An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

# Alternative Care - Inspection and Monitoring Service

## Children's Residential Centre

**Centre ID number: 007**

**Year: 2020**

# Inspection Report

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| **Year:** | **2020** |
| **Name of Organisation:** | **Novas Initiatives** |
| **Registered Capacity:** | **6 young people** |
| **Type of Inspection:** | **Announced themed inspection** |
| **Date of inspection:** | **29th January and 12th February 2020** |
| **Registration Status:** | **Registered without attached conditions from the 13th March 2018 to the 13th March 2021** |
| **Inspection Team:** | **Linda Mc Guinness**<br>**Eileen Woods** |
| **Date Report Issued:** | **22nd May 2020** |

# Contents

# 1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality Assurance Directorate within TUSLA, the Child and Family Agency.
The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined.
During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

- **Met:** means that no action is required as the service/centre has fully met the standard and is in full compliance with the relevant regulation where applicable.
- **Met in some respect only:** means that some action is required by the service/centre to fully meet a standard.
- **Not met:** means that substantial action is required by the service/centre to fully meet a standard or to comply with the relevant regulation where applicable.

Inspectors will also make a determination on whether the centre is in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996. Determinations are as follows:

- **Regulation met:** the registered provider or person in charge has complied in full with the requirements of the relevant regulation and standard.
- **Regulation not met:** the registered provider or person in charge has not complied in full with the requirements of the relevant regulations and standards and substantial action is required in order to come into compliance.

## National Standards Framework

## 1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration in 2003. At the time of this inspection the centre was in its fifth registration and was in year two of the cycle. The centre was registered without attached conditions from the 13th March 2018 to the 13th March 2021.

The centre was registered to accommodate six young people of both genders from age twelve to seventeen years upon admission. It provided medium to long term care placements for separated young people seeking or granted asylum. The model of care was described as a person centred, holistic approach where young people were met with unconditional positive regard. It was based on Maslow's hierarchy of needs and sought to meet basic, social emotional educational developmental and religious needs. There was a strong focus on preparation for leaving care. There were four young people living in the centre at the time of the inspection.

## 1.2 Methodology

The inspector examined the following themes and standards:

| Theme | Standard |
|---|---|
| 3: Safe Care and Support | 3.1, 3.2, 3.3 3.4 |
| 5: Leadership, Governance and Management | 5.1, 5.2, 5.3 5.4 |

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young people, staff and management for their assistance throughout the inspection process.

## 2. Findings with regard to registration matters

A draft inspection report was issued to the registered provider, senior management, centre manager and to the relevant social work departments on the 2nd March2020. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 12th May 2020. It should be noted that any delay in returning the CAPA was due to the outbreak of the Covid 19 pandemic. The CAPA was deemed to be satisfactory and the inspection service received evidence of the issues addressed. The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 007 without attached conditions from the 13th March 2018 to the 13th March 2021 pursuant to Part VIII, 1991 Child Care Act.

# 3. Inspection Findings

**Regulation 16**

**Theme 3: Safe Care and Support**

**Standard 3.1 Each Child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.**

The centre had a suite of policies and at the time of inspection they informed inspectors that an overall review of these was underway but not yet completed. The child protection policies in place did not reference Children First: National Guidance for the Protection and Welfare of Children, 2017 or the updated legislation and must be reviewed and signed off as a matter of priority. Staff had completed training in the Tusla E-Learning module: Introduction to Children First, 2017. There was no separate training in relation to the centres policies on child protection and the centre manager said this would be provided when the policy was updated. Inspectors found that through interviews with staff and review of returned questionnaires they were clear about their reporting responsibilities under Children First, 2017 however, there was a lack of clarity as it was assumed that all staff members were mandated persons under the legislation but this was not the case. A list of mandated persons was not held in the centre as required.

Inspectors noted significant deficits in respect of vetting in relation to recently employed staff members where there was no CV on file, verified references or qualifications. There was no evidence that police clearance from abroad was sought or provided even though it was required.

