An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 012

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Matt Talbot Services**
Registered Capacity:	**Six young people**
Type of Inspection:	**Announced**
Date of inspection:	**11th & 12th February 2020**
Registration Status:	**Registered with conditions from 14th July 2020 to the 14th July 2023**
Inspection Team:	**Joanne Cogley** **Paschal McMahon**
Date Report Issued:	**14th July 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 March 2006. At the time of this inspection the centre was in its fifth registration and was in year three of the cycle. The centre was registered without attached conditions from the 14th July 2017 to the 14th July 2020.

The centre is a specialist drug /alcohol residential service and is part of a charitable organisation providing its services across four centres to young people, young adults and their families that are struggling with substance misuse. The organisation operates a harm reduction approach throughout its services, which is delivered within the four tier model of service delivery. They describe their model of treatment throughout the service as being informed by evidence-based interventions appropriate to each centre, including the bio psychosocial model of treatment, restorative practice and is embedded in the principles of trauma informed care (TIC). The centre provides residential treatment for a maximum of six male teenagers in the 14 – 18 age group. There were two 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
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 and centre manager on the 9th March 2020. 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 20th May 2020. It was the decision of the registration panel at this point to propose to attach conditions to the registration of the centre as for non -compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996 Part III, Article 5. The condition being:

- There must be no further admissions of a young person under the age of 18 to this centre.

The registered providers made representations in response to the proposal to attach the conditions as per Article 61, (12) of the Child Care Act 1991. These representations and supporting documents to evidence progress that had been made in implementing the CAPA were reviewed and it was deemed that the proposed condition could be amended and instead a new condition attached to the registration. This condition being that:

- The corrective and preventative action plan is implemented in full.

As such it is the decision of the Child and Family Agency is to register this centre, ID Number: 012 with attached conditions from the 14th July 2020 to the 14th July 2023, with a review date of the 30th of November 2020 for the attached conditions pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 16

Theme 3: Safe Care and Support

Standard 3.1

Inspectors reviewed the child protection policies in place and found these to be in line with Children First: National Guidance for the Protection and Welfare of Children, 2017. The centre had a child safeguarding statement that was generic to the organisation and needed to be reviewed in order to be centre specific. The centre manager must also ensure this safeguarding statement in kept updated in line with any changes in risk including any new admissions or discharges. Inspectors found that there were no current formal mechanisms in place for the governance and oversight of child protection and safeguarding practices and the chief executive officer (CEO) must ensure a mechanism is implemented.

The centre had an anti bullying policy in place. Part of the centre's treatment model included the prohibition of mobile phones and internet usage therefore young people did not have access to online material during the time of inspection. Inspectors met with young people, parents and staff and there was no evidence of bullying between the current residents. Inspectors found through interviews with staff that there was a noted incident with a previous resident and this was managed through the centre's use of their anti bullying policy and staff interviewed confirmed that interventions utilised saw a decrease in behaviours of concern.

Staff had received appropriate education and training regarding recognising and responding to allegations of abuse at induction phase. Staff training records evidenced that each staff member had completed training in early 2018 in the Tusla E-Learning module: Introduction to Children First, 2017. During interviews, inspectors found that staff struggled to communicate an understanding and awareness of the child safeguarding statement and its purpose, in some cases they were not aware of who the appointed designated liaison person (DLP) was and they were not familiar with the process of reporting an allegation. The centre manager must ensure that staff members are aware of the child safeguarding statement along with the risks identified and the proposed control measures for same. They must also be aware of who the appointed designated liaison person is and understand the DLP role and be familiar with the reporting process. It is recommended that staff

complete the e-learning training again as it has been two years since it was previously completed and there were uncertainties in areas as highlighted above.

Arrangements were in place to inform parents of allegations of abuse where appropriate. Inspectors interviewed the parents of one young person in placement and they confirmed there was a collaborative approach adopted by the centre and themselves to ensure the safety and wellbeing of their child was paramount. Of the two young people in placement at the time of inspection, neither were under social work supervision. The centre worked closely with the local duty social work department and the centre manager confirmed they would report any concerns to a link person there if required.

