The Regulation and Quality Improvement Authority

Inspection Report

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

Provider: **The Cedar Foundation**

Date of Inspection: **26 February 2026**

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

1.0 Service information

Organisation/Registered Provider:	The Cedar Foundation
Responsible Individual:	Mrs Mary Elaine Armstrong
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 26 February 2026, between 9.10 am and 4.30 pm.

The inspection was jointly undertaken by care inspectors from the Adult Care Services (Agencies) 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.

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 17 July 2025; and 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 to service users was safe, effective and compassionate. As a result of this inspection, 20 out of 25 areas for improvement previously identified were assessed as being met by the provider. Five areas for improvement have been stated for the second time; and a new area for improvement has been identified in relation to staff training. Full details, including a new area for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

Service users said that the care and support provided by staff within The Mews Supported Living Service was a good experience. Service users who were unable to voice their opinions due to physical and/or cognitive needs were observed to be comfortable in their interactions with staff. Refer to Section 3.2 for more details.

RQIA imposed Conditions on the registration of The Mews Supported Living Service which came into effect on 2 June 2025; these Conditions prohibit all forms of admissions to the service (whether permanent, respite or emergency) 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.

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.

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

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

Service users we spoke with told us they were happy living in The Mews Supported Living Service and with the care and support provided by staff. Service users were observed to be relaxed and comfortable in their interactions with staff.

Staff told us that they had no concerns to raise; they said that they felt well supported in their roles. The staff also told us that they felt that "the care provider/management are doing well for both the service users and the staff members". The Mews Supported Living Service was described by staff as being "well-run with great team leaders and management". One staff member expressed some dissatisfaction and this was shared anonymously with the Registered Manager for consideration and action, as needed.

HSC Trust representatives told us that collaborative working with the staff had improved significantly, contributing to improved service user quality of life.

3.3 Inspection findings

3.3.1 Governance and managerial arrangements

There has been no change in the management of the agency since the last inspection. Miss Chelsea Lewis has been the registered manager in this agency since 16 August 2022.

Those consulted with commented positively about the management team and described them as supportive and approachable. Review of the staffing roster identified that the person in charge in the absence of the Registered Manager was clearly noted. Competency assessments for this role, however, were not consistently completed. The area for improvement previously identified in this regard was partially met and has been stated for the second time.

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, advice was given to the management team in relation to ensuring that any areas for improvement included in the RQIA QIP are reviewed each month.

Complaints were managed appropriately and it was good to note that any identified learning arising from complaints received was shared with staff on a regular basis.

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. It was good to note that these were reviewed in detail as part of the monthly quality monitoring process. Incident debriefing sessions were undertaken with staff in a timely manner; and where staff declined the debriefing session, a record was retained. An area for improvement previously identified in this regard had been addressed.

RQIA was generally notified appropriately of any incidents in line with requirements. There was one incident which had not been notified, however, this had occurred in the absence of the manager and was submitted to RQIA on the day of the inspection. This will be reviewed at a future inspection.

RQIA is aware that an incident from 2024 is being investigated under the BHSCT Serious Adverse Incidents (SAI) procedures. RQIA will review any recommendations that may be identified in this regard, when the investigation report has been concluded.

Checks were made to ensure that staff were appropriately registered with the Northern Ireland Social Care Council (NISCC); there was a system in place for professional registrations to be monitored by the manager. Where any staff had previously been registered with NISCC and their registrations had lapsed, the recruitment process ensured that they needed to be re-registered before they could commence work in The Mews Supported Living Service. An area for improvement previously identified in this regard had been addressed.

There were systems and processes in place to manage the safeguarding and protection of adults at risk of harm. There was an incident that that not been managed in keeping with the regional guidance, in that there had been a delay in submitting the relevant documentation to the Adult Gateway Protection Team; and in relation to communication of the protection plan to the relevant staff. It was evident that lessons had been learned in relation to the safeguarding reporting processes and these had been shared with the staff.

The ongoing compatibility of service users who live within The Mews Supported Living Service was discussed with the manager. An escalation plan had been developed with the BHSCT for instances where service users' placements had the potential to break down. An area for improvement in this regard had been met.

Review of the management on-call system identified that those named, possessed the requisite skills and knowledge for this role. An area for improvement previously identified in this regard had been addressed.

3.3.2 Staffing arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training, effective communication systems and ensuring that the number and skill of staff on duty each day meets the needs of service users.

