Inspection Report

Name of Service: **The Mews Supported Living Service**

Provider: **The Cedar Foundation**

Date of Inspection: **24 February 2025, 13 March 2025 and 21 March 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 Devlin
Registered Manager:	Miss Chelsea Lewis
Service Profile: The Mews Supported Living Service is a domiciliary care agency, supported living type service, situated in Belfast. The staff provides personal care and housing support for up to 12 service users who are living in individual flats. The service user group includes individuals who have a learning disability, autism or brain injuries and a range of complex needs, who require support to increase independence and enhance their quality of life. The service users' care and support is commissioned by the Belfast Health and Social Care Trust (the 'Trust').	

2.0 Inspection summary

Following RQIA's receipt of information on 6 February 2025, an unannounced inspection was undertaken on 24 February 2025, 13 March and 21 March 2025.

The inspection was jointly undertaken by care inspectors from the Adult Care Services team, the Mental Health and Learning Disability team; and Pharmacy team. The approach adopted was informed by two pieces of primary legislation, the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and the Mental Health (Northern Ireland) Order 1986.

Under the 2003 Order, RQIA is required to monitor and assess agencies such as The Mews Supported Living Service to ensure compliance with statutory requirements, the safe and effective delivery of care, and the protection and well-being of service users.

In line with its duties under The Mental Health (Northern Ireland) Order 1986 and in particular Article 86 (1) it is the duty of RQIA to keep under the review the care and treatment of patients with a mental disorder, regardless of where that person resides. Under RQIA's duties in this regard, this inspection considered the care and treatment of patients (hereafter, 'service users') with a mental disorder, who reside in The Mews Supported Living Service.

The inspection was undertaken to evidence how the service is performing in relation to the regulations and standards; and focused on the concerns raised within the aforementioned information received.

Enforcement action resulted from the findings of this inspection. Serious concerns were identified regarding the care and treatment of service users which had fallen below an acceptable and expected standard. For instance, there was evidence of some restrictive practices which lacked clear rationale and/or were disproportionate to the risks presented; some service users' living environments required improvement and service users' daily routines lacked structure, predictability and purposeful activity. Concerns were also identified regarding the training, competence and skill levels of staff and in relation to staff knowledge and understanding of care plans.

The inspection also highlighted serious concerns regarding the overall quality of service provision and care delivery to service users. The service had not meaningfully implemented a supported living model of care, which is essential in promoting autonomy, choice and independence for service users. As a consequence, service users' quality of life was compromised, with limited opportunities for independent living, decision-making, and community inclusion. There was also a lack of robust governance and managerial oversight; in addition, serious concerns were identified in relation to the staffing arrangements in place.

RQIA convened a number of enforcement meetings with the Registered Provider on 14 April 2025 in line with RQIA's enforcement procedures; these are outlined below:

A Serious Concerns meeting was held to discuss concerns relating to the care and treatment of service users.

An Intention to serve three Failure to Comply (FTC) notices meeting was held in respect of identified breaches under The Domiciliary Care Agencies Regulations (Northern Ireland) 2007, namely:

- Regulation 14 (a)(b)(c)(d)(e)(f) relating to the provision of care to service users
- Regulation 16 (1)(a)(b)(d)(e) relating to staffing arrangements
- Regulation 11 (1) relating to management and governance arrangements

An Intention to serve a Notice of Proposal meeting was also held in respect of noncompliance with the aforementioned regulations.

These meetings were attended by the Responsible Individual, Registered Manager and members of the senior executive/management team for The Cedar Foundation (the Registered Provider).

During the meetings, the Responsible Individual provided an account of the arrangements they had made and/or intended to make to ensure the improvements necessary to achieve full compliance with the required regulations.

While RQIA welcomed the efforts made by the Registered Provider to address the identified deficits, it was agreed that a revised action plan relating to the care and treatment of service users would be submitted to RQIA within a specified timeframe. Areas for improvement identified during this inspection have been included in the Quality Improvement Plan (QIP) in Section 4 of this report.

In relation to those deficits discussed during the aforementioned FTC meeting, it was noted that more time was required so as to ensure that necessary improvements are achieved in a meaningful and consistent manner.

On that basis, the decision was made to issue two Failure to Comply notices (FTC); in relation to:

- Regulation 14 (a)(b)(c)(d)(e)(f) relating to the provision of care to service users (Ref FTC000243)

- Regulation 11 (1) relating to management and governance arrangements (Ref FTC000244)

Based on the assurances provided, the decision was made not to serve the FTC Notice in respect of Regulation 16 (1)(a)(b)(d)(e), pertaining to staffing arrangements.

Given the need for ongoing improvements within the service, RQIA also issued a Notice of Proposal to impose Conditions on the registration of The Mews Supported Living Service; this enforcement process remains ongoing in line with RQIA's enforcement procedures.

RQIA's focus on the standard of care and treatment being provided to service users also included consideration of the role and accountability of the commissioning Trust, namely, the Belfast Health and Social Care Trust (the Trust) responsible for the service. As a result of the identified concerns, RQIA held a Serious Concerns meeting with the Trust on 17 April 2025. The meeting was attended by senior representatives from the Trust.