On- going regular training in the prevention, detection and response to abuse was not in place at the time of inspection. Team meetings or management meetings did not have a specific focus on safeguarding and child protection. The centre had a child safeguarding statement and a letter of compliance from the Tusla Child Safeguarding Statement Compliance Unit. During interviews with staff, inspectors found that their knowledge about the purpose and content of the statement must be assessed and improved through oversight and training.

There had been no child protection and welfare notifications since the last inspection however there were a number of concerns which had not been reported following consultation with social work. These were managed instead by risk assessments,

strategy meetings and safety plans. There was no specific child protection register in place to record and track child protection and welfare reports. There was no system in place to record the rationale for decisions made not to report a child protection and welfare concern. These measures must be built into the update of child protection and safeguarding policies and procedures in line with Children First: National Guidance for the Protection and Welfare of Children, 2017.

There was an anti-bullying policy in place however it did not specifically include risks relating to the internet and social media and must be updated. Inspectors found that staff knew how to recognise bullying and put measures in place to minimise impact if it did occur. This was evident when an issue arose outside the centre for one young person and they worked closely with a community group to resolve the issue promptly.

The purpose of the centre was to accommodate young people who were separated from families so it was difficult to work in partnership and while there were no specific arrangements in place to inform parents of allegations of abuse, this could be facilitated by the social work department if there was contact with families of origin. There was evidence of excellent working relationships with the referring social work department.

Pre-admission risk assessments took place at the outset of the placement to identify and address areas of vulnerability and risk for young people. There was evidence through interviews and across young people's planning documents that staff were aware of the need to keep them safe. Individual safeguards were implemented promptly if required. The team used a set programme to support young people appropriate to their age and ability to develop skills needed for self-care and protection and these were very much evident across care files. There was evidence that this was effective in practice recently, when one young person was able to approach staff when they felt unsafe. This issue was managed in a sensitive and proactive way in consultation with the supervising social work department.

The centre did not have a specific policy or procedure on protected disclosures and there was confusion as to the purpose and content of such a policy. Senior management must ensure the management and staff team are fully aware of their responsibilities and rights in this regard. A draft policy was sent to the lead inspector following the onsite inspection.

Risk assessments, risk management plans and safety plans were implemented if required, in close consultation with supervising social workers. All four social workers commended the individual person centred approach in place and were confident that the centre had a strong focus on the safety and wellbeing of their young people placed in the centre. They reported that young people were well cared for, kept safe and making good progress. Young people interviewed during the inspection stated that the placement has been really positive for them and that their keyworkers talked with them around a variety of issues including their safety.

**Standard 3.2 - Each child experiences care and support that promotes positive behaviour.**

Staff had been trained in a recognised model of behaviour management however the training had expired for some staff and they were due refresher training. The manager and another staff member had recently completed a train the trainer programme and had plans were in place to facilitate this update at the earliest opportunity.

There were policies in place to guide approaches to behaviour management in the centre and the inspector was provided with a draft policy in relation to the management of challenging behaviour. A policy to promote the positive approach to behaviour management was also at draft stage during inspection. During interviews with staff, inspectors found that they understood the approaches to behaviour management and were able to implement this on a day-to-day basis. Young people were also aware of the expectations for behaviour and there was evidence that regular key working took place to support them. They spoke highly to inspectors of the day to day support and positive relationships with staff.

Social workers for young people had provided adequate pre-admission information to the centre if it was available. Each young person had an individual crisis management plan however, some of these were outside the scope of the stated model and an individual behaviour support plan would be more appropriate. A draft one was provided following inspection.

There were some sanctions which were being used regularly however there was no evidence that they were effective in changing behaviour or facilitating learning. There was no evidence of a system in place whereby sanctions and rewards and behaviour management practices in place in the centre were audited by an external person.

A draft policy in respect of restrictive practices in the centre was provided during the inspection. There were alarms on young people's bedroom doors which were operational at night time. This measure had been implemented due to overarching concerns about the safety and welfare of young people. It was not based on individual or specific risks for young people or recorded separately on their record. While this measure may be appropriate in the early stages of placement when there are often many unknowns given the purpose and function of the centre, it should be reviewed on an on-going basis as they get to know young people and reassess any possible risks.