There was a process in place to ensure that recruitment was managed appropriately; this ensured that all pre-employment checks, including criminal record checks (AccessNI), are completed and verified before staff members commenced employment and have direct engagement with service users.

The management team were able to describe those actions they would take in regard to robustly reviewing AccessNI information relating to staff working within the service. To further enhance this managerial oversight, advice was given in relation to adding a prompt on the induction checklist used with agency staff; and in relation to adding this to the person in charge competency template. An area for improvement previously identified in this regard has been stated for the second time.

The staff induction procedure was in the process of being reviewed. It was good to note that the proposed induction template included information on learning disabilities and the Positive Behaviour Support (PBS) framework. Further improvements were required to be included, to ensure that the induction document reflects the ethos of supported living. Staff informed us that plans are also in place to use this template for any staff supplied into the setting by recruitment agencies. The area for improvement previously identified in this regard was partially met and has been stated for the second time.

Records of all staff training were retained and were generally noted to be up to date. It was noted, however, that a number of staff required Ligature training. An area for improvement has been identified.

All staff had received Crisis Prevention Intervention training in keeping with the organisation's policy and procedures. An area for improvement previously identified in this regard had been addressed. An analysis on the use of CPI was also displayed, which showed a decrease in the use of CPI in The Mews Supported Living Service.

It was also good to note that the induction training included Disability Induction training and staff were further required to watch a video on Trauma Informed Care. Staff said that they were satisfied with the training provided. The staff spoken with said that they attended regular meetings with the PBS team, which supported their understanding of presenting behaviours and the personalised proactive strategies in place to support service users.

There was evidence of robust systems in place to manage staffing. It was evident that the staffing requirements for each service user had been kept under meaningful review and in the best interests of those service users. An area for improvement previously identified in this regard had been addressed.

There was evidence of effective communication between staff across shifts. This is essential for ensuring consistent, safe and effective care to service users. Review of the staff handover records identified that all relevant information was included; and that these records were signed by all staff who attended. An area for improvement previously identified in this regard had been addressed.

Multi-disciplinary team (MDT) meetings convened, reviewed the care and support provided to service users. Effective systems were in place to communicate agreed strategies and outcomes to the staff team, ensuring consistent care delivery. An area for improvement previously identified in this regard had been addressed.

Staff demonstrated knowledge and understanding relating to individual care plans, including Recommendations for Eating Drinking and Swallowing (REDS) as assessed by the Speech and Language Therapy (SLT) team. An area for improvement previously identified in this regard had been addressed.

3.3.3 Care and Treatment

The Regional Policy on the use of Restrictive Practices in Health and Social Care Settings, Department of Health, November 2023 (the 'Regional Policy'), provides the regional framework to integrate best practice in the management of restrictive interventions and restraint.

Recently revised guidance, which had been issued by the registered Provider regarding the management of restrictive practices, required further development to equip staff to consider the core principles when managing restrictive practices. The area for improvement previously identified in this regard has been stated for a second time.

Restrictive practices implemented within the service included the periodic use of some locked doors, enhanced supervision levels, the use of PRN ('when required') medications, use of physical interventions and managed access by service users to their finances and/or

medication. Service users' documentation evidenced that restrictive practices were appropriately recorded and implemented, based on each individual's assessed needs and associated risks.

A restraint reduction plan was in place for each service user which demonstrated progress in regard to reducing the use of restrictive practices, through the implementation of active support and skill development. The area for improvement previously identified in this regard had been addressed.

Service users were supported to access the community through a variety of transport options including a communal vehicle and public transport. We were told the responsible Health and Social Care Trust were in the process of addressing service user access to Motability vehicles where appropriate. The area for improvement previously identified in this regard had been addressed.

3.3.4 Living environments

Observation of the setting identified that the standard of cleanliness in most service users' accommodation was satisfactory. Where improvements were required regarding cleanliness, this was highlighted to the Registered Manager during the inspection who agreed to action as appropriate. Cleanliness audits were not in place to maintain effective oversight of service user accommodation. An area for improvement has been stated for the second time.

The service's care planning documentation demonstrated an active support approach, which included clear strategies to support service users to maintain their living environments. Tasks were broken down appropriately in care plans and associated cleaning schedules, which informed staff of the level of support required by individual service users while promoting skill development. Two areas for improvement previously identified in this regard had been addressed.

Indicators of a good, 'capable environment' had been incorporated into the Positive Behaviour Support (PBS) audit. An area for improvement previously identified in this regard had been addressed.

