The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Church Lane Mews Supported Living Service

Provider: Northern HSC Trust

Date of Inspection: 27 August 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:	Northern HSC Trust
Responsible Individual/Responsible Person:	Ms Jennifer Welsh
Registered Manager:	Miss Samantha Irwin
Service Profile: Church Lane Mews Supported Living Service is a supported living type domiciliary care agency located in Magherafelt, which provides personal care and housing support to up to 16 service users with mental health needs.	

2.0 Inspection summary

An unannounced inspection was undertaken 27 August 2025, between 10.10 am and 4.40 pm by a care Inspector.

The inspection was undertaken to evidence how the agency is performing in relation to the regulations and standards and to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 18 October 2024. Additionally, the inspection sought to determine if the agency is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that care delivery was safe and that effective and compassionate care was delivered to service users, however, improvements were required to ensure the effectiveness and oversight of certain aspects of the agency, such as monitoring of employee registration status with a regulatory body, monthly quality monitoring reports, training and service user plans.

Service users said that the care and support provided by Church Lane Mews Supported Living Service was a good experience.

As a result of this inspection, two areas for improvement previously identified were assessed as having been addressed by the provider. One previous area for improvement has been stated for a second time, and four new aras for improvement were identified. Full detailscan be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

Church Lane Mews Supported Living Service uses the term 'tenants' to describe the people to whom they provide care and support. For the purposes of the inspection report, the term 'service user' is used, in keeping with the relevant regulations.

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 Church Lane Mews Supported Living Service was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this agency. This included the previous Quality Improvement Plan issued, registration information, and any other written or verbal information received.

Throughout the inspection process inspectors seek the views of those living, working in and visiting the service and examine a sample of records to evidence how the agency is performing in relation to the regulations and standards.

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

Service user feedback was positive. One service user told us "Church Lane Mews is an excellent place to live. The staff are very good to the tenants". It was reassuring to be advised by service users that they felt listened to by staff. We were told by service users that they felt able to talk to staff about any concerns they may have.

Service users told us about the benefits of the locality of Church Lane Mews Supported Living Service; being close to the town centre allows for easy access to local amenities which, in turn, promotes engagement in the local community. We were told how assistance from staff has supported service users' to increase their independence, and helping with "learning how to look after yourself".

Service users told us about the importance of having a key to their own home and being empowered to "live the way you want to". Service users understood how to make a complaint, however told us, "there is nothing to complain about. I love it here".

All the staff spoken with were very complimentary about the Manager. They told us how invested they were in the service and ensuring best outcomes were achieved for the service users they support.

Staff advised they felt well supported by the Manager as well as their colleagues. Staff confirmed that they received regular supervision. We were told how effective and collaborative the team work was within Church Lane Mews Supported Living Service.

It was also positive to hear that staff felt senior leaders within the Northern HSC Trust had been "very responsive" to changing risks within the service and acted in a timely manner to ensure their safety whilst at work.

We were told how support provided was person-centred and staff believed it was of a high standard. Staff demonstrated knowledge as to mental health conditions and the resources available to service users through both statutory and voluntary organisations.

When discussing the experience of the people they support, staff did so with compassion. They acknowledged the importance of maintaining positive working relationships with service users. Staff expressed commitment to the ethos of supported living, stating how rewarding their work has been in witnessing progression achieved by service users.

Other professionals engaged with service users living in Church Lane Mews Supported Living Service described the staff as "friendly" and "approachable". They described situations where staffs' persistence promoted engagement and participation of service users. They spoke positively about the continued facilitation of the breakfast club, which reduces risk of social isolation whilst offering opportunity to engage with peers and staff. Allied professionals advised the communication with staff was good and they found them to be responsive.

3.3.1 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of service users. There was evidence of robust systems in place to manage staffing.

The rota clearly denoted each employees' positions and hours allocated. The rota was planned in advance, permitting opportunity to acquire adequate cover as needed.

Observation of the delivery of care evidenced that service users' needs were met by the number and skills of the staff on duty. It was observed that staff responded to requests for assistance promptly, in a caring and compassionate manner.