**Standard 3.3 - Incidents are effectively identified, managed and reviewed in a timely manner and outcomes inform future practice.**

Young people were provided with the opportunity to provide feedback on the day-to-day operations of the centre through young people's meetings, their allocated key workers and the availability of the centre manager. Inspectors met with three of the four young people resident who described being listened to and being able to bring concerns to the staff team. The head of service also met with young people when they were on site in the centre although this was not formally recorded for issues arising.

The centre had a complaints process which was explained to young people upon admission. The children's rights alliance and Empowering People in Care (EPIC) had been invited to meet with the young people in the centre and it was evident that there was an open culture where concerns could be raised.

Due to the nature of the service parents were generally not involved in the discussions relating to care being provided young people but there were mechanisms to receive feedback from the referring social work department.

There was policy relating to the notification of significant events and all four social workers interviewed during inspection were satisfied that they were notified promptly of any incident relating to their young person. There was evidence of an initial review of incidents in the centre and also at team meeting level however, at the time of inspection there was no formal significant event review group to analyse trends or patterns for learning purposes. The manager and compliance officer indicated their intention to commence this immediately in line with the requirements of national standards and a draft policy had been drawn up. Learning from incidents should be communicated to all relevant persons and used to inform the development of best practice.

| Compliance with Regulation | |
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| **Regulation met** | **Regulation 16** |

| Compliance with standards | |
|---|---|
| **Practices met the required standard** | **None identified** |
| **Practices met the required standard in some respects only** | **Standard 3.1**<br>**Standard 3.2**<br>**Standard 3.3** |
| **Practices did not meet the required standard** | **None identified** |

**Actions required**

- The director of service must ensure that all child protection policies and procedures are in line with Children First: National Guidance for the Protection and Welfare of Children, 2017 and staff must receive regular training in the prevention, detection and response to abuse.
- The director of service must ensure that there is a fully understood policy in relation to protected disclosures.
- The centre manager must ensure that there is a list of mandated persons held in the centre.
- The centre manager must ensure that there is centre register of child protection and welfare reports in line with Children First: National Guidance for the Protection and Welfare of Children, 2017.
- The centre manager must ensure that there is a record of the rationale for decisions made not to report a child protection and welfare concern in in line with Children First: National Guidance for the Protection and Welfare of Children, 2017.
- The director of services must ensure that issues relating to vetting of staff are addressed and that there is adequate oversight of this in future.
- The centre manager and director of service must ensure that refresher training relating to the model of behaviour management takes places within the required timeframes.
- The centre manager and director of service must ensure that the use of restrictive procedures is individually risk assessed, recorded on each young person's care record and monitored on an on-going basis. There should be a register of any restrictive practices used in the centre.
- The director of services and centre manager must ensure that incidents are formally analysed for trends, patterns and learning purposes and that outcomes are communicated to staff and social work departments.

## Regulations 5 and 6 (1 and 2)

## Theme 5: Leadership, Governance and Management

### Standard 5.1 - The registered provider ensures that the residential centre performs its functions as outlined in relevant legislation, regulations, national policies and standards to protect and promote the care and welfare of each child.

Inspectors found that there were not yet adequate mechanisms were in place to ensure that the centre operating in compliance with standards. Arrangements in place to ensure that there was external oversight of the centre's care practices and operational procedures were not adequate and this must be addressed as a matter of priority. New legislation and updated national standards had not been incorporated into centre policies in a timely manner. This was despite evidence that this requirement was flagged at management meetings in early 2019. The staff team had been involved in an exercise to review the centre's policies and procedures in line with the National Standards for Children's Residential Centres, 2018 (HIQA) but this was still a work in progress. While staff demonstrated understanding of many of the relevant policies some aspects of regulations and standards, including protected disclosures and the child safeguarding statement were not fully understood or reflected in staff practice.