It was evident through interviews that individual areas of vulnerability were identified at admission stage. Staff and young people interviewed demonstrated an awareness of individual vulnerabilities and safeguards. However, while there were risk assessments on file these did not address the level of risk or how risk was to be managed by staff. The risk assessment and risk management processes in the centre need to be reviewed to ensure that strategies direct staff on how risk is to be managed and this is recorded in risk documents. Due to the centre being a treatment facility it was an inbuilt part of the programme that each young person must be assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection and this was drawn up through their individual treatment plan and revisited on a daily basis through their individual counselling sessions.

The centre had a policy on protected disclosures and staff members interviewed were familiar with this policy and stated to inspectors that they would be confident to utilise it should they feel the need to.

Standard 3.2

Inspectors found through interviews that the centre adopted a positive approach to behaviour that challenges. The centre worked under a model of treatment in which counselling was an integral part of daily routine. As such any issues or incidents were discussed and worked through with counsellors on a daily basis. Natural consequences would still be implemented where required such as repatriation for damages caused etc. The staff in the centre consisted of both social care professionals and counselling professionals and it was evident from interview that staff members had the up to date knowledge and skills to respond to and manage behaviours. Counselling staff were aware of the need to identify underlying causes of behaviours

and to assist the young person in managing their behaviours together with being mindful of the impact on the young person. It was evident from speaking with both young people that they were being supported to develop their understanding of behaviour and being given the tools to enable their own growth and development.

Inspectors found all staff members to be trained in a recognised model of behaviour management. While not all young people required an individual crisis management plan, inspectors did not find one on file for a young person who had displayed outburst behaviours. An ICMP was subsequently forwarded to inspectors post inspection for this young person; however this had been created by another service for a previous placement and had not been updated by the current service to identify risks within the centre, management strategies for outburst behaviours, and the fact that physical interventions were not in use in the centre. The centre manager must ensure that an individual crisis management plan is drawn up by the service and implemented for young people when required.

The CEO confirmed that they received all significant event notifications and were made aware of incidents within the centre. However, they did not have a mechanism implemented to ensure regular auditing and monitoring of the residential centre's approach to managing behaviour that challenges and one needed to be developed. The centre was utilising an external company based in the UK to carry out accreditation audits on a three year basis. The last audit had been completed in September 2019. Inspectors reviewed this and found it to not be benchmarked against the National Standards for Children's Residential Centres, 2018 (HIQA) with no review of child protection, behaviour management or complaints.

Inspectors did not find any evidence to show that young people were subjected to any restrictive procedure within the centre.

Standard 3.3

Inspectors found from the staff members interviewed that they presented as confident in raising concerns, reporting incidents and identifying areas for improvement. At the time of inspection there was an ongoing review in relation to a protected disclosure which had been made by an employee.

Inspectors noted through review of management meeting minutes and exit interviews carried out with young people and their parents that feedback on the service user's experience was welcomed and encouraged. These were in the form both of

compliments and areas for improvement. There was evidence that this feedback was reviewed at management meetings for learning and improvement.

The centre had a policy in place for the notification, management and review of incidents. Inspectors noted when reviewing significant event notifications that there was no evidence to demonstrate these had been reported or done so in a timely manner. The centre manager was using the postal service to send any significant event notifications with no proof of postage or receipt. These documents should be encrypted and sent electronically to the relevant professionals with the electronic communications attached to same to evidence timely reporting and notification. Due to the lack of information available, inspectors could not confirm that incidents were reported to all relevant professionals in a timely manner. The centre manager must review the current system for recording and reporting incidents.

In two instances inspectors noted that a significant event notification had been written up for incidents that had occurred on site. In these two instances, one report covered four young people and the other covered two young people respectively. This issue was not identified or addressed by the centre manager or the CEO. The centre manager must ensure where a significant event arises that there is a report written up through the significant event notification system for each individual young person and reported to their relevant professionals. The centre did not hold a significant event register and the centre manager must ensure one is implemented. From a review of team meetings since the last inspection, inspectors did not find evidence of incidents being discussed at team meetings or a discussion in relation to any learning from an event. The CEO must ensure that there are appropriate mechanisms in place for reviewing, tracking and monitoring trends of incidents and that there is a mechanism for communicating any learning to the staff team.

