

Inspection Report

Name of Service: MENCAP

Provider: MENCAP LIMITED

Date of Inspection: 17, 18 and 23 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:	MENCAP LIMITED
Responsible Individual/Responsible Person:	Mr Barry Joseph McMenamin
Registered Manager:	Ms Donna Martin
Service Profile: MENCAP is a supported living type domiciliary care agency located close to Bangor town centre. The agency's staff provide 24-hour care and currently support 21 service users with a learning disability at both the registered address and within the local community.	

2.0 Inspection summary

Following RQIA's receipt of information on 3 February 2026, an unannounced inspection was undertaken on 17,18 and 23 February 2026. The inspection was jointly undertaken with an inspector from the finance team.

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 in relation to: the lack of robust governance arrangements and managerial oversight of the agency; the management of potential adult safeguarding incidents; the financial oversight of service users; the management of incidents; the enhanced supervision of service users; management of the environment; management of staff and monthly monitoring arrangements.

A serious concerns meeting was held on 9 April 2026 with the Responsible Individual to discuss these shortfalls.

During the meeting, the Responsible Individual provided a full account of the actions taken/to be taken in order to drive improvement and ensure that the concerns raised at the inspection were addressed.

Following the meeting, RQIA decided to allow the Responsible Individual a period of time to demonstrate that the improvements had been made and advised that a further inspection will be undertaken to ensure that the concerns had been effectively addressed.

Service users said that the care and support provided by Mencap was a positive and supportive experience. Service users who were unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Refer to Section 3.2 for more detail.

Ten areas for improvement were identified and can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.0.

MENCAP uses the term 'people who we support' 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.

The findings of this report will provide the management team with the necessary information to improve the quality of service provision.

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 agency 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 information held by RQIA about this agency was reviewed. Registration information and any other written or verbal information received from service users, relatives, staff or the commissioning Trust was reviewed.

Throughout the inspection process inspectors seek the views of those working for or being supported by the agency; and review/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

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

As part of the inspection process we spoke with a number of staff, relatives and a service user. A number of staff and relatives spoke in positive terms about the service in relation to care and support provided. The service user and relatives were aware of the complaints procedure and stated they felt comfortable raising concerns and issues.

However, a number of staff told the inspector that they were dissatisfied with some elements of support they received from the management team and raised concerns of potential safeguarding incidents. These comments were relayed to the manager for review and action as appropriate.

3.3 Inspection findings

3.3.1 Governance and Managerial Oversight

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

For example, review of governance records and discussion with staff did not assure the Inspector that the Manager maintained a meaningful and consistent presence within the service so as to quality assure care provision and service delivery at all times. An area for improvement was identified.

Concerns were also identified regarding a lack of robust managerial oversight relating to the financial management of service users' monies. It was also concerning to note that there were monies owed to one identified service user, without adequate explanation, which had yet to be reimbursed. See also Section 3.3.4.

Review of Monthly Monitoring reports during the inspection did not assure the Inspector that these were being carried out in a sufficiently robust manner to proactively identify deficits and drive improvements in a consistent and sustained manner. An area for improvement was identified.

The management of incidents, including those involving medication errors, was considered. Review of governance records and discussion with staff identified inadequate systems so as to ensure that the Manager maintains robust oversight of all incidents at all times.

Incident debrief guidance was available for staff and this guidance was discussed with staff. They stated that debriefs happen on occasions when physical intervention is used. Staff shared their experience in relation to the senior management team's (SMT) response to a significant incident, which occurred, which did not relate to the use of physical intervention. This was discussed with the manager who provided evidence of the SMT response to the incident and resources available to support staff. Whilst it was evident support was available for staff, there was no evidence of an incident debrief having been completed following this incident. An area for improvement was identified.

Review of records and feedback from staff also highlighted potential adult safeguarding concerns relating to medicines management. RQIA reported this information to the South Eastern Health and Social Care Trust adult safeguarding team for further action, as appropriate. An area for improvement was identified.