### Standard 5.2 - The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-cantered, safe and effective care and support.

There was a clearly set out organisational structure with identified lines of reporting. The structure was appropriate to the size and structure of the centre however improvements were required in respect of external governance and management arrangements. The roles and responsibilities of staff within the centre were clear however the responsibilities for senior line management were not as clearly defined. It was not clear who was ultimately responsible for ensuring compliance with legislation and relevant national standards at the time of inspection. A draft policy to address these issues relating to implementation of theme 5 of National Standards for Children's Residential Centres, 2018 (HIQA) was provided to inspectors following the onsite visits.

The centre manager reported to the director of service who was also responsible for a large number of adult services within the organisation. There was evidence that this person had a regular presence in the centre, had reviewed care files, attended management meetings and met with young people on occasion however this oversight had not addressed deficits identified during this inspection. They had not ensured that policies and procedures for the centre were developed, updated or reviewed in line with regulatory requirements.

There was a compliance officer for the entire organisation who had undertaken audits in 2018 and 2019 however a report had not been generated for 2019 at the time of inspection. This centre was the only children's centre within the organisation and the audits were based on a framework that was not relevant to children's residential care.

The centre manager was the designated person in charge and there was evidence that they were responsible and accountable for the delivery of care within the centre. Interviews with staff and review of questionaires indicated that they provided good leadership. There were arrangements in place for one of two team leaders to act up in the manager's absence however there was no specific record for times or circumstances and key decisions made when management responsibilities were delegated and this is required.

There was a service level agreement in place with Tusla; the Child and Family Agency but at the time of inspection there was no evidence yet that the organisation had provided evidence of compliance with legislation and national standards as required by the 2018 national standards.

There was not an operating risk management framework in place for the identification, assessment and management of risk in the centre however inspectors were provided with a draft document during the onsite visit. This must be finalised and communicated clearly to staff as a matter or priority.

**Standard 5.3 - The residential centre has a publicly available statement of purpose that accurately and clearly describes the services provided.**

There was a recently revised draft statement of purpose and function for the centre which outlined the aims and objectives of the service and other requirements of regulations. The day to day operation of the centre reflected the statement of purpose, staff were familiar with it and there was a version available for young people and others. There was evidence that the staff team understood the model of care and

were competent in its delivery within the centre. There was evidence that the practical day to day care care and support needs of young people were being met to a high standard.
There was evidence on site and feedback from professionals that services were being delivered in line with the statement. A formal system within the governance structure to evaluate and assess delivery of care was being devised as part of the overall review of policies and procedures. This must be prioritised.

**Standard 5.4 - The registered provider ensures that the residential centre strives to continually improve the safety and quality of the care and support provided to achieve better outcomes for children.**

Some improvements were required within the governance structures to ensure that there was review of the quality, safety and continuity of care. There were signs that work had begun to put structures in place to assess compliance with the National Standards for Children's Residential Centres, 2018 (HIQA). Draft policies relating to theme 5 (leadership, governance and management) outlining specific responsibilities in this regard was provided following inspection. These, along with auditing against all national standards must be completed and implemented as a matter of priority.

There was no centre complaint register as complaints were recorded on individual care records. They were not recorded in a way that they could be effectively reviewed for learning and this must be incorporated into the policy update. There was no evidence that complaints were reviewed at staff team meetings or management meetings, although a database was held centrally for the organisation for formally notified complaints. This did not facilitate tracking for learning or service improvement for those which had been managed internally. The proposed significant event review group intended to meet the requirement to monitor and analyse incidents and this must be implemented as a matter of priority.