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

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 Registered Provider to ensure compliance with legislation, standards and best practice, and to address any deficits, including any deficiencies in care and treatment, 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 seek the views of the service users/relatives who are in receipt of care and support; the staff who work for The Mews Supported Living Service; and review/examine a sample of records to evidence how the service is performing in relation to the regulations and standards.

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

While some positive feedback was received from Trust representatives and from some service users spoken with, the majority of staff feedback was consistent with the inspection findings.

Some service users reported feeling able to raise concerns with staff and described The Mews Supported Living Service as a “real nice place to live” and that they liked the “kind” staff and support received. However, some concerns were also raised.

One service user reported difficulty accessing team leaders, and another expressed a desire for a sensory room that could be used by all. Additionally, some service users felt they were not being supported to achieve the level of independence they believed they were capable of and expressed concerns about being denied opportunities for greater autonomy and personal development.

In relation to the provision of activities, the feedback received was mixed. While some service users stated they enjoyed their freedom and the activities on offer, others expressed dissatisfaction regarding restricted mobile phone access, locked areas within their home, and limited access to their personal finances. Concerns were also raised about not receiving adequate support to make their own choices about how to spend their day.

3.3 Inspection findings

3.3.1 Model of Care

It was identified that the service required improvement so as to consistently and meaningfully implement a supported living model of care for service users focused on promoting their independence, choice and the delivery of person-centred care; and empowering service users to live as autonomously as possible. Promotion of these core principles of supported living is essential to ensuring that service users’ quality of life is maximised in a manner which respects their wellbeing, dignity and choices.

The use of restrictive practices within the service was concerning and it was evident that there was a lack of meaningful managerial oversight of service users’ risk reduction plans. For instance, staff routinely used back doors to enter service users’ bungalows for their own convenience; however, this degree of autonomy and independence was not afforded to service users. It was also concerning that a number of service users’ back doors were kept locked during the day and could not be unlocked by them. Service users were also restricted from exiting through their front door to the garden area and also externally beyond the boundaries of the garden, when they should have ordinarily been supported to do so. These restrictions were applied uniformly across the service, and included service users who had been assessed as having capacity to make their own decisions.

The inspection highlighted that an inflexible and indiscriminate approach was maintained by staff in relation to the use of ‘fobs’ so as to control access to internal doors and gates, regardless of whether service users had mental capacity in this regard. It was concerning that staff did not recognise that the use of such restrictive practices in this way, impacted upon the service users’ rights, dignity and choice. Further reference is made in Section 3.3.4.

RQIA observed that there are multiple service users living within The Mews Supported Living Service who present with complex behaviours which are, at times, challenging. The resulting staff-heavy presence was observed to dominate the setting and thereby created an environment which focused excessively on managing risk at the cost of promoting service users' autonomy, privacy and wellbeing. It was evident that the group dynamics of service users living within the service had not been given due recognition in terms of compatibility and the potential to impact the quality of life and/or independence of service users.

It was concerning to note that the service's approach to care was more aligned with a traditional medical model rather than the principles of a supported living model. This approach did not adequately promote choice or independence, and while the Trust's Behavioural Support Team had developed behaviour support plans for service users, it was evident that staff employed within the service lacked the requisite knowledge, skills and confidence to effectively manage and avert behavioural incidents. Due to the absence of effective behavioural support, service users were often contained within restrictive environments, rather than being supported to achieve independence, social inclusion and community integration. It was evident that staff required training in relation to the proactive management of behaviours which may be challenging.

Service users were not informed of the names of the carers who were assigned to support them. While RQIA acknowledge that this may have been appropriate for some service users, it was concerning that a 'blanket approach' was in place for all service users in this regard.

Concerns were also identified in relation to medicines management arrangements. Medicines for all service users were locked in a medicine trolley and stored in a locked medicine room under closed-circuit television (CCTV) surveillance; such arrangements are not in keeping with a supported living model of care. Discussion with staff also highlighted that there were no effective systems in place so as to regularly review service users' capacity to become more independent, with regard to their own medicines management, and thereby focus on enabling them to self-administer their medicines, as appropriate.

The approach to financial management reflected a blanket restriction, rather than a personalised, capacity informed practice. The majority of service users' monies were held in a locked safe within an identified designated location, without appropriate consideration of individual capacity. This meant that service users were denied the opportunity to develop or exercise independence in managing their own money. Immediate review is required to ensure that financial arrangements are aligned with legal and ethical standards and to ensure independence, dignity and choice is promoted for all service users.

A number of service users were supported with their meal preparation. While fresh produce was noted within some service users' living spaces, discussion with staff evidenced an over-reliance on ready-meals, rather than preparing nutritious meals with the service users, so as to promote their health, wellbeing and independence.

RQIA invited the Responsible Individual to attend a Serious Concerns meeting on 14 April 2025 and requested the submission of an action plan outlining how they intended to address the concerns highlighted regarding the care and treatment of service users. A level of assurance was noted within the revised action plan submitted by The Registered Provider following this meeting. RQIA will continue to monitor progress against the actions outlined within the revised action plan.

During the Intention to serve three Failure to Comply Notices meeting held on 14 April 2025, RQIA was not assured that robust systems and processes were fully embedded into practice so as to drive the necessary improvements in regard to the deficits outlined above.

