An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 047

Year: 2020

Inspection Report

Year:	**2020**
Name of Organisation:	**Galtee Clinic Ltd**
Registered Capacity:	**Four young people**
Type of Inspection:	**Announced**
Date of inspection:	**08th and 09th January 2020**
Registration Status:	**Registered without conditions from 18th May 2018 to the 18th May 2021**
Inspection Team:	**Joanne Cogley** **Anne McEvoy**
Date Report Issued:	**24th February 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 on the 18th May 2012. At the time of this inspection the centre was in its third registration and was in year two of the cycle. The centre was registered without attached conditions from 18th May 2018 to the 18th May 2021.

The centre was registered to provide care to four young people of both genders from age thirteen to seventeen years on admission. Young people residing in the centre availed of a home style living environment with a small, dedicated, and flexible staff team made up of two house pedagogues who reside in the centre for one week periods at a time. Their work was supported by activity therapists who work alongside the house pedagogues on a daily basis in caring for the young people, overseen by the centre manager assigned to the centre and the service manager who has responsibility for the service as a whole.
The centre's therapeutic programme relied on a three pronged approach of social pedagogy, attachment theory and therapeutic activities. The model utilised in the centre aimed to offer attachment relationships to the children in their care. The primary attachment figure for the young people was known as the primary activity therapist. There were four children 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 worked 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 on the 27th January 2020 and to the relevant social work departments on the 27th January 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 February 2020. This was deemed to be satisfactory.

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: 047 without attached conditions from the 18th May 2018 to the 18th May 2021 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 compliant with Children First: National Guidance for the Protection and Welfare of Children, 2017. The centre had a child safeguarding statement that was supported by a letter of compliance to say that this had been reviewed and approved by the Tusla Child Safeguarding Statement Compliance Unit. The centre also had an anti bullying policy in place which accounted for internet and social media usage and the risks associated with same. Inspectors found that there were no current formal mechanisms in place for the governance and oversight of child protection and safeguarding however the service manager did meet with young people both in the centre and off site at the head office on a weekly basis. The service manager must ensure they implement a formal governance mechanism for oversight of child protection and safeguarding.

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 the Tusla E-Learning module: Introduction to Children First, 2017. Staff members had not yet completed up to date training in the organisation's own child protection policies and procedures however inspectors saw evidence that this was due to occur in late January. During interviews, inspectors found that staff members were aware of the process around responding to and reporting issues of concern. Staff did however struggle to communicate an understanding and awareness of the child safeguarding statement and its purpose. 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. Arrangements were in place to inform parents of allegations of abuse where appropriate. The centre manager did not keep a separate child protection register and this must be implemented. The inspectors met with all young people in placement and they stated they felt safe and cared for within the service. Social workers for young people also confirmed they were satisfied their allocated young people were safe and cared for effectively.

The centre completed placement plans for young people on a bi monthly basis. Inspectors reviewed these plans and found there to be a standard template to follow. One section on this template included 'keeping the young person safe'. Inspectors found from review of these plans that this section was not being appropriately utilised on a bi monthly basis. Inspectors did not find any evidence in placement plans of appropriate self-care skills being addressed. The centre manager must ensure they are reviewing placement planning for appropriate goals.

The centre had recently developed a protected disclosure policy however this was yet to be rolled out to the staff team. Due to the registered provider being involved in the day to day operations of the centre, the centre had an assigned external complaints officer as part of their protected disclosure policy. Inspectors saw evidence on file of this appointed individual emailing all staff members in December 2019 informing them of their role and providing contact details. Through interview staff members were aware of this appointed individual and were confident they could approach them if required.

Standard 3.2

Staff had been trained in a recognised model of behaviour management and there was evidence of regular refresher training being completed. However, it should be noted that while staff were trained in disengagement (blocking) techniques, they were not trained to level 9 (physical intervention). There was a policy in place that provided details to the staff team on the nature of and approaches to behaviour management in the centre. 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. The centre employed a 'no restraint' policy. This is taken into consideration when the service manager and centre manager are considering referrals to the centre however from a review of safe plans, it was not evident what the staff members should do in the event of a significant escalation in violent behaviour. The safe plan also has a section that refers to 'physical intervention' and this should specify that the team are not trained to this level and reference the centres policy. The centre manager must ensure that safe plans are risk assessed and there is evidence of a contingency plan on what to do should a young person become physically aggressive considering staff are not trained to Level 9 in a recognised model of behaviour management. The service manager must consider providing training to Level 9 as a precautionary measure in the event it may be required.