The registered provider must ensure that an annual review of compliance with objectives is conducted and identifies specific actions to inform service improvement.

| Compliance with Regulation | |
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| **Regulation met** | **Regulation 5**<br>**Regulation 6.2**<br>**Regulation 6.1** |
| **Regulation not met** | **None identified** |

| Compliance with standards | |
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| **Practices met the required standard** | **Standard 5.3** |
| **Practices met the required standard in some respects only** | **Standard 5.1**<br>**Standard 5.2**<br>**Standard 5.4** |
| **Practices did not meet the required standard** | **None identified** |

**Actions required**

- The director of care must ensure that there are adequate governance arrangements in place to ensure oversight of the centre's care practices and operational policies and procedures. Legislation and national policy must be reviewed regularly and identified gaps in compliance must be addressed in a timely manner.
- The director of services must ensure that policies and procedures are developed, reviewed and updated as required by regulations and national standards.
- The director of services and centre manager must ensure that the framework for the identification, assessment and management of risk is communicated to all staff and implemented in practice.
- The centre manager must ensure that there is a specific record for times, circumstances and key decisions made when management responsibilities are delegated to other appropriately qualified staff members.
- The director of services must ensure that there are formal arrangements in place to assess the safety and quality of care against the National Standards for Children's Residential Centres, 2018 (HIQA).
- The director of services must ensure that the policies relating to recording monitoring and analysing complaints, concerns and incidents are reviewed and implemented in practice.
- The registered provider must ensure that an annual review of compliance with centre objectives is conducted and that it identifies specific actions to inform service improvement.

## 4. CAPA

| Theme | Issue Requiring Action | Corrective Action with Time Scales | Preventive Strategies To Ensure Issues Do Not Arise Again |
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| 3 | The director of service must ensure that all child protection policies and procedures are in line with Children First: National Guidance for the Protection and Welfare of Children, 2017 and staff must receive regular training in the prevention, detection and response to abuse. | The director of services and the center's manager have already updated and introduced the center's child protection policies in line with Children's First 2017. Implementation of these policies is ongoing and all staff are being trained on the updated versions at team meetings. (Safeguarding Statement and Child Protection Policy addressed at team meeting 5th March 2020). Furthermore, all staff are required to discuss their understanding of the child protection policies in supervision where more guidance and advice can be given so to ensure that all staff have clarity and have fully understood and implemented the requirements in their care practice. | The director of services and the center manager will ensure that the child protection policies and any matters arising in terms of welfare of children are discussed and reviewed on regular basis and any finding or change identified is communicated and implemented in timely manner. |
| | The director of service must ensure that there is a fully understood policy in relation to | Staff are already fully aware of the organisational whistleblowing policy available in the staff handbook. | The director of services ensures that the policy is implemented and matters arising from protected disclosures are dealt with in |

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| | protected disclosures. | Additionally, a protective disclosure policy has been developed specifically for this service and staff are being asked to share their understanding in upcoming team meetings and supervisions. The process is ongoing. | line with the policy. |
| | The centre manager must ensure that there is a list of mandated persons held in the centre. | List of mandated persons has been formalized and it consists of two team leaders and five staff members and all staff on the list are aware of their responsibilities in relation to reporting child protection and child welfare concerns using the TUSLA Portal, recording and reporting such concerns to the Designated Liaison Person and Social Workers. | The manager shall ensure that all staff are aware of the responsibilities of mandated persons, designated named person, DLP and deputy DLP as well as for the whole organisation. The manager will review the list of mandated persons once a year and any changes identified are being communicated and implemented in timely manner. |
| | The centre manager must ensure that there is centre register of child protection and welfare reports in line with Children First: National Guidance for the Protection and Welfare of Children, 2017. | A child protection template register has been implemented, and staff will receive specific presentation on recording child protection and welfare reports in the register, in team meetings and further discussions on this subject will take place in supervision of staff. This has been | The register of child protection and welfare reports is now live and the manager will ensure that all entries are properly recorded. The manager will review the register on regular basis along with the relevant paper work to ensure that all concerns are being addressed in line with |