Staff said there was good teamwork, they felt well supported in their role and that they were satisfied with the staffing levels. It was also positive to learn that this was kept under review and had been increased in the past due to an increase in presenting risk.

Review of the agency's staff recruitment records could not be completed on the day of inspection. Following the inspection, records were provided that confirmed all pre-employment checks, including criminal record checks (AccessNI), were completed and verified before staff members commenced employment and had direct engagement with service users.

There was evidence that all newly appointed staff, inclusive of the Manager, had completed a structured orientation and induction, having regard to the Northern Ireland Social Care Council's (NISCC) Induction Standards for new workers in social care, to ensure they were competent to carry out the duties of their job in line with the agency's policies and procedures.

Although there was evidence of a process in place to monitor staffs registration with their professional body, checks were not undertaken on a regular basis. This was identified as an area for improvement where action is required to ensure compliance with the Regulations.

A review of staff training records identified that the electronic matrix did not record overall compliance rates. It was also evident that the system failed to recognise some occasions on which mandatory training of some staff had expired, for example, in relation to Adult and Children's Safeguarding, Fire Safety and Emergency First Aid. This was identified as an area for improvement where action is required to ensure compliance with the Standards.

Whilst it was positive to note that some service user specific training was provided to staff, there was no evidence that staff had been provided with training in care/support plan writing. Additionally, some staff were found to still require diabetes awareness training. Due to this, an area for improvement where action is required to ensure compliance with the Standards will be stated for a second time.

Staff advised they received regular supervision and confirmed that appraisals had taken place.

3.3.2 Care Delivery

There was a daily handover at the beginning of each shift which included information about any changes to the service user care needed by staff to assist them in their roles. There was evidence of regular staff meetings held and minutes with shared with staff unable to attend. It was positive to note the date and agenda for the next scheduled team meeting was made available to all staff in advance, with opportunity provided for staff to submit any additional topics they would like to discuss.

Staff interactions with service users were observed to be friendly, with service users actively seeking engagement with staff in whose company they appeared relaxed.

In discussion with service users and staff we were told about activities organised by the service, such as Friday Breakfast Club, monthly Sunday dinners and barbeques. One to one support was also provided to enable engagement in the local community. Staff also supported development of peer relationships through planned coffee trips. It was positive to observe service users contribution regarding suggestions for activities, such as attending Antrim Castle Gardens during Christmas.

Where service users required support with the management of medication, an assessment to determine the level of support required had been completed for each individual. For those service users who required higher levels of support that involved restrictive practice, this was clearly highlighted within their plans. Where service users required medicine on an as needed basis, there was a system in place that enabled timely monitoring regarding frequency of administration.

The service completed regular medication audits to assure compliance with organisational policies and procedures. Discussion occurred with the Person in Charge as to how this process could be improved. This will be examined during the next scheduled inspection.

3.3.3 Management of Care Records

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

A review of records identified that service user consent was sought in relation to delivery of care/support and staff contacting/requesting information from other healthcare professionals on their behalf. There was evidence that service users had been appropriately advised about the service's use of CCTV. Consent was also sought regarding restrictive practices relating to the safe and secure storage of medications. There was, however, no evidence of key holding agreements in place, which would reflect consent provided for staff to hold and use a key to gain access to a service users' home in cases of emergency. This was highlighted to the person in charge and will be reviewed during the next inspection.

Service users' care records were stored securely and accessible to authorised personnel in accordance with data protection regulations.

Care records were person-centred, well maintained and regularly reviewed and updated to ensure they continued to meet the service users' needs. Failure to archive older versions of service users' plans, however, was highlighted as a risk to the person in charge, who agreed to address this. This will be reviewed at the next inspection.

A review of a sample of care records evidenced that service users, where possible, were involved in planning their own care and efforts had been made to ascertain service users' preferences and choices around how their support was provided. The details of care plans were shared and signed by service users.

Whilst some service users' plans were found to contain sufficient detail to guide staff practice, one service user plan was found to lack relevant information regarding management of diabetes. Diabetes, for example, was not included within the physical health section of the plan, acceptable blood glucose range was not stated, nor were risks associated with diabetes such as hypoglycaemia, hyperglycaemia or ketoacidosis included. In the records of another service user who was experiencing a deprivation of liberty, no documentation could be produced. This was identified as an area for improvement where action is required to ensure compliance with the Standards.