RQIA therefore issued an FTC Notice under Regulation 14 (a)(b)(c)(d)(e)(f) of The Domiciliary Care Agencies Regulations (Northern Ireland) 2007 (Ref FTC000243). The Registered Provider is required to ensure compliance with the actions stated within this Notice by 12 June 2025.

While RQIA welcome the efforts made by the Registered Provider to address identified deficits in service provision and care delivery to service users, it was noted that more time is required so as to ensure that necessary improvements are achieved in a meaningful and consistent manner. Therefore, RQIA also issued a Notice of Proposal to impose Conditions on the registration of The Mews Supported Living Service; this enforcement process remains ongoing in line with RQIA's enforcement procedures.

3.3.2 Governance and managerial arrangements

Serious concerns were identified regarding the lack of robust governance arrangements and managerial oversight.

For instance, staff had an inadequate understanding of the incident reporting procedures; and Inspectors were informed that team leaders operated on a 'need to know basis' and failed to follow up with staff following incidents. It was evident that the system for reviewing incidents was ineffective; and that any identified key themes/trends had not been disseminated among staff, so as to enhance their learning and effect improvements in care delivery.

Deficits were also identified in relation to the analysis of incidents; for example, where lessons had been identified from in-depth analysis of an incident, this learning had not been shared with the staff.

In addition, incident reports had not been consistently completed, when referrals were made to the relevant Adult Protection Gateway Team (APGT). Discussion with staff also demonstrated that they lacked an effective understanding of adult safeguarding best practice principles/procedures so as to ensure that these were embedded into practice. It was identified that there is a need for robust arrangements to be in place in relation to adult safeguarding training for staff; this should include quality assurance actions by the Registered Manager so as to quality assure staff understanding and compliance in relation to adult safeguarding best practice guidance.

Discussion with staff also evidenced that the system in place for managing complaints, either from service users and/or staff, was ineffective.

It was concerning that the monthly quality monitoring arrangements were not sufficiently robust so as to identify these deficits and address them in a meaningful and timely manner. There was a need to ensure that the person designated with the responsibility for undertaking the quality monitoring visits possesses the requisite skills, knowledge and experience to undertake this task in an effective manner.

The serious concerns identified above were discussed with the Responsible Individual, Registered Manager and members of the senior executive/management team for The Registered Provider on 14 April 2025. RQIA was not assured that robust systems and processes were fully embedded into practice to drive the necessary improvements in regard to the deficits outlined above. RQIA therefore issued an FTC Notice under Regulation 11(1) of The Domiciliary Care Agencies Regulations (Northern Ireland) 2007 (Ref FTC000244). The Registered Provider is required to ensure compliance with the actions stated within this Notice by 12 June 2025.

3.3.3 Staffing arrangements

Serious concerns were identified regarding the lack of effective managerial oversight so as to ensure that staff deployment promotes the delivery of safe, high quality and person-centred care.

For instance, the staff sign-in system was not consistently used by staff; there was also a lack of oversight and purposeful and effective delegation by the management team/team leaders including those staff who were observed either arriving early for duty and/or occupying the staff room for significant periods of time.

Feedback from staff indicated that staff supplied by recruitment agencies (hereafter, 'agency staff') spent the majority of their shift in the staff room, being selective in the alarm calls they responded to. There was a lack of understanding among staff in relation to staffing requirements for service users who required enhanced observations.

While staff spoken with were aware of who they were assigned to support, Inspectors were not assured that arrangements were in place to ensure that these staff were assisting service users in a purposeful and meaningful way. It was evident that the current staffing arrangements need to be reviewed so as to ensure that the staffing levels are appropriate and not excessive. An area for improvement has been identified to ensure that the staffing arrangements are reviewed, in consideration of: the assessed needs of service users; the skill mix of staff; and overall staff numbers so as to promote a balanced, supportive and purposeful environment that encourages service user privacy and independence. This area for improvement has been subsumed into the FTC Notice FTC000243.

Agency staff working within the service lacked the requisite knowledge and/or experience to effectively meet service users' needs. While there was evidence that agency staff had received an induction to the building and the assessed needs of service users, the induction process was insufficiently underpinned by the core principles of supported living. This was particularly concerning given that there were occasions when agency staff were in charge of the service. An area for improvement has been identified.

In addition, Inspectors were not assured that all staff had received Crisis Prevention Intervention training in keeping with the organisation's policy and procedures. An area for improvement has been identified.

It was noted that the staff handover system was insufficiently robust. While there were improvements noted in this regard throughout the duration of this inspection, it was concerning to note that written handover records were not consistently provided to staff.

Effective communication across shifts is essential for ensuring consistent, safe and effective care to service users. An area for improvement has been identified.

Inspectors also lacked assurance regarding the system in place for ensuring that staff named on the management on-call system possessed the requisite skills and knowledge for this role. An area for improvement has been identified.

The processes in place to manage staff registrations with the Northern Ireland Social Care Council (NISCC) were not sufficiently robust. An area for improvement has been identified.