Mencap's Adult Safeguarding Policy available for staff dated September 2025 reflected up to date guidance. Training compliance in relation to safeguarding was very good for both Mencap and Agency staff.

Deficits were noted in regard to the management and oversight of potential adult safeguarding incidents. As a result, the Inspector requested that two further adult safeguarding referrals be made to the appropriate Health and Social Care Trust.

3.3.2 Staffing (ratios, training and supervision)

The enhanced supervision of service users was also examined. Review of care records and discussion with staff evidenced that these arrangements were not adhered to in a consistent manner; this has the potential to place service users at risk of harm. An area for improvement was identified.

Review of staff records and discussion with staff evidenced inadequate arrangements with regard to staff training; it was concerning to note that the Registered Manager could not provide assurances in regard to staff training and that staff training records were found to be inconsistent.

The accuracy of Mencap's training data was discussed with the manager and assurances sought that this issue was reflected on Mencap's Corporate Risk Register. This was confirmed and evidence provided.

Deficits were also noted in regard to the provision of formal supervision for staff; review of governance records demonstrated that staff had not received formal supervision as frequently as required.

The agency's Supervision Policy (My Mencap Review) stated staff should receive supervision once every three months. Supervision records viewed and discussions with staff confirmed that they had not received supervision in line with the agency's policy. Whilst this had been identified during an internal audit completed in September 2025, the agency's monthly quality monitoring reports viewed did not accurately reflect information in relation to supervision compliance. It was noted one member of staff had no recorded supervision on file since they commenced in the service in 2019. The service had recently developed a service specific tracking tool to ensure they maintained oversight. An area for improvement was identified in relation to staff training and formal staff supervisions.

3.3.4 Management of service users' finances and property

A safe place was provided within the agency for the retention of service users' monies. There were satisfactory controls around the physical location of the safe place and the members of staff with access to it. A review of a sample of records of service users' monies held at the agency showed that the record balances were accurate and up to date at the time of inspection.

The manager confirmed that no member of staff was the appointee for any service user. Families managed the service users' finances and there was evidence that personal allowances were topped up weekly.

Service users' financial support plans detailed the arrangements for staff involved in providing support to the service user regarding their finances including assisting service users with shopping.

Individual ledgers were maintained on an electronic app for each service user. The electronic ledgers were used to record the details of transactions undertaken on behalf of service users, such as the purchase of items and the recording of monies deposited at the agency on behalf of service users.

Service users support plans detailed that reconciliations (checks) between the monies held on their behalf and the records of monies held should be performed twice daily by two members of staff. Review of records indicated that reconciliations were often completed only once daily and were not always countersigned by a second member of staff.

A review of a sample of records of purchases undertaken on behalf of three service users showed that the records were up to date. However, only one signature was recorded against each entry in the service users' records; this is not good practice. For two service users there had been a number of minor discrepancies noted on daily ledger counts; these discrepancies were rectified over the month. Staff must accurately count monies at each cash count.

Receipts from purchases were filed by month, numbered and retained for inspection; this is good practice. The 'Supporting a person with their finances policy' states staff should complete a petty cash voucher for the money removed from cash tins. This is a temporary voucher for going shopping until a receipt and money is returned. Petty cash vouchers were not being completed and held in cash tins on all occasions; staff had not been adhering to the policy.

There was evidence of additional controls in place, the manager carried out a monthly audit on service users' financial records to ensure expenditure was appropriate and any discrepancies are identified and addressed. However, these audits did not include reviewing adherence to twice daily reconciliations, countersigning of reconciliations, second signatures for purchases, accurate cash counts and petty cash vouchers. These findings were discussed with the service manager who agreed to implement a more robust system to include the issues identified above. An area for improvement was identified.

