The Regulation and Quality Improvement Authority

Inspection Report

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

Provider: **The Cedar Foundation**

Date of Inspection: **16 June 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

An unannounced inspection took place on 16 June 2025, between 9.15 a.m. and 5.15 pm.

The inspection was jointly undertaken by care inspectors from the Adult Care Services team; and the Mental Health and Learning Disability 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 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.

This inspection was undertaken to assess compliance with the actions required within the Failure to Comply (FTC) notices (FTC Ref: FTC000243; and FTC000244) issued on 17 April 2025 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 11 (1) relating to management and governance arrangements

The date of compliance for the notices to be achieved was 12 June 2025.

During this inspection, there was evidence that a number of improvements had been made to address some of the actions stated within the notices. However, sufficient evidence was not available to validate full compliance with the FTC Notices. RQIA considered the inspection findings and decided to extend the compliance date of the FTC Notices.

FTC Ref: FTC000243E1 and FTC000244E1 were subsequently issued with compliance to be achieved by 17 July 2025.

In addition, RQIA imposed Conditions on the registration of The Mews Supported Living Service which came into effect on 2 June 2025; these Conditions restrict new admissions to the service without the prior written agreement of RQIA. Any proposed admission must be discussed with RQIA in advance, and written confirmation obtained prior to proceeding. These Conditions will remain in place until such time as RQIA is satisfied that the service is operating in line with its Statement of Purpose.

Due to the specific focus of this inspection, fifteen areas for improvement previously identified were carried forward for review at a future inspection; and two areas for improvement have been stated for the second time. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

The areas for improvement identified at the previous inspection were carried forward for review.

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

There was a mixed response from service users regarding their lived experience. Those who chose to speak with us, and were able to clearly express their view generally indicated that they were content living in The Mews.

However, the environment including each service user's individual accommodation and the communal area was not consistent with a least restrictive approach and did not reflect the principles required in the promotion of a restrictive practice reduction framework, which aims to support dignity, autonomy, and person centred care.

During our inspection, observations of the physical environment did not always demonstrate there was a strong focus on enhancing the quality of life for service users.

Some individual living areas were noted to be in need of improvement particularly in relation to natural light, service user dignity and overall cleanliness.

Communal areas were not enabling, appeared stark and clinical with features more consistent with secure settings. Observations such as unrepaired damage to windows and graffiti in an outdoor space detracted further from the overall environment.

Engagement between staff and service users showed inconsistency in the application of person centred principles. Staff interactions were often limited and observed to be primarily task orientated, rather than centred around building therapeutic relationships and promoting independence.

One visiting relative at the time of the inspection said they were happy with their family members care in the Mews.

3.3 Inspection findings

3.3.1 Compliance with FTC (relating to the provision of care to service users)

FTC Ref: FTC000243

Notice of failure to comply with Regulation 14 (a)(b)(c)(d)(e)(f) *of The Domiciliary Care Agencies Regulations (Northern Ireland) 2007*

Conduct of the Agency

Regulation 14

Where the agency is acting otherwise than as an employment agency, the registered person shall make suitable arrangements to ensure that the agency is conducted, and the prescribed services arranged by the agency, are provided—

(a) so as to ensure the safety and well-being of service users;
(b) so as to safeguard service users against abuse or neglect;
(c) so as to promote the independence of service users;
(d) so as to ensure the safety and security of service users' property, including their homes;
(e) in a manner which respects the privacy, dignity and wishes of service users, and the confidentiality of information relating to them; and
(f) with due regard to the sex, religious persuasion, racial origin, and cultural and linguistic background and any disability of service users, and to the way in which they conduct their lives.

In relation to this notice the following eleven actions were required to comply with this regulation:

The registered person shall ensure that:

1. a system is developed and implemented so as to ensure that all restrictive practices are carried out, monitored and regularly reviewed in keeping with Regulation and the Regional Policy on the use of Restrictive Practices in Health and Social Care Settings (November 2023); this arrangement should also ensure that there is meaningful managerial oversight of service users' risk reduction plans on an ongoing basis

2. a system is developed and implemented which will enable the Registered Manager to regularly review service users' access to and use of 'fobs' for gaining access / egress to and within the building as appropriate; this should include the provision of person-centred risk assessments for all service users so as to ensure that any restrictions concerning the use of such 'fobs' is necessary and proportionate to the assessed risks.