It was concerning to note that the Registered Manager was unaware of significant details contained within an enhanced AccessNI check relating to an agency staff member and was therefore unable to provide assurances in this regard. An area for improvement has been identified.

Staff meetings were infrequent and discussion with staff highlighted a lack of interest in attending the employee forum. It was evident that there is a need for management to undertake a cultural review of the service so as to better understand the values, behaviours and attitudes shaping staff and service users' experiences. An area for improvement in this regard has been subsumed into the FTC notice FTC000244.

In addition, the service user agreement used by the service did not consistently detail the hours of care and support the service users were entitled to. Therefore, RQIA was not assured that service users were being supported appropriately in keeping with their care and support plans. An area for improvement has been identified.

Competency assessments for the person in charge in the absence of the Registered Manager were not completed on all staff and there was a lack of clarity among staff regarding who was in charge before the Registered Manager attended the inspection on 24 February 2025. An area for improvement has been identified.

The serious concerns identified above were discussed with the Responsible Individual, Registered Manager and members of the senior executive/management team for The Registered Provider on 14 April 2025. RQIA welcomed the efforts made by the Registered Provider to address the identified deficits. On this basis, the decision was made not to serve the FTC Notice in respect of Regulation 16 (1)(a)(b)(c)(d)(e); however, areas for improvement, relating to these matters are included in the Quality Improvement Plan noted in Section 4.0.

3.3.4 Care and Treatment

As referenced in Sections 3.3.1 and 3.3.3, there was limited evidence of meaningful engagement and/or purposeful activity for service users. Daytime structure was insufficient, with a lack of consistent routines or scheduled activities tailored to the specific needs and preferences of individual service users. Several service users were observed to be without any clear structure or planned activity during the day; provision of structured activities is essential to ensuring that service users' needs for predictability, routine and positive engagement is effectively and consistently met.

The absence of personalised, structured support not only limits opportunities for skill development and social inclusion but also poses a risk of escalating behaviours of distress and deterioration in emotional and psychological well-being.

It was evident that the provision of daytime structure and purposeful activity for service users needed to be improved; actions in this regard were raised during a Serious Concerns meeting held with the Registered Provider on 14 April 2025. Following this meeting, a revised action plan was submitted to RQIA outlining proposed corrective measures and timeframes for implementation. Progress will be monitored via action plan updates to RQIA. Specific actions to address this deficit have been subsumed into the FTC Notice FTC000243.

The inspection identified serious concerns regarding the widespread and, in some instances, inappropriate use of restrictive practices, particularly in relation to service users assessed as having mental capacity under the Mental Capacity Act (Northern Ireland) 2016. Care records did not clearly specify the decision-making domains for which service users had been assessed as having capacity, nor did they demonstrate that restrictions were the least restrictive option necessary to meet a legitimate need. Service users with assessed capacity were subject to continuous supervision and control and were not free to leave the service raising significant concerns regarding breaches of service users' liberty and autonomy. Feedback from service users in relation to this matter varied; for instance, some service users reported feeling safer due to the restrictions, while others expressed frustration at being denied autonomy and opportunities to develop skills in areas such as money management and personal safety at home and in the community.

A restrictive practice register was maintained and included restrictions applied regardless of individual service user's capacity assessments. Blanket restrictions were described within the restrictive practice register as standard practice, without sufficient evidence of individualised assessment of necessity or proportionality or without the least restrictive alternatives being considered or implemented. Although multidisciplinary team (MDT) review meetings with the Trust were occurring monthly and the restrictions in place for each service user were listed in individual service users' MDT meeting notes, there was limited evidence of meaningful reduction in such practices.

In most cases, restrictive measures remained unchanged over time indicating a lack of dynamic and responsive care planning and the ineffective use of the monthly MDT meeting. These findings evidence that restrictive practices, including those affecting service users with capacity, were being implemented without sufficient scrutiny, review or justification. While systems for recording and discussing restrictions were in place, they lacked the effectiveness and urgency required to ensure that such restrictions are necessarily time-limited, proportionate, and rights-based.

Post inspection, Serious Concerns meetings were held separately with the Registered Provider and relevant staff from the Trust respectively. During these meetings, the Responsible Individual committed to ensuring that all restrictive practices would be reviewed internally, and in collaboration with the Trust, as part of a more rigorous governance process. This commitment was endorsed by the Trust during a Serious Concerns meeting held with them on 17 April 2025, and assurance was provided that all implemented restrictions would be reviewed with urgency, in line with the Regional Policy. The commitments made by the Responsible Individual and by the Trust during the separate Serious Concerns meetings formed the basis of time bound actions within two separate, formal action plans subsequently submitted to RQIA.

The effectiveness of the actions recorded will be monitored by RQIA and will inform the ongoing regulatory oversight of this service by RQIA. Specific actions in relation to restrictive practices within The Mews Supported Living Service have been subsumed into the FTC Notice FTC000243.

Additionally, the Regional Policy on the use of Restrictive Practices in Health and Social Care Settings, Department of Health (DoH), November 2023 (the Regional Policy), provides the regional framework to integrate best practice in the management of restrictive interventions, restraint and seclusion. While the organisation's guidance on reducing restrictive practices promotes independence and use of the least restrictive approach, it was found to be outdated at the time of inspection, with the most recent version dated July 2020.

