

Inspection Report

Name of Service: Spelga Mews
Provider: Radius Housing Association
Date of Inspection: 26 May 2026

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

1.0 Service information

Registered Provider:	Radius Housing Association
Responsible Person:	Mrs Fiona McAnespie
Registered Manager:	Mrs Olive Jones –Awaiting Registration
Service Profile Spelga Mews is a supported living type domiciliary care agency which provides personal care and housing support for 12 residents aged over 65 living with dementia. The agency is owned and operated by Radius Housing and the service is commissioned by the Southern Health and Social Care Trust (SHSCT).	

2.0 Inspection summary

An unannounced inspection was undertaken on 26 May 2026 between by 10.00 am and 3.00 pm by a care Inspector.

The last care inspection completed by a care inspector took place on 8 May 2026. No areas for improvement were identified. This care inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards; and to determine if the agency is delivering safe, effective and compassionate care and if the service is well led.

The inspection found that safe, effective and compassionate care was delivered to service users and that the service was well led. Details and examples of the inspection findings can be found in the main body of the report.

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 staff in Spelga Mews was a positive experience.

No areas for improvement were identified during this inspection. Details of the findings of the inspection can be found in the main body of the report.

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 service 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, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors will seek the views of those living, working and visiting the service; and review/examine a sample of records to evidence how it 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 questionnaires and an electronic survey.

3.2 What people told us about the service and their quality of life

We spoke to a range of service users, a relative and staff to seek their views of living, visiting and working within Spelga Mews. The information provided indicated that good care and support was provided to service users by staff working for the agency. Service users who spoke with the inspector spoke very positively about the care and support they received from staff and said that they got to partake in a good range of different activities of their choice.

A relative who provided feedback on the service indicated high levels of satisfaction about the care provided to their loved one and that staff were good at communicating any issues or concerns regarding their well-being. The information indicated that safe, effective and compassionate care was provided and that the service was well-led.

Staff who spoke with the Inspector said that they really enjoyed working with the service users and the care delivery, training and management support provided by the agency was of a very high standard.

3.3 Inspection findings

3.3.1 Inspection findings

The agency's provision for the welfare, care and protection of service users was reviewed. The organisation's adult safeguarding policy and procedures were reflective of the Department of Health's (DoH) regional policy and clearly outlined the procedure for staff in reporting concerns. The organisation had an identified Adult Safeguarding Champion (ASC). The agency's annual Adult Safeguarding Position report was reviewed and found to be satisfactory.

Staff were required to complete adult safeguarding training during induction and every two years thereafter. Staff who spoke with the inspector had a clear understanding of the process for reporting and managing adult safeguarding concerns and their responsibility in identifying and reporting any actual or suspected incidences of abuse in normal business hours and out of hours. They could also describe their role in relation to reporting poor practice and their understanding of the agency's policy and procedure with regard to raising concerns in the public interest (Whistleblowing). The agency had provided service users with information about keeping themselves safe and the details of the process for reporting any concerns.

The agency retained records of any referrals made to the HSC Trust in relation to adult safeguarding. The manager advised that one adult safeguarding concern had been raised since the last inspection with respect to unexplained bruising. An examination of documentation relating to this identified that a body map had not been completed. This was discussed with the manager who agreed to ensure this was immediately addressed.

Service users said they had no concerns regarding their safety; they described how they could speak to staff if they had any concerns about safety or the care being provided. The agency had provided service users with information about keeping themselves safe and the details of the process for reporting any concerns.

The manager was aware that RQIA must be informed of any safeguarding incident that is reported to the Police Service of Northern Ireland (PSNI).

The agency's governance arrangements for the management of accidents/incidents was reviewed and confirmed that an effective reporting policy and system was in place and that the agency had responded appropriately to the concerns raised in line with the with the Trusts' reporting requirements. It was recommended to the manager that a monthly tracker document for centrally recording and reviewing accidents and incidents which occurred should be implemented to aid in the swift identification of patterns or trends. This will be reviewed at a future inspection.