Compliance with Regulation	
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** **Standard 3.2**
Practices did not meet the required standard	**Standard 3.3**

Actions required

- The centre manager must ensure the safeguarding statement is centre specific and is updated in line with any changes in risk including any new admissions or discharges.
- The CEO must implement a mechanism for auditing, governance and oversight of child protection and safeguarding practices.
- The centre manager and CEO must ensure that staff members are aware of the child safeguarding statement and its purpose. They must also ensure staff are aware of the DLP and the reporting process.
- The centre manager and CEO must ensure all staff members are refreshed in Children First: National Guidance for the Protection and Welfare of Children, 2017.
- The CEO and centre manager must ensure the risk assessment and risk management processes in the centre are reviewed to ensure that strategies that direct staff on how risk is to be managed are included in risk documents.
- The centre manager must ensure, where required, an individual crisis management plan is drawn up and implemented for young people.
- The CEO must implement a mechanism for regular auditing and monitoring of the residential centres approach to managing behaviour that challenges.
- The centre manager must implement a system for the prompt notification of significant events and ensure that there is an individual SEN record for each young person.
- The centre manager must ensure a significant event register is implemented.
- The CEO must ensure that there are appropriate mechanisms in place for reviewing, tracking and monitoring trends of incidents and that there is a mechanism for communicating any learning to the staff team.

Regulations 5 and 6 (1 and 2)

Theme 5: Leadership, Governance and Management

Standard 5.1

The centre had policies and procedures in place that were developed in line with relevant legislation and regulations however they were aligned to the National Standards for Children's Residential Centres, 2001 as opposed to National Standards for Children's Residential Centres, 2018 (HIQA). A number of these policies had not been reviewed since 2016 and 2017 which was outside of the centre's own procedure for policy reviews to occur every three years. Inspectors were shown a three year plan covering a period of 2019 to 2022 in order to bring all policies in line with the National Standards for Children's Residential Centres, 2018 (HIQA). Given recent changes and the fact there are outstanding policies from 2016 to be reviewed, inspectors did not deem this to be an appropriate timeframe for review. The CEO must ensure that all policies are reviewed within an appropriate timeframe to ensure compliance with National Standards for Children's Residential Centres, 2018 (HIQA). Inspectors found through interviews with management and staff members there was a limited understanding of regulations and standards for the care and welfare of children. Staff members were not familiar with the roll out of the new National Standards for Children's Residential Centres, 2018 (HIQA). The CEO and centre manager must ensure all staff members can demonstrate an understanding of policies and national standards and implement them in their day to day work.

Standard 5.2

Inspectors found at the time of inspection leadership was not demonstrated and evidenced at all levels in the residential centre. Inspectors found that there were significant deficits in the governance and auditing mechanisms in place and this needed to be addressed. Inspectors observed that while there were clear lines of accountability and lines of authority, there were no clearly defined auditing and oversight structures in place. The centre manager attended senior management meetings on a monthly basis. However, inspectors found that a number of minutes for these meetings were copied (cut and paste) and that new information was not included. Discussions were replicated on the minutes for the 23/10/19, 12/11/29 and 10/12/19 with the same policies and some actions (for example getting Hep B vaccines for staff) were included. The minutes for these meetings needed to improve and inspectors found that discussions on policy review were not sufficient.

The clinical aspect of these minutes did not reflect sufficient discussion around the centre's model of care, approaches being used, effectiveness or lack of, treatment planning for young people or risk management. There was also a significant five month gap in minutes from April 2019 to September 2019. The centre provided copies of these meeting minutes to inspectors after the onsite inspection process was completed. The centre manager provided a monthly report to the CEO. Inspectors reviewed this report and while the template was good, there was little room for child centred discussion, with the focus on operations. These reports also did not contain any action plan or a mechanism for validation by the CEO. The CEO must review the current governance structures in place and their effectiveness.