RQIA are aware that a regional working group, led by the DoH, is considering matters associated with the implementation of the policy, however an area for improvement has been identified to ensure guidance available for staff in the service is updated to reflect the current Regional Policy.

The practice of hourly staff rotations appeared to affect continuity of care and had the potential to negatively impact service users' ability to engage meaningfully in structured activities. Staff told Inspectors that the rationale behind the hourly rotation system was not clearly understood, suggesting an opportunity to review this approach in order to better support both staff and service users. An area for improvement in relation to the review of staffing arrangements has been subsumed into the FTC Notice FTC000243.

A lack of accessible and flexible transport options was evident within The Mews Supported Living Service. Although a communal vehicle was available, its use was constrained by the need to consider compatibility among those sharing transport, which significantly reduced opportunities for spontaneous and/or individualised community outings. The cost of public transport was also identified as a barrier for some service users, particularly where financial resources or support arrangements did not sufficiently account for such expenses.

While a number of service users were noted to have mobility vehicles, these were not routinely available at the service. This further limited the consistency and reliability of access to external activities. As a result, opportunities to support service users' independence, social inclusion, and person-centred outcomes through community participation were not being fully realised. Concerns in relation to deficiencies in service users' individual access to transport options were discussed with the Responsible Individual during the aforementioned Serious Concerns meeting. The Responsible Individual confirmed their commitment to review current arrangements to ensure service users are fully informed and involved in decision making in relation to the management of their personal monies and access to mobility vehicles. An area for improvement has been identified to ensure that the deficiencies in service users' individual access to transport options are addressed.

The serious concerns identified above were discussed during the Serious Concerns meeting on 14 April 2025. During the meeting, the Responsible Individual provided an account of the actions taken/planned to ensure the minimum improvements necessary to achieve compliance with the aforementioned legislation. While RQIA welcomed the efforts made by the Registered Provider to address the identified deficits, it was agreed that a revised action plan would be submitted to RQIA within a specified timeframe. The revised action plan was subsequently received as agreed and progress will be reviewed as part of an improvement monitoring process.

A number of actions required have been subsumed into the FTC Notice FTC000243; and additional areas for improvement have been included in the Quality Improvement Plan noted in Section 4.0.

3.3.5 Living environments

Some service users' living environments were observed to be overly cluttered with the general standard of cleanliness falling below what is expected in a supportive care setting. While it is recognised that some service users may require tailored support to manage their personal space, staff intervention to assist in maintaining these environments to an acceptable standard appeared to be limited. See Section 3.3.7 for further detail.

In addition, maintenance issues had not been consistently addressed in a timely or proactive manner. Delays in completing repair works contributed to an overall sense of deterioration within some areas of accommodation. These environmental factors, if left unaddressed, may have a negative impact on service users' sense of dignity, personal identity, and emotional well-being. An area for improvement has been identified.

Furthermore, the conditions observed did not align with best practice standards in relation to fire safety or infection prevention and control, both of which are essential to ensuring a safe and respectful living environment. An area for improvement has been identified.

The service should develop and implement personalised support plans that include clear strategies for assisting individuals in maintaining their living environments. These plans should consider each service users' preferences, capabilities, and support needs, ensuring a respectful and empowering approach. An area for improvement has been identified.

These deficits were discussed during the aforementioned Serious Concerns meeting with the Registered Provider on 14 April 2025. During the meeting the Responsible Individual provided an account of the actions taken/planned to ensure the minimum improvements necessary to achieve compliance with the aforementioned legislation. While RQIA welcomed the efforts made by the Registered Provider to address the identified deficits, it was agreed that a revised action plan would be submitted to RQIA within a specified timeframe. The revised action plan was subsequently received as agreed and progress will be reviewed as part of an improvement monitoring process. Areas for improvement have been included in the Quality Improvement Plan noted in Section 4.0.

3.3.6 Staff training, competence and skill

There was evidence of insufficient staff skill, competency, and oversight in effectively supporting and therapeutically engaging service users with complex care needs. Dysregulated behaviours, manifested through heightened levels of verbal and physical aggression towards staff and the surrounding environment, reflected challenges in the consistent and safe management of these needs. Actions in relation to addressing in-compatibility issues have been subsumed into the FTC notice FTC000243.

Additionally, there was limited clarity regarding the availability of post-incident support for staff or how they were supported to understand and apply updated behavioural strategies, potentially affecting their ability to reduce the likelihood of further incidents. An area for improvement in this regard has been subsumed into the FTC notice FTC000244.

While behaviour support staff employed by the Trust were present, there was insufficient assurance that substantive staff and staff supplied by recruitment agencies were adequately trained, informed, or competent to manage complex behaviours effectively in the absence of Trust employed behaviour support staff. These concerns also highlighted a lack of clarity regarding the respective roles and responsibilities of the two staff groups, and reinforced the need for improved training, oversight, and communication to ensure consistent delivery of person-centred care. Actions relating to the review of staff training have been subsumed into the requirements set out within the FTC Notice FTC000243.