3.3.2 Mental Capacity and Restrictive Practice

The Mental Capacity Act (MCA) provides a legal framework for making decisions on behalf of service users who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, service users make their own decisions and are helped to do so when needed. When service users lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff had completed appropriate Deprivation of Liberty Safeguards (DoLS) training appropriate to their job roles.

There were arrangements in place to ensure that service users who required high levels of supervision or monitoring and restriction had had their capacity considered and, where appropriate, assessed. On review of documentation of service users who were experiencing a deprivation of liberty, it was identified that one service user with Emergency DoLS required a review from the Health & Social Care Trust to ascertain if the safeguards initially implemented for the service user's safety and well-being were still required. The manager requested this information immediately and confirmed after the inspection that this had been addressed. A review of other care records confirmed that all other service users subject to DoLS authorisations contained the required information and documentation in keeping with MCA legislation.

The service maintained a Restrictive Practice register in place to record service users that were subject to restrictions such as locked doors and bed sensors. The manager advised that all restrictions recorded were assessed as per the direction and guidance of the multi-disciplinary team; and that they were subject to regular review to ensure adherence to principles of proportionality and necessity in line with best practice guidance.

3.3.3 Staff Recruitment, Induction and Training

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.

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 the Northern Ireland Social Care Council (NISCC). There was a system in place for professional registrations to be monitored by the manager.

A review of training records of the most recently recruited staff evidenced a structured orientation and induction had been completed. This included shadowing of a more experienced staff member. Staff were required to complete medication management training and a competency assessment was carried out with staff to ensure competence before assisting with this task. An examination of the training matrix confirmed that all staff were up to date with mandatory and other training relevant to their roles and responsibilities in line with the agency's policies and procedures.

Procedures were in place for appraising staff performance and staff were provided with supervision on a regular basis.

3.3.4 Management of Care Records

From reviewing service users' care records and through discussions with service users, it was positive to note that service users' care plans contained details about their likes and dislikes and the level of support they may require. Care and support plans were kept under regular review and service users and /or their relatives participated, where appropriate, in the review of the care provided on an annual basis, or when changes occur.

Discussions with staff and review of service users' care records reflected the multi-disciplinary input and the collaborative working undertaken to ensure service users' health and social care needs were met within the agency.

The agency held service users' meetings on a regular basis which enabled service users to discuss the provisions of their care and to put forward their activity preferences. A review of minutes of the meetings noted that actions arising from previous meetings were not reviewed so as to update service users of any progress made between meetings. The manager agreed to address this so that service users are kept fully informed of any actions taken to drive improvement within the service.

There was a timetable of activities which included events such as church services, singing, yoga, Reminiscing, bean bag target, beauty therapy, balloon volleyball, quizzes, coffee morning, toss-and-talk ball, bingo, music therapy, arts and crafts, bowls, massage therapy, tea and talk, knitting club, granny pans, crosswords, memory boxes, board games, pet therapy.

Residents who spoke with the inspector expressed enthusiasm for the choice of activities available within the service.

3.3.5 Governance and Managerial Oversight

There has been no change in the management of the agency since the last inspection. Mrs Olive Jones has been the Acting Manager since 25 January 2025. An application to RQIA to register as manager has been received; this will be reviewed in due course.

There were monitoring arrangements in place in compliance with Regulations and Standards. A review of the reports of the agency's quality monitoring established that there was engagement with service users, service users' relatives, staff and HSC Trust representatives. The reports included details of a review of service user care records; accident/incidents; safeguarding matters; staff recruitment and training, and staffing arrangements.

No incidents had occurred that required investigation under the Serious Adverse Incidents (SAI) procedure.

The agency's registration certificate was up to date and displayed appropriately.

The Annual Quality Report was reviewed and was satisfactory.

There was a system in place to ensure that complaints were managed in accordance with the agency's policy and procedure. The manager advised that there had been no complaints received since the last inspection.

It was positive to note that there were several compliments received and recorded from the previous inspection from relatives expressing their gratitude and satisfaction with the care and support provided to their loved one.

4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Olive Jones, Acting Manager as part of the inspection process and can be found in the main body of the report.



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