The centre had an internal management structure that consisted of a centre manager, deputy manager and five childcare leaders. This was deemed appropriate to the size, purpose and function of the centre. When the centre manager took leave, the deputy manager would assume the role of person in charge during that time. The centre manager and deputy manager had clear job descriptions that outlined the tasks they were responsible for thus not requiring a delegation record. At the time of inspection inspectors interviewed one social care leader and although they confirmed they had received a written job description they appeared unclear as to their role in relation to specific management tasks and this should be addressed by the service.

The CEO confirmed with inspectors that there were service level agreements in place for the provision of services. They also confirmed that reports were being provided to the funding body. At the time of inspection one of the funding bodies was carrying out their own review in relation to the centre's governance and provision of services. A copy of this review must be shared with inspectors when completed.

As mentioned previously in this report, the centre had policies and procedures in place that were developed in line with relevant legislation and regulations however they were aligned to the National Standards for Children's Residential Centres, 2001 as opposed to National Standards for Children's Residential Centres, 2018 (HIQA) and these must be reviewed in an appropriate timeframe.

The centre had a risk management policy in place which had not been reviewed since 2016 and required updating. Inspectors found the centre to have implemented a risk register which clearly highlighted the identification, assessment and management of risk in some areas. Inspectors found through interviews and from review of practices that risk was mainly classed as environmental with little to no focus on risk

associated with the young people and their behaviours. Prior to admission a risk assessment was completed for young people and while this identified the risk associated with the young person's behaviours, there were no measures or strategies identified to manage or reduce the risk. From a review of team meetings and management meetings, 'risk' was a standing agenda item however inspectors found that it was not being adequately or appropriately discussed, evaluated and addressed within these forums. The centre manager must review the current risk management framework to ensure it encompasses all elements of risk including environmental, young people and corporate risks.

Standard 5.3

The centre had a statement of purpose which briefly described the model of care together with the aims and objectives of the centre, the range of services available and the arrangements for the wellbeing and safety of children within the centre. The statement of purpose also outlined information relating to the management and staff employed there.

Inspectors found through interview that the statement of purpose of the centre was clearly understood by staff members. Inspectors found that it was detailed in young people's booklets and parent's booklets which were provided in advance of admission. The centre's website also communicated a reader friendly version of the purpose and function.

Inspectors found through interview staff members were clear on the model of treatment being provided within the centre and had received training from the clinical manager in order to be able to practice under this model of treatment.

Standard 5.4

Inspectors found there were no mechanisms in place by the CEO to audit and assess the safety and quality of care provided in the centre against the National Standards for Children's Residential Centres, 2018 (HIQA). The CEO must develop and implement an audit tool and it must be bench-marked against the National Standards for Children's Residential Centres, 2018 (HIQA). The CEO must also ensure they implement an annual review of compliance in relation to the centre's objectives.

Inspectors found there was evidence of complaints being recorded and acted on. From speaking with both young people on site, they were aware of how to complain,

they stated they felt listened to and understood the rationale behind decisions made. The deputy manager completed an in depth analysis of complaints on a regular basis that was stored on a central database in the centre. There was good evidence of analysis from reviewing this database; however there was no evidence to show this was overseen by the centre manager or the CEO. There was no evidence to show that the CEO monitored and analysed complaints or identified and acted on any trends. There was limited evidence to suggest complaints were a regular discussion at team meetings or management meetings. The CEO must ensure monitoring and analysis of complaints and the communication of any trends identified to staff members.

Compliance with Regulation	
Regulation met	**Regulation 6.2** **Regulation 6.1**
Regulation not met	**Regulation 5**

Compliance with standards	
Practices met the required standard	**Standard 5.3**
Practices met the required standard in some respects only	**Standard 5.4**
Practices did not meet the required standard	**Standard 5.1** **Standard 5.2**

Actions required

- The CEO must ensure that all policies are reviewed within an appropriate timeframe to ensure compliance with National Standards for Children's Residential Centres, 2018 (HIQA).
- The CEO and centre manager must ensure all staff members can demonstrate an understanding of policies and national standards and implement them in their day to day work.
- The CEO must review the current governance and auditing structures in place to ensure they are effective and fit for purpose.
- The CEO must ensure that social care leaders in the service are fully aware of their roles and the specific management tasks allocated to them.
- The CEO must ensure that a copy of the funding body review into governance and service provision is shared with inspectors when completed.
- The centre manager must review the current risk management framework to ensure it encompasses all elements of risk including environmental, young people and corporate risks.