Although regular MDT meetings were held, it remained unclear how the outcomes of these discussions were communicated to staff or embedded into daily practice. Structured systems to ensure staff were informed of, and able to implement, agreed strategies appeared to be lacking. An area for improvement has been identified.

Some staff demonstrated a lack of confidence and uncertainty in their roles, with evident gaps in knowledge relating to key aspects of individual care plans. Of particular concern was the inconsistent adherence to eating and drinking guidelines as assessed by the Speech and Language Therapy (SALT) team, posing a potential risk to service user safety. This matter was raised with the Registered Manager on the day of the inspection, and assurances were provided that immediate action had been taken, in liaison with the SALT team, to address the concern. The Registered Manager also provided assurance that a revised care plan would be made available for staff to align with SALT guidance. An area for improvement has been identified.

The serious concerns identified above were discussed with the Registered Provider during the serious concerns meeting on 14 April 2025. During the meeting the Responsible Individual provided an account of the actions taken/planned to ensure the minimum improvements necessary to achieve compliance with the aforementioned legislation. While RQIA welcomed the efforts made by the Registered Provider to address the identified deficits, it was agreed that a revised action plan would be submitted to RQIA within a specified timeframe. The revised action plan was subsequently received as agreed and progress will be reviewed as part of an improvement monitoring process. Areas for improvement have been included in the Quality Improvement Plan noted in Section 4.0.

Concerns relating to a lack of clarity around the role and responsibilities of Trust employed behaviour support staff were raised with the Trust during a serious concerns meeting on 17 April 2025. In response, the Trust provided a further commitment, during the meeting and within its submitted action plan, to review and clarify the involvement of its staff within the service.

3.3.7 Care plans

There was limited evidence to offer assurance that all individuals accommodated at The Mews Supported Living Service were consistently supported to achieve their optimum level of independence and therefore enjoy an acceptable quality of life.

It was positive to note from a review of a sample of care plans that these were written in a person-centred manner with the aim of promoting individual autonomy; the care plans provided clear, practical guidance for staff on how to deliver care and support in a way that reflected each person's needs, preferences, and goals.

However, despite the quality of the care planning documentation, there was limited evidence that the plans were being consistently adhered to and realised during day-to-day practice. This inadequate implementation of prescribed care appeared to limit the effectiveness of care delivery. As a result, service users reported feelings of frustration and dissatisfaction, particularly in relation to their limited autonomy and involvement in key decisions about their care and personal finances. An area for improvement has been identified.

Structured opportunities for individuals should be created to enable individuals to meaningfully participate in decisions about their care, daily routines and personal finances. Advocacy services should also be engaged and encouraged where appropriate. An area for improvement has been identified.

These concerns suggest a lack of meaningful engagement with individuals in their own support planning and daily routines, which can undermine person-centred principles and adversely affect service users' confidence, self-esteem, and sense of control. Supporting service users to be actively involved in decisions that affect them, particularly in relation to their independence and financial autonomy, is essential to promoting dignity, inclusion, and improved quality of life outcomes.

The Registered Provider should ensure that care plans are not only person-centred in design but are meaningfully and consistently used to guide and inform daily practice by staff. Regular staff meetings and reflective sessions should be utilised to reinforce the consistent application of documented care strategies.

The serious concerns identified above were discussed with the Registered Provider during the serious concerns meeting on 14 April 2025. During the meeting, the Responsible Individual provided an account of the actions taken/planned to ensure the minimum improvements necessary to achieve compliance with the aforementioned legislation. While RQIA welcomed the efforts made by the Registered Provider to address the identified deficits, it was agreed that a revised action plan would be submitted to RQIA within a specified timeframe. While a number of actions pertaining to the above have been included in the FTC Notices, FTC000243 and FTC000244, additional areas for improvement have been identified and are included in the Quality Improvement Plan.

3.3.8 Medicines management

As detailed in Section 3.3.1, review of care plans for the administration of, or assistance with medication indicated that they were not person-centred and did not support service users to manage some or all aspects of their medicines; staff were providing full support with medicines management for all service users. There were no effective systems in place to regularly review each service user's capacity to become more independent, with regard to managing their medicines. Individualised support plans which are tailored to specific needs, preferences, routines and communication styles so as to avoid a 'one-size-fits-all' approach should be developed and implemented.

Serious concerns in relation to the model of care (Section 3.3.1) included this 'blanket approach' to the management and storage of medicines and this was discussed with the Responsible Individual and members of the senior executive team for The Registered Provider on 14 April 2025. RQIA was not assured that robust systems and processes were fully embedded into practice to drive the necessary improvements in regard to these deficits. RQIA therefore issued a FTC Notice under Regulation 14 (a)(b)(c)(d)(e)(f) of The Domiciliary Care Agencies Regulations (Northern Ireland) 2007 (Ref FTC000243). The Registered Provider is required to ensure compliance with the actions stated within this Notice by 12 June 2025.

In addition to reviewing the care plans for medicines management, Inspectors reviewed the arrangements for the storage and disposal of medicines, record keeping, the administration of medicines, staff training and governance and audit.