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| | | finalised March 2020. | the Children First: National Guidance for the Protection and Welfare of Children 2017. |
| | The centre manager must ensure that there is a record of the rationale for decisions made not to report a child protection and welfare concern in in line with Children First: National Guidance for the Protection and Welfare of Children, 2017. | The center register of child protection and welfare is available on site as of March 2020 and all such matters are being reported to TUSLA via the Portal and/or Significant Event Notification system. Staff are aware of their reporting and recording responsibilities. | All child protection and welfare concerns are being reported to TUSLA and recorded in the Register of Child Protection. If a decision is taken mot to report this will be recorded appropriately. |
| | The director of services must ensure that issues relating to vetting of staff are addressed and that there is adequate oversight of this in future. | In line with the recommendation the absent documents outlined (for one staff member in particular), in the report, have already been sought. | The Director of Services will ensure in conjunction with HR Department that all vetting documents are on file with emphasis on staff transferring internally so that all employees are vetted in accordance with Children First National Guidance For the Protection and Welfare of Children, 2017. |
| | The centre manager and director of services must ensure that refresher training relating to the model of behaviour | The refresher training had already taken place on February 6th for all staff due the refresher. The timeframe has been elapsed for two months due to the center manager | The people in charge of this training will attend to their own training refreshers in timely fashion and certificates are received, so that no gaps between training timeframes |

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| | management takes places within the required timeframes. | and one team leader awaiting certificates from Cornell University as they are now in charge to providing the training. | are being recorded in the future. However, due to restrictions caused by the Covid-19 pandemic, training might need to be rescheduled to later dates as per public health advice. |
| | The centre manager and director of service must ensure that the use of restrictive procedures is individually risk assessed, recorded on each young person's care record and monitored on an on-going basis. There should be a register of any restrictive practices used in the centre. | A policy that outlines the restrictive measures had been developed and implemented. Every young person has a risk assessment regarding any restrictive measure that applies. A register of same has been put in place as of March 2020. | The restrictive measures will be individually risk assessed and then reviewed regularly, timeframes pending on each individual case. The register shall also be amended in accordance with any change in the individual risk assessment. Together, the manager and director of services will review the restrictive measures on quarterly basis or at a time that any changes need to be applied between those timeframes. |
| | The director of services and centre manager must ensure that incidents are formally analysed for trends, patterns and learning purposes and that outcomes are communicated to staff and social work | The Serious Event Review Group (SERG) has been established and it consists from the Director of Services, Head of Compliance, Center Manager, one Deputy Manager and in rotation a member of staff. The group will meet every quarter (or else on emergency basis, should this be | The SERG will stay consistent with their quarterly meetings with the focus on learning from findings of the review, communicate these transparently to the team and insuring that any changes in the approach of the delivery of care are being implemented as required. The manager and |

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| | departments. | required), to ensure that matters arising from incidents are analyzed, patterns are established and new approaches in the delivery of care are being considered. The staff team will be informed of all findings at team meetings after every review meeting. | the director of services will ensure that the meetings are happening within the proposed timeframes, they are documented and any finding communicated to staff. Due to restrictions caused by the Covid-19 pandemic, these meetings will take place on line via Microsoft Teams until further notice. |
| **5** | The director of care must ensure that there are adequate governance arrangements in place to ensure oversight of the centre's care practices and operational policies and procedures. Legislation and national policy must be reviewed regularly and identified gaps in compliance must be addressed in a timely manner. | The Director of care (CEO), shall ensure the overall governance of the centre and supervise the provision of care in the centre. The director of services shall participate at monthly manager's meetings (happening on-line until farther notice due to public health restrictions), with an established agenda that will include matters of staffing, matters arising from the young people, complaints and incidents, standard of paper work and the centre's relationship with external agencies. The director of services is also part of SERG and review of complaints group, which will meet quarterly. The director of services will ensure that all documentation is in line with the | There is an updated policy on general governance, which outlines structures, roles and responsibilities of each person that provides leadership, governance and management. A record of meetings, reviews and communication within the governance structure are kept in the centre. Any findings in relation to the delivery and quality of the care provided are being addressed communicated and implemented so that the young people have clear understanding of the centre being well managed. |