- The CEO must implement an audit tool to assess the safety and quality of care provided in the centre and it must be bench-marked against the National Standards for Children's Residential Centres, 2018 (HIQA).
- The CEO must ensure they implement an annual review of compliance in relation to the centre's objectives.
- The CEO must ensure they are monitoring and analysing complaints and communicating any trends identified to staff members.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The centre manager must ensure the safeguarding statement is centre specific and is updated in line with any changes in risk including any new admissions or discharges.	The clinical/ centre manager will ensure the safe guarding statement is centre specific and updated in line with any changes in risk including any new admissions or discharges. The safeguarding statement was reviewed and updated on 23rd March 2020 and will be updated in line with any changes in risks including any new admissions or discharges – and in line with CSSCU guidelines and/ or as circumstances in the centre change such that a review would be required. This will be forwarded to the inspection team by April 15th.	Date for review of statement according to CSSCU will be February 2022. The safeguarding statement will now be used in the in-house admissions meeting and as part of our re-integration programme and discharge process ensuring any new identified risks will be updated to the safeguarding statement.
	The CEO must implement a mechanism for auditing, governance and oversight of child protection and safeguarding practices.	The CEO will implement a mechanism for the external auditing by the provider of child protection and safeguarding practices within the Centre.	This role will be fulfilled by the CEO and implemented from 20th April 2020 (Covid 19 pandemic circumstances permitting). Monthly records of this will be available from April 2020.

	The centre manager and CEO must ensure that staff members are aware of the child safeguarding statement and its purpose. They must also ensure staff are aware of the DLP and the reporting process.	The clinical/ centre manager and CEO will ensure that refresher training is provided to all staff on the child safeguarding statement and its purpose, are aware of the DLP and the reporting process. The clinical/ centre manager will require staff to review the statement prior to the centre manager interviewing each staff member to process their awareness and understanding using a specific questionnaire – to be completed by 30th April. A copy of the questionnaire will be forwarded to the inspection team by April 15th. The questionnaires include a section on the DLP and reporting process. Completed questionnaires will be available if requested. (see also next section also for DLP and reporting process). The CEO will review the above process at monthly line management.	The safeguarding statement will become a standing item on the staff meeting agenda. The safeguarding statement will also be a standing item agenda in monthly CEO & clinical/ centre manager meetings.

	The centre manager and CEO must ensure all staff members are refreshed in Children First: National Guidance for the Protection and Welfare of Children, 2017.	The clinical/ centre manager will ensure that all staff members are refreshed in Children First: National Guidance for the Protection and Welfare of Children, 2017. Staff updating their online e-learning module by March 27th. Clinical/ centre manager forwarded the updated certificates to TUSLA inspectors Monday the 30th of March 2020.	The clinical/ Centre manager will keep a data base of training for renewal dates for e-learning certificate in Children First: National Guidance for the Protection and Welfare of Children, 2017. Children First: National Guidance for the Protection and Welfare of Children, 2017 will become a standing agenda at staff meetings. Children First: National Guidance for the Protection and Welfare of Children, 2017 will also be a standing item agenda in monthly CEO & clinical/ centre manager meetings.
	The CEO and centre manager must ensure the risk assessment and risk management processes in the centre are reviewed to ensure that strategies that direct staff on how risk is to be managed are included in risk documents.	The risk assessment has been enhanced to include a column titled 'Risk Management Strategy', which will detail the interventions to address the risk.	The clinical/ centre manager will monitor to ensure compliance.