As detailed in Section 3.3.1, medicines for all service users were locked in a medicine trolley and stored in a locked medicine room under CCTV surveillance; such arrangements are more in keeping with care delivery within a residential care home setting. Storage was tidy and organised so the medicines belonging to each service user could be easily located. However, the temperature of medicine storage areas and the medicine refrigerator were not monitored and recorded to ensure that medicines were stored at the manufacturers' recommended temperature. This was discussed with the management team for corrective action. In addition, the Registered Manager was reminded that medicines awaiting collection for disposal should be returned to the community pharmacy in a timely manner.

Review of records of medicines ordered, received, prescribed, administered and disposed of were accurately maintained.

The personal medication records were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to confirm that they were accurate. Staff were reminded that obsolete personal medication records must be cancelled and archived so that they are not referred to in error.

A sample of the medicines administration records was reviewed. The records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review. The Registered Manager and staff were reminded that pre-printed medicine administration records must be signed and verified as accurate by two trained members of staff.

Records reviewed showed that medicines were available for administration when service users required them. The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. Audit discrepancies observed in the administration of a small number of medicines were discussed in detail with the staff on duty and the Registered Manager for on-going monitoring.

Occasionally, service users may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the service user's care plan. One care plan required more detail to direct the required care. This was highlighted to the Registered Manager for immediate action.

Policies and procedures for the management of medicines were up to date and readily available for staff reference. There were records in place to show that staff responsible for medicines management had been trained and deemed competent.

Management and staff audited the management and administration of medicines on a regular basis within the service. The date of opening was recorded on the majority of medicines to facilitate audit and disposal at expiry. The audits completed at the inspection indicated that the majority of medicines were administered as prescribed.

A medicines incident log was maintained. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence.

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	15	2

Areas for improvement and details of the Quality Improvement Plan were discussed with the Responsible Individual and members of the senior executive/management team of The Registered Provider during and/or following 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 16 (5)(a) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that the staff induction is further developed, to ensure that it is underpinned by the core principles of supported living. Ref: 3.3.3
	Response by registered person detailing the actions taken: Induction for staff includes key competency assessments for Positive Behaviour Support (BILD), Safeguarding, How to Raise a Concern and Complaints. A specific induction to the Mews service has also been devised which includes in depth overview of the service users and their individual needs. A programme for Supported Living refresher training has been planned and will be part of induction going forward.
Area for improvement 2 **Ref:** Regulation 16 (2)(a) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that all staff receive training in respect of Crisis Prevention Intervention; this includes all substantive staff and any staff supplied by recruitment agencies who work in the service on a regular basis/block booking arrangement. Ref: 3.3.3
	Response by registered person detailing the actions taken: All staff attend the CPI Safety Intervention Training within 3 months of start date. Refresher Training is delivered on an annual basis. It is requested that Agency staff have CPI Safety Intervention Training. Cedar offer this training to agency staff and all agency staff who are block booked are also scheduled on Cedar refresher training.
Area for improvement 3 **Ref:** Regulation 16 (1)(b)(i)(ii) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that the staff handover system is robust and includes the names of all staff in attendance; and written records are consistently provided to staff. Ref: 3.3.3
	Response by registered person detailing the actions taken: There is a staff handover record completed by Registered Manager or nominee. An attendance sheet is signed by all staff who attend handover. This handover sign in sheet is reviewed and signed off by Registered Manager. For staff who have not

	attended verbal handover, the written records are available in the handover file for staff to read when next on shift.
Area for improvement 4 **Ref:** Regulation 14 (a)(b)(c)(d)(e)(f) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall review the management on-call system to ensure that they possess the requisite skills and knowledge for this role. Ref: 3.3.3
	Response by registered person detailing the actions taken: On Call Management System HOS and Registered Manager from the Mews are available to take calls after working hours Monday to Thursday. There is a two Tier on Call system in place at weekends and bank holidays and there are guidance documents to support this process and guide staff as to their roles and responsibilities. The on call Team are all members of the Living Options team at HOS, Registered and Deputy Manager Levels and are deemed competent to carry out this role. Tier 1- Calls are taken, advice/guidance provided. Any serious concerns/incidents are escalated to Tier 2 Tier 2 – Calls are taken.Tier 2 assesses the information- provides support and guidance as appropriate. Escalation to Director (RI) via Tier 2 with High Level/Significant incidents) or if there is advice/guidance needed. Escalation to CEO as assessed by Director (RI) A record of all on-calls/advice/escalation is recorded on the On-Call database and reviewed weekly by the Living Options Senior Team.
Area for improvement 5 **Ref:** Regulation 13 (d) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall further develop and implement the policy in relation to professional registrations, to ensure that all staff, including those supplied by recruitment agencies, are appropriately registered with the Northern Ireland Social Care Council (NISCC); staff whose registration lapsed, for whatever reason, must not be afforded a second grace period to register. Ref: 3.3.3
	Response by registered person detailing the actions taken: All staff NISCC registrations are audited on a monthly basis to ensure full compliance. This is completed by The Mews management team and an additional check is completed by MMV