A robust system should be in place for monies deposited into service users' ledgers including maintaining a clear record of receipt and the provision of a receipt to service users' families. A review of a sample of deposits made to three service users' ledgers showed the records of receipt had been accurately maintained but that receipts had not been issued to family members. Immediate action was taken and receipt books were implemented during the inspection. The issue of receipts for deposits received is not detailed in the current 'Supporting a person with their finances policy', see below.

Staff had identified a discrepancy in one service user's ledger in October 2025. This had been investigated by the service manager and reported to the area manager; the cause of the discrepancy was not identified. The service user's ledger had not been reimbursed the amount of the discrepancy; RQIA received assurances following the inspection that this reimbursement had been provided. When a discrepancy is identified, the ledger must be reimbursed without delay. An area for improvement was identified.

To ensure that service users' finances are managed appropriately, staff who support people with their finances must be appropriately trained. The registered manager has a responsibility to check that staff are competent in supporting people with their finances.

Policies and procedures should include sufficient detail on how finances are managed in the service, be up to date and readily available for staff reference.

Review of the current 'Supporting a person with their finances policy' indicated it did not include detailed procedures on all aspects of managing service users' finances. The policies and procedures should be reviewed, revised and shared with staff. An area for improvement was identified.

Review of training records showed that a small number of staff training in relation supporting people with their finances and annual finance work based observations had recently expired in the week of the inspection. The manager provided assurances that these staff will complete training on their next shift and that the findings of this inspection would be discussed with all staff to drive the necessary improvements.

3.3.5 Health and Safety

It was noted that identified fire safety checks had not been carried out by staff in line with expected frequency; this has the potential to place service users at risk of harm. The manager was advised to action this, they confirmed checks were completed on 18 February 2026 and will be kept up to date.

Concerns were also identified with regard to the ineffective management of service users' 'key fobs' so as to ensure the security of the environment at all times. The manager was advised to action as a matter of priority given the potential risk to security and advised to establish a system for tracking/recording the movement of fobs and to ensure they are held securely. An area for improvement was identified.

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	8	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Donna Martin, 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 11 (1) Stated: First time To be completed by: Immediate from the date of the inspection	The registered person shall maintain a meaningful and consistent presence within the service so as to quality assure care provision and service delivery at all times. Ref: 3.3.1 Response by registered person detailing the actions taken: A new operating model has been implemented and a new Service operations Manager has been recruited. The Service Operations Manager has been in post from 13th April 2026 and is the acting registered manager pending approval of the application for permanent registration. The Service Operations Manager is based full time in Bangor and rotates her time between the four sites supported by the Area Operations Manager.
Area for improvement 2 Ref: Regulation 23 Stated: First time To be completed by: Immediate from the date of the inspection	The registered person shall ensure the monthly quality monitoring reports accurately reflect information in relation to the key performance quality indicators; outline all actions required to address deficits/concerns identified as part of this process and contain evidence they have been reviewed by the manager. Ref: 3.3.1 Response by registered person detailing the actions taken: Quality monitoring actions are reviewed at monthly managers meetings and form part of the agenda. Outstanding actions are reviewed the following month to ensure they are completed. The Regional Operations Manager completes spot checks and alerts the AOM of actions outstanding.
Area for improvement 3 Ref: Regulation 14 Stated: First time To be completed by: 30 September 2026	The registered person shall implement a robust audit system, which covers all aspects of the managing service users' finances. Any shortfalls identified should be detailed in an action plan and addressed. This is in relation to ensuring: • twice daily cash counts (every shift change) • cash reconciliations and transactions to ledgers are performed and signed off by two members of staff • accurate counting of money to minimise discrepancies • petty cash vouchers are written when cash is removed from cash tins • issuing receipts for monies deposited.