3. a review of current staffing arrangements is carried out so as to ensure that staffing levels are appropriate and not excessive; the review should include a 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

4. a review of the compatibility of service users living within the service is carried out so as to ensure that the group dynamic supports service users' autonomy, privacy and wellbeing; the review should also identify any compatibility issues which are/have the potential to impact the quality of life and/or independence of service users and record appropriate actions taken to address such concerns

5. robust arrangements are in place in relation to providing relevant staff training regarding the proactive management of behaviours which are challenging; this should include quality assurance actions by the Registered Manager so as to quality assure staff understanding and compliance in relation to such training

6. a system is developed and implemented so as to strengthen the staff approach to planning and supporting service users' routines and activities; the system should clearly evidence actions taken by staff aimed at ensuring that these are person-centred, and tailored to each service user's interests, assessed needs and personal goals

7. arrangements are put in place which facilitate a regular review, in discussion with relevant stakeholders, of all service users' routines and activities so that a collaborative approach is maintained by staff and which ensures that service users' routines and activities are adapted as the assessed needs and preferences of service users evolve and change

8. a review of current medicines management arrangements within the service is carried out so as to promote person-centred care and autonomy; the review should include a consideration of: managing medicines in the least restrictive manner possible; promoting and supporting service users to self-administer medicines safely and confidently, where possible; ensuring individualised support plans which are tailored to specific needs, preferences, routines and communication styles so as to avoid a 'one-size-fits-all' approach

9. a system is developed and implemented which ensures that arrangements in place for managing service users' monies is regularly reviewed and which focuses on promoting service users' financial independence and financial skills; these arrangements should include clear evidence of financial planning for service users which best reflects their goals / lifestyle choices and how support arrangements are proportionate to service users' assessed needs

10. a system is developed and implemented which ensures that arrangements in place for managing service users' nutritional needs is regularly reviewed and which focuses on meal planning and service user decision making reflective of their personal tastes, cultural backgrounds and assessed dietary needs; these arrangements should consider approaches needed to support and encourage service users to participate in shopping, meal preparation, and cooking in order to promote their independence and develop life skills

11. daily notes should record when service users refuse the main meal option and the alternative meal offered

Action taken by the registered persons:

1. During the inspection, RQIA noted that further improvement was required in relation to the management of restrictive practices. There was evidence that restrictive practices had reduced for some service users, as appropriate. The Cedar Foundation had reviewed all the service users in relation to restrictive practices. However, six service users still required a Multi-Disciplinary Team (MDT) review of restrictive practices to be undertaken.

2. There was evidence that this action had been met.

3. There was evidence that the staffing arrangements had been reviewed. An audit of alarm response times had been completed; however, further analysis noting the length of time staff are involved in each incident is required to fully inform the review of staffing arrangements. The ongoing need to ensure that sufficient female staff are on duty, to support female service users with their daily routines and activities was also highlighted.

4. Reviews had been undertaken in relation to the compatibility of service users living within the service. The Cedar Foundation reviewed the appropriateness of placement for all service users living within The Mews Supported Living Service and identified a number of service users who may not be appropriately placed. The Belfast Health and Social Care

Trust (BHSCT) had undertaken Focused Reviews in relation to the appropriateness of the service users' placements; however, eight service users had yet to be reviewed in this respect. RQIA remains concerned regarding the group dynamic, given that staff continue to utilise restrictive practices in an effort to prevent potential incidents occurring between service users.

5. There was evidence that this action had been met.

6. There was a system in place which had strengthened the provision of activities. Daily and weekly activities were displayed for staff and a review of daily notes evidenced that the service users were being supported with various activities. There was an Active Support PowerPoint Presentation in a communication folder for staff to read; however, a significant number of staff have yet to receive this training. Despite the notable improvements in the provision of activities, improvements are still required in relation to how the service users' daily routines are person centred and meaningful.