3.3.4 Quality of Management Systems

There has been a change in the management of the agency since the last inspection. Miss Samantha Irwin has been the acting Manager in this agency since 25 May 2025. Miss Samantha Irwin has submitted an application to become the Registered Manager for Church Lane Mews Supported Living Service.

Those consulted with commented positively about the manager and described her as supportive, approachable and able to provide guidance.

The agency was visited each month by a representative of the registered provider to consult with service users, their relatives and staff and to examine all areas of the running of the agency. The reports of these visits were completed in detail, however, actions identified in the body of the report did not always feature in the action plan. Review of the agency's regulatory checks and training compliance was also reported as being satisfactory which was contradictory to findings of this inspection. This was identified as an area for improvement where action is required to ensure compliance with the Regulations.

Complaints were managed appropriately and it was good to note that any identified learning was shared with staff.

Review of incident records identified that they were managed appropriately. There was evidence that incidents were audited on a regular basis, to establish any patterns/trends. There had been a serious adverse incident within the agency since the date of the previous inspection. All relevant documentation was available for review.

There was evidence that the agency responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the agency.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the Regulations and the Standards.

	Regulations	Standards
Total number of Areas for Improvement	2	3*

*The total number of areas for improvement includes one that has been stated for a second time.

Four new areas for improvement have been identified.

Areas for improvement and details of the Quality Improvement Plan were discussed with Chloe McKinney, Person in Charge, 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 13(d) Schedule 3 (7) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure regular checks are conducted of staff registrations with an appropriate regulatory body. Ref: 3.3.1
	Response by registered person detailing the actions taken: The staff registrations are up to date and will be checked on a monthly basis. The registered manager will ensure that these are signed on a monthly basis to evidence that this process is operating effectively.
Area for improvement 2 **Ref:** Regulation 23 (4) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure monthly monitoring reports are accurately completed and prescribe any actions required to drive service improvement within the agency. Ref: 3.3.4
	Response by registered person detailing the actions taken: The registered person will continue to ensure the monthly monitoring reports are completed. Any actions from the previous month will be appropriately documented on an action plan and completed within agreed time frame to promote service improvement.
Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 **Ref:** Standard 12.3 **Stated:** First time **To be completed by:** 27 October 2025	The Registered Person shall ensure that training of individual staff is completed in line with their roles and responsibilities and systems for monitoring compliance kept up to date and accurate. Ref: 3.3.1
	Response by registered person detailing the actions taken: The Trust training matrix that is currently implemented will remain in place and will be checked on a monthly basis. A record of training for all staff is retained within the scheme and a renewal date for training is highlighted within it. The registered manager will ensure that the compliance rate is clearly documented and a record kept of when the matrix is reviewed.

Area for improvement 2 **Ref:** Standard 12.4 **Stated:** Second time **To be completed by:** 27 October 2025	The registered person shall ensure that all staff receive training in respect of Diabetes Awareness; and all staff, as relevant to their roles and responsibilities, receive training in respect of care and support plan writing. Ref: 3.3.1
	Response by registered person detailing the actions taken: Diabetes awareness had been completed by all staff in October 2024. The new registered manager has also completed their training in July 2025. This recommendation which was previously made last year was completed as advised in October 2024. Support plan training has been sourced and completed by all staff and the training matrix has been updated to reflect this. Care plans are completed by the Community Mental Health Team (CMHT) - the registered manager of the scheme will share the finding from this inspection with the CMHT.
Area for improvement 3 **Ref:** Standard 3.3 **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The Registered Person shall ensure service user plans contain all necessary information to adequately and safely respond to identified needs and presenting risks. This is to include interventions such relating to diabetes and Deprivation of Liberty Safeguards (DoLS). Ref: 3.3.3
	Response by registered person detailing the actions taken: Within the current implementation of the Deprivation of Liberty legislation, this is not applicable. However, it is recognised that any restrictive practice should be included in the service users care and support plan, noting service users consent.

Please ensure this QIP is completed in full and uploaded via Web Portal

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