	auditor (manager level staff from another registered service). Mews Management staff will contact staff to provide additional reminder to ensure registration is maintained annually. Additional check has been added to recruitment documentation to ensure that any staff member who has previously been registered with NISCC has their registration renewed prior to commencement of employment.
Area for improvement 6 **Ref:** Regulation 13 (d) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that the process for managing AccessNI disclosures is also applied to staff provided by recruitment companies; all persons in charge of the service must be able to articulate their role in relation to any disclosures identified on agency staff profiles. Ref: 3.3.3
	Response by registered person detailing the actions taken: Agency profiles are provided when agency shifts are booked. If AccessNI disclosures are noted on a profile the management team will make contact with the agency to gain more information and ensure appropriate risk assessment has been completed to ensure the person is suitable to carrry out the role.
Area for improvement 7 **Ref:** Regulation 15 (11) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that guidance on the management of restrictive interventions, restraint and seclusion is updated to reflect the Regional Policy on the use of Restrictive Practices in Health and Social Care Settings, Department of Health, November 2023. Ref: 3.3.4
	Response by registered person detailing the actions taken: Cedar have a Procedure and Guidance on Managing Restrictive Practices to guide staff through a structured, ethical decision-making process when considering, using, or reviewing restrictive interventions, in line with the Three Steps to Positive Practice Framework and regional regulatory requirements
Area for improvement 8 **Ref:** Regulation 14 (f) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that the deficiencies in service users' individual access to transport options are addressed. Ref: 3.3.4
	Response by registered person detailing the actions taken: The service has a vehicle which is for shared use. The service does not have access to mobility vehicles for individual service users. Service users avail of public transport to access the local community. Within the activity plans, access to appopriate transport will be identified.

Area for improvement 9 **Ref:** Regulation 14 (a)(b)(c)(d)(e)(f) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that maintenance issues are addressed in a timely and proactive manner. Ref: 3.3.5
	Response by registered person detailing the actions taken: All outstanding maintenance issues have been escalated with Choice Housing Association and there is an action plan in place to address outstanding repairs. There are regular meetings with the Housing Association and Cedar to ensure timely response within the SLA. Review of Maintenance issues are reviewed in MMVs.
Area for improvement 10 **Ref:** Regulation 14 (d) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that the practice of locking service users doors at specified times is reviewed to ensure compliance with fire safety regulations. Ref: 3.3.5
	Response by registered person detailing the actions taken: All restrictive practices have been reviewed with the Belfast Trust to ensure that all practices are appropriate, proportionate and aligned to assessed need. In the case of fire safety concerns fob controls are automatically released at these times.
Area for improvement 11 **Ref:** Regulation 14 (a)(b)(c)(d)(e)(f) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall develop and implement personalised support plans that include clear strategies for assisting service users in maintaining their living environments; these plans should consider each person's preferences, capabilities, and support needs, ensuring a respectful and empowering approach. Ref: 3.3.5
	Response by registered person detailing the actions taken: All care and support plans have identified service user individual needs and goals are linked to the care plan to identify areas for development in independent living.
Area for improvement 12 **Ref:** Regulation 16 (1)(b) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall review the system of MDT meetings, to ensure that the outcomes of these discussions are communicated to support staff or embedded into daily practice. Ref: 3.3.6
	Response by registered person detailing the actions taken: MDT minutes are stored on iplanit for individual service users which all staff are able to access. Communication is also shared through staff email and communication file.

Area for improvement 13 **Ref:** Regulation 16 (1)(a) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that all staff are familiar with and able to articulate the recommendations on the service users SALT care plan. Ref: 3.3.6
	Response by registered person detailing the actions taken: All staff have access to SALT recommendations for individuals which is contained in their care plan. SALT assessment is also uploaded to media section of iplanit. Reminder is provided to staff at handover each day.
Area for improvement 14 **Ref:** Regulation 14 (a)(b)(c) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that the care plans are actively used to guide daily practice; regular staff meetings and reflective sessions should be utilised to reinforce the consistent application of documented care strategies. Ref: 3.3.7
	Response by registered person detailing the actions taken: All staff have access to care plans which are stored on iplanit system. Regular discussion is held with staff regarding individual service user needs through staff meetings, reflective practice and debrief sessions (CPI Instructors) and reflective practice sessions with clincial pychology.
Area for improvement 15 **Ref:** Regulation 15 (5)(c) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that there is meaningful engagement with service users in their own support planning and daily routines; decision making tools should be used to identify the best ways in which to support service users, particularly in relation to their independence and financial autonomy. Ref: 3.3.7
	Response by registered person detailing the actions taken: All service users have input into deciding their activities of daily living and how they would like to be supported. Individual goals are recorded on iplanit with progress notes. MDT reviews have been completed to discuss service user capacity regarding management of service user monies.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	

Area for improvement 1 **Ref:** Standard 4 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that the service users are provided with a service user agreement, which details the hours of care and support the service users were entitled to. Ref: 3.3.3
	Response by registered person detailing the actions taken: All service users have an Individual Service User Agreement detailing the hours of care and support which are provided.
Area for improvement 2 **Ref:** Standard 8 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that the person in charge in the absence of the registered manager is identified on the staff rota; and a competency assessment must be completed by all staff designated with this responsibility. Ref: 3.3.3
	Response by registered person detailing the actions taken: All team leaders and deputy managers have completed Competency Assessments. The team leader in charge is identified on the rota.

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

The Regulation and Quality Improvement Authority

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