7. Whilst there was evidence of regular auditing of the activities service users were supported with, this should be further developed to ensure that the service users are similarly supported with their daily routines.

8. Whilst the medicines management arrangements for some service users had been reviewed, there remained a number of service users who still required to be reviewed in this respect.

9. There was evidence that a system had been developed and implemented in relation to service users' monies. However, not all service users had been reviewed in relation to this aspect of their care and support.

10. Whilst there was evidence that the staff recorded when service users refused their main meal option and an alternative meal was offered, improvements are still required in relation to the manner in which service users' nutritional needs are met. Whilst The Cedar Foundation plans to undertake an evaluation to assess which service users purchase and consume ready meals, including the frequency and nutritional value of same, some service users continue to have ready meals provided; observation during the inspection identified that staff were inconsistently using the meal time preparation as an opportunity to engage with service users to develop their skills or promote their independence.

11. There was evidence that this action had been met.

There was insufficient evidence to validate compliance with this Failure to Comply Notice. RQIA considered the inspection findings and decided to extend the compliance date of this FTC Notice (Ref: FTC000243E1) with a compliance to be achieved by 17 July 2025.

3.3.2 Compliance with FTC (relating to Governance and managerial arrangements)

FTC Ref: FTC000244

Notice of failure to comply with Regulation 11 (1) of The Domiciliary Care Agencies Regulations (Northern Ireland) 2007

Registered person — general requirements and training

Regulation 11. —

(1) The registered provider and the registered manager shall, having regard to the size of the agency, the statement of purpose and the number and needs of the service users, carry on or (as the case may be) manage the agency with sufficient care, competence and skill.

In relation to this notice the following six actions were required to comply with this regulation:

The registered person shall ensure that:

1. a system is developed and implemented so as to ensure that all incidents are managed in a robust, effective and timely manner

2. a robust and effective system is developed and implemented so as to ensure that all incidents are regularly reviewed in order to identify key themes/trends and disseminated among relevant staff to enhance their learning and implement targeted improvements with regard to care delivery and service provision

3. robust arrangements are in place in relation to adult safeguarding training for all relevant 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

4. the system for managing complaints is reviewed so as to ensure that complaints are recorded in keeping with regulation and regional best practice guidance

5. monthly monitoring reports, as required by legislation, are completed in a robust, thorough and timely way so as to identify deficits and drive necessary improvements in a consistent and meaningful manner; these reports should only be completed by identified staff within The Cedar Foundation who possess the requisite skills, knowledge and experience to undertake this task in an effective manner

6. the management team undertake a cultural review of the service so as to better understand the values, behaviours and attitudes shaping staff and service users' experiences; this review should then be used in due course to produce a targeted and time bound action plan focused on driving improvements for both staff and service users

Action taken by the registered persons:

1. There was evidence that this action had been met.

2. There was evidence that audits of incidents had been undertaken to identify patterns and trends, and that this learning had been shared with staff. It was good to note that learning which identified an alternative staff response to some service users' behaviours had been shared with staff. There was evidence that incident management and reporting training had taken place. A lessons learned section had also been included in the staff handover proforma. However, debriefing sessions with staff were not consistently undertaken in a timely manner. Whilst there was sufficient evidence to validate compliance with this action, a new area for improvement has been identified in relation to the timeliness of debriefing sessions.

3. There was evidence that this action had been met.

4. There was evidence that this action had been met.

5. There was evidence that this action had been met.

6. Whilst there was some evidence that The Cedar Foundation intends to carry out a cultural review to better understand the values, behaviours and attitudes of staff, this work is at an early stage and requires further development.

There was insufficient evidence available to validate compliance with this Failure to Comply Notice. RQIA considered the inspection findings and decided to extend the compliance date of this FTC Notice (Ref: FTC000244E1) with a compliance to be achieved by 17 July 2025.

Additionally, the area for improvement identified above has been included within the Quality Improvement Plan in Section 4.0.