Each young person had a safe plan however there was no evidence to show these had been reviewed regularly nor was their evidence to show social workers had input or approval of same. The centre manager must ensure there is a mechanism for reviewing safe plans on a regular basis. Social workers for young people had provided sufficient pre-admission referral information to the centre.

Sanctions were evident and there was clear link to behaviours. The centre supported natural consequences. Young people were also aware of the expectations for behaviour and there was evidence that this had been discussed with young people both on an individual basis and a communal basis through young person's meetings.

Inspectors found from staff interviews that there was an awareness of mental health issues and bullying however there was limited individual work evidenced to support this had been discussed with young people. Staff members had also been supported by the registered provider to attend conferences both within the country and abroad to broaden their knowledge and skills. In one instance the staff team were working with a complex young person where a specialist report had been compiled. The centre had also requested specialist training following this report and inspectors viewed this as an essential component to the staff team having the knowledge and skills to work with this young person. Approval and funding for this training had been requested through the social work department in September 2019 and was yet to be followed through by the young person's social worker.

Inspectors did not find evidence of regular auditing and monitoring of the centres approach to managing behaviours that challenge. The service manager must ensure an audit tool is developed to regularly audit and monitor the centres approach to managing behaviours that challenge.

The centre had recently developed a policy on restrictive practice due to using elements of restrictive practice with one young person in placement. The centre was using two forms of restrictive practise with a young person. There was clear rationale behind the need for these and there was evidence through a number of interviews that in one of the instances it was continuously being reviewed. However there was limited written evidence to support the use of restrictive practice and no evidence to demonstrate these had been signed off by social workers or reviewed in the safe plan or through risk assessments. The centre manager must ensure that there is written evidence to support the use of restrictive practice that has been approved and agreed by the young person's allocated social worker with evidence of regular review and individual work occurring.

Standard 3.3

Inspectors found that young people's meetings were held regularly in the centre and each resident had an allocated primary activity therapist. Both of these aspects of care provided young people with the opportunity to provide feedback on the day-to-day operations of the centre and the care that the young people were receiving. Young people had also been recently visited by a member of the Empowering People in Care (EPIC) team, and in three out of four instances, there was evidence of regular social work visits to the centre.

Parents and social worker feedback was evident through care plan reviews however the service manager must ensure that the centre has its own mechanisms in place for parents and social workers to provide feedback directly to them outside of statutory review meetings for learning and improvement purposes.

The centre had a policy on the notification, management and review of incidents and inspectors were informed by the allocated social workers that all incidents were being reported in a prompt manner both via phone and email.

Inspectors did not find evidence of incidents being regularly reviewed for learning. Inspectors reviewed management meeting minutes which did evidence a look back at incidents for the month however did not provide an analysis of what was going on for the young person, a review of any approaches used or a review of safe plans for effectiveness. Inspectors also reviewed team meetings and found no evidence of incident discussion, review or learning's being shared. There was also limited evidence of trends being identified and addressed. The service manager and centre manager must develop a forum for reviewing and assessing incidents for learning purposes and an appropriate recording mechanism for same.

Compliance with Regulation	
Regulation met /not 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** **Standard 3.3**
Practices did not meet the required standard	**None identified**

Actions required

- The service manager must ensure they implement a formal governance mechanism for oversight of child protection and safeguarding.
- 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.
- The centre manager must implement a child protection register.
- The centre manager must ensure that work is undertaken with young people on their specific risks and vulnerabilities and on how to keep themselves safe.
- The centre manager must ensure that safe plans are risk assessed and there is evidence of a contingency plan on what to do should a young person become physically aggressive considering staff are not trained to Level 9 in a recognised model of behaviour management.
- The service manager must consider providing training to Level 9 as a precautionary measure in the event it may be required.
- The service manager must ensure an audit tool is developed to regularly audit and monitor the centres approach to managing behaviours that challenge.
- The centre manager must ensure that there is written evidence to support the use of restrictive practise that has been approved and approved and agreed in writing by the young person's allocated social worker with evidence of regular review and individual work occurring.
- The service manager must ensure that the centre has its own mechanisms in place for parents and social workers to provide feedback directly to them outside of statutory review meetings for learning and improvement purposes.
- The centre manager must ensure that work being completed with young people in relation to bullying and mental health issues is evidenced through young people's reports.
- The service manager and centre manager must develop a forum for reviewing and assessing incidents for learning purposes and an appropriate recording mechanism for same.

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, regulations and standards. These were last updated in February 2018 and were currently in the process of being reviewed for 2020 to ensure they complied with The National Standards for Children's Residential Centres, 2018 (HIQA). There was evidence of this through a management policy review meeting in October 2019 and through the implementation of some new policies such as restrictive practice and protected disclosures at the time of inspection. The policy review meeting also evidenced a clear timeframe and action plan for policy development and was attended by the registered provider, service manager and centre manager. From interview with the centre manager and the service manager there was no noted instances whereby the centre had operated outside of policy or legislation.

Inspectors found that although the service manager and centre manager demonstrated an understanding of legislation, regulations, policies and standards for the care and welfare of children, staff members struggled to demonstrate this through interview. Staff members also confirmed some of the newer policies, mentioned above, were not yet rolled out to the team so they were not aware of same. The centre manager informed inspectors that these were to be introduced at the upcoming January team meeting. The service manager 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

Through staff interviews and review of paperwork it was evident that there was clear leadership demonstrated within the centre. While lines of authority and accountability were clearly set out for all managers and staff, the board was referred to as an oversight board. Inspectors were not clear of their role and responsibilities specifically in relation to governance and oversight. There was evidence of the service manager providing reports to the board however there was no evidence of a mechanism for feedback to be provided to the centre or information being validated on these reports. There was also no evidence of any decisions that may impact on the

running of the centre being fed back down to the service manager or centre manager. The registered provider should ensure the board provides written feedback on decisions directly impacting on the running of the centre and management of staff and young people to the centre manager.

The centre consisted of a manager supported by two lead pedagogues and four daily activity therapists. Given the model of care the management structure was appropriate to the size, purpose and function of the centre. During periods of absence, the service manager substituted for the centre manager. The centre manager, through interview, stated that due to the set up of the centre, no management tasks were delegated therefore there wasn't a requirement for a delegation record at this time.

The service manager confirmed that a service level agreement was in place relating to referrals to the centre and regular bi-annual reports are provided to this funding body. The registered provider had a system in place for ensuring all policies were developed, reviewed and updated in line with regulatory requirements. These were updated on an eighteen month basis and were currently in the process of review with inspectors noting a clear action plan and timeframe for completion.

Inspectors found the centre to have a risk management framework that was noted as non risk-averse practice. The centre's ethos was to reflect the idea that a residential centre should as much as possible reflect a normal family environment. The centre utilised a recognised behaviour management model informed risk assessment and ensured the young people were actively involved in completing these risk assessments with staff members. Inspectors reviewed a sample of risk assessments and found them to be comprehensive, however did note that once a risk is identified, scored and control mechanisms are put in place, the centre should re-score the risk to determine whether or not the control mechanisms reduced the risk. While these were comprehensive documents there were a number that did not have dates, did not show evidence of who wrote them and did not show evidence of who reviewed them or approved them. The service manager, as a governance mechanism, must ensure all paperwork is dated, details who it is completed by and demonstrate evidence of approvals from appropriate people. The centre, at the time of inspection did not operate a risk register. The service manager must ensure one is developed and implemented.

Standard 5.3

Inspectors reviewed the centres statement of purpose and found this to clearly describe the model of service provision and included information on the aims and objectives of the service, the management and staffing employed in the centre and the arrangements for the wellbeing and safety of children placed in the centre. From observation it was clear that the statement of purpose was reflected in the day-to-day operation of the centre. It had been recently reviewed and updated by the registered provider. It was also clearly outlined in information booklets that the centre used as a resource. From interviews with staff members, inspectors found that the centres model of care was clearly understood and implemented. Inspectors also found that the statement of purpose was incorporated into young person, parents and social workers handbooks to ensure they were aware of the ethos of the centre. From speaking with the young people on site it was also evident they were aware of it in a child appropriate manner.

Standard 5.4

The centre currently had a system whereby an auditor external to the company attended the service annually to complete an audit. From review of this audit it was not a mechanism for assessing the quality, safety and continuity of care provided to the young people and is not in line with standards. There was no system in place whereby the registered provider or the service manager audited the work completed in the centre. The registered provider must ensure that arrangements are put in place to assess the safety and quality of care provided in the centre against the National Standards for Children's Residential Centres, 2018 (HIQA). In addition to this the registered provider must work towards ensuring an annual review of compliance with the centre's objectives is conducted in 2020.

It should be noted throughout this inspection, inspectors found it difficult to navigate paperwork as there were a significant amount of documents with no dates or details of people completing them, this should also be covered through the centre's governance systems.

Inspectors reviewed complaints and found none to have been recorded since April 2018. The centre manager informed inspectors that they recorded and reported formal complaints to social workers but did not formally record informal complaints or dissatisfactions, instead addressing them in daily logs. From review inspectors found missed opportunities for addressing complaints in young person's meetings

and saw themes emerging through continual expression of dissatisfaction. Through interviews, there appeared to be confusion around what constituted a complaint and the centre manager must adopt an approach that all expressions of dissatisfaction should be recorded and responded to. The centre manager must implement a complaints register to allow for tracking and identification of complaint trends together with learning opportunities and improvements. The service manager must ensure the current complaints policy is congruent with Tusla 'Tell Us' and that it is implemented within the centre and understood by staff members. There was no evidence of the registered provider ensuring complaints were monitored and analysed and a mechanism for same must be implemented.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6.2** **Regulation 6.1**
Regulation not met	**None identified**

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

Actions required

- The service manager 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 registered provider should ensure the board provides written feedback on decisions directly impacting on the running of the centre and management of staff and young people to the centre manager.
- The service manager, as a governance mechanism, must ensure all paperwork is dated, details who it is completed by and demonstrate evidence of approvals from appropriate people.
- The service manager must ensure a risk register is developed and implemented.
- The registered provider must ensure that arrangements are put in place to assess the safety and quality of care provided in the centre against the National Standards for Children's Residential Centres, 2018 (HIQA).

- The registered provider must work towards ensuring an annual review of compliance with the centre's objectives is conducted in 2020.
- The centre manager must implement a complaints register to allow for tracking and identification of complaint trends. The service manager must ensure the current complaints policy is congruent with Tusla 'Tell Us' and that it is implemented within the centre and understood by staff members.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
3	The service manager must ensure they implement a formal governance mechanism for oversight of child protection and safeguarding.	Child protection and safeguarding have been already inserted into the management meeting template as standing items on the agenda and therefore will be discussed and reviewed as part of those meetings which occur every 2 – 3 weeks. This process is currently underway. A child protection and safeguarding register has been purchased and it will be the responsibility of the service manager to update, review and monitor this regularly.	The Child protection and safeguarding register will be part of the internal audit which will take place every quarter. The register will be implemented by the 1st of March 2020. First quarterly audit will be completed by the end of June 2020. Responsibility of the service manager for same.
	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.	Centre manager emailed the team the updated safeguarding statement on the 5th of February 2020 with an explanation as to what the purpose the statement is. The statement outlines identified risks and control measures for same and a letter of compliance has also been received for	The safeguarding statement has been added to the induction checklist to ensure that every new staff member has read and signed the statement and understood its purpose. At every team meeting there will be 2 policies discussed by 2 nominated people

		same.	at the meeting, in that they will give a short presentation on those 2 policies, and the statement will be part of this ongoing process. The statement will be updated every 18 months and/or in line with upcoming relevant legislation.
	The centre manager must implement a child protection register.	A register has been purchased and this will be implemented by March 1st 2020.	The Service Manager will review the child protection register as part of the quarterly internal audit, the first audit being completed by the end of June 2020.
	The centre manager must ensure that work is undertaken with young people on their specific risks and vulnerabilities and on how to keep themselves safe.	In the current placement plan there is a section "keeping the young person safe". A new placement plan is being developed which will highlight 4 broad areas of the child's placement underpinned by core social pedagogical concepts - Head, Heart and Hands; Common Third Activities, Shared Living Space and Attachment. Each of these areas will have more specific subsections that will cover education, health, family and so on, but all will be viewed through a pedagogical lens. A more robust system for placement planning is	Oversight of the placement planning process will be provided through the quarterly audits. As the placements are medium to long term the placement plan is developed every two or three months, depending on the individual placements needs of the child at the time. If plans need to be reviewed more regularly, that will be assessed by the service manager in an ongoing way.

		being currently developed by the service manager and centre manager. The PAT for each child will use the new placement plan from March 11th and will receive input and feedback from the rest of the team. The PAT will then meet with the child and use where appropriate a child friendly and age appropriate form that will then inform the placement plan. The PAT will collate all of this and create the placement plan and disseminate it to the rest of the team. The team meeting template will be amended to include a section on placement planning for each child. Better placement planning will ensure more regular discussion and review of all issues relating to safety.	
	The centre manager must ensure that safe plans are risk assessed and there is evidence of a contingency plan on what to do should a young person become physically aggressive considering staff are not trained to Level 9 in a recognised model of behaviour management.	Currently the staff team are trained in Unit 8 of MAPA: "Physical Interventions – Disengagement Skills". The physical behaviours that this enables the team to manage effectively covers the following; strikes, holds (wrist/arm, clothing, hair, neck, body) and bites. Each of the aforementioned physical interventions are	Centre Manager will update Safe Plan template to include the matrix by the 11th of March 2020. The centre manager will then ensure that each child's PAT will update the Safe Plan accordingly using the matrix to assess the risk by the 1st of April 2020.

		taught to the team in order to cover low, medium and high risk scenarios. Each child's Safe Plan needs to be reviewed and updated to insert the MAPA risk assessment matrix to deem the risk low, medium or high.	
	The service manager must consider providing training to Level 9 as a precautionary measure in the event it may be required.	The Service Manager has considered this and in conjunction with the Clinical Director/Registered Provider has deemed that the training outlined above (Unit 8) is appropriate and sufficient for the needs of the service.	Our policies and procedures are based heavily, reviewed and updated on experiential learning and on an evidence based approach. Since the inception of the service (April 2012) there have been a total of 7 incidents of physical interventions, all low level interventions.
	The service manager must ensure an audit tool is developed to regularly audit and monitor the centres approach to managing behaviours that challenge.	This will be developed by the Service Manager and Clinical Director and the first audit will be completed by the end of June 2020. The audits will be completed every quarter thereafter and will feed into an annual review of compliance scheduled to take place towards the end of 2020.	A section on behaviours that challenge and a section on SENs will be inserted into the management meeting template to ensure specific focus on this area in every management meeting. A register has been purchased to record, assess and manage risk and track trends and patterns around same. This register will be in use from March 1st 2020 and oversight will be

			provided by the Service Manager every quarter through the audit process. A specific SERG meeting will take place every quarter, to be scheduled by the service manager.
	The centre manager must ensure that there is written evidence to support the use of restrictive practise that has been approved and agreed in writing by the young person's allocated social worker with evidence of regular review and individual work occurring.	On 30th January 2020 the centre manager sent the relevant SW the risk assessment around the two restrictive practices that are in place for approval. Centre manager waiting response re same.	A review of one of the restrictive practices took place at the last CICR on the 6th February 2020 and both practices will be reviewed at every CICR (which take place monthly for the child in question) going forward. Oversight of restrictive practices will also be documented as part of the risk register (being implemented by March 1st 2020). Restrictive practices will also form part of the quarterly audits being implemented by the end of June 2020. PATs will be reminded to regularly log individual work around any restrictive practices. Effective immediately.
	The service manager must ensure that the centre has its own mechanisms in place for parents and social workers to provide feedback directly to them outside of statutory review meetings for	There is currently weekly if not daily contact between the PAT and the family member. One of the reasons why there is only one PAT for each child is to focus heavily on building this relationship with	This mechanism is currently in place and the families have ample opportunity to provide feedback on a regular basis to the PAT, the SPs and the centre manager. The service manager also meets family

	learning and improvement purposes.	the family and for consistency purposes; the family have the same point of contact. The centre manager also has regular contact with the families outside of the CICR process. The SPs have contact with the families every weekend as they often facilitate the family visits. As part of this mechanism the PAT, centre manager and SPs all write any significant note to files and insert into the family contact section of the child's care record.	members.
	The centre manager must ensure that work being completed with young people in relation to bullying and mental health issues is evidenced through young people's reports.	The centre manager will raise this issue with the PATs and the SPs in their next supervision session to highlight that this work needs to be documented for all children. The centre manager will then follow up with the individual responsible to ensure that this has occurred and ensure that individual work has been documented around this.	The oversight of this will be conducted through supervision sessions with the centre manager and will also be part of the internal auditing process.
	The service manager and centre manager must develop a forum for reviewing and assessing incidents for learning purposes and an appropriate	SENs are recorded daily in the management handover report submitted to the Service Manager at the end of every week. A SEN section along with a section	SEN register will provide recording and oversight of incidents and is to be implemented by March 1st. Patterns and trends will be quickly identified with the

	recording mechanism for same.	on behaviour that challenges are to be inserted into the management meeting template thereby ensuring regular review and discussion of incidents. Learning outcomes also to be included and recorded as part of the management meeting. The template will be amended by the service manager and will be used at management meetings from March 1st 2020.	use of a register. SERG meetings will be held every quarter with the first SERG meeting scheduled for the 17th February 2020.
5	The service manager 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.	At every team meeting since the start of 2020 there are two people nominated to do a short presentation on two policies. As time goes on and all policies can be discussed in a regular way the team will be more aware, have more understanding of and more confidence in talking about policies and standards.	Each staff member requires a days training on the new HIQA standards. Three days will be required to deliver that to the team. Service Manager to speak with training providers before March 1st about how/when to roster these three days. Training for all staff to be completed by the end of September 2020. Centre Manager is in the house every morning until 12 and this gives time and opportunity to ensure policies and

			standards are being implemented effectively and appropriately. The centre manager meets the children regularly and can observe the team's work practices with the children. The Service Manager is in the house at least once a week, meets with the team daily and meets with some of the children weekly. The Clinical Director is in the house every Tuesday and meets with the children and the team on a regular basis. The centre manager supervises the team, the service Manager supervises the centre manager and this process ensures accountability around the implementation of policies and standards.
	The registered provider should ensure the board provides written feedback on decisions directly impacting on the running of the centre and management of staff and young people to the centre manager.	This was communicated verbally to the BOM by the Clinical Director at the last BOM meeting on the 13th January 2020. The registered providers have been furnished with this report and will be discussed at the next BOM meeting in more detail. Date TBC.	Clinical Director/Registered Provider to ensure that this issue is a standing item on the agenda at every BOM meeting. Needs to be agreed at next BOM meeting.

	The service manager, as a governance mechanism, must ensure all paperwork is dated, details who it is completed by and demonstrate evidence of approvals from appropriate people.	Service Manager will be completing the internal quarterly audits, the first one being implemented by the end of June 2020. As part of this process the Service Manager will go through the child's care record and document any paperwork that is not signed or dated. The centre manager on a weekly basis goes through all daily logs, fire folder, consequence logs, medication logs and redirects the issue back to the relevant staff member and informs the service manager of any outstanding paperwork.	All risk assessments, restrictive practices, complaints, safe plans and placement plans need to be emailed to the SW for review and sign off. Effective immediately. The service manager will be cc'd on all of this outgoing documentation to ensure oversight. Effective immediately.
	The service manager must ensure a risk register is developed and implemented. The registered provider must ensure that arrangements are put in place to assess the safety and quality of care provided in the centre against the National Standards for Children's Residential Centres, 2018 (HIQA).	As discussed above the register has already been purchased and it will be implemented by March 1st 2020. The internal quarterly audit will be a substantial part of the arrangements that are to be put in place to assess the safety and quality of care provided. The first audit is due to be completed by the end of June 2020.	Will be in use as of March 1st 2020. Oversight provided by the service manager. The Clinical Director and Service Manager will develop this audit over the coming weeks and months and will be due to be rolled out by June and every quarter thereafter.
	The registered provider must work	It is planned that the quarterly audits will	It is planned that the first annual review of

	towards ensuring an annual review of compliance with the centre's objectives is conducted in 2020.	feed into an annual review of compliance. There are several other processes that need to get underway first and various systems that need to be set up in order to be able to complete an annual review. Currently undergoing a review of personnel and resources that are required to implement the above.	compliance will take place towards the end of 2020. Clinical Director and Service Manager responsible for same.
	The centre manager must implement a complaints register to allow for tracking and identification of complaint trends. The service manager must ensure the current complaints policy is congruent with Tusla 'Tell Us' and that it is implemented within the centre and understood by staff members.	Register already purchased. Will be in use by March 1st 2020. There is reference to and a brief explanation of the Tell Us policy in the complaints policy.	Complaints register to be implemented by the centre manager and overseen by the service manager. Policies to be discussed as a standing item on the agenda for the team meeting. The complaints policy will be regularly discussed by the team as part of this process.