A system was in place to regularly review service users' access to and use of 'fobs' for entering and exiting the main building. Person centred risk assessments included appropriate actions to mitigate potential fire safety risks associated with restricted access where relevant. Regular review of service users' access to and use of 'fobs' aligned with best practice as outlined with the Regional Policy in assessing the practice as necessary and proportionate to the risk identified.

Additionally, procedures were in place in relation to ensuring fire safety. Weekly checks were undertaken on the fire alarm system. Each service user received training in respect of fire evacuations and personal emergency evacuation procedures (PEEPS) were in place for both day and night procedures. The manager advised that these were available to service users in easy read-format. The practice of locking identified service users' doors at specified times had been reviewed by the provider. Where this practice continued, sufficient staffing levels and visual monitoring arrangements were in place, to ensure that the service users could be safely evacuated in the event of a fire; and this was included within the Fire Risk Assessment.

Review of the service users' environments identified that an inappropriate glass door covering which had been in place, was replaced by a more suitable covering. Whilst it would be preferable for an integrated window blind to be installed, Inspectors were assured that there was a sufficient amount of natural light in the service user's accommodation. This was discussed with the manager who agreed to progress this going forward. An area for improvement previously identified in this regard had been addressed.

Maintenance issues had been addressed in a timely manner. Inspectors were satisfied that the area for improvement previously identified in this regard had been addressed.

3.3.5 Care records

Review of care planning documentation and discussions with service users evidenced service user involvement in the development, implementation and review of care plans. Care plans were utilised as 'live' documents guiding and informing staff to embed agreed person centred strategies into daily practice. Two areas for improvement previously identified in this regard had been addressed.

It was good to note that the care plan goals included skills development in relation to enhancing service users' involvement and independence in meal preparation. An area for improvement previously identified in this regard had been addressed.

The care and support hours the service users were entitled to, were detailed on the Care and Support timetable, rather than on the service user agreement. Whilst these hours were combined, Inspectors were assured that the service users were being supported appropriately in keeping with their care and support plans. RQIA was also assured that the organisation's finance department can separate the hours for care and support, if requested. An area for improvement has been identified in this regard had been addressed.

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	5*	1*

* the total number of areas for improvement includes five that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Chelsea Lewis, Manager, 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) **Stated:** Second 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: 3.3.2
	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. In addition this has been added to the Agency Induction form to complete prior to a staff member commencing a shift. All staff with management responsibilities for the service will receive a training briefing so they understand their role in relation to this process, in particular what is required of them to respond to any disclosures identified on agency staff profiles.
Area for improvement 2 **Ref:** Regulation 16 (5)(a) **Stated:** Second 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: 3.3.2
	Response by registered person detailing the actions taken: The staff induction for The Mews will be updated to provide more emphasis on core principles of Supported Living model of service. Resources developed will be reviewed and enhanced with additional training sessions provided, supplementing the posters currently displayed as reminders of good practice. The specific induction to the Mews now includes a comprehensive checklist to capture all aspects of the role. This includes an in-depth overview of service users and their individual needs living within the supported living service.

Area for improvement 3 **Ref:** Regulation 15 (11) **Stated:** Second 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: 3.3.3
	Response by registered person detailing the actions taken: Cedar has developed 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 aligned to the Regional Policy Framework and regional regulatory requirements. The procedure has been reviewed to ensure it fully reflects the Regional Policy on the use of Restrictive Practices and in particular, minimisation practices and principles. Training on Restrictive Practices has been delivered by BHSCT to support staff understanding of the core principles so they are better equipped when managing restrictive practice in the service.
Area for improvement 4 **Ref:** Regulation 14 (e) **Stated:** Second time **To be completed by:** Immediate from the date of the inspection	The registered person shall develop and implement cleanliness audits for service users' accommodation. Ref: 3.3.4
	Response by registered person detailing the actions taken: Environmental audit has been developed which occurs on a weekly basis by team leaders/Deputy Managers. An enhanced monthly audit of the environment has been developed for managers to complete which includes cleanliness, health and safety and repairs.
Area for improvement 5 **Ref:** Regulation 14 (e) **Stated:** First time **To be completed by:** Immediate from the date of the inspection	The registered person shall ensure that staff are provided with training in relation to Ligature cutting. Ref: 3.3.2
	Response by registered person detailing the actions taken: All staff have completed ligature training and further sessions scheduled for any new staff and to complete refreshers if required.

Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 **Ref:** Standard 8 **Stated:** Second 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: 3.3.1
	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

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