3.3.3 Living Environments / Communal Areas

Observation on the day of the inspection identified that maintenance issues, particularly in communal areas required attention. A number of glass doors and windows throughout the building, both internally and externally, had been broken and boarded up. Whilst there was evidence that The Cedar Foundation had repeatedly requested these to be repaired by the owners of the building, it was concerning that the repairs had not been undertaken in a timely manner. Delays in completing repairs may impact negatively on service users' sense of dignity, personal identity, and emotional well-being. An area for improvement has been stated for the second time.

Observation on the day of the inspection identified that the level of cleanliness of some service users' accommodation required attention. Although the cleanliness of the service users' accommodation was satisfactory in most areas, not all were at a standard expected in a service delivering care and support. An area for improvement has been stated for the second time to ensure that service users are supported to maintain their living environments.

The environment in which individuals who require Positive Behaviour Support (PBS) live is a vital part of their overall PBS plan. For people who display dysregulated behaviours, a capable and supportive environment is essential. It enables them to thrive, experience a good quality of life, have their needs met, and engage in meaningful interactions and activities that matter to them.

Indicators of a good, "capable environment" include: a safe and well-maintained physical environment, positive social interactions, person centred personal care and health support, support to participate in meaningful activity, encouragement of greater independence, and consistent, predictable personalised routines tailored to the service user's needs and preferences. An area for improvement has been identified to ensure that the indicators above are incorporated into a PBS audit.

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	16*	3*

* the total number of areas for improvement includes fifteen that are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with members of the senior executive/management team of The Registered Provider 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 14 (a)(b)(c)(d)(e)(f) **Stated:** Second 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:** 3.3.3
	Response by registered person detailing the actions taken: Maintenance tracker has been updated to enable monthly review and outstanding actions to be carried over and clearly identified. Monthly meetings have been arranged with the Housing Association to ensure regular update on outstanding actions and to ensure all repairs are carried out in timely manner.
Area for improvement 2 **Ref:** Regulation 14 (a)(b)(c)(d)(e)(f) **Stated:** Second 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:** 3.3.3
	Response by registered person detailing the actions taken: All care plans reviewed and updated to include clear strategies for support within living environment.
Area for improvement 3 **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: 2.0
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 4 **Ref:** Regulation 16 (2)(a) **Stated:** First time **To be completed by:**	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: 2.0

Immediate from the date of the inspection	**Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**
Area for improvement 5 **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: 2.0
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 6 **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: 2.0
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 7 **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: 2.0
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 8 **Ref:** Regulation 13 (d) **Stated:** First time **To be completed by:**	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: 2.0

Immediate from the date of the inspection	**Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**
Area for improvement 9 **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: 2.0
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 10 **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: 2.0
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 11 **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: 2.0
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
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: 2.0
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.

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: 2.0
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
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: 2.0
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
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: 2.0
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 16 **Ref:** Regulation 14 (a) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall develop and implement a PBS audit which includes the indicators of a good 'capable environment'; audits should be undertaken on a regular basis and there should be evidence of actions taken in respect of any matters identified. Ref: 3.3.3
	Response by registered person detailing the actions taken: Registered manager has implemented an additional monthly PBS audit of individual care and support plans to monitor progress and include indicators of good capable environments. Actions are documented on a monthly summary and shared with staff teams. Regular meetings held with BHSCT PBS team to review impact of environment on behaviours. Further training on PBS model and Capable environments planned for staff team in Sept/Oct 2025.

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: 2.0 **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**
Area for improvement 2 **Ref:** Standard 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: 2.0 **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**
Area for improvement 3 **Ref:** Standard 8.3 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that incident debriefing sessions are undertaken with staff in a timely manner and which is as close to the incident as possible. Ref: 3.3.2 **Response by registered person detailing the actions taken:** All staff are offered debrief sessions following every incident. If staff do not wish to take part in debrief session on day of incident this is followed up the following day. Post incident meetings are held on a monthly basis which review proactive strategies and reflective practice following incidents. There are also reflective practice sessions with clincial pychologist which is offered on a regular basis.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority

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