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| | | Legislation and will oversee the child protection policies and practices in the centre, matters of compliance alongside the head of compliance. The director of services will offer supervision, guidance and support to the centre's manager. | |
| | The director of services must ensure that policies and procedures are developed, reviewed and updated as required by regulations and national standards. | The centre manager is overall responsible with the development, updates and implementation of policies. The director of services shall be directly supervising this process, will advise on reviews of policies and will inform the centre on the approval for any new, updated or reviewed policy in timely fashion. | The director of services is informed regularly by any new or updated policy, a copy of it will be sent to him for review, at the draft stage, and he will advise on any changes and timeframes for implementation. |
| | The director of services and centre manager must ensure that the framework for the identification, assessment and management of risk is communicated to all staff and implemented in practice. | The director of services, the manager and the head of safety and compliance are responsible for identification, assessment and management of risks. The risk register is being reviewed once every year or as required if new risks are being identified. Any findings arising from these reviews are communicated in timely manner to all | There is a risk register in place which states the main risks associated with the service, the levels and measures for risk management. This will be reviewed annually and any changes arising from these reviews are recorded. |

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| | | staff, while the centre manager provides support and guidance on the implementation of risk management. | |
| | The centre manager must ensure that there is a specific record for times, circumstances and key decisions made when management responsibilities are delegated to other appropriately qualified staff members. | A handover record book shall be used to record all tasks to a delegated person in the acting manager's role or when some management tasks are being transferred to a deputy manager and their responsibilities clearly noted. The hand over record book shall be used for the time the manager goes on leave also. | A handover record book shall be used to record all tasks to a delegated person in the acting manager's role and their responsibilities clearly noted, and any other transfer of tasks to a deputy manager. A report shall be given to the manager, consisting in all aspects of the tasks and the care provided in the centre. |
| | The director of services must ensure that there are formal arrangements in place to assess the safety and quality of care against the National Standards for Children's Residential Centres, 2018 (HIQA). | The SERG is also responsible for the review of the quality of care and will review the complaints log and any matters arising from complaints at their quarterly meetings or at any time the situation requires. All aspects of the quality of care, monitoring and analyzing complaints and incidents are part of the staff meeting agenda and any feedback from the review group will be given to staff in timely manner. The director of services and the | The review group will be meeting once very quarter to assess the safety and quality of care against the National Standards for Children Residential Centre's 2018 (HIQA) . These meetings are now moved on-line due to restrictions of gatherings during the Covid-19 pandemic. These will recommence in a normal fashion as restrictions will be lifted in accordance with public health advice. Records of these meetings will be kept on the premises and any matters |

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| | | centre manager will provide guidance and support to all staff in informing their practice and delivery of care. In addition, the head of compliance will carry out audits of the safety and quality of care bi-annually, and all findings will be communicated to staff with the focus on informing their practice. | arising will be communicated to the staff team at team meetings and supervisions. The head of compliance will also do audits twice a year which will be measured against the standards. |
| | The director of services must ensure that the policies relating to recording monitoring and analysing complaints, concerns and incidents are reviewed and implemented in practice. | In line with the recommendation the director of services shall ensure that the policies relating to recording, monitoring of complaints are up to date, reviewed and fed back to the team for implementation in practice. The complaint review group will meet and discuss any matters arising from complaints and will make recommendations to better inform the practice in the centre. | The centre manager will keep the director of services up to date on matters of complaints in the centre and will bring such matters for discussions to the complaint review group in their quarterly meetings (moved on-line due to public health restrictions during Covid-19 crisis). |
| | The registered provider must ensure that an annual review of compliance with centre objectives is conducted and that | In accordance to this recommendation the head of safety and compliance, the director of services and the centre manager will review the safeguarding statement, risk | A report will be compiled and record of these reviews will be kept in the centre outlining any changes and timeframes for communicating and implementing these |

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| | it identifies specific actions to inform service improvement. | register, child protection policies, protective disclosures policy and any other relevant policies once every year. Any changes arising from these meetings will be communicated to the staff team and implemented under the manager's supervision, within the agreed timeframes. This group will assess review of compliance with organisation policies and centre objectives. | changes. |