	Ref: 3.3.4 Response by registered person detailing the actions taken: Money checks are completed by two staff during each shift, once during day shift and a further during nightshift and detailed on the handover. The checks are recorded on the What Matters Most app (WMMA). When money is taken from the tin, a temporary petty cash voucher is placed in the tin. When the money is returned the appropriate receipts are placed in the tin and the temporary petty cash voucher is removed. This is checked by all managers and recorded on the What Matters Most App.
Area for improvement 4 Ref: Regulation 14 Stated: First time To be completed by: Immediate from the date of the inspection	The registered person should ensure that any unexplained discrepancy identified in a service user's ledger and cash tin is reimbursed. Ref: 3.3.1. & 3.3.4 Response by registered person detailing the actions taken: The identified discrepancy has been addressed and monies reimbursed. Regular checks are made by managers to ensure any discrepancies are addressed in a timely manner.
Area for improvement 5 Ref: Regulation 11 (1) Stated: First time To be completed by: Immediate from the date of the inspection	The registered person shall ensure that a robust system is developed and implemented in regard to the management and oversight of incidents. This shall include but not be limited to: • Robust audits to ensure appropriate risk rating; • Theme and trend analysis; • Mechanisms to ensure incidents are actioned/escalated appropriately; and • Incident debriefs with staff. Ref: 3.3.1 Response by registered person detailing the actions taken: A trend analysis of incidents is generated from the Quality Monitoring System (QMS) by the AOM and discussed at the monthly manager's meeting. This report is saved with the minutes and reviewed at the next meeting to identify trends. The recently introduced Quality Management System ensures once incidents are recorded they are triaged and escalated as appropriate. A National panel meets weekly to review all Red rated or critical incidents and provide support as required.

Area for improvement 6 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 the enhanced supervision of service users, where needed, is adhered to in keeping with their assessed needs at all times. Ref: 3.3.2 Response by registered person detailing the actions taken: The rota is updated when there is an unexpected staff change and clearly shows the replacement cover that was arranged at the time. This is monitored and reviewed by the SOM and AOM.
Area for improvement 7 Ref: Regulation 16 (2) (a) and (4) Stated: First time To be completed by: Immediate from the date of the inspection	The registered person shall ensure: • there are robust governance and oversight arrangements to provide assurances in relation to staff training compliance; and • staff receive formal supervision in accordance with the agency's policy. Ref: 3.3.2 Response by registered person detailing the actions taken: Staff training is up to date and monitored at monthly manager's meetings. Outstanding training is added to the action plan and discussed at the following month's meeting. The Learner Management system alerts staff and management when training is due for renewal.
Area for improvement 8 Ref: Regulation 14 (a) (b) Stated: First time To be completed by: Immediate from the date of the inspection	The registered person shall ensure: • there are robust systems in place to ensure fire safety checks are completed in line with expected frequency; and • systems and processes are implemented to effectively manage service users' 'key fobs' so as to ensure the security of the environment at all times. Ref: 3.3.5 Response by registered person detailing the actions taken: Checks completed by the SOM and AOM to ensure all fire checks are completed in a timely manner. A register of fobs is maintained and checked by the SOM and all fobs are accounted for and recorded.

Action required to ensure compliance with The Domiciliary Care Agencies Minimum Standards, revised 2021	
Area for improvement 1 Ref: Standard 9 & 12 Stated: First time To be completed by: 30 September 2026	The registered person should ensure policies and procedures are reviewed to include sufficient detail on how finances are managed in the service. Staff should receive training on the revised policy and procedures. Ref: 3.3.4
	Response by registered person detailing the actions taken: Financial Procedures have been developed. All staff have refreshed their finance training and been re-observed.
Area for improvement 2 Ref: Standard 7.13 Stated: First time To be completed by: Immediate from the date of the inspection	The registered person shall ensure incidents, including those involving medication errors are reported in accordance with procedures to the appropriate authorities. Ref: 3.3.1
	Response by registered person detailing the actions taken: Incidents, including those involving medication are reviewed at monthly managers meetings and during supervisions. All incidents are reviewed by the AOM to ensure that, if appropriate, they have been reported to the Trust.

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