	The centre manager must ensure, where required, an individual crisis management plan is drawn up and implemented for young people. The CEO must implement a mechanism for regular auditing and monitoring of the residential centres approach to managing behaviour that challenges. The centre manager must implement a system for the prompt notification of significant events and ensure that there is an individual SEN record for each young person.	The clinical/ centre manager will continue to ensure that ICMP's are drawn up and implemented, where required. The CEO will interrogate on a monthly basis, the approach and management of behaviour that challenges. In addition the CEO will implement a mechanism for the external auditing of the centres approach to managing behaviour that challenges. For information purposes, see letter from Tusla in relation to prompt reporting. In addition, e-mail confirmation of receipt will be sought from Tusla on each occasion. An individual SEN will be completed for each young person, as appropriate.	The clinical/ centre manager will monitor to ensure compliance. The CEO will implement this mechanism from 20th April 2020 (Covid 19 pandemic circumstances permitting). Monthly records of this will be available from April 2020. To be initiated as a desktop process with immediate effect with fieldwork to follow - July 2020 - pending Covid 19 - for completion by 2020.

	The centre manager must ensure a significant event register is implemented. The CEO must ensure that there are appropriate mechanisms in place for reviewing, tracking and monitoring trends of incidents and that there is a mechanism for communicating any learning to the staff team.	The clinical/ centre manager will continue to use the SEN Register. The CEO will ensure that debriefing and learning takes places following incidents, as required.	The clinical/ centre manager will monitor to ensure compliance. The clinical/ centre manager will monitor to ensure completion of individual SENs. The clinical/ centre manager will monitor to ensure compliance. The CEO will implement this mechanism from 20th April 2020 (Covid 19 pandemic circumstances permitting). Monthly records of this will be available from April 2020.
5	The CEO must ensure that all policies are reviewed within an appropriate timeframe to ensure compliance with National Standards for Children's Residential Centres, 2018 (HIQA). The CEO and centre manager must ensure all staff members can demonstrate an understanding of policies and national standards and	MTAS accepts that the original timeframe identified for the review of policies was too long. A process has now been initiated whereby all policies will have been reviewed no later than 31st May 2020. The clinical/centre manager will ensure all staff members can demonstrate an understanding of policies and national standards and implement them in their	The review of policies will be completed no later than 31st May 2020 to ensure compliance with National Standards for Children's Residential Centres, 2018 (HIQA). All staff training will take account of the need to update staff on developments in relation to regulations and standards.

	implement them in their day to day work.	day-to-day work. Management will designate staff to take responsibility for each of the themes and related policies for presentation and learning at staff meetings. (Plan for the above will be forwarded to TUSLA inspectors by April 20th).	
	The CEO must review the current governance and auditing structures in place to ensure they are effective and fit for purpose.	As the Director of Services post is currently vacant, an external consultant will be engaged to audit the complete governance structure against the HIQA 2018 Standards, as per attached audit tool.	To be initiated as a desktop process with immediate effect with fieldwork to follow - July 2020 - pending Covid 19 - for completion by 2020.
	The CEO must ensure that social care leaders in the service are fully aware of their roles and the specific management tasks allocated to them.	The CEO will ensure a review of social care leaders job descriptions including their roles and specific management tasks allocated to them by 11th May 2020 with staff sign-off by 25th May 2020.	The CEO will ensure annual review of social care leaders job descriptions.
	The CEO must ensure that a copy of the funding body review into governance and service provision is shared with inspectors when completed.	This will be forwarded when it becomes available, but is currently delayed due to the pressure within the HSE arising out of Covid 19.	

	The centre manager must review the current risk management framework to ensure it encompasses all elements of risk including environmental, young people and corporate risks.	The register will be reviewed by the centre manager to include items of risk including environmental, young people and corporate risks. This will be developed by 31st May 2020.	This role will be fulfilled by the clinical/ centre Manager with corporate risks escalated appropriately.
	The CEO must implement an audit tool to assess the safety and quality of care provided in the centre and it must be bench-marked against the National Standards for Children's Residential Centres, 2018 (HIQA).	The CEO will implement an audit tool as required.	This role will be fulfilled by the CEO and/ or external auditors, as appropriate. The external audit findings will be available to the Board of Directors.
	The CEO must ensure they implement an annual review of compliance in relation to the centre's objectives.	An annual review of compliance in relation to the centre's objectives will be completed.	On completion of audit of Standards (see above) and no later than October 2020.
	The CEO must ensure they are monitoring and analysing complaints and communicating any trends identified to staff members.	This will form part of managerial oversight of centre's management of complaints, and will be formally reviewed monthly.	Monthly records will be available from April 2020.