person will ensure that the Quality and Governance officers are fully aware of the complaints policy and procedure to ensure any complaints are being processed appropriately. A Complaints Register is in place to document details on complaints and any action to be taken. This register will enable the Registered person to idenitfy any trends or patterns.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 **Ref:** Standard 13.3 **Stated:** First time **To be completed by:** 23 June 2026	The Registered Person shall ensure all employees receive appropriate and regular supervision associated with their role. Ref: 3.3.1 **Response by registered person detailing the actions taken**: The Registered person will ensure all employees receive appropriate supervision as per the organisations Policies and Procedures. All supervisions are currently up to date as per their role.

Area for improvement 2 **Ref:** Standard 13.5 **Stated:** First time **To be completed by:** 23 June 2026	The Registered Person shall ensure that staff have recorded appraisal with their line manager to review their performance against their job description and agree personal development plans. Ref: 3.3.1
	Response by registered person detailing the actions taken: The Registered Person will ensure that staff have recorded appraisals with Line Manager. Any outstanding appraisals idenitifed as part of inspection has been completed by Manager. All appraisals are up to date and in line with Policy and Procedures.

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

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James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel: 028 9